

LEGISLATED REVIEW OF AGED CARE 2017

Title: Legislated Review of Aged Care 2017

ISBN: 978-1-76007-325-1

Online ISBN: 978-1-76007-326-8

Publications Number: 11825

Creative Commons Licence



This publication is licensed under the Creative Commons Attribution 4.0 International Public License available from <https://creativecommons.org/licenses/by/4.0/legalcode> ("Licence"). You must read and understand the Licence before using any material from this publication.

Restrictions

The Licence may not give you all the permissions necessary for your intended use. For example, other rights (such as publicity, privacy and moral rights) may limit how you use the material found in this publication.

The Licence does not cover, and there is no permission given for, use of any of the following material found in this publication:

- the Commonwealth Coat of Arms. (by way of information, the terms under which the Coat of Arms may be used can be found on the Department of Prime Minister and Cabinet website <http://www.dpmc.gov.au/government/commonwealth-coat-arms>);
- any logos and trademarks;
- any photographs and images;
- any signatures; and
- any material belonging to third parties.

Attribution

Without limiting your obligations under the Licence, the Department of Health requests that you attribute this publication in your work. Any reasonable form of words may be used provided that you:

- include a reference to this publication and where, practicable, the relevant page numbers;
- make it clear that you have permission to use the material under the Creative Commons Attribution 4.0 International Public License;
- make it clear whether or not you have changed the material used from this publication;
- include a copyright notice in relation to the material used. In the case of no change to the material, the words "© Commonwealth of Australia (Department of Health) 2017" may be used. In the case where the material has been changed or adapted, the words: "Based on Commonwealth of Australia (Department of Health) material" may be used; and
- do not suggest that the Department of Health endorses you or your use of the material.

Enquiries

Enquiries regarding any other use of this publication should be addressed to the Branch Manager, Communication Branch, Department of Health, GPO Box 9848, Canberra ACT 2601, or via e-mail to corporatecomms@health.gov.au

LETTER OF TRANSMITTAL

The Hon Ken Wyatt AM MP
Minister for Aged Care
Parliament House
CANBERRA ACT 2600

Dear Minister

As the independent reviewer appointed under section 4 of the *Aged Care (Living Longer Living Better) Act 2013* (the Act), I am pleased to provide you with my completed review of reforms implemented under the Act.

The Review concludes that these reforms have successfully taken the aged care system further along the road to a consumer driven and sustainable system, as intended, but that further reforms will be needed in future. The recommendations in the report seek to continue the reform process.

In undertaking this Review I have taken into account feedback received from a range of stakeholders within the aged care sector, including peak bodies, aged care providers, those in the aged care workforce, consumers of aged care services, carers and their representatives, and government.

Yours sincerely

A handwritten signature in black ink, appearing to read 'David Tune'.

David Tune AO PSM
31 July 2017

TABLE OF CONTENTS

Executive summary6

Recommendations13

Chapter 1 Introduction18

Chapter 2 Aged care overview22

Chapter 3 Moving toward a consumer demand-driven system34

Chapter 4 Demand and supply38

Chapter 5 Means testing in home and residential care68

Chapter 6 Accommodation payments in residential care93

Chapter 7 The protection of lump sum accommodation payments107

Chapter 8 Access to services123

Chapter 9 Equity of access.....146

Chapter 10 The aged care workforce172

Appendix A192

Appendix B194

Appendix C197

EXECUTIVE SUMMARY

Aged care is in transition. It is evolving into a system that better supports the wellbeing of older people and the delivery of care in ways that respect their dignity and support their independence. There is an increased focus on consumer choice and control. At the same time, Australia's population is ageing, and both the proportion and number of people needing care are increasing. Planning for this growth is one of the main challenges of aged care policy.

Over the last decade aged care has undergone several reviews. These reviews have catalysed changes in the system, particularly in 2012–14, when the government implemented reforms in response to recommendations made by the Productivity Commission (the Commission) in its 2011 report, *Caring for older Australians*. Those changes, referred to as the Living Longer Living Better (LLLLB) reforms, included:

- additional support and care to help older people remain living at home
- additional help for carers to have access to respite and other support
- establishing a gateway to services to assist older Australians to find information and to navigate the aged care system
- changes to means testing in home and residential aged care
- changes to improve services for people with dementia
- additional funding for the aged care workforce.

Since the reforms were initiated, there have been significant further changes in aged care policy. These have included:

- major changes to the original LLLB measures, in the areas of dementia care and the aged care workforce
- increased consumer control through transfer of the funding for home care packages from aged care providers directly to consumers.

Several important recommendations from the Commission were not implemented but remain at the centre of aged care policy discussion, particularly the issue of 'uncapping supply': the removal of regulatory restrictions on the number of aged care places and packages made available to the community.

The LLLB reforms were significant reforms but also a step along a path that would bring further change. When the changes were announced, the government stated that a "five year review will assess progress of the first phase of reform and the pathway ahead".¹

This report is the product of that review. Its scope is confined to aspects of the LLLB reforms rather than the aged care system more generally. For this reason, there are several important aspects of aged care that are not reviewed in depth, including quality and safety issues, the Aged Care Funding Instrument, the Commonwealth Home Support Programme and palliative care.

AGED CARE

Aged care describes a range of services that support older people's physical, medical, psychological, cultural and social needs. It is centred on the individual, responding to their capacities, abilities and requirements. Most aged care is informal, provided by families, friends, communities and volunteers. Some care is organised and paid for privately. A large portion of aged care is government funded, and it is aspects of this formal, government-funded system that are the subject of this Review.

Eligibility for government-funded aged care rests on an assessment of need. Around 1.3 million people access government-funded aged care each year. In 2015–16 these included:

- an estimated 925,000 people who accessed home supports: entry-level services that support people in their homes through services such as home maintenance and cleaning, meals and transport services

¹ Australian Government, April 2012, *Living longer living better*, p. 29.

- nearly 90,000 people who accessed home care packages, which provide a range of personal care, support, clinical and other services tailored to meet the assessed needs of the consumer
- nearly 235,000 people who accessed residential care, for people who are unable to continue to live in their own home
- a small number (less than 25,000) who accessed a range of other targeted and specialist programs.

These services cost around \$20 billion each year, just under a quarter of which is contributed by consumers. The majority of aged care funding is provided by government.

MOVING TOWARDS A CONSUMER DEMAND-DRIVEN SYSTEM

There is a broad consensus shared by government and sector stakeholders that aged care requires further reform to become a more consumer-centred system. This includes orienting care and the supply of different care types around the demands of consumers, and giving consumers greater choice and control. This objective is evident in the work of advisory bodies in the sector: the Aged Care Financing Authority, the Aged Care Sector Committee, and the National Aged Care Alliance.

There are four key conditions that must be met before one of the main steps in creating a demand-driven system—removing regulatory controls to uncapped supply—can be realised. Those are:

- Government needs an accurate understanding of the underlying demand for aged care services.
- Consumers must make equitable and sufficient contributions to the costs of their care, without those contributions being so high that they create a barrier to accessing care.
- There must be a robust system for assessing eligibility for government-funded aged care services.
- Government policy needs to ensure equitable supply of services across different population groups, and in settings where there is limited choice or competition, such as remote locations.

Many of the recommendations of this Review are steps towards meeting these four conditions.

DEMAND AND SUPPLY

Understanding the nature and level of demand for aged care is difficult but important, both to determine whether government is offering the right amount and mix of services now, and to plan for changes in demand in the future. There are several sources of information about demand for and use of aged care, including data collected by the Australian Bureau of Statistics and by the Department of Health (the department). However, for different reasons, none of these is currently able to function as a robust measure of demand.

While accurate assessments of demand are yet to be developed, the available evidence, including advice from sector stakeholders, reliably shows two things:

- there is a need for more high-level care at home
- meeting projected future demand will need additional investment by government beyond that currently planned.

Currently the supply of home care packages and residential care places is determined using a national target of aged care places for every 1,000 people aged 70 years and over. This is known as the Aged Care Provision Ratio (the Ratio). The Ratio is currently set at 125 places per 1,000 people aged 70 and over, and is split into three targets: 78 residential care places, 45 home care package places and 2 restorative care places.

The number of home care packages has been growing steadily, and is currently set to expand significantly from around 90,000 at present to around 140,000 by 2021–22. That expansion is a significant positive feature of the LLLB reforms. As government and stakeholders seek to determine and meet the demand for services, increasing the availability of home care packages will continue to be a priority. In contrast, residential aged care supply is growing more slowly than home care, and it is possible demand for residential care is broadly in line with supply.

Two changes will help meet the current demand. The first is to change the mix of low-level and high-level home care packages within the existing overall target of 45 places. Some low-level packages should be switched to high-level, reflecting where the greatest demand lies.

The second change required is greater flexibility within the Ratio between home care packages and residential care places over the next 10 years. If the occupancy level of residential care places falls, the government should allow funding to be temporarily

reallocated from residential care places to additional home care packages. This will allow the release of more home care packages in the short term without affecting the underlying supply of residential aged care.

This system of flexible allocation of places has another vital benefit. It will test the proposition that supply of residential care is currently meeting or is close to meeting demand, providing important information required by government before it can consider uncapping supply. Further, it is an opportunity to test the demand limits for home care packages by providing additional packages beyond the current supply restrictions.

The evidence indicates that while many consumers prefer to remain living in their own home, the value of support packages are inadequate to provide this opportunity for those with high care needs. A level 5 home care package should be introduced to support people with high care needs to stay at home longer.

The allocation of residential aged care places can be improved by discontinuing the Aged Care Approvals Round (ACAR), which allocates places to providers, and instead allocating them to consumers, as is already the case for home care packages.

As an increasing proportion of care occurs in the home, the availability of respite care will need to increase to ensure that carers have the necessary support. The number of people accessing respite care is rising, but it is not clear what is driving this change and whether there is sufficient respite available. The government needs to review the existing respite arrangements to ensure that its objectives are being met, and when it discontinues the ACAR for residential care it will need to review how best to ensure adequate supply and equitable access to residential respite care.

Implementing these recommendations will not only improve the supply of aged care, but will create the conditions for more accurately assessing demand for aged care. This will, in turn, meet one of the four conditions that will allow government to consider uncapping supply.

While these changes will help address existing demand, it is clear that current planning mechanisms are not going to deliver sufficient services in the long term. Based on the current average age of entry to aged care services (82.0 years for men and 84.5 years for women), and the demographic 'bulge' of baby boomers who will start to enter aged care a decade from now, continuing to use an age indicator of 70+ and over as the foundation for the planning Ratio will eventually result in a significant under-supply of places.

A shift to using the population aged 75 and over as the basis for the Ratio from 2022-23 will better meet the expected aged care needs of the population into the 2030s. This should result in an additional 28,000 places over the decade from 2022-23. When the government makes this change, it should consider whether a change in the mix of places within the new Ratio is required to better reflect demand. It should at that time also consider further opportunities for removing supply controls.

MEANS TESTING IN HOME AND RESIDENTIAL CARE

There is no doubt that the demand for aged care will increase significantly over the next few decades, particularly as the 'baby boomer' generation reaches age 80 and over. This, in turn, will require significant investment and expenditure on recurrent funding of the system. A key issue is how this will be financed and the costs shared.

Currently, the government provides around three-quarters of all aged care funding, with consumers meeting less than a quarter of the cost. This is likely to be unsustainable into the future and there is a strong case to increase the proportion of the costs that are met by consumers.

Some steps in this direction were taken through the LLLB reform package. The LLLB reforms changed means-testing arrangements for both home and residential care. Income-testing arrangements for home care packages were reformed and a combined income and assets test was introduced in residential care. Annual and lifetime caps on care fees in both home and residential care were also implemented.

Well over 80 per cent of consumers of home care packages are pensioners, and contribute only a very small proportion of the costs of care. Most providers are not charging consumers the full basic daily care fee, despite it being a modest amount, while consumers are contributing less than 3 per cent of the income-tested component of care costs. As a result, while there are no financial barriers to access for people of limited means, consumers with the capacity to do so are not making significant contributions to the cost of their home care. The LLLB reforms did little to change this.

The current arrangements for consumer contributions and fees in home support and home care packages are creating several problems. The flat rate of basic daily care fee being charged across all home care package levels means that low-level

packages may be perceived as poorer value for money. This is affecting uptake of packages, and in turn the extent to which assessed needs are being met. Meanwhile, the low level of fees and inconsistent charging practices in home support is encouraging people to enter and stay in home support services, even though home support does not always offer the most appropriate level of service to meet their needs.

To solve these problems, there should be mandatory consumer contributions for home support, aligned to a consumer's income. The basic daily fee for home care packages should be renamed as a basic care fee, to make clear that it is a contribution to care. It should then be made mandatory for providers to charge both this basic care fee and the income tested care fee, ensuring that everyone who has been assessed as having the means to contribute to their care, does so. To help ensure consistency and seamless transition between care types and levels, the value of the basic care fee for a home care package should be made proportionate to the value of the package. To ensure that this does not cause undue hardship for people who need high levels of care, the government should retain an upper limit on the value of that fee, indexed to the value of the single age pension.

Consumers contribute a higher proportion of all costs for residential care, but the amount remains constrained due to fee caps, and the reforms appear to have resulted in only very modest improvements. The most significant change is that the government's contribution to care costs has dropped from 98 to 94 per cent of total cost, but this is a small shift. Changes in contributions to accommodation costs have been more significant.

Several changes should be made to the way means testing and fees are structured in residential aged care. Inequities in how consumers contribute to the cost of their residential care should be removed by including the full value of a person's former home in the asset test, provided a family member is not still living in that home. The charging of a minimum daily care fee in residential care is currently discretionary, but should be made mandatory. For non-low means residents (which mostly means self-funded retirees), residential care homes should be able to charge higher daily care fees, but services should have to publish the maximum fees they will charge, and there should be independent scrutiny of the highest fees.

Across all forms of care, the annual and lifetime caps for fees should be abolished. Removing these caps will ensure that consumers contribute to the costs of their care commensurate with both their care needs and relative financial capacity, and end the current system by which taxpayers effectively provide a greater subsidy to those higher-wealth individuals who remain in care for longer periods of time.

These changes should help ensure that consumers make equitable and sufficient contributions to the costs of their care.

ACCOMMODATION PAYMENTS IN RESIDENTIAL CARE

In residential care, accommodation is treated as a distinct cost component separate from the costs of care and of daily living. Those with the means to do so are required to pay the full costs of their accommodation, based on market prices and negotiated directly with their provider. For those with limited means, the government pays a subsidy—the accommodation supplement—to cover the cost of accommodation.

The LLLB reforms changed accommodation payment arrangements so that:

- for non-low means consumers, accommodation charges are not capped, but providers must publish their maximum accommodation prices
- lump sum accommodation payments can be accepted across all residential care
- consumers can choose whether to make daily or lump sum payments for their accommodation (or a combination of both), and the two options have to be equivalent in cost
- there is a maximum accommodation payment amount, and providers are required to apply for independent approval from the Aged Care Pricing Commissioner to charge higher amounts.

These reforms appear to be serving the sector well. Levels of investment in residential aged care infrastructure have risen, while consumers appear to be exercising the choice around how to pay for their accommodation. Analysis of admission data indicates that there has been no decline in the numbers of full pensioners entering care, indicating that the changes to pricing have not created economic barriers to obtaining care.

The system for requiring independent review of lump sum accommodation payments above a certain threshold (fixed at \$550,000 in 2014 and not changed since) is working well and should be retained. However, to reduce administrative burden on providers and in recognition of changing property values over time, the threshold should be increased to \$750,000, and a system for indexing that amount should be developed. There is a lack of transparency around additional service fees that some providers charge, and these

should be required to be published. The role of the Pricing Commissioner should be extended to review other uncapped fees, such as additional service fees and uncapped basic daily fees, where they are proposed to be above certain thresholds. The ongoing role of the Pricing Commissioner should continue, at least for as long as residential care continues to be delivered in a supply-constrained environment.

THE PROTECTION OF LUMP SUM ACCOMMODATION PAYMENTS

Many people entering residential care contribute to the costs of their accommodation using a lump sum accommodation payment. These payments typically represent a large proportion of residents' wealth, so it is vital that the money is safe. There are two elements of aged care regulation that aim to ensure residents' money is protected: prudential regulation and the Accommodation Bond Guarantee Scheme (the Scheme).

Prudential regulation can be regarded as the 'first line of defence' protecting residents' funds. It includes four standards relating to liquidity, records, disclosure and governance, and a system of reporting information to the department, which provides prudential monitoring.

Prudential controls have evolved over time; however, the last changes were six years ago and there has been substantial evolution (and growth) in the pool of lump sum payments in that time. The department engaged consultants to review the prudential standards in the context of protecting the interests of residents, as well as the current controls supporting the management of the risk underwritten by the government. The final report from that review recommended:

- changes to the disclosure standard to improve provision of information to consumers
- changes to the disclosure standard to require disclosure of corporate structures to the department
- changes to the liquidity standard to introduce a liquidity threshold.

Implementing these recommendations offers a substantial benefit for all stakeholders.

The Scheme is the 'last line of defence' protecting residents' funds. It is a safety net that protects residents' lump sum payments in the event of provider insolvency. If a provider becomes insolvent and the residents cannot get their money back, the government will pay the sum owing to them.

The Scheme has been very effective in protecting residents' funds, but presents uncertainty of costs for both government and providers, while residents, who also benefit from the Scheme, do not contribute to its operation.

The government should maintain the Scheme, but reform it to improve certainty and to ensure that aged care providers make contributions to its cost, when the benefits outweigh the costs. This would include that the government levy providers to recoup the costs of default events, where the total amount of those events exceeds, say, \$5 million in any fiscal year.

ACCESS TO SERVICES

One of the main recommendations made by the Commission in 2011, and implemented through the LLLB reforms, was the creation of a single gateway through which older Australians would obtain information about, and access to, aged care services. That gateway is My Aged Care, initially established in 2013, which became fully functional in its present form in early 2016.

My Aged Care includes a contact centre and website, a central client record to facilitate the collection and sharing of information, holistic needs assessment through a national standardised assessment form (NSAF), online referral management and web-based portals for clients, assessors and service providers. The system includes two assessment pathways: the Regional Assessment Services (RAS), whose main function is to conduct assessments for those who seek entry-level support at home; and the Aged Care Assessment Teams (ACAT), who assess consumers for entry to home care packages and residential care. It includes a match-and-refer capability: an electronic system to support assessors to identify and assist in matching eligible clients to service providers in their local area.

The introduction of My Aged Care was a major reform to Australia's aged care system, and it faced substantial implementation challenges. Stakeholders continue to have concerns around accessibility of the system, timeliness of assessment, and the consistency and quality of assessment processes. Despite these issues, My Aged Care represents an important step forward for service delivery, which is reflected in the high satisfaction levels reported in surveys of consumers and carers who use the system.

There are several areas where improvement can occur. There needs to be improvement of the My Aged Care ICT platform, with particular emphasis on improving the information sharing between My Aged Care and other government agencies and aged care provider ICT systems.

My Aged Care is an effective system for most people. However, there is some evidence that hard-to-reach populations, those with complex needs, and those with limited access to technology, are not gaining as effective access as they should. For this reason, the government should introduce aged care system navigator and outreach services to assist consumers who have difficulty engaging through the existing channels with My Aged Care.

Broad community awareness of My Aged Care and the aged care system is low, and this generally reduces the effectiveness of planning for aged care, whether by individuals, service providers, or government. Everyone will benefit from consumers having a better understanding of the aged care system. While this Review was underway, the government undertook an advertising and marketing campaign for My Aged Care. A campaign such as this needs to be repeated regularly, not just as a 'one-off'. Once consumers come into contact with My Aged Care, particularly the website, the design and layout needs to be easier to use, and information needs to be in more accessible, plain English formats.

While the assessment system is delivering large numbers of assessments in a relatively timely way, stakeholders have concerns about the consistency of assessments, and said there was duplication, perceiving that many assessments were required.

These issues require a more rigorous and integrated assessment system. A first step will be to combine the RAS and ACAT workforces. This will result in less duplication, greater efficiency, and above all, better service to consumers, who will experience less confusion and 'tell their story' once. Once the Aged Care Funding Instrument has been reviewed, the government can integrate residential aged care funding assessment with the combined RAS and ACAT functions.

Issues were also identified with the NSAF, with some stakeholders indicating the current form can lead to inappropriate referrals or the assessor missing key signs. The NSAF was also criticised for not always appropriately leading to referral to some services. Revision of the form should increase the accuracy of assessment and reduce duplication.

These recommendations on access are important not only to make My Aged Care a better pathway to care, but also to meet one of the conditions for uncapping supply, which is a robust system for assessing eligibility for care.

EQUITY OF ACCESS TO CARE

One of the central concerns for the design of aged care policy is that it ensures access to care for all older Australians, and that affordability does not create a barrier to access. There are several features of the system designed to ensure access:

- Consumer contributions in home care packages and residential care are set according to means.
- Providers are offered an incentive to ensure that people with limited income and assets receive care.
- Standards put in place by aged care law require providers to attend to the needs and preferences of each person in their care.
- Aged care legislation and processes for the allocation of places recognise population groups with specific needs.
- Government funding models provide additional funds where people with special needs require additional support.
- Dedicated programs exist to support access and care for some population groups.

While few of the LLLB reforms were targeted specifically at improving access to care for particular groups, the substantial changes to the system mean that it is important to evaluate how access has been affected.

The Review considered what information was available regarding access to care for a dozen different populations. It identified several particular opportunities for improvement, including the further expansion of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, a review, in cooperation with states and territories and service providers, of the Multi-Purpose Service Program, consideration of further expansion of services to people who are homeless or at risk of homelessness, and resolution of the ongoing coordination and policy issues between the Australian and state/territory governments that is preventing optimal provision of aids and equipment to people over 65 with disabilities.

More generally, it was clear from this work that while good information is available for some groups (such as Aboriginal and Torres Strait Islander and culturally and linguistically diverse populations), in most cases data are inadequate to monitor the patterns of access for different groups. To address this data deficiency, and to lay a foundation for ensuring people with special needs are able to access suitable services, the government should give consumers the opportunity to identify as belonging to a population group with special needs as part of their client record.

This improved client record needs to be matched with greater functionality in My Aged Care. The gateway needs to provide information that meets consumers' special needs by allowing 'pre-qualified' providers to indicate that they have expertise in delivering services to particular population groups, and through provision of a search function that allows consumers to search providers by population group.

It is important that the government gather better data on population groups, and also analyse and act on it. This will be essential if government wants to meet the fourth condition for a fully consumer demand-driven aged care system: an equitable supply of care across different population groups.

WORKFORCE

The workforce is a critical part of aged care, and was the subject of a Senate Community Affairs References Committee at the same time as this Review took place. As the Senate Committee examined a broad range of workforce issues in great depth, this Review focussed on the LLLB reforms that were targeted at workforce issues, key workforce issues raised during consultation, and on the development of an aged workforce strategy.

The most significant workforce measure in the LLLB reform package was \$1.2 billion allocated over four years intended to be used to increase wages in the sector. Following a change in government, the funding was directed into the sector more generally rather than specifically to wages, primarily through an increase in the basic subsidy received by aged care providers.

Wages in the sector have been, and remain, relatively low and are an ongoing source of concern for both employees and the sector more broadly. Other workforce issues include the need for stronger education and training; the sector expressed concern about the adequacy of entry level qualifications, the role of ongoing education and training in maintaining skills and providing career pathways, and problems with the performance of some training providers. In this field, the sector needs to take the lead, in collaboration with the vocational education and training and tertiary education sectors, to ensure education and training is responsive to the aged care sector's needs.

While this Review was underway, the government announced funding to support development of an aged care workforce strategy. Aged care providers are best able to determine their workforce needs and the development of a workforce strategy is best led by the sector with support from government. The strategy should address pay, training and education, developing recruitment, retention and growth, improving the sector's image as a place to work, and should encourage cross-sectoral workforce linkages.

CONCLUSION

The LLLB reforms have been successful in taking Australian aged care further along the road towards a consumer demand-driven and sustainable system that will meet both current and future aged care needs. Some of the improvements have been significant, such as the development of the My Aged Care gateway and the facilitation of investment in residential aged care infrastructure. Other changes, such as those that sought to increase consumer contributions to care, have had a more modest effect.

Further reforms are needed in information, assessment, consumer choice, means testing, and equity of access. These can build on the LLLB reforms and subsequent changes, and create a policy environment in which government can consider removing supply constraints. All of these changes will serve the important goal of creating a system that is more consumer centred.

RECOMMENDATIONS

RECOMMENDATION 1

That the government review the management policy regarding offline residential care places and, if required, implement changes that maximise their availability to consumers.

RECOMMENDATION 2

That the government, in the medium term, continue to maintain control over the number and mix of aged care places (residential care and home care), in line with the improvements detailed in Recommendations 3–10.

RECOMMENDATION 3

That, as soon as possible, the government discontinue the Aged Care Approvals Round for residential care places, instead assigning places directly to the consumers within the residential care cap, with changes to take effect two years after announcement by government.

RECOMMENDATION 4

That a government announcement on discontinuation of Aged Care Approvals Round (Recommendation 3) be accompanied by appropriate provisions to ensure continuing supply of residential care services in areas with limited choice and competition.

RECOMMENDATION 5

That the government re-balance the distribution of home care packages, by increasing the proportion that are high care packages, without a change in the overall home care ratio.

RECOMMENDATION 6

That the government further increase access to high level home care packages to better reflect current demand by allowing for the temporary allocation of a home care package where there is a residential care place that is not being used.

RECOMMENDATION 7

That the government introduce a level 5 home care package to allow people with higher care needs to stay at home longer, with the level of assistance being no higher than the average costs of care in residential care.

RECOMMENDATION 8

That the government:

- a) in the short-term, review the existing respite arrangements to ensure that its objectives are being met.
- b) in the medium term, in discontinuing the Aged Care Approvals Round for residential care (Recommendation 3), review how best to ensure adequate supply and equitable access to residential respite care.

RECOMMENDATION 9

That the government change the Aged Care Provision Ratio to the population cohort aged 75 years and over, following achievement of the 125 Ratio in 2021–22, to better meet future demand.

RECOMMENDATION 10

That the government, in implementing Recommendation 9, consider whether a change in the mix of places within the new Ratio is required to better reflect demand, and that it consider further opportunities for removing supply controls.

RECOMMENDATION 11

That government and providers work together to determine how to ensure comparability of home care pricing for consumers and how best to publish on My Aged Care.

RECOMMENDATION 12

That the government should revise the naming and structure of fees to:

- a) Rename the 'basic daily fee' as a 'basic care fee' in home care.
- b) Require that providers charge the 'basic care fee' in home care.
- c) Require that providers charge the income-tested care fee in home care.
- d) Make the value of the basic care fee proportionate to the value of the home care package, retaining an upper limit relating to the value of the single aged pension.

RECOMMENDATION 13

That the government include the full value of the owner's home in the means test for residential care when there is no protected person in that home.

RECOMMENDATION 14

That the government:

- a) Require that providers charge the minimum basic daily fee in residential care;
- b) Retain the cap on the value of the basic daily fee in residential care for low means (fully and partially supported) residents;
- c) Allow providers to charge a higher basic daily fee to non-low means residents, with amounts over \$100 to be approved by the Aged Care Pricing Commissioner;
- d) Require that the maximum basic daily fee be published on the My Aged Care website, the provider's website and in written materials to be given to prospective residents.

RECOMMENDATION 15

That the government abolish the annual and lifetime caps on income-tested care fees in home care and means-tested care fees in residential care.

RECOMMENDATION 16

That the government introduce mandatory consumer contributions for services under the Commonwealth Home Support Programme. Consumer contributions should be standardised according to an individual's financial capacity.

RECOMMENDATION 17

That the government inform consumers of the value of the subsidy that is provided for their care.

RECOMMENDATION 18

That the government improve the transparency of fees for residents by requiring providers to publish information on My Aged Care in a way that assists informed choice by consumers.

RECOMMENDATION 19

That the government retain and reform the role of the Aged Care Pricing Commissioner by:

- a) increasing the maximum accommodation payment, above which approval by the Pricing Commissioner must be sought, from a refundable deposit of \$550,000 to \$750,000 (or equivalent daily payment);
- b) implement an automatic link between the future maximum accommodation payment and median house prices; and
- c) expand the Pricing Commissioner's role to include providing independent assessment of other fees, e.g. additional service fees and uncapped basic daily fees (see Recommendation 8).

RECOMMENDATION 20

That the government maintain the Bond Guarantee Scheme, but reform it to improve certainty and to ensure that aged care providers make contributions where the benefits outweigh the costs. This would include that the government:

- a) announce a date after which it will require that non-government residential aged care providers be levied to recoup all of the costs of default events, where the total amount of those events exceeds, say, \$5 million in any fiscal year
- b) introduce a formal process for notifying the sector of defaults that have occurred that exceed that threshold, and the cost of the levy that will be applied
- c) declare that the costs to the Scheme of provider insolvency events that were triggered prior to the reform commencement date will not be recouped.

RECOMMENDATION 21

That the government reform prudential standards and oversight, taking account of the recommendations in the independent review of prudential standards conducted by Ernst and Young to:

- correct gaps in prudential information received by the government
- strengthen the standards to improve liquidity, capital adequacy and disclosure requirements
- strengthen governance standards.

RECOMMENDATION 22

That the government improve the functionality and performance of the My Aged Care ICT platform with particular emphasis on improving information-sharing between My Aged Care and other government agency and provider ICT systems.

RECOMMENDATION 23

That the government introduce aged care system navigator and outreach services to assist consumers who have difficulty engaging through the existing channels to effectively engage with My Aged Care. The services should be funded by the government and not be delivered by the government or aged care providers.

RECOMMENDATION 24

That the government invest in regular advertising and awareness activities for My Aged Care, to explain the process for accessing government-funded aged care services.

RECOMMENDATION 25

That the government continues to improve the My Aged Care website for consumers and providers by making the design and layout easier to use and providing information in more accessible, plain-English formats.

RECOMMENDATION 26

That the government trial a simplified My Aged Care assessment process for consumers seeking a short-term single, simple service.

RECOMMENDATION 27

That the government integrate the RAS and ACAT assessment workforces.

RECOMMENDATION 28

That, following review of ACFI, the government integrate residential aged care funding assessment with the combined RAS and ACAT functions, independent of aged care providers.

RECOMMENDATION 29

That the government and providers work to improve access to wellness and reablement activities to provide greater choice and better support for consumers to live independently, including by:

- increasing access to short-term reablement supports and/or episodic care, rather than the provision of ongoing care, including an increased focus on the use of assistive technology
- enabling better integration with other available support systems such as the health care system and community-based support
- supporting staff and consumers to better understand and access information about wellness, reablement and restorative care
- providing aged care assessors with training on wellness, reablement and restorative care.

RECOMMENDATION 30

That the government immediately review the National Screening and Assessment Form.

RECOMMENDATION 31

The government expand the NATSIFACP to better support Aboriginal and Torres Strait Islander people.

RECOMMENDATION 32

That the government engage with state and territory governments and service providers to review the MPS Program to better align its service delivery model with mainstream aged care programs, where appropriate, to ensure greater consistency of services for aged care consumers and providers, and to consider the location of services to ensure that MPS funding is properly targeted.

RECOMMENDATION 33

That the government review whether further ways of assisting in the delivery of improved services to homeless people are needed in the context of reform to home care and residential care.

RECOMMENDATION 34

That the Australian, state and territory governments work together to resolve current issues with the provision of aids and equipment for older people.

RECOMMENDATION 35

That the government give consumers the opportunity to identify as belonging to a population group with special needs as part of their client record.

RECOMMENDATION 36

That the government enhance the capacity of My Aged Care to provide information that meets consumers' special needs by:

- a) allowing 'pre-qualified' providers to indicate that they have expertise in delivering services to particular population groups; and
- b) adding a search function on My Aged Care to allow consumers to search providers by population group.

RECOMMENDATION 37

That the aged care sector, in collaboration with the vocational education and training, and tertiary education sectors, should act to ensure education and training is responsive to the sector's needs including:

- identifying the scope of training required for on-the-job training, continuing professional development, and specialised training
- exploring a range of options to deliver what is required, e.g. partnerships, cooperative models or arrangements with existing non-aged-care training providers
- promoting and encouraging ageing and aged care as a specialisation in nursing education
- making effective use of allied health workers.

RECOMMENDATION 38

That the aged care sector, in developing a workforce strategy, ensure that the strategy:

- reflects that primary responsibility for workforce rests with providers, with government providing support
- draws on engagement with relevant sector and interest groups to ensure that all workforce groups are included
- results in actions that can be sustained by the sector, including particular focus on the areas of pay, education and training, developing retention, recruitment and workforce growth, improving the sector's image, and considering cross-sectoral workforce linkages

CHAPTER 1

INTRODUCTION

- 1.1 In 2012, the Australian Government announced a package of major changes to Australia's aged care system, known as the Living Longer Living Better (LLLLB) reforms. The legislation to implement those changes, the *Aged Care (Living Longer Living Better) Act 2013* (the LLLB Act), required a review to be undertaken of the reforms' effects, known as the Aged Care Legislated Review (the Review).
- 1.2 Section 4 of the LLLB Act required that the Review be independent and undertaken as soon as practicable three years after the commencement of legislative changes.² The first group of provisions commenced from 1 August 2013, thus setting the Review period to commence as soon as practicable after 1 August 2016.
- 1.3 Section 4 of the LLLB Act also specified that the person who undertook the Review must give the minister a written report within 12 months of the end of the three-year period, making the final report due for submission by 1 August 2017.
- 1.4 On 22 September 2016, the Hon Ken Wyatt AO MP announced my appointment as the independent reviewer.

THE SCOPE OF THE REVIEW

- 1.5 The terms of reference for this Review focus on the changes to aged care that were contained in the LLLB reforms rather than issues affecting aged care more broadly.
- 1.6 The terms of reference require consideration of:
 - whether unmet demand for residential and home care places has been reduced
 - whether the number and mix of places for residential care and home care should continue to be controlled
 - whether further steps could be taken to change key aged care services from a supply-driven model to a consumer demand-driven model
 - the effectiveness of means testing arrangements for aged care services, including an assessment of the alignment of charges across residential care and home care services
 - the effectiveness of arrangements for regulating prices for aged care accommodation
 - the effectiveness of arrangements for protecting equity of access to aged care services for different population groups
 - the effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers
 - the effectiveness of arrangements for protecting refundable deposits and accommodation bonds
 - the effectiveness of arrangements for facilitating access to aged care services
 - any other related matters that the minister specified.
- 1.7 The minister did not specify any other matters to be considered as part of this Review.
- 1.8 There are a number of important aspects of aged care that lie largely outside the scope of this Review. They include quality and safety issues, the Aged Care Funding Instrument (ACFI), the Commonwealth Home Support Programme (CHSP), and access to palliative care.

Quality and safety issues

- 1.9 Older Australians have the right to expect a high quality aged care system that delivers care, including complex care, to everyone who needs it. Many people, particularly in residential care, are frail and vulnerable and need appropriate safeguards for their wellbeing. This is why the Productivity Commission (the Commission), while favouring deregulation and market-based measures in many areas, recommended that quality and safety standards and oversight be retained. I

² Schedule 1 of the *Aged Care (Living Longer Living Better) Act 2013*.

concur. While quality and safety were largely outside the scope of the Review, I touch on some aspects of those issues in chapter 10 on the aged care workforce.

- 1.10 During the later stages of the Review, there was significant public, media and government concern triggered by significant failures at Oakden Older Persons Mental Health Service in South Australia. Responding to these events, on 1 May 2017 the government commissioned an independent review of the government's aged care accreditation, monitoring, review, investigation, complaints and compliance processes. The review is expected to report on 31 August 2017. This inquiry into the government's compliance and review processes should help ensure that quality and safety in aged care are improved where necessary.
- 1.11 In addition, on 13 June 2017, the Senate required that the Senate Community Affairs Reference Committee inquire and report on the effectiveness of the aged care quality assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. The reporting date for this inquiry is 18 February 2018.
- 1.12 The Department of Health (the department) is currently working with the sector to develop a new set of quality standards and processes to apply across all of aged care, called the Single Aged Care Quality Framework. A formal public consultation process was conducted in the first half of 2017, which will be followed by a pilot and implementation of the Framework intended to commence in 2018.

Aged Care Funding Instrument

- 1.13 ACFI is the mechanism that government uses to allocate funding to residential care providers based on the assessed needs of residents. The effectiveness of ACFI has long been a source of concern for government and the sector, and has been subject to a number of changes intended to manage higher than expected increases in ACFI funding for residents. Options for an alternative long-term aged care funding model are currently being developed by the department. I have commented on assessment arrangements in chapter 8 on access to services.

Commonwealth Home Support Programme

- 1.14 While residential aged care is the most expensive aged care service, the CHSP (referred to as home support) is accessed by the largest number of individuals. Home support services are not regulated under *the Aged Care Act 1997* but are governed by the conditions in each service provider's grant agreement and through departmental program guidelines.
- 1.15 The LLLB reforms did not materially change the way that consumers received home support services but did change their funding arrangements, moving from the Home and Community Care program to the CHSP except in Victoria and Western Australia.³ However, some aspects of the LLLB reforms, particularly the relationship between home care packages and CHSP, have emerged as significant issues in the Review. Accordingly, CHSP is discussed where it is relevant to reviewing the LLLB reforms.

Palliative care

- 1.16 Access to palliative or end-of-life care is an issue that was raised numerous times by consumers, carers and providers during this Review but that does not align specifically with the terms of reference. The Commission is currently undertaking a public inquiry into the increased application of competition, contestability and informed user choice to human services. One of the areas the Commission has focussed on is end-of-life care. The draft report on which it has sought comment concludes:

Each year, tens of thousands of people who are approaching the end of life are cared for and die in a place that does not reflect their choice or fully meet their end of life care needs. Most people who die do so in two of the least preferred places — hospitals and residential aged care.

- o More community based palliative care services are needed to enable more people who wish to die at home to do so.

³ From 1 July 2016, funding and management for Victorian Home and Community Care (HACC) program services transferred to the CHSP. Western Australian HACC services will transition to the CHSP from 1 July 2018.

- End of life care in residential aged care needs to be better resourced and delivered by skilled staff, so that its quality aligns with that available to other Australians.⁴

1.17 The Commission's final report is due in October 2017. Services in residential aged care are identified by the Commission as a particular issue and I touch briefly on these issues in chapter 10 on the aged care workforce.

THE REVIEW PROCESS

1.18 In addition to setting out the scope and timing of the Review, the LLLB Act also specified some consultation requirements. It states:

The review must make provision for public consultation and, in particular, must provide for consultation with:

- a) *approved providers; and*
- b) *aged care workers; and*
- c) *consumers; and*
- d) *people with special needs; and*
- e) *carers; and*
- f) *representatives of consumers.*

- 1.19 I undertook a range of consultation activities. On 14 October 2016, I called for written submissions, which closed on 4 December 2016. I received 145 submissions from a range of stakeholders, including consumers, carers, providers and peak bodies. Of these, 37 asked that their submissions not be published, and these requests were respected; I was still able to draw on the information and experiences they offered. Other submissions were published on the review's webpage. A list of submissions is provided in Appendix B.
- 1.20 Throughout February and March 2017, I held consultation workshops with stakeholders. The workshops were held in every capital city as well as in three regional centres—Bendigo, Bundaberg and Port Augusta.
- 1.21 These workshops included three sessions: one for aged care providers; one for consumers, carers and representatives of consumers; and one for workers in the sector. Around 250 people in total participated across the workshops.
- 1.22 I undertook detailed engagement with two key advisory bodies in aged care: the Aged Care Sector Committee (ACSC), and the National Aged Care Alliance (the Alliance). I also held an additional workshop with members of the Alliance focusing on special needs groups.
- 1.23 The ACSC “provides advice to the Government on aged care policy development and implementation and helps to guide the future reform of the aged care system. The Committee also acts as the mechanism for consultation between the Australian Government and the aged care sector.”⁵ I sought advice from the ACSC regularly between October 2016 and June 2017.
- 1.24 The Alliance is the representative body of peak national organisations in aged care, including consumer groups, providers, unions and health professionals, and has had extensive involvement in aged care policy development and reform for over a decade. The Alliance provided a submission to the Review, and I met with the Alliance on three occasions between October 2016 and May 2017.
- 1.25 I provided both the ACSC and the Alliance with draft recommendations and parts of the draft report to foster discussion and to help develop the thinking that is reflected in this final report. I also met individually with a range of organisations to discuss their particular concerns and issues.
- 1.26 In developing recommendations for this Review, modelling and analysis of policy options was sometimes necessary. This is most evident in the work on how the supply of aged care should be modified over the next decade, as well as in costing and understanding recommendations relating to means testing. Where needed, I requested the department to undertake modelling and provide it to the Review.

⁴ Productivity Commission, 2017, *Introducing competition and informed user choice into human services: reforms to human services, draft report*, p. 2.

⁵ Department of Health, Aged Care Sector Committee, <https://agedcare.health.gov.au/aged-care-reform/aged-care-sector-committee>

REPORTS THAT HAVE INFORMED THE REVIEW

- 1.27 The Aged Care Financing Authority (ACFA) was tasked by the minister to undertake two key pieces of work to provide analysis of financial data for this Review. These are the *Report on the protection of residential aged care lump sum accommodation payments* and the *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*. These substantial pieces of work were critical to the Review. The chapters in this report on means testing in home and residential care (chapter 5), accommodation payments in residential aged care (chapter 6), and the protection of accommodation payments (chapter 7) all draw heavily on ACFA's work.
- 1.28 In 2015–16, the ACSC developed the *Aged care roadmap* (the Roadmap). It “presents the Committee's views on the short, medium and long-term actions required to transform the current aged care system into a sustainable, consumer driven and market based system”.⁶ The Roadmap has been a valuable reference point for this Review, allowing me to assess the likely congruence of the proposals developed in this Review with sector views.
- 1.29 I also drew on a range of other reports and analyses that were made available to me; these are identified in the relevant chapters.

ACKNOWLEDGEMENTS

- 1.30 I especially thank the aged care consumers, carers, providers and workers who shared their personal experiences with me and provided invaluable insight into how the aged care sector works.
- 1.31 Members of the ACSC and the Alliance were crucial sounding boards for ideas and brought their extensive knowledge and experience to bear in providing input to the Review process.
- 1.32 The Department of Health's Ageing and Aged Care Group provided extensive support to this Review, responding to many requests for advice, information, modelling and research. I particularly thank the project team of Tania Haslam, Kathryn Foley, Olivia Neal, and Victoria Angel for their outstanding efforts.
- 1.33 Ian Holland and Lisa Fenn from consultancy Hamilton Stone provided valuable advice and editorial support.

⁶ Department of Health, Aged Care Sector Committee, <https://agedcare.health.gov.au/aged-care-reform/aged-care-sector-committee>

CHAPTER 2

AGED CARE OVERVIEW

INTRODUCTION

- 2.1 Australia's aged care system has evolved over many decades. It is not a single service but comprises a range of programs and policies, large and small, which together are intended to meet a wide range of care needs. This chapter provides a description of these services, their purpose, and the context in which they operate. It also describes the aged care sector at the time of the Living Longer Living Better (LLLBB) reforms and the factors that influenced the reform approach.

WHAT IS AGED CARE?

- 2.2 Aged care describes a range of services that support older people as they age, responding to an individual's physical, medical, psychological, cultural and social needs.
- 2.3 The purpose of aged care is to support older people to undertake their day-to-day activities, and, where possible, to enable them to remain connected with their community. The intended outcomes of these services are that older people remain independent, receive support to stay in their own home, or receive services that respond to their needs in residential care.
- 2.4 Most aged care is informal, provided by families, friends, communities and volunteers.⁷ Some care is offered through formal services, organised and paid for privately. Other formal services are government funded; it is aspects of the formal, government-funded aged care system that are the subject of this Review.

THE NATURE OF AUSTRALIA'S AGED CARE SYSTEM

- 2.5 The government's primary roles in the aged care system are to regulate and fund aged care services. Recently, aged care policy has moved towards encouraging individuals to plan and provide for themselves, rather than relying solely on government support. Most government-funded aged care is one of three kinds: home support, home care packages or residential care.
- 2.6 Eligibility for government-funded aged care rests on an assessment of need, including a determination that those needs can be appropriately met through funded aged care services.⁸

WHO USES WHAT AGED CARE?

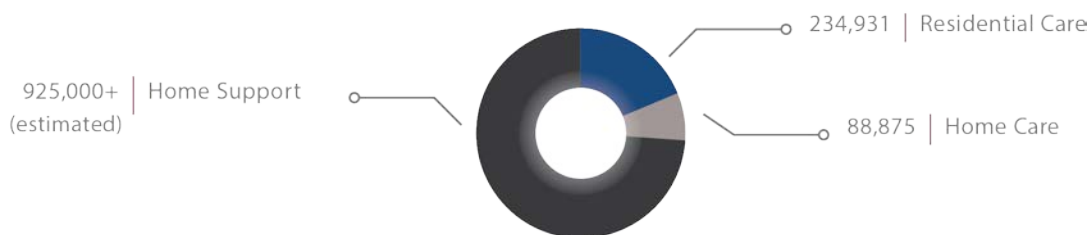
- 2.7 Around 1.3 million people access government-funded aged care each year (Figure 2.1). In 2015–16 these included:
- an estimated 925,000 people who accessed home support
 - nearly 90,000 people who accessed home care packages
 - nearly 235,000 people who accessed residential care.⁹

⁷ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p. xxiv.

⁸ *Aged Care Act 1997* s. 21.

⁹ Department of Health, 2016, *2015–16 report on the operation of the Aged Care Act 1997*.

Figure 2.1 people who received care, 2015-16¹⁰

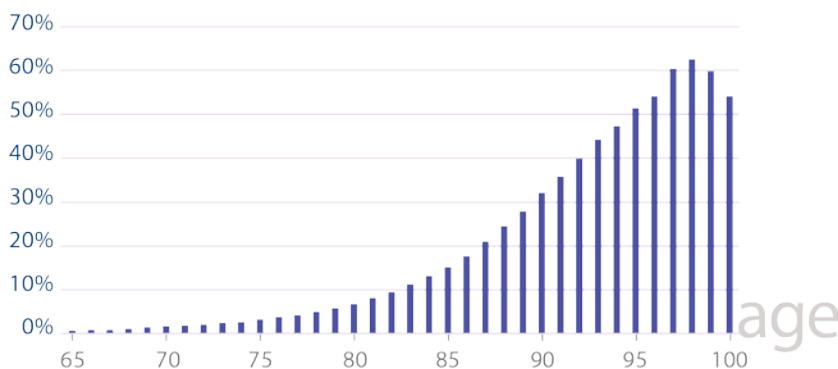


Notes: Figures include all unique care recipients accessing care at any point during the financial year. Data are for recipients of all ages unless otherwise noted. Care recipients may access care from more than one program within a year. 'Residential care' includes recipients of permanent care, respite care, or both types of care.

'Home support' is an estimated yearly number of older recipients nationwide.

- 2.8** Australia's population is ageing, and the proportion and number of people needing aged care is increasing. Planning for this growth is one of the main features of aged care policy, and is discussed in chapter 4 on demand and supply.
- 2.9** The proportion of older people who use aged care increases markedly as they age (Figure 2.2). Around 1.3 per cent of 70-year-olds use home care or residential care; this compares to around 15 per cent of 85-year-olds and 50 per cent of 95-year-olds.

Figure 2.2 Proportion of people using residential or home care by age, 2016¹¹



- 2.10** At present, the government determines the number of residential and home care places it will fund using a ratio of aged care places to the population aged over 70 years. The Ratio, and the amount of care places it delivers, is discussed in chapter 4 on demand and supply.
- 2.11** In order to maintain the supply of places in line with the Ratio as the population increases, the government releases funding for places at regular intervals. For residential care, this is through an annual competitive application process called the Aged Care Approvals Round. Prior to 2017 there was a similar application process for home care, but now places are released to a national queue.
- 2.12** Over time there has been a change in the types of aged care services that are sought by consumers and offered by providers. Supply of home care has grown, responding to consumers' preference to stay living in their own homes. This issue is further discussed in chapter 4 on demand and supply.

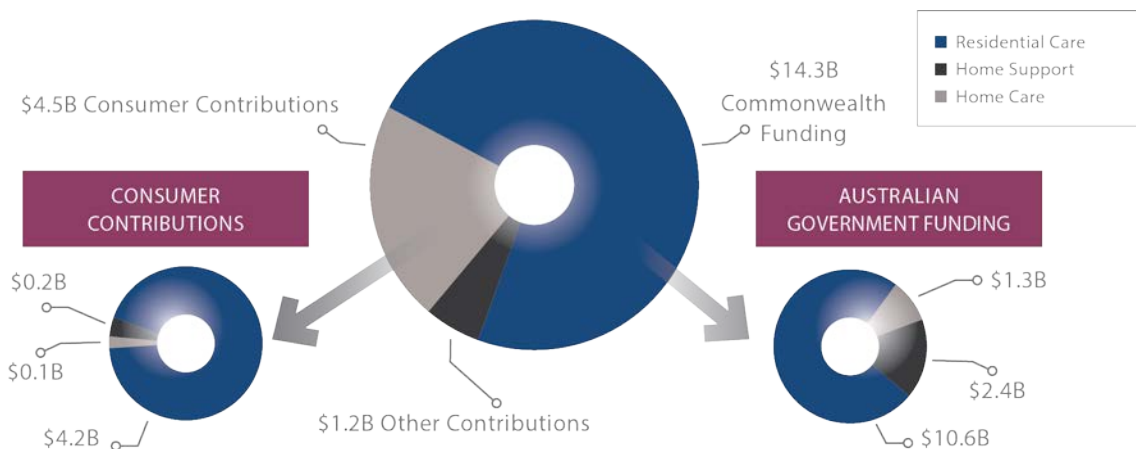
¹⁰ Department of Health, unpublished data.

¹¹ Department of Health, unpublished data.

GOVERNMENT FUNDING AND CONSUMER CONTRIBUTIONS

- 2.13** While consumers make contributions to government-funded aged care, government funding covers most of the cost. For home care packages and residential care (the more expensive services), the value of the consumer contribution is determined through means testing. For home care, this is an assessment of income only, while for residential care both income and assets are assessed. Means testing plays a role in ensuring equity in consumer contributions, protecting people with low levels of wealth, and contributing to the long-term sustainability of the aged care system. It is discussed in chapter 5 on means testing. Consumers receiving home support services may also contribute to the cost of their services, but the value of those contributions is not set by means testing. Figure 2.3 provides a summary of the funding provided by government and consumer contributions.

Figure 2.3 Funding for home support, home care and residential care 2014–15¹²



Notes: 'Australian Government funding' includes government outlays for home support, home care and residential care in 2014-15. 'Consumer contributions' shows client contributions for aged care by the program type accessed. Fees paid by aged care consumers vary across programs and across service providers. Data for residential care does not include bonds held by providers. Funding for flexible care, information, quality, capacity building, and other expenditure are not included.

- 2.14** The government controls the number of people able to access government-funded aged care. For home care packages and residential care, the government specifies a maximum number of consumers (often referred to as operational places) that it will subsidise at a given point in time.
- 2.15** Although the main source of funding for aged care is the government, most of the services are delivered by non-government providers. The aged care sector is made up of religious, charitable or community-based not-for-profit organisations, private and publicly listed for-profit companies, and some state, territory and local government entities.
- 2.16** The *Aged Care Act 1997* (the Act) and associated principles provide the legislative framework for home and residential aged care. The Act describes who can provide care and their roles and responsibilities, who can receive care and their rights and responsibilities, the type of aged care services available, and how aged care is funded. Home support is not governed by the Act; instead it is shaped by the program guidelines and requirements specified in grant funding agreements.
- 2.17** Government-funded aged care operates alongside other services to meet the differing needs of the older population, including health care, disability services and specialist palliative care. Older Australians often need more than one service system simultaneously, particularly making use of both health care and aged care.

EVENTS LEADING TO THE LIVING LONGER LIVING BETTER REFORMS

- 2.18** Prior to 2012, the government was aware that the demand for aged care services was placing pressure on government planning, policy and finances and the existing aged care system. There were several key government reports at the time that contributed to the development of the LLLB reforms in 2012. These included:

¹² Department of Health, unpublished data; Consumer and other contributions data are sourced from the Aged Care Financing Authority, 2016, *Fourth report on the funding and financing of the aged care sector*.

- analysis of future demographic trends published in the *Intergenerational report 2010*, indicating an increased demand for services
- reforms to the health care sector which identified a need to increase the availability of services, and specific research into the aged care sector
- the completion of the 2011 Productivity Commission's (the Commission) report on aged care, *Caring for older Australians*.

2010 Intergenerational report

2.19 The 2010 Intergenerational report raised a range of issues related to the predicted growth in the number of older people who could need aged care services relative to the number of people working, and therefore the available funding base to provide aged care services (Figure 2.4).

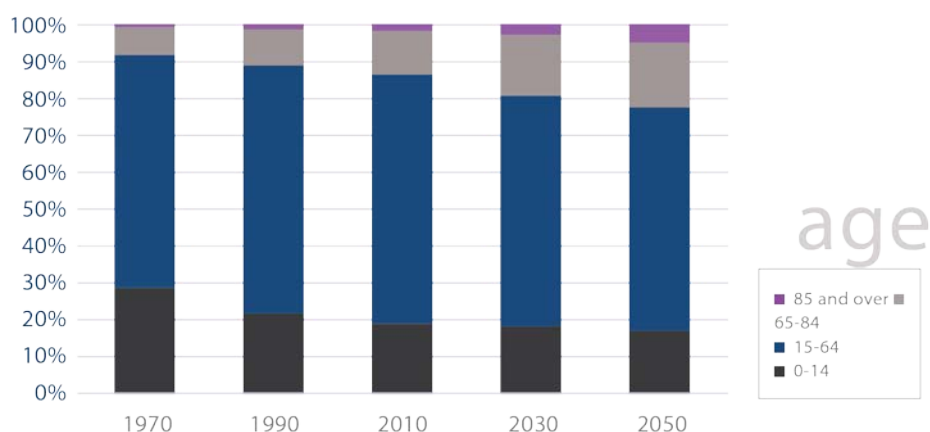
2.20 The report noted that:

...the proportion of people aged 65 years or over is projected to increase from 13 per cent in 2010 to 23 per cent by June 2050. At the same time, the proportion of working-age people in the total population is expected to fall by 7 per cent to 60 per cent.¹³

Therefore, there will be relatively fewer people of working age to support an increasing number of older Australians.

- In 2010, there will be an estimated 5 people of traditional working age for every person aged 65 and over.
- By 2050 only 2.7 people of traditional working age are projected for every person aged 65 and over.¹⁴

Figure 2.4 Proportion of the Australian population in different age groups¹⁵



2.21 The report also noted that:

Population ageing will increase spending on health, age-related pensions and aged care. At the same time, slowing economic growth as a result of an ageing population will reduce the capacity of Australia to fund this increasing spending. Today, around a quarter of total spending is directed to health, age-related pensions and aged care. This is expected to rise to around half by 2049–50.¹⁶

2009–11 National Health and Hospitals Reform

2.22 Between 2009 and 2011, the government undertook major reform of the health sector commencing with the National Health and Hospitals Reform (NHHR) Commission's final report in 2009 and concluding with reforms implemented in 2010 and 2011. This consideration of the health care sector included aged care. The NHHR Commission made several

¹³ The Treasury, 2010, *Australia to 2050: future challenges*, 2010 Intergenerational Report, p. 4.

¹⁴ The Treasury, 2010, *Australia to 2050: future challenges*, 2010 Intergenerational Report, p. 4.

¹⁵ The Treasury, 2010, *Australia to 2050: future challenges*, 2010 Intergenerational Report, p. 10.

¹⁶ The Treasury, 2010, *Australia to 2050: future challenges*, 2010 Intergenerational Report, p. 7.

recommendations about future changes to aged care that would consolidate aged care under Australian Government funding and operation change the way planning the supply of aged care would occur, and remove some of the distinctions and barriers between residential care and care at home.¹⁷

- 2.23 The major reform in the NHHR package was the transfer of full funding and policy responsibility for aged care from state and territory governments to the Australian

Government on 1 July 2011. Implementation commenced on 1 July 2012 when the government assumed full funding, policy and operational responsibility for Home and Community Care (HACC) services for older people in all states and territories (except Victoria and Western Australia).¹⁸

- 2.24 A number of the NHHR Commission's major aged care recommendations were not acted on at that time. However, many were then considered by the Commission in an inquiry that, unlike the work of the NHHR Commission, was focussed solely on aged care.

2011 Productivity Commission *Caring for older Australians* report

- 2.25 In 2010 the Commission was tasked by the then Assistant Treasurer to undertake a comprehensive inquiry into Australia's aged care system. It was envisaged that the inquiry would provide the government with advice on how to redesign the aged care system to cope with future demand.
- 2.26 The Commission's report *Caring for older Australians* was provided to government on 28 June 2011. It found that prior to 2012, the aged care system was growing and providing care of increasing quality. However, it suffered from delays, discontinuity in care, financing and pricing problems, workforce shortages, and lack of sufficient quality and complaints-handling processes. In addition, at the time of the LLLB reforms, there was "no comprehensive information portal" for aged care services, leaving the system "complex and difficult to navigate".¹⁹
- 2.27 The report made 58 recommendations on ways to improve the aged care system. Significant recommendations included:
- removing the regulatory restrictions on the number of aged care places and packages
 - removing the regulatory controls on the value of accommodation payments
 - establishing an Australian Seniors Gateway Agency to provide information, needs assessment, care coordination and carer referral services
 - replacing existing places and packages with a single integrated and flexible system of care entitlements
 - creating an independent regulatory agency—the Australian Aged Care Commission—to undertake regulation of quality, complaints, approval of providers and prudential monitoring.²⁰

THE LIVING LONGER LIVING BETTER REFORMS

- 2.28 In April 2012, the government responded to these reports with the LLLB reform package which provided \$3.7 billion over five years. The government intended that the package would build a better, fairer, sustainable, nationally consistent aged care system to meet the social and economic challenges of the national ageing population.²¹
- 2.29 The reforms gave priority to providing more support and care for older people at home, better access to residential care, more support for those with dementia and strengthening the aged care workforce.

¹⁷ NHHR, 2009, *A healthier future for all Australians: final report*, p. 22.

¹⁸ Department of Health, Commonwealth HACC Program, <https://agedcare.health.gov.au/programs-services/commonwealth-home-support-programme/commonwealth-hacc-program>

¹⁹ Productivity Commission, 2011, *Caring for older Australians*, vol.1. pp. xxix, 103.

²⁰ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, pp. lxiii – lxxxi.

²¹ Department of Health and Ageing, 2012, *2011–12 report on the operation of the Aged Care Act 1997*, p. 13.

- 2.30 Key components of the LLLB reforms considered in this Review include:
- establishing a gateway to services to assist older Australians in finding information and to navigate the aged care system
 - additional support and care to help older people remain living at home
 - additional help for carers to have access to respite and other support
 - changes to classification and funding of residential aged care
 - changes to means testing in home and residential aged care
 - additional funding for the aged care workforce.
- 2.31 The launch of the My Aged Care website and contact centre from 1 July 2013 created a single entry point to the aged care system for aged care consumers and their families. Expansion of the My Aged Care platform in 2015 increased its function by adding a central client record, electronic matching and referral capabilities, and introducing a Regional Assessment Service (RAS) for the Commonwealth Home Support Programme (CHSP).
- 2.32 Under the LLLB reforms a new program was announced that provided an increase in home care packages. Home care packages were also changed from two levels of care²² to four levels:
- level 1, to support people with basic care needs that are greater than those of HACC consumers
 - level 2, to support people with low care needs (previously Community Aged Care Packages (CACPs))
 - level 3, to support people with intermediate care needs
 - level 4, to support people with high care needs (previously Extended Aged Care at Home (EACH) and Extended Aged Care at Home–Dementia (EACH-D)).
- 2.33 The aged care reforms made changes to residential care²³ including:
- requiring providers to advertise a price for their accommodation. This improved a consumer's ability to compare services and more clearly understand the value of their accommodation
 - removal of restrictions on providers receiving lump sum accommodation payments for consumers with higher care needs
 - allowing consumers to choose how they pay for their accommodation, either using a refundable deposit, a daily payment (equivalent) or a combination of both.
- 2.34 The LLLB reforms included a focus on improving access to services for people with dementia. These included additional funding and services for providers who cared for people experiencing behavioural and psychological symptoms of dementia. Further discussion about the impact of these reforms is included in chapter 9 on equity of access.
- 2.35 Access to and maintaining a skilled and well-qualified workforce was also a component of the LLLB reforms. The package included a mechanism to make additional funding available to providers who improved the working conditions of their staff by providing higher wages and enhanced training and education opportunities. The LLLB reforms on workforce and their impact are discussed in greater detail in chapter 10 on workforce.
- 2.36 The LLLB reforms came into effect on 28 June 2013. Key elements were implemented in stages between 2013 and 2015, and are shown in Figure 2.5.

²² Prior to the LLLB reforms, home care services were provided through two levels of package: a low-level package called a CACP and a high-level package called an EACH package. In addition, a small number of dementia-specific EACH packages were available that provided increased services for people with dementia (EACH-D).

²³ Residential care was also provided at two care levels, with low care focused on personal care, support services and some allied health services. High care provided 24-hour care and almost complete assistance with most activities of daily living. Consumer contributions and funding were different between the two levels.

Figure 2.5 Timeline of aged care reforms relating to Living Longer Living Better



2014**2015****2016****2017**

Australian Aged Care Quality
Agency established

Assessment of
accommodation prices
commenced

Providers required to publish
accommodation prices on
My Aged Care

High/low split in residential
care removed

Means testing changes for
home care and residential
care

Quality Agency commenced
reviewing home care services

Accommodation payment
reforms commenced

Higher accommodation
supplement commenced

Workforce supplement ceased

Dementia supplement in
residential care ceased

Payroll Tax
Supplement ceased

Expansion of My
Aged Care website

CDC applied to all
home care packages

Commonwealth Home
Support Programme
commences

My Aged Care
commenced
management of all
assessment and
referrals for aged care
services

Aged care complaints
handling transferred
to the Aged
Care Complaints
Commissioner

Short-Term
Restorative Care
(STRC) places
announced in
the ACAR

Increasing Choice in
home care commenced

First STRC places
allocated

THE DIFFERENT KINDS OF AGED CARE IN 2017

- 2.37 The aged care system provides services that support people in their homes, referred to in this report as home support, through the CHSP.²⁴ It aims to keep people living independently at home and in the community. Support services can include: home maintenance and cleaning, meals and transport services. A consumer can receive home support services from more than one provider. Home Support is funded via a grant to service providers and is governed by grant funding arrangements.
- 2.38 Delivering a more comprehensive service, home care packages provide a range of personal care, support, clinical and other services tailored to meet the assessed needs of the consumer. Often services provided within a home care package will complement care already provided by a consumer's family or carers. The Home Care Packages Programme is governed by the Act.
- 2.39 Residential care provides accommodation and a range of care services to people who are unable to continue to live in their own home. Residential care can provide 24-hour care for people who need almost complete assistance with most activities of daily living. Government-subsidised residential care is governed by the Act.
- 2.40 In addition, there are also a range of targeted services known as flexible care services, which are an adjunct to the main home and residential care services, and extend across the spectrum of care needs to meet the needs of consumers that require a different approach. These include transition care, short-term restorative care, multi-purpose services, and flexible care for Aboriginal and Torres Strait Islander communities. These are a small part of the system, delivering services to around 25,000 consumers, compared to approximately 1.3 million consumers who access home support, home care or residential care.
- 2.41 A range of services are available to give carers respite from their daily caring activities. Respite services can be accessed through the CHSP, home care or residential care programs depending on the period of respite required and the needs of the consumer. The impact of the reforms on the use of respite is discussed in chapter 4 on demand and supply and chapter 5 on means testing.

Accessing aged care

- 2.42 Because government-funded aged care is limited, there are systems for determining eligibility for care and controlling access. These are aimed at ensuring the amount of care provided meets planned targets and maintaining fiscal sustainability for the government, as the major financier. At the centre of the system is the aged care gateway, My Aged Care.
- 2.43 My Aged Care is a website, contact centre, information technology system and assessment service that acts as the central pathway for older people to access aged care information and services. It includes:
- a website that provides information for consumers and their families about what aged care services are available and how to access those services
 - a call centre that provides consumers and their families with advice on the different services available in their community and how they can access those services
 - a central client record to facilitate the collection and sharing of information between assessment services and providers
 - holistic needs assessment through a national standardised assessment process
 - online referral management for providers
 - web-based portals for clients, assessors and service providers.
- 2.44 Once initial screening has been undertaken through My Aged Care, the consumer is then referred to either a RAS or Aged Care Assessment Team (ACAT) for an assessment of their care needs.
- 2.45 RASs provide assessments of people seeking low-level support at home, provided under the CHSP. ACATs comprehensively assess the care needs of a consumer taking into account their physical, medical, psychological,

²⁴ CHSP services are not provided Western Australia. Home support services are provided through the HACC program. Plans are in place for Western Australia to transition to the CHSP by 1 July 2018.

cultural, social and restorative care needs, and assist them to access the most appropriate services. This may involve approving them as a person eligible for home care, residential aged care, flexible care services or respite care.

- 2.46 If the consumer is assessed as eligible for a type of care, the system for receiving a service is different for each of the three main service types.

For home support, the RAS works with the client to refer them to services they are eligible for. Clients choose which provider(s) they would prefer within the eligible service types.

For home care packages, consumers who have been assessed as eligible are placed in a single national queue, managed by My Aged Care. As packages become available, they are allocated to the consumer at the top of the queue, who can then purchase their services from any approved provider of home care.

For residential care, consumers who have been assessed as eligible can approach any approved residential care provider to request access to services.

- 2.47 The role and effectiveness of the system for providing access to care is discussed in chapter 8 on access to services. The introduction of a gateway for accessing aged care was one of the most significant reforms in the last decade.

Regulating aged care services

- 2.48 Home, residential and flexible care providers are regulated by the government to ensure that they comply with quality standards, and any complaints about quality or performance are addressed. Home support providers must deliver services to a level and quality specified in their funding agreements.

Quality and accreditation

- 2.49 The government's quality and accreditation framework is designed to provide assurance to care recipients of aged care services. Providers are required to have management systems that enable the organisation to achieve a standard of quality, and to continually work to improve that standard. The Australian Aged Care Quality Agency is responsible for accrediting residential care services, undertaking monitoring and compliance activities against the standards in which they are accredited, and conducting quality reviews of home care services.

Complaints

- 2.50 Consumers who have complaints about their aged care services should generally raise such issues with their care provider in the first instance. If they do not receive a satisfactory resolution, they can raise issues with the Aged Care Complaints Commissioner (the Complaints Commissioner).
- 2.51 The Complaints Commissioner is an independent statutory office holder and provides a free service for anyone to raise their concerns about the quality of aged care and services subsidised by the government.
- 2.52 The Complaint Commissioner's primary functions under the Act and the *Complaints Principles 2015*, include:
resolving complaints about government-subsidised aged care services
educating people and aged care providers about the best ways to handle complaints and the issues they raise.

Other services that provide care to older Australians

- 2.53 In parallel to the aged care services they receive, older people need access to other services that help maintain their everyday activities or to respond to specific needs. The most common of these services are discussed below.

Primary care and Primary Health Networks

- 2.54 Older Australians represent around 14 per cent of the Australian population, but 28 per cent of visitors to general practitioners.²⁵ People receiving aged care continue to need access to primary care services. This includes access to general medical, allied and community health services.

²⁵ Britt, Helena et al, 2015, *General practice activity in Australia 2014–15*, General practice series no. 38, Sydney University Press, chapter 14, pp. 4-5.

- 2.55 Primary Health Networks (PHNs) support the primary care system “to increase the efficiency and effectiveness of medical services for patients, particularly those at risk of poor health outcomes, and to improve coordination of care”.²⁶ They work with general practitioners, other primary health care providers, and hospitals to facilitate improved outcomes for patients. The local approach of PHNs means that each PHN takes an individual approach to achieving better health outcomes in their community.
- 2.56 While aged care providers must facilitate access to these services, the PHNs also have a role to play in ensuring that those receiving aged care services can access the right care in the right places at the right time. The government has identified aged care as one of the six key priorities for targeted work by PHNs. I would encourage providers across the aged care sector to engage with their PHN in order to improve primary health services for their consumers.

Hospitals

- 2.57 The hospital system is a major component of health care, costing over \$69 billion in 2014-15.²⁷ Older Australians rely significantly on hospital care: of around 10 million hospitalisations that occurred in Australia in 2014-15, people over 65 “accounted for 41 per cent of hospitalisations and 49 per cent of patient days” across the system.²⁸
- 2.58 There are important linkages between aged and hospital care, and the effectiveness of those connections impacts on both consumer care outcomes and the efficient usage of each care system. The government administers a transition care program that is dedicated to providing short-term support to older people leaving hospital. It funds low-intensity therapy such as physiotherapy, nursing support for clinical care such as wound care, and personal care.²⁹

Palliative care

- 2.59 Palliative care is “an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual”.³⁰ For aged care consumers and their families, this means access to effective end-of-life care, including advanced care planning, pain management, palliative care and family support.
- 2.60 Urbis, in its evaluation of the National Palliative Care Strategy, described the various settings palliative care can be provided in across the health care system:
- Palliative care has become available within almost every health care setting, including... general practices, acute hospitals, residential and community aged care services, and generalist community services. Palliative care is also provided through specialist palliative care services...including specialist inpatient consulting services, specialist inpatient settings, hospices and community-based specialist services.*³¹
- 2.61 Palliative care is provided by state and territory governments. Around 1 in 25 consumers in residential care homes had an assessment indicating the need for palliative care, which may be delivered by aged care services.³² I have

²⁶ Department of Health, PHN Background, <http://www.health.gov.au/internet/main/publishing.nsf/Content/PHN-Background>

²⁷ Includes recurrent expenditure on public hospital services (including by Local hospital networks and state/territory health authorities, except in Queensland), and recurrent expenditure by private hospitals. Australian Institute of Health and Welfare, Australian hospitals 2014–15 at a glance, hospital resources, <http://www.aihw.gov.au/haag14-15/hospital-resources/#5>

²⁸ Australian Institute of Health and Welfare, Australian hospitals 2014–15 at a glance, admitted patient care, <http://www.aihw.gov.au/haag14-15/admitted-patient-care/#1>

²⁹ My Aged Care, After-hospital care (transition care), <https://www.myagedcare.gov.au/after-hospital-care-transition-care>

³⁰ World Health Organisation, *WHO Definition of Palliative Care*, <http://www.who.int/cancer/palliative/definition/en/>

³¹ Urbis, September 2016, *Evaluation of the National Palliative Care Strategy 2010 final report*, p. 7.

³² Australian Institute of Health and Welfare, Palliative care in residential aged care, <http://www.aihw.gov.au/palliative-care/>

commented on the need for increased specialised training for aged care staff in chapter 10 on workforce.

- 2.62 The government funds national activities that support the provision of high quality palliative care in Australia through workforce development, quality improvement and data development activities and supporting advance care planning. These activities include the National Palliative Care Projects and the Specialist Palliative Care and Advance Care Planning Advisory Services.

Disability care

- 2.63 As people age, there is an increasing possibility that they will have a disability. People who acquire a disability before the age of 65 may be eligible for care under the National Disability Insurance Scheme (NDIS). They may continue to receive care through the scheme as they age, and the department has indicated that by 2020 it is likely that around 15,000 older Australians will be receiving care under the NDIS.³³ State and territory governments operate specialised aids and equipment schemes to assist people with disabilities, including older people.
- 2.64 As outlined in chapter 9 on equity of access, aged care services provide care to people who were ineligible for the NDIS and are now over the age of 65, and those who acquire a disability when over 65.

³³ In addition, there is a small cohort, estimated at around 8,000 people, who will be aged 65 and over (and Indigenous people aged 50 and over) who are currently in receipt of state-managed specialist disability services but (because of their age) are ineligible for the NDIS at the time of NDIS implementation in a region. They will receive ongoing care under the Commonwealth Continuity of Support Programme.

CHAPTER 3

MOVING TOWARD A CONSUMER DEMAND-DRIVEN SYSTEM

INTRODUCTION

- 3.1 Aged care is in transition. When the Productivity Commission (the Commission) reviewed aged care in 2011, it made a suite of recommendations that services and care be “redesigned around the wellbeing of older people and be delivered in ways that respect their dignity and support their independence”.³⁴
- 3.2 The government responded to the Commission’s recommendations, through the Living Longer Living Better (LLL) package of reforms. In addition, further steps have been taken since the LLL reforms, particularly to give consumers, instead of providers, control of home care packages.
- 3.3 Several key Commission recommendations have not been implemented. In particular, moving to a consumer demand-driven system by phasing out of limits on the number of aged care places—widely referred to as ‘uncapping supply’—has not been achieved.
- 3.4 In addition, the Commission’s vision was that “consumers contribute, in part, to their costs of care...and meet their accommodation and living expenses”. Though the measures in the LLL reforms went some way towards this, consumer financial contributions to aged care remain relatively low.
- 3.5 The establishment of this Review by the LLL legislation³⁵ was acknowledgement that the reforms only moved part of the way to a consumer-driven aged care system. This is also recognised in the *Aged care roadmap* (the Roadmap), designed collaboratively by representatives of consumers, carers, providers and workers, through the Aged Care Sector Committee. As Chair of that Committee, I introduced the Roadmap by writing:

*Increased consumer choice will be a major change into the future. A fiscally sustainable aged care system that requires consumers to contribute to their care costs where they can afford to do so means that there will be increased consumer expectations for greater choice and control. The ability for consumers to choose who provides care and support will create a more competitive and innovative market. This, accompanied by an aged care sector that has more flexibility to respond to the increasing diversity of consumers’ care needs, preferences and financial circumstances will contribute to a sustainable system.*³⁶

- 3.6 One of the key questions for this Review, therefore, is whether further steps should be taken toward a consumer demand-driven model. I consider that further steps can and should be taken. This chapter outlines why further steps should be taken, while subsequent chapters set out the steps and analysis in detail.

SUPPORT FOR A CONSUMER DEMAND-DRIVEN SYSTEM

- 3.7 The current system could be described as a supply-constrained system where the government controls the number, funding level and location of residential aged care places and the number and level of home care packages.
- 3.8 By contrast a consumer demand-driven system is one in which the quantity and types of consumer demands for care drive the size and shape of the aged care system. Under such a system, once a consumer is assessed as needing care,

³⁴ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p. xix.

³⁵ *Aged Care (Living Longer Living Better) Act 2013*.

³⁶ Aged Care Sector Committee, 2016, *Aged care roadmap*, p.2.

they would receive appropriate funding, and could obtain services from a provider of their choice and also choose how, where and what services would be delivered.

- 3.9 Submissions provided to the Review argued that measures made to date to increase consumer choice have been effective. They indicated that:
- Consumers have embraced measures to provide choice.
 - Despite initial implementation problems, the single gateway for aged care services (known as My Aged Care) generally provides a positive experience for consumers and carers who use it, but further improvement is necessary.
 - Consumers have embraced the capacity to choose between lump sum and daily payments for accommodation in residential care; both types of payments, and combinations of the two, are widespread.
- 3.10 In addition, it is also clear from submissions and discussion with stakeholders that they remain committed to a system that is more consumer oriented and responsive to consumer demand. The National Aged Care Alliance drew attention to its second blueprint for the future of aged care, released in 2015,³⁷ which stated in part that the system should include:
- 1) *A single care and support service system that is consumer-led and demand-driven, with access based on assessed need. Such access must ensure appropriate and equitable access and outcomes for special needs groups.*
 - 2) *Consumers assessed with having care needs will be able to access care appropriate to their needs and preferences.*³⁸
- 3.11 Consumer representative organisation, Council on the Ageing, endorsed the approach of the Commission to:
- ...place the consumer of aged care at the centre of the reforms, proposing funding should be attached to the consumer rather than allocated to the aged care service provider. This is fundamental to the current reform process and achieving it across the aged care system is essential for the achievement of a consumer focused, market based, high quality and financially sustainable aged care for all across coming decades.*³⁹
- 3.12 Further, analysis conducted for the Review indicated that reforms are needed to the system so that it better matches consumer demand. In particular there is continuing demand for more care at home.

CONDITIONS FOR SUPPLY BEING BASED ON CONSUMERS' ASSESSED NEED

- 3.13 Uncapping supply is a substantial policy shift and requires at least four conditions to be met:
- Government needs an accurate understanding of the underlying demand that the system will be designed to meet.
 - Consumers must make equitable and sufficient contributions to the costs of their care, without those contributions being so high that they create a barrier to accessing care.
 - There must be a robust system for assessing eligibility and ongoing care needs for government-funded aged care services.
 - Government policy must ensure the equitable supply of care across different population groups, and in settings where there is limited choice or competition, such as remote locations.
- 3.14 First, as the major financier of the system, government should not uncap the supply of aged care places (and, hence, the fiscal costs) if it does not know what demand the system will need to meet. To effectively measure demand the government needs to define what aged care needs the system will meet (and thus count as demand). It needs then to accurately measure the level of that demand.

³⁷ National Aged Care Alliance, 2015, *Enhancing the quality of life of older people through better support and care*.

³⁸ National Aged Care Alliance submission, p. 9.

³⁹ Council on the Ageing submission, p. 5.

- 3.15 However, as discussed further in chapter 4 on demand and supply, defining and measuring demand is very difficult. A number of indicators considered to date have, for various reasons, not provided a clear picture of demand. The chapter concludes with an outline of how this first condition could be met in future.
- 3.16 The second condition critical to basing the supply of care on consumer demand, is that consumers must make equitable and sufficient contributions to care. The current fees, prices and means testing arrangements do not result in consumers making equitable contributions to care. They also inhibit two other objectives, set out in the Roadmap, that are essential to a consumer demand-driven system: seamless movement between care types; and helping consumers choose the best care for their needs and means. Improvements to means testing and contributions are discussed in chapter 5 on means testing; reforms to accommodation payments are discussed in chapter 6 on accommodation payments.
- 3.17 The third condition that supports access on the basis of assessed need, is robust assessment. This is required to ensure effectiveness, sustainability, and equity. Without robust assessment, there will be a mismatch between the intended scope of the care system, and the care actually delivered, potentially resulting in inappropriate exclusion of people who need care, or people being directed to the wrong kind of care, wasting resources and time. If assessment is weak it may incorrectly provide access to people who do not meet the eligibility criteria, or direct them to care that is beyond what is needed. Such outcomes increase costs, threatening the system's sustainability. Assessment that is fragmented, poorly guided or conducted by staff without sufficient skills will undermine equity.
- 3.18 Further improvement is needed to the existing assessment framework. This is discussed further in chapter 8 on access to services.
- 3.19 The fourth condition that must be met if access is to be based on need, is equitable supply of care across different population groups, including in settings where there is limited choice or competition. Uncapping supply in a market-based system can result in most services being targeted to consumers whose care is cheapest and easiest to provide, or who can pay the most out of their own pocket. A capped system that determines who receives care and where may not be able to meet all needs, but can deliberately provide access for those whose care is expensive or complex.
- 3.20 Chapter 9 reviews what we know about equity of access across different population groups and how it has been affected by the LLLB reforms. Chapter 6 on accommodation payments looks at some aspects of how economic status relates to access to care. Some population groups appear to have relatively good levels of access. However, it is also clear that there is a lack of data about whether people from different populations enter care and what outcomes they experience. Without clear records from first contact with the system, through assessment, to entry and subsequent care, government is not able to determine whether different population groups receive sufficient care. This situation will need to be improved by collecting and analysing data prior to any uncapping of supply.

STEPS ALONG THE ROAD

- 3.21 There are many policy and practice changes that will need to occur in aged care for it to become a fully consumer demand-driven system of care. The Roadmap, for example, sets out steps across nine different domains, from how eligibility will be determined to how quality of care will be ensured.
- 3.22 This report does not consider all aspects of possible future change. Because I was asked to evaluate particular changes brought about by the LLLB reforms, this report has a focus on the economics and financing of aged care and on understanding demand for, and supply of, services.
- 3.23 While I do not recommend that supply be uncapped at this time, this does not represent a departure from the objective of consumer-driven aged care. On the contrary, one of the key objectives of this report is to trigger changes that are prerequisites for a fully consumer-driven system.
- 3.24 The recommendations in this report are designed to move aged care further towards a consumer-focused demand-driven system. Some do this by targeting a better understanding of, and response to, demand, some by seeking improved information and assessment, some by improving sustainability, and others by supporting equity of access.
- 3.25 Many of the recommendations are similar to proposals set out in the Roadmap. These include:
- ceasing allocation of residential aged care places using the Aged Care Approvals Rounds, instead transitioning those places to consumers, as has been done for home care packages
 - changing the provision of home care packages to better match their availability with current and future consumer demand

- strengthening My Aged Care to provide more accessible information, and increased ability for consumers to use it to identify and choose services that meet their specific needs
- increasing the focus of aged care on reablement so that consumers are better able to live independently
- developing a single assessment workforce that will operate across all care types, and that will be independent and rigorous
- strengthening prudential standards and reforms to the accommodation payment guarantee.

3.26 Collectively, the recommendations in this report are intended as the next steps on the road to consumer demand-driven care.

CHAPTER 4

DEMAND AND SUPPLY

INTRODUCTION

- 4.1 This chapter responds to matters (a) and (b) in the Review's terms of reference: whether unmet demand for residential and home care places has been reduced since the introduction of the Living Longer Living Better (LLLBB) reforms; and whether the number and mix of places for residential care and home care should continue to be controlled. It focuses on home care packages and residential care, which are collectively referred to as aged care services or aged care places.⁴⁰
- 4.2 The chapter begins by describing the drivers of demand. It considers the challenges in trying to measure demand and whether demand is being met. The second half of the chapter considers the supply of aged care and how it might be changed to better meet demand.

DEMAND FOR AGED CARE SERVICES

The nature of demand

- 4.3 Demand for aged care services is complex and dependent on a range of demographic, service need, and economic factors. These include the number of people needing care and support and the types of care they need. When it comes to government-subsidised services, demand also depends on eligibility, on which type of service is sought to meet the demand, and on people's willingness to pay for services when they are able to do so.
- 4.4 For many years the government has been working to understand and respond better to a growing demand for aged care services. It has increased the supply of subsidised care, and in doing so, has also needed to manage the growth in costs. The history of policy in this area reflects a difficult balancing act between:
- uncertainty about what care needs exist
 - increasing care provision for a growing and ageing population
 - the mix of services to reflect the preferences of consumers
 - trying to ensure people receive the right services in the right care system, whether aged care, health care, or disability services
 - managing Budget expenditure on the costs of care.

The key demand-side driver—demography

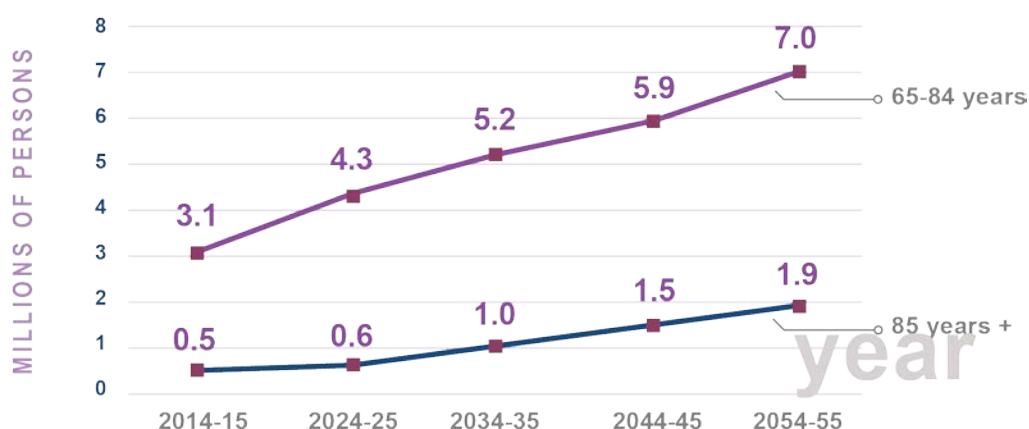
- 4.5 The key driver of the demand for aged care is demographic change. Australia, like most developed nations, is experiencing a long-term ageing of its population. The *Intergenerational report* (IGR) shows that both the number and proportion of Australians aged 65–84 and 85 years and over, are projected to grow substantially. In 2015, approximately 3 million people, or 13 per cent of the population were aged 65–84, and 500,000 people, or 2 per cent of the population, were aged 85 years and over.⁴¹ By 2054–55, the 65–84 cohort is projected to be around 7 million people, or just under 18 per cent of the population, and the 85 years and over cohort is projected to be around two million people, or 5 per

⁴⁰ The Commonwealth Home Support Programme, which provides entry level support services to people living in their homes, is not directly within the scope of this Review. However, as CHSP is the care program that supports the largest number of individuals, it is essential to include it in developing an understanding of demand for aged care and how that demand is met. Accordingly, it is also mentioned in this chapter.

⁴¹ The Treasury, 2015, *Intergenerational report*, p. 12.

cent of the population.⁴² Figure 4.1 demonstrates the projected growth in these older population cohorts over the next 40 years.

Figure 4.1 Population projections (millions of persons), 2014–15 to 2054–55⁴³



- 4.6 With these changing demographics comes an increasing demand for, and use of, health and aged care services, particularly as the ageing of the population means an associated increasing number of people with dementia. The Australian Institute of Health and Welfare (AIHW) estimated that in 2015, there were around 342,000 people living with dementia. The AIHW has projected that this number will increase to nearly 900,000 people by 2050.⁴⁴
- 4.7 The most recent IGR (2015) projected that as a result of these demographic changes, government spending on aged care services is likely to almost double, from less than 1 per cent of gross domestic product (GDP) in 2014–15 to 1.7 per cent of GDP in 2054–55.^{45, 46}

Understanding current and future demand

Box 4.1 Snapshot: Consumers of aged care 2015–16⁴⁷

- More than 925,000 older people received home support.
- 57,000 people received residential respite care.
- 89,000 people received care through a home care package.
- 57,000 people received residential respite care.
- 235,000 people received permanent residential aged care.
- Approximately 50 per cent of all residential care consumers had a diagnosis of dementia.
- 192,000 Aged Care Assessment Team (ACAT) assessments were undertaken.

⁴² The Treasury, 2015, *Intergenerational report*, p. 12.

⁴³ The Treasury, 2015, *Intergenerational report*, p. 12.

⁴⁴ AIHW, *Dementia*, <http://www.aihw.gov.au/dementia/>

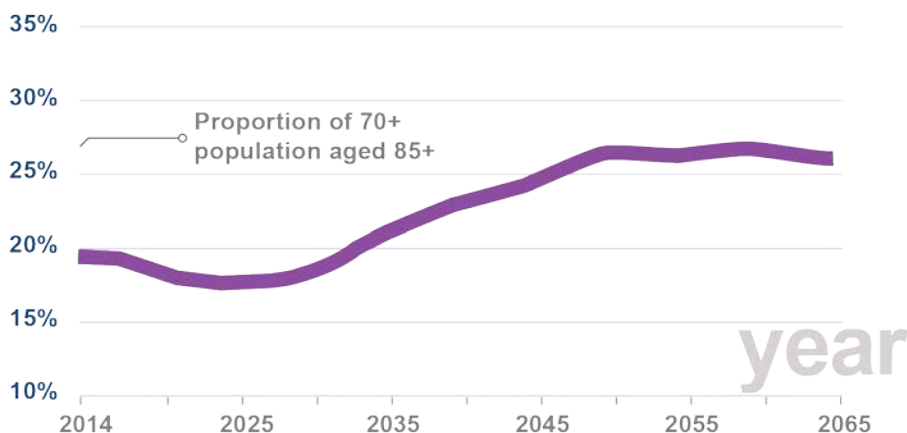
⁴⁵ The Treasury, 2015, *Intergenerational report*, p. 71.

⁴⁶ Note, expenditure projections in the 2015 *Intergenerational report* were based on the then current aged care planning framework.

⁴⁷ Department of Health, 2016, *2015–16 report on the operation of the Aged Care Act 1997*, p. xi.

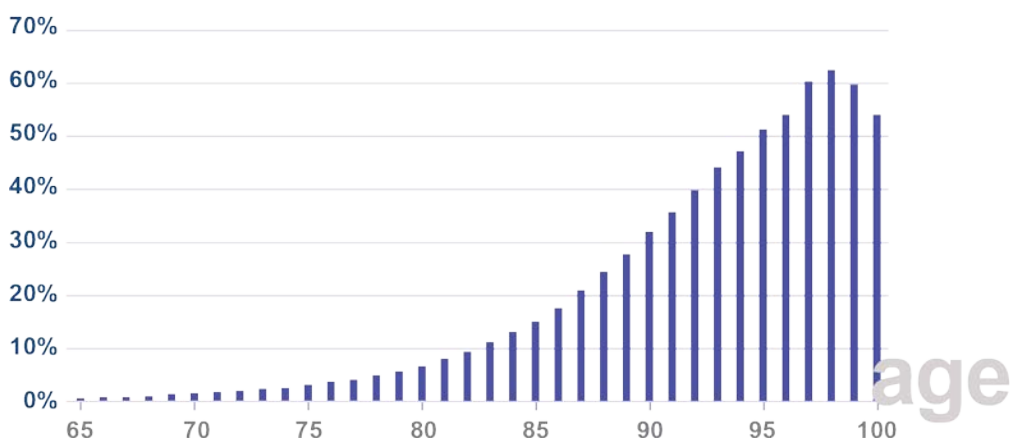
4.8 However, the demand for care is more complex than a simple projected increase in the older population. As discussed more fully in the second half of this chapter, the growth in aged care will not be linear over the next 40 years. This is because ‘baby boomers’ are such a large group compared with the pre-war generation. As a result, the proportion of the older population (aged 70 years and over) that is aged 85 years and over will reduce over the next decade, but will then significantly increase as the baby boomers reach the age of 85 years and over (Figure 4.2).

Figure 4.2 Proportion of 70+ age group who are aged 85+, 2014 to 2062⁴⁸



4.9 This growth in the proportion of the 70 years and over population that is aged 85 years and over is important because, as age increases, the likelihood of needing aged care services increases (Figure 4.3).

Figure 4.3 Proportion of people using residential or home care by age, 2016⁴⁹



4.10 This overall demographic change, when considered in light of the age-specific usage rates (Figure 4.3), means that, while there will be ongoing increases in demand, there will be a very significant increase in demand for aged care services in 10–15 years’ time, rather than over the next decade. This will require increased investment activity from the mid- to late-2020s to build the capacity and infrastructure to meet this challenge. The interaction of these changes in population with current aged care service planning arrangements (which are based on the number of people aged 70 years and over) is discussed in more detail in the second half of this chapter.

⁴⁸ Aged Care Financing Authority (ACFA), 2016, *Report on the funding and financing of the aged care industry*, p. xxv.

⁴⁹ Department of Health, unpublished data.

- 4.11 While the impact of demography is, and will remain, the primary driver of demand for aged care, there is a range of other factors involved.

Factors that influence demand

- 4.12 The Productivity Commission (the Commission) recognised the complex interplay between factors that impact demand in its 2011 report, *Caring for older Australians*:

*The demand for aged care services depends on the number of older people needing care and support. However, care needs are not homogenous and the nature and location of aged care services demanded will depend on the physical and mental health of older people, their capacity and willingness to pay, their preferences, and the availability of informal carers.*⁵⁰

- 4.13 All of these factors have an impact on the level of demand for subsidised aged care services. However, they are often not quantifiable, making them difficult to account for in any method developed to measure demand. For example:
- **Consumer preferences:** there are several factors that influence a consumer's decision on whether or when they choose to access care, as well as the type of care they want to access. This includes the perceived urgency in addressing the need, the cost of accessing the service, and potential preference for a particular provider.
 - **Availability of other supports:** a consumer's demand for access to aged care services may be influenced by the availability of other care and support such as that provided by a family member. Informal support makes up a significant proportion of the care provided to elderly people, particularly care provided in people's homes.
 - **Demand is not a single measure:** aged care is not a single type of service, so the measurement of demand covers several different kinds of service and changes in consumer preferences for those different kinds of care.
 - **Availability of different service types:** supply and demand are inherently linked, and in aged care, this is particularly evident when the supply of some forms of aged care impacts on the demand for others. In the current aged care system, this is an issue with the relationship between the two home-based care and support services: the Commonwealth Home Support Programme (CHSP) and home care packages. There was a consensus presented in submissions and workshops that there is currently a disincentive for consumers to move from the CHSP into a home care package or to take up a home care package in the first instance. This is the result of consumers not being asked to make a significant financial contribution towards the cost of their CHSP services, making it more attractive. This issue is further exacerbated by a disjointed and inconsistent assessment process across the two programs which I discuss further in chapter 8 on access to services.

Approaches to measuring demand

- 4.14 With these factors in mind, this Review considered available information that might assist to estimate the demand for aged care, and whether there are estimates available for what, if any, portion of that demand is unmet. Three approaches were considered, noting that all three have limitations.

The Survey of Disability, Ageing and Carers

- 4.15 A broad measure of demand is consumers' self-reported assessment of their need for assistance. The Australian Bureau of Statistics Survey of Disability, Ageing and Carers (SDAC) reports every three years on the prevalence of disability, the need for support of older people and those with a disability, and the needs of those who provide care to people with a disability and older people.⁵¹

⁵⁰ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p. 38.

⁵¹ In this survey, a person has a disability if he/she reports a limitation, restriction or impairment that has lasted, or is likely to last, for at least six months and restricts everyday activities. The SDAC samples a subset of the population which is then extrapolated to represent the whole population. It also separates the responses on need for assistance for the population aged 65 years and over. Australian Bureau of Statistics, SDAC, Disability, Ageing and Carers, Australia: Summary of Findings, cat. no. 4430.0, 2012 and 2015, referred to in this report as SDAC, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4430.0Main+Features902015?OpenDocument>

4.16 Table 4.1 shows a breakdown of all people aged 65 years and over who reported having a need for assistance, by assistance type, in the 2015 SDAC.

Table 4.1 People aged 65 years and over reporting a need for assistance with at least one activity, 2015⁵²

ACTIVITIES REQUIRING ASSISTANCE	PROPORTION OF PEOPLE	NUMBER OF PEOPLE (THOUSANDS)
Self-care	12.3	435.2
Mobility	16.1	569.4
Communication	4.6	161.6
Cognitive or emotional tasks	8.9	314.4
Health care	22.9	813.8
Reading or writing tasks	8.7	308.0
Transport*	15.2	538.9
Household chores*	16.1	571.7
Property maintenance*	20.2	715.8
Meal preparation*	4.8	169.1
All needing assistance with at least one activity**	38.6	1,369.4
Assistance not needed	61.4	2,177.2

Notes: *Need for assistance with these tasks was not asked of those people living in residential care.

**Totals may be less than the sum of the components as some people may need assistance with more than one activity.

4.17 Based on a national population of approximately 3.5 million people aged 65 and over,⁵³ these figures suggest that just over a third, or approximately 1.4 million older Australians, feel they need assistance with at least one activity.

4.18 However, translating this estimate of need into an understanding of demand for aged care is complex because:

- The data relates to the need for assistance, but not for assistance that is specifically aged care. The largest single reported need is for assistance with health care. It is likely that much of this is being met by the primary health care system. Only some proportion would translate as need for aged care.
- SDAC asks respondents to make an assessment of their own needs. It is not known what proportion of the self-assessed needs reported in the survey are eligible to be met through subsidised aged care services.
- The survey does not determine whether a person receiving formal assistance is receiving government subsidies for the services received or whether they are privately funded.
- SDAC is about need, not demand. Needs are complex and people may choose not to seek services to meet a need. More specifically, they may not seek government-funded care, or might not be willing to pay the contributions required to access those services.

4.19 In any of these circumstances, it cannot be assumed that need reported in the SDAC would be the same as the demand for aged care.

4.20 Accordingly, the SDAC, while a valuable tool for understanding need for care, must be treated as an estimate only, and likely an over-estimate. Nevertheless, taking account of the factors listed, the number of the 65 years and older population that consider they need assistance with at least one activity (1.4 million older Australians) is broadly similar to the total population receiving any sort of assistance through government-funded aged care (over 1 million older Australians).

⁵² Australian Bureau of Statistics, 2015, SDAC, tables 28.1 and 28.3.

⁵³ AIHW, Ageing, <http://www.aihw.gov.au/ageing/>

Commonwealth eligibility data

- 4.21 A second way to estimate demand for aged care is to monitor approval for, and usage of, existing funded care services. In residential care, the government records the numbers of:
- approvals for residential care, including approvals for residential respite
 - people receiving residential care (permanent and respite)
 - allocated and operational places available at any one time.
- 4.22 For home care packages, the government collects additional data. It currently records the numbers of:
- approvals for home care packages, including by package level
 - consumers who have asked to be placed in the national prioritisation queue
 - consumers who turn down a package when offered
 - consumers who access a lower-level interim package where a higher package is not available
 - home care packages at any one time, including by package level.
- 4.23 The government also monitors occupancy rates for both residential care and home care packages.
- 4.24 While these data are useful as a broad indicator of demand for aged care services, they have the potential to both overstate and understate the true level of demand for aged care services (Box 4.2).

Box 4.2 Using eligibility data

The eligibility criteria for approval to access aged care services are broad and allow a consumer to be approved for a number of types of care at the same time. For example, a person can be assessed as eligible to receive respite care, home care and residential care. However, these multiple approvals may not represent a consumer's need for each type of care at that point in time. Rather, the approvals may take into account possible future needs, meaning that eligibility data have the potential to overstate the level of true demand for aged care services. Further, for all types of care with the exception of transition care, the approval does not expire.

It is also possible that a perception of long wait times for accessing care, or challenges in accessing the referral process, may discourage some people who have a need for services from obtaining an assessment. This means that there may be people who require aged care services who are deterred from seeking access to them due to the requirement to undergo an assessment. These people will never be captured in eligibility data and therefore there is also the possibility that the data understates the true level of demand.

- 4.25 The national prioritisation queue for home care has only recently been established, so there are currently no data available. Once the data are available, the national prioritisation queue will help to better assess and understand the level of demand for home care packages. However, even once the queue system is more established, it will still have limitations.
- 4.26 Some of the reasons for the queue being a limited estimator of demand are outlined in Box 4.2. In addition, the prioritisation queue is for home care packages only. As stakeholders have made clear, demand for services is influenced by accessibility to, and cost of, different services. Without an integrated system of services and of allocating places, a queue for only one part of the system cannot offer a robust measure for demand. It will only be more meaningful to judge demand once queues for different types of care are established and made transparent.

Modelling of demand

- 4.27 Due to the limitations of available data, the department on behalf of this Review commissioned external analysis by Deloitte to better understand the demand and unmet demand for aged care services.

- 4.28 A model was developed using eligibility data that estimated the level of demand for home care packages and residential care, based on the proportion of the population that receives a home care package or residential care, plus the proportion of the population that is approved to access those services through a comprehensive ACAT assessment, but that currently does not receive any aged care service. This was used to estimate historical levels of demand (number that required government-funded aged care services) (Table 4.2).

Table 4.2 Thousands of persons who needed care, 2011–12 to 2015–16

	2011–12	2012–13	2013–14	2014–15	2015–16
Require government-funded aged care ('000)	417.1	430.4	459.6	454.4	466.6

- 4.29 On this basis, the number of people who require aged care services has increased over the period 2011–12 to 2015–16 (Table 4.2). This largely reflects population growth. This estimate of demand has been used to determine a level of unmet demand for home care packages and residential care (see below). Note, however, that for various reasons it has not been possible to include the CHSP in this analysis. This is important, as it is likely that many of the people included in the unmet demand analysis receive support through the CHSP.

Has unmet demand reduced since implementation of the Living Longer Living Better reforms?

- 4.30 For consumers and policy-makers alike, 'unmet demand'—the demand for aged care services that cannot be met by current supply—is a key concern. The complexity of measuring demand makes it difficult to determine the extent to which that demand has gone unmet.
- 4.31 A number of submissions pointed out that currently there is no clear measure of unmet demand in the aged care sector. For example:

*Aged & Community Services Australia is unaware of a current robust data source which provides accurate and timely information about the extent of unmet demand...There is no data that allows this to be determined objectively.*⁵⁴

and

*Robust assessment of unmet demand in the aged care service system requires high quality macro and micro level data. At present this data is not available for analysis, making it impossible to accurately assess unmet demand.*⁵⁵

- 4.32 Despite the limitations, available data about demand does give some indications about unmet demand. This, combined with extensive feedback from stakeholders, paints a picture of where the greatest areas of demand and unmet demand for services lie.

Stakeholder views on unmet demand

- 4.33 The Review received little advice during consultations to suggest that there is significant unmet demand in aged care overall. Rather, advice received suggests that there is currently a mismatch between the components of supply and demand; that is, that supply should better align service types with levels of need and consumer preference. This is addressed in the second half of this chapter.⁵⁶
- 4.34 Specifically, there was uncertainty about whether there is unmet demand for residential care, with some suggesting that demand may have decreased. For example, the National Aged Care Alliance (the Alliance) thought that:

⁵⁴ Aged & Community Services Australia submission, p. 5.

⁵⁵ Brotherhood of St Lawrence submission, p. 5.

⁵⁶ There is, of course, regional variance in terms of levels of unmet demand, and the Review acknowledges that there are specific population groups that may experience greater difficulty in accessing aged care services. Further analysis on equity of access issues are addressed in chapter 9 on equity of access.

...occupancy rates of residential aged care placements nationally have fallen however there is anecdotal feedback from members of waiting time pressures for access to residential beds in some areas.⁵⁷

4.35 And the Aged Care Guild (the Guild) commented:

...while unmet demand may have stabilised in recent years (noting that this is difficult to measure), the impacts of the government's regulation of the Act do not point to promising signs for future demand being met by corresponding growth in bed numbers.⁵⁸

4.36 Sunnyside Lutheran Retirement Villages also reported that:

...unmet demand for residential care may have decreased slightly in the short term. There are two reasons for this. Firstly, the efforts to keep people in their own homes will have an impact until the needs outweigh that service's ability to manage the person... Secondly, there is a great deal of confusion and anxiety in the community about the processes and costs to enter care that some people are 'battling' on their own.⁵⁹

4.37 The area where many stakeholders indicated that there may be unmet demand is higher-level home care packages. For example:

... Victorian health services and community health organisations have indicated that there is still considerable unmet need for Home Care Packages across metropolitan, regional and rural areas. There are numerous reports of clients assessed as needing a level 3 or 4 package that are either receiving no package or are receiving a level 2 package and waiting considerable periods of time for the level 4 package they require.⁶⁰

and

To date our experience has been that unmet need for home care places is still evident. We are receiving referrals through My Aged Care which indicates that demand remains. Additionally, we have existing Level 2 clients who have been assessed for a Level 3 or 4 package that are unable to upgrade their package at this point in time due to lack of appropriate vacancies.⁶¹

4.38 Consumer feedback indicates that there are consumers having to accept lower-level packages, while waiting for a level 3 or 4 package to become available, indicating unmet demand for these higher packages. However, as the national prioritisation queue is still in its infancy, the data are not yet available to show the extent of this issue.

4.39 Commentary in submissions and workshops also focussed on how other LLLB reforms, such as the introduction of consumer-directed care and My Aged Care, have led to a more informed, and therefore more proactive, consumer. This may be affecting how people are approaching aged care, undertaking more planning and being less likely to have their first contact with the care system during a care crisis. HammondCare noted that:

It may even be that recent reforms have increased the time taken by residents and clients before they commence services. The stronger emphasis on choice, coupled with greater levels of information about services, may well have prompted people to begin investigating aged care options earlier and to spend more time deliberating over the available options.⁶²

4.40 This may mean that more people are seeking assessment for approval to access services in preparation for future needs, rather than for a current need. While consumers becoming informed about aged care is welcome, seeking assessment before a need exists adds complexity to any attempt to measure unmet demand through assessing eligibility data and service queues.

⁵⁷ National Aged Care Alliance submission, p. 7.

⁵⁸ Aged Care Guild submission, p. 4.

⁵⁹ Sunnyside Lutheran Retirement Villages submission, p. 3.

⁶⁰ Victorian Healthcare Association submission, p. 4.

⁶¹ Merri Health submission, p. 3.

⁶² HammondCare submission, p. 4.

Unmet demand using the SDAC

4.41 The SDAC asks respondents the extent to which they feel their needs have been met. Examining the SDAC before and after implementation of the LLLB reforms could be a broad indicator of whether the reforms have impacted on the level of unmet demand for aged care services.

4.42 The last two SDAC surveys were in 2012 and 2015, falling before and after the implementation of the LLLB reforms. Table 4.3 shows the extent to which people aged 65 years and over who reported having at least one need for assistance felt their needs were met (not including people living in residential care accommodation).

Table 4.3 SDAC reporting of unmet need, 2012 and 2015⁶³

SDAC YEAR	FULLY MET		PARTIALLY MET		NOT MET		TOTAL	
	Number ('000)	%	Number ('000)	%	Number ('000)	%	Number ('000)	%
2012	787.4	66.2	372.6	31.3	30.2	2.5	1,189.90	100
2015	823.2	69.2	329.8	27.7	37.4	3.1	1,190.40	100

4.43 Table 4.3 indicates that there has been no substantial change in reported meeting of needs. The majority of people who reported a need for assistance with at least one care activity said their needs were being fully met, with a small decrease in the proportion of people saying their needs were partially met. It remains rare for people to report that their needs were not met at all.

Unmet demand using elapsed time

4.44 Another possible indicator of unmet demand using eligibility data is the measure of time elapsed: the time between when a person is assessed as eligible for aged care, and when that person enters care. Time elapsed has been used as a proxy for 'waiting times' between obtaining eligibility for care and the time of accessing care. Time elapsed is reported annually in the *Report on government services* and was referred to by many submissions.

4.45 Tables 4.4–4.6 summarise the time elapsed for entry into aged care services.⁶⁴ Table 4.4 presents results for residential care, Table 4.5 shows results for level 1 and 2 home care packages, previously known as a community aged care package (CACP), Table 4.6 presents results for level 3 and 4 packages, previously known as an extended aged care at home package (EACH) and EACH-Dementia (EACH-D). The rows show the percentage of people for whom the time elapsed between assessment and entering care was greater than a particular period. The first row shows the percentage for whom it took longer than a month, the second row greater than three months, and the third row greater than nine months. The final row expresses the same data differently, by describing the median time elapsed, or the number of days within which half of all consumers entered care. The data covers the period from 2011–12 to 2015–16.

⁶³ Australian Bureau of Statistics, SDAC, 2012, table 28, and SDAC, 2015, table 29.1.

⁶⁴ Productivity Commission, 2017, *Report on government services*, chapter 14 (Aged care services), Table 14A.25 for extended data, including data notes and caveats.

Table 4.4 Elapsed time between approval and entry into permanent residential care⁶⁵

	2011–12 (%)	2012–13 (%)	2013–14 (%)	2014–15 (%)	2015–16 (%)
≥ 1 month	55.7	56.1	58.8	69.4	73.5
≥ 3 months	30.1	30.8	33.3	41.6	48.0
≥ 9 months	10.7	11.8	13.3	18.7	25.7
Median time elapsed, days	40.0	40.0	45.0	68.0	84.0

Table 4.5 Elapsed time between approval and commencement of level 1 and level 2 home care package⁶⁶

	2011–12* (%)	2012–13* (%)	2013–14** (%)	2014–15** (%)	2015–16** (%)
≥ 1 month	60.9	64.9	69.0	66.4	67.4
≥ 3 months	30.5	34.6	40.5	42.4	43.8
≥ 9 months	6.4	7.9	12.9	19.9	24.1
Median time elapsed, days	44.0	52.0	67.0	71.0	76.0

Notes: *data are for CACP prior to 1 August 2013; **data are for level 1 and level 2 home care packages.

Table 4.6 Elapsed time between approval and commencement of level 3 and level 4 home care packages⁶⁷

	2011–12* (%)	2012–13* (%)	2013–14** (%)	2014–15** (%)	2015–16** (%)
≥ 1 month	62.6	69.2	70.4	65.7	67.1
≥ 3 months	35.6	43.3	42.1	37.8	39.8
≥ 9 months	16.0	20.2	18.4	15.6	17.3
Median time elapsed, days	51.0	69.0	69.0	56.0	63.0

Notes: *data for the years 2011–12 and 2012–13 are for EACH packages but do not include time elapsed for EACH-D packages. This may skew the results when comparing to post-2012–13 data, as EACH-D admissions had a longer elapsed time than EACH admissions. **data from 1 August 2013 are for level 3 and level 4 home care packages.

4.46 Overall, the elapsed time from approval to entering aged care services has increased since implementation of the LLLB reforms.

4.47 It is not clear what, if anything, can be determined from these data, particularly as they appear inconsistent with feedback from the sector. As reported annually in the *Report on government services*, this indicator needs to be interpreted with caution. The measure is referred to as ‘elapsed time’, rather than ‘waiting time’, because the period between ACAT approval and entry into care may arise from care not being available; however, it may also arise from a consumer not being ready to enter care or choosing not to enter care. Changes in consumer contributions policy, the introduction of the Home Care Packages Programme and the availability of home care, and the removal of ACAT assessment lapsing requirements during this period, all confound the matter further.

⁶⁵ Productivity Commission, *Report on government services*, 2016, table 13A.35, and 2017, table 14A.25.

⁶⁶ Productivity Commission, *Report on government services*, 2016, table 13A.35, and 2017, table 14A.25.

⁶⁷ Productivity Commission, *Report on government services*, 2016, table 13A.35, and 2017, table 14A.25.

4.48 Overall, information on elapsed time is useful but is a poor proxy for estimating unmet demand.

Unmet demand using eligibility data

4.49 The final measure of unmet demand that I considered was from the external analysis by Deloitte, commissioned by the department. The modelling on demand using eligibility data (paragraph 4.28 refers), was used to estimate historical levels of demand and unmet demand, which was considered to be the difference between the supply and demand for aged care services. Table 4.7 shows the outcomes of this modelling.

Table 4.7 Unmet demand, thousands of persons by care type and level, 2011–12 to 2015–16

	2011–12	2012–13	2013–14	2014–15	2015–16
Residential care ('000)	-15.1	-16.5	-19.9	-23.8	-24.5
Home care package 3 and 4 ('000)*	16.3	19.0	38.6	58.7	67.7
Home care package 1 and 2 ('000)**	45.8	49.5	46.3	27.1	20.9
Total ('000)	47.0	52.0	65.0	62.0	64.1

Notes: *data are for EACH and EACH-D prior to 1 August 2013; **data are for CACP prior to 1 August 2013.

4.50 This model does not include consumers whose needs are met through the CHSP.

4.51 Broadly, the modelling indicates that, in total, unmet demand has increased somewhat since implementation of the LLLB reforms. However, the distribution of this demand is also significant. It indicates that, as some submissions suggest, the supply of residential aged care may be exceeding the demand for those services. It also indicates that there may be significant unmet demand for home care package levels 3 and 4, in line with growing consumer preferences to remain living at home as long as possible. The data also show a decreasing level of unmet demand for home care package levels 1 and 2.

4.52 While it is unclear to what extent the raw numbers in Table 4.7 reflect true unmet demand, analysis of the broad trends by service type presents a picture consistent with much of the feedback received from providers, consumers and carers.

Conclusion

4.53 Understanding demand and the extent to which that demand goes unmet requires consideration of a range of data, all of which are valuable. However, none provide an accurate estimate of demand. The results must be considered alongside what consumers, providers and other stakeholders have said about the need for aged care and the extent to which they believe it is being met.

4.54 Taken together, it appears that the level of unmet demand for aged care services is relatively low, but that it may have increased slightly since implementation of the LLLB reforms.

4.55 Moreover, the current mix of services may not be appropriate to match the areas where there are the greatest levels of unmet demand, which appears to be for higher-level home care packages. This issue is considered further in the second half of this chapter, on the supply of aged care services.

4.56 It is important to note however, that the LLLB reforms include significant growth in home care packages between now and 2021–22. This growth is already part of government policy settings for the future and should help reduce unmet demand. This too is discussed in the second half of this chapter on supply of aged care services.

4.57 There are two other conclusions that can be drawn from considering demand and unmet demand. First, however imprecise the measure of demand for care might be, there is no doubt that, as the baby-boomer generation ages, a significant growth in service provision and expenditure will be required.

- 4.58 Second, the uncertainty around demand means that the government is not yet able to predict it with the degree of precision and confidence that would be desirable, prior to making any decision to uncap supply. Robust measures of demand and unmet demand in aged care are a significant way off. The creation of the national queue for home care packages is a significant step on that journey, with further steps recommended in the second half of this chapter.

THE SUPPLY OF AGED CARE SERVICES

Introduction

- 4.59 The government controls the supply of aged care places by fixing the number of places it will fund. That number is not set in absolute terms, but by setting a national target of operational aged care places for every 1,000 people aged 70 years and over. This is known as the Aged Care Provision Ratio (the Ratio). The Ratio is used to determine the number of aged care places supplied, proportionate to the growth of the 70 years and over population.
- 4.60 The purpose of the Ratio is to allow the government to plan for the provision of services, and to predict and manage its expenditure.
- 4.61 In practice, the Ratio places a cap on the number of government-funded services available at any one time. As the Commission noted in 2011:
- Planning ratios do not necessarily reflect the level of demand. If demand exceeds supply the ratios are binding, while if there is excess supply the ratios are irrelevant and could be removed.⁶⁸*
- 4.62 In addition to setting the total number of aged care places, the government maintains targets for the mix of home and residential aged care places within the Ratio.
- 4.63 Australia's changing demographic profile, with a predicted substantial increase in the proportion of older people in the population over the next 40 years, means government will need to make changes to the Ratio targets to better meet demand.
- 4.64 This part of chapter 4 discusses improvements that can be made to current supply arrangements and therefore the current and future supply of aged care places. The Review's recommended changes seek to improve the responsiveness of the system to consumer demand. Importantly, the changes will also create mechanisms that allow the government to better monitor and test the demand for aged care services and to consider further changes to deregulate supply.

History of supply-side reforms

- 4.65 The history of policy reforms on the supply of aged care reflects ongoing grappling with three underlying issues: providing the right amount of aged care services taking into account both demand for services and costs of supply; providing the right mix of service types to meet consumer needs and preferences; and, more recently, balancing government control over supply with a market-driven approach.

The number and mix of aged care services

- 4.66 The outcomes of policy reforms can be seen in changes to the Ratio over time. When it was first introduced in 1985, the Ratio was set at 100 places per 1,000 people aged 70 years and over, which included targets of 60 hostel places (low level residential care) and 40 nursing home places (high level residential care). It did not include home care. At that time, it was reported that Australia had one of the highest rates of residential care for the aged in the world—some 140 beds per 1,000 people aged 75 years and over.⁶⁹ Implementation of the Ratio sought to reduce reliance on high level residential care, encouraging more appropriate levels of care and moderating the growth in new services.⁷⁰

⁶⁸ Productivity Commission, 2011, *Caring for older Australians*, p. 65.

⁶⁹ Department of the Parliamentary Library, 1993, *Residential care for the aged: overview of government policy from 1962–1993*, p. i.

4.67 Governments have increased the Ratio several times and changed the target service mix, continuing to base the targets on the population of 1,000 people aged 70 years and over:

- In 1993, the mix of places within the 100 place Ratio was changed to 52.5 low-level residential care places, 40 high-level residential care places and 7.5 home care package places.⁷¹
- In 1995, the mix of places within the 100 place Ratio changed to 50 low-level residential care places, 40 high-level residential places and 10 home care package places.
- In 2004, the Ratio was increased to 108 places, including targets of 48 places for low-level residential care, 40 places for high-level residential care, and 20 home care package places.
- In 2007, the Ratio was increased to 113 places, including targets of 44 places for high-level residential care, 44 places for low-level residential care, and 25 home care package places.
- In 2012, under the LLLB reforms, the Ratio was increased to 125 places, including targets of 80 residential care places⁷² and 45 home care package places, to be achieved by 2021–22.
- In 2015, the targets for the mix of places within the 125 Ratio was changed to allow for the creation of 2 restorative care places resulting in a reduction to the residential care target to 78 places.⁷³

Box 4.3 The Current Ratio

The current Ratio is set at 125 aged care places per 1,000 people aged 70 years and over, including 78 residential care places, 45 home care places and 2 restorative care places, to be achieved by 2021–22.

Controlling supply

4.68 When it reviewed aged care in 2011, the Commission recommended the removal of supply-side limits on residential and home care places:

*The Australian Government should remove regulatory restrictions on the number of community care packages and residential bed licences. It should also remove the distinction between residential high care and low care places (Recommendation 7.1).*⁷⁴

4.69 The Commission suggested that, as an interim measure to improve service responsiveness, the government add an additional service level. In support of this recommendation the Commission commented that:

*...a more flexible system would also enable providers to increase the range and scope of their services, freeing them from the current highly regulated, risk-averse regime. Regulations should revert to a more appropriate role of ensuring safety and quality, protecting the vulnerable and addressing market failures.*⁷⁵

4.70 In recommending these changes, the Commission was aware that it was proposing the removal of a mechanism used by government to control aged care expenditure:

⁷⁰ Department of the Parliamentary Library, 1993, *Residential care for the aged: overview of government policy from 1962–1993*, p. i.

⁷¹ Note home care packages were referred to as community care places until 2012.

⁷² The distinction between residential high and low care was removed as part of the LLLB reforms.

⁷³ Restorative care places include places under the Short-Term Restorative Care Programme and the Transition Care Programme.

⁷⁴ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p lxiv.

⁷⁵ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p. xxv.

The relaxation of supply-side constraints is essential to improving choice and competition, but it will add to the risk of even greater public expenditure unless there are also changes to funding arrangements.⁷⁶

4.71 Nevertheless, it concluded that:

...As the Australian Government could manage its fiscal exposure by setting the criteria for needs assessment, the resource levels for approved services, the co-contribution schedules and the standard for basic accommodation, the Commission considers that the removal of restrictions on supply is warranted and appropriate.⁷⁷

4.72 The government partially supported the Commission's recommendations. The LLLB reform package introduced:

...a substantial but controlled expansion of aged care places, including a relaxation of supply controls.⁷⁸

4.73 The LLLB reforms did this by introducing the Home Care Packages Programme (replacing community care packages), which introduced new levels of care, expanding access to home care packages by increasing the number of places to be made available and removing the high/low distinction in residential care, allowing greater consumer choice of, and access to, a range of service providers.

4.74 The government did not, however, support the Commission's recommendation to remove supply controls, because:

A premature removal of supply restrictions would create significant risks both for consumers and the aged care sector, which would find it difficult to adjust to a fully competitive market...with the potential for significant financial dislocation and closure of services.⁷⁹

4.75 In the government's second submission to the Commission, the Department of Health and Ageing argued that there were other risks related to the removal of supply control that could not be easily mitigated without significant impact on vulnerable consumers. Areas of risk included:

- the ability of the residential care sector to respond quickly to supplying services for consumers whose services fail
- provision of services in areas with less competitive markets
- planning mechanisms to encourage provision of services to areas with thin or single markets, or to people with identified special needs.⁸⁰

Reforms under Living Longer Living Better: 2012–2015

4.76 Although the government did not fully support the Commission's recommendations, the LLLB reforms did make substantial changes to the way home care packages are delivered.

4.77 The most significant change from a supply perspective was that, in response to the demand for more home care packages, there was a significant increase to the Ratio (from 113 to 125 aged care places per 1,000 people aged 70 years and over to be achieved by 2021–22). Within this, the Ratio target for the number of home care packages was increased from 27 to 45 places with a gradual decrease in the target for residential care places, from 88 to 80 places.

4.78 The increased target for home care packages translates to 140,000 packages by 2021–22, an increase of 80,000 packages since 2012–13. While the reform reduces the proportion of new residential care places, the ageing of the population means that the absolute number of residential places continues to grow each year.

⁷⁶ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p. xxxi.

⁷⁷ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p. xxxix.

⁷⁸ Australian Government, 2012, *Australian Government response to the Productivity Commission's Caring for older Australians report*, p. 6.

⁷⁹ Australian Government, 2012, *Australian Government response to the Productivity Commission's Caring for older Australians report*, p. 6.

⁸⁰ Department of Health and Ageing, 2011, Second submission to the Productivity Commission, pp. 5–6.

Reform beyond 2015

- 4.79 Since the LLLB reforms, further policy changes have impacted on supply, including introducing restorative care places and increased flexibility in the Aged Care Approvals Round (ACAR)⁸¹ by allocating new residential care places by state/territory, rather than by the previously used 73 aged care planning regions.
- 4.80 The main reform, however, was the February 2017 changes to the Home Care Packages Programme through the Increasing Choice in Home Care measure. The changes mean that:
- The ACAR is removed as the mechanism to assign home care packages. Instead, a national prioritisation queue has been established and is being used to assign available packages to eligible consumers.
- New packages are released periodically and assigned directly to eligible consumers. For 2016–17, approximately 10,000 new home care packages were placed into the national pool attached to the national prioritisation queue.
- Consumers now own their package, rather than packages being owned by providers. This means that once assigned a package through the queue, consumers can approach any approved provider to deliver their care and can transfer their package funding to another provider if they wish.
- 4.81 The government's intention is to give consumers greater choice and control over their package and to create competition within the market that, in turn, should drive quality and innovation in the delivery of care. It should also make it easier for new providers to enter the home care market, and for existing residential and flexible care providers to 'opt in' to provide home care services.

Current supply of aged care

- 4.82 To understand how supply meets the Ratio set by the government, it is important to recognise that achievement of the Ratio is based on the number of *operational* places available to consumers, not the number of *allocated* places. *Allocated* means that a residential care place has been assigned (through an ACAR process), and is owned by a provider; however, that place is not yet available for use by a consumer. Once a place is ready for use by a consumer, the place becomes *operational*.
- 4.83 Home care places have always become operational shortly after allocation, because they require limited capital investment or infrastructure. For example, between 2012 and 2016, there was approximately a 30 per cent increase in the total number of home care packages allocated, yet there was only an increase of about 1 per cent in the total number of packages that were non-operational over the same period.⁸² As at 30 June 2016, there were 80,176 home care places, of which 79,819 (99.6 per cent) were operational.⁸³
- 4.84 The introduction of the national pool in home care, where packages are now allocated directly to the consumer, means the distinction between an allocated and operational place is no longer relevant for home care. As funding is automatically available for use, all home care packages are assumed operational once assigned to a consumer.
- 4.85 However, the situation is very different in residential aged care, where there is a delay between the *allocation* of new aged care places and the places becoming *operational* and therefore available to a consumer. As at 30 June 2016, there were 242,500 allocated residential care places Australia-wide, of which just under 200,000 (or 82.2 per cent) were operational.⁸⁴ This is because, once a residential place has been allocated, construction of residential accommodation takes an average of 4.3 years.

⁸¹ The ACAR is a competitive application process that enables prospective and existing approved providers of aged care services to apply for a range on new government-funded aged care places.

⁸² Department of Health, 2016, *Stocktake of Australian Government subsidised aged care places*, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2016/stocktake_comparison_30_june_2012_-_30_june_2016.pdf

⁸³ Department of Health, 2016, *Stocktake of Australian Government subsidised aged care places*, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2016/stocktake_comparison_30_june_2012_-_30_june_2016.pdf

⁸⁴ Department of Health, 2016, *Stocktake of Australian Government subsidised aged care places*, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2016/stocktake_comparison_30_june_2012_-_30_june_2016.pdf

- 4.86 In addition, providers of residential aged care can choose to take operational places 'offline'. This happens for a range of reasons, including rebuilding or refurbishing homes, the inability to sell a service to another provider, or an inability to use a second bed in a shared room.
- 4.87 As at 30 June 2016, there were around 43,000 non-operational residential aged care places (excluding flexible care places), of which 35,000 were provisionally allocated places and nearly 8000 were offline places.⁸⁵ Due to the large number of non-operational places—approximately 18 per cent of all allocated places—the Review considered whether improvements could be made to encourage providers to make places operational more quickly.
- 4.88 Changes to how provisionally allocated places are managed were made in February 2016. The new rules give providers four years to operationalise their provisionally allocated residential care places and limit the number of extension requests providers can submit. The changes better align the provisional allocation period with the median time taken for a provider to operationalise their places and seek to encourage the timely delivery of care.
- 4.89 Unlike provisionally allocated places, there is currently no process to monitor how long offline places have been offline. In addition, there is no mechanism for government to require providers to bring these places online, or for government to reclaim these places.
- 4.90 As a first step, the department should undertake a stocktake to gain a clear understanding of how long offline places have remained offline. If required, the department should implement a process similar to that for provisionally allocated places, which requires providers to bring their places online within a required timeframe and allow government to reclaim these places where providers do not comply with these requirements.

Recommendation 1

That the government review the management policy regarding offline residential care places and, if required, implement changes that maximise their availability to consumers.

Will supply meet the Ratio's targets?

- 4.91 Table 4.8 shows the number of allocated and operational places by service type for the period 2012–2016, and demonstrates the difference in translating allocated places to operational places between home care and residential care.

Table 4.8 Number of allocated and operational aged care places, 2011–12 to 2015–16⁸⁶

YEAR (AS AT 30 JUNE)	ALLOCATED PLACES AND RATIOS							OPERATIONAL PLACES AND RATIOS						
	Residential care		Home care		Restorative care**		Grand total	Residential care		Home care		Restorative care**		Grand total
	Places	Ratio	Places	Ratio	Places	Ratio	Ratio	Places	Ratio	Places	Ratio	Places	Ratio	Ratio
2012	214,059	96.1	61,064	27.4	4,000	1.8	125.3	187,941	84.4	60,949	27.4	4,000	1.8	113.6
2013	220,030	98.0	66,732	29.7	4,000	1.8	129.5	189,761	84.5	61,087	27.2	4,000	1.8	113.5
2014*	220,585	94.5	66,954	28.7	4,000	1.7	124.9	192,834	82.6	66,954	28.7	4,000	1.7	113.0
2015	231,615	95.9	73,626	30.5	4,000	1.7	128.0	195,953	81.1	73,550	30.4	4,000	1.7	113.2
2016	242,500	96.9	80,176	32.0	4,000	1.6	130.5	199,449	79.7	79,819	31.9	4,000	1.6	113.2

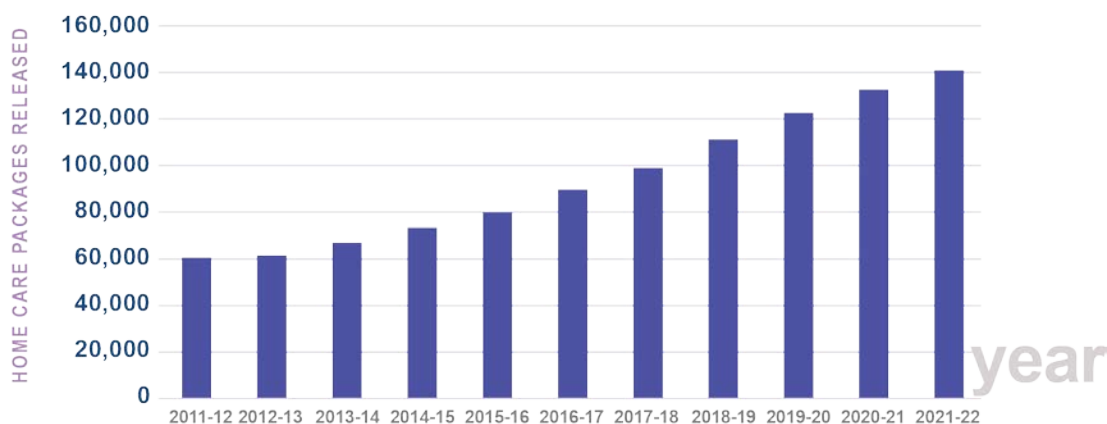
⁸⁵ Note this is self-reported data provided to the government by approved providers

⁸⁶ Department of Health, 2016, *Stocktake of Australian Government subsidised aged care places*, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/09_2016/stocktake_comparison_30_june_2012_-_30_june_2016.pdf

Notes: *From 1 August 2013, home care includes levels 1 to 4 plus home care places in the Multi-Purpose Service (MPS) Programme, National Aboriginal and Torres Strait Islander Flexible Aged Care Programme and Aged Care Innovative Pool Programme. Prior to 1 August 2013, Home care included CACP (now level 2), EACH and EACH-Dementia (now level 4) places. This also includes places in the MPS Programme, National Aboriginal and Torres Strait Islander Flexible Aged Care Programme and Aged Care Innovative Services.
 ** Restorative care includes places in the Transition Care Programme and the Short-Term Restorative Care Programme. As at 30 June 2016, restorative care includes places in the Transition Care Programme only. New places in the Short-Term Restorative Care Programme will progressively become available from 2016–17.

- 4.92 The sector has expressed concern about whether the government will achieve the Ratio of 125 places per 1,000 people aged 70 years and over by 2021–22, given that over recent years, the operational Ratio has remained stable at around 113 places. Moreover, at the end of 2015–16, the home care operational ratio stood at 31.9 places; significantly below the target of 45 places 2021–22.
- 4.93 This issue deserves some exploration, as it links to the broader issues of supply meeting demand and whether the government should continue to control the supply of aged care places.
- 4.94 The government is close to realising the residential care ratio of 78 places, sitting at 79.7 places as at 30 June 2016 (Table 4.8).
- 4.95 As was set out in the LLLB reforms, the government is only now entering the growth phase for home care packages, which were to see a marked increase in the release of home care packages from 2016–17 onwards.
- 4.96 Figure 4.4 demonstrates the release rate of home care packages from 2011–12 to 2016–17 and the projected release rate from 2017–18 to 2021–22 to reach the target of 45 places.

Figure 4.4 Release of home care packages, 2011–12 to 2021–22⁸⁷



- 4.97 In broad terms, Figure 4.4 shows that an additional 50,000 home care places will need to be released over the next five years to achieve the home care ratio.
- 4.98 I am satisfied that the government has the mechanisms in place to release the required number of home packages to reach the Ratio. However, while the sector has been able to expand to accommodate growth in packages over the past few years, it remains unknown whether it can continue to expand at a sufficient rate to accommodate the significant growth in packages over the next few years. Chapter 10 on workforce and the recommendations contained within it will be important to sector readiness.

Should the government continue to control the number and mix of aged care places?

- 4.99 The Commission recommended removing regulatory restrictions that control the supply of aged care places. However, the government considered that it would have been premature to uncap supply at that time but it did take steps to loosen supply controls. It also built into the terms of reference for this Review that the issue of government control of supply be revisited.

⁸⁷ Department of Health, unpublished modelling.

- 4.100 More recently, the *Aged care roadmap* (the Roadmap), as developed by key sector stakeholders through the Aged Care Sector Committee, envisions a sector that has no cap on the number of aged care places, but rather is “market based and consumer driven, with access based on assessed need”.⁸⁸
- 4.101 In line with the Roadmap, I agree that the long-term objective is to uncap the supply of aged care services, with government no longer controlling supply through the Ratio. This would mean that consumers with an assessed need would be able to access services, and providers would determine how many and what type of aged care services are supplied and expand or contract supply based on their assessment of demand.
- 4.102 Many submissions to this Review drew attention to the negative impacts of the current supply-based approach, including dampening usage, reducing choice and creating unmet demand for services. Alzheimer’s Australia, for example, stated that:

*Controlling the supply of care may limit the choices available to service users, increase waiting lists, resulting in people who need care missing out or waiting a long time, limit supply, giving residential aged care providers an incentive to choose wealthier potential residents or those with less complex care needs, and limit competition, which may affect quality.*⁸⁹

- 4.103 Shepparton Retirement Villages argued that:

*The removal of the number and mix of places for residential and home care is the only way that there can be widespread equity and fairness for all consumers. In such an environment, the market determines what and how many services, packages and or residential places there are in any given area. This will also give rise to greater competition, consumer choice and ultimately the efficiency of the industry.*⁹⁰

- 4.104 However, feedback from submissions and workshops on the issue of whether government should continue to control the supply of aged care places, was mixed. Some argued that government should remove all supply controls, but others were strongly opposed. Some argued that government should take a stepped approach in removing supply controls to ensure provider viability and continuity of service for consumers. Those who argued for the removal of supply controls nevertheless acknowledged the risks associated with a consumer demand-driven system and favoured special provisions to ensure adequate supply for people in rural and remote areas, and for special needs groups such as financially disadvantaged people.

- 4.105 National Seniors Australia stated that they:

*...support increased competition in the provision of aged care services. This can be achieved through a relaxation of the restrictions on places that exist currently.*⁹¹

However, they acknowledged that maintaining equity of access may affect this decision:

*While providers need more flexibility, National Seniors is wary of removing government control if this had a negative impact on equity.*⁹²

- 4.106 Many submissions pointed to the risks of market-based models.

- 4.107 On equitable access, the National Presbyterian Aged Care Network wrote that:

NPAC [National Presbyterian Aged Care Network] supports in principle the removal of supply-side planning controls in aged care, as recommended by the National Aged Care Alliance (NACA) and the Aged Care Sector Committee (ACSC) Roadmap... We note however that maintaining equitable access to aged care is vital in any market-based model. NPAC

⁸⁸ Aged Care Sector Committee, *The aged care roadmap*, p. 4.

⁸⁹ Alzheimer’s Australia submission, p. 9.

⁹⁰ Shepparton Retirement Villages submission, pp. 3–4.

⁹¹ National Seniors Australia submission, p. 3.

⁹² National Seniors Australia submission, p. 3.

*does not support Australia moving to a three class system: haves; have nots; rural and remote... NPAC believes we will need an alternative model developed that properly supports retention of infrastructure in rural and remote areas.*⁹³

4.108 On the issue of provider viability, the Guild stated:

*Whilst the Guild supports increased competition in the marketplace, and progressive measures towards deregulation of supply, we do not support full deregulation in the short term. The Guild observes that there are risks around not controlling places in the broader market. For instance, impacts on investor sentiment will be an important consideration, as risks on returns (from an investor perspective) will need to be managed and addressed to ensure a minimal disruption. It may also be that some controls will need to remain in place.*⁹⁴

4.109 Some stakeholders opposed the move altogether, on the basis that only government could ensure access remained equitable. For example, Mercy Aged and Community Care stated that:

*There must be some mechanism for Government to control the quantum of services and subsidy cost. Mercy Health does not support full deregulation of licences due to the risk of inequity of access for special needs, rural and remote clients... in residential aged care, the deregulation of bed licences, and the removal of the socio-demographic allocation model, would likely to lead to an increase in the number of beds provided in areas of relative affluence, to the detriment of lower socio-economic areas. Access to services in regional Australia would be at-risk in a deregulated environment.*⁹⁵

Preparing for uncapping supply

4.110 I consider that, ultimately, it would be desirable for the supply of aged care to be uncapped. There is, however, significant work to do before government could safely remove supply controls while ensuring the system is fiscally sustainable for government and equitable for consumers.

4.111 As noted in chapter 3, there are at least four requirements to ensure the uncapping of supply is sustainable

- an accurate understanding of the underlying demand that the system is designed to meet
- equitable and sufficient contribution by care recipients to their costs of care
- a robust system for assessing eligibility for subsidised services
- provisions for ensuring equitable and continuing supply of aged care services in places where there is limited choice and competition within the market, e.g. rural and remote areas.

4.112 Reforms to date have taken aged care part of the way. The government has already reduced the supply constraints on home care and to some extent, in residential care. In home care, packages are now assigned directly to consumers. In residential aged care, the government has reduced locational supply controls by allocating places through the ACAR by state/territory.

4.113 However, the government currently lacks the capacity to meet the first requirement: it cannot reliably gauge current demand nor can it accurately predict future demand. While on balance it appears to be safe to conclude that there is high demand for high level home care packages compared to other kinds of aged care services, it is not possible to reliably say how close the system currently is to meeting demand. To allow for a fully uncapped system, the government will need to be assured that it can accurately forecast the demand for aged care services.

4.114 Some limited progress has been made towards the second requirement, improving the fiscal sustainability of the aged care system through consumer contributions to care. The LLLB reforms have made important but modest improvements. However, the changes in government versus consumer contributions so far represent only 1 to 3 percentage points at most, in either home or residential care.⁹⁶

⁹³ National Presbyterian Aged Care Network submission, pp. 3–4.

⁹⁴ Aged Care Guild submission, p. 5.

⁹⁵ Mercy Aged and Community Care submission, p. 3.

⁹⁶ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, pp. 26–27.

- 4.115 There needs to be substantial further policy reform to ensure consumer contributions are equitable across service types and to ensure long-term fiscal sustainability for government. Further steps to improve the fiscal sustainability of the aged care system, as outlined in chapter 5 on means testing, are needed.
- 4.116 The third requirement is to have robust assessment processes for determining eligibility for subsidised aged care services. This includes consistency in assessment across geographic locations and better matching of approvals (service type and level) to consumer's needs. These are discussed further in chapter 8 on access to aged care services.
- 4.117 The fourth requirement is to have provisions in place to ensure equitable access to services. In an uncapped market, additional provisions may be required to ensure that this continues.
- 4.118 It is essential that these four requirements are addressed before government can safely remove supply controls.

Recommendation 2

That the government, in the medium term, continue to maintain control over the number and mix of aged care places (residential care and home care), in line with the improvements detailed in Recommendations 3–10.

Improvements to supply controls

- 4.119 While I recommend that the government continue to control the number and mix of aged care places in the medium term, there should be further improvements made to the current supply controls to better meet current demand. Such improvements will also enable government and the aged care sector to test true demand within the current planning parameters. This will, in turn, allow for policy revision, moving towards an uncapped, consumer demand-driven system in the future.

A consumer-driven residential aged care system

- 4.120 As detailed previously, the government has already taken some steps to reduce supply controls, particularly in home care by assigning home care packages directly to consumers.
- 4.121 Changes should also be made to the process for allocating residential care places, to make it more responsive to consumer need.
- 4.122 For residential care, the change to state/territory-based allocation of places in the 2016–17 ACAR was a first step in loosening locational controls over the supply of places.
- 4.123 The next step should be the removal of ACAR for residential care, instead assigning 'places' directly to the consumer. Similar to the approach taken in home care, this could be achieved while maintaining a cap on the number of places through the Ratio.
- 4.124 HammondCare supported such a move, stating:

HammondCare welcomes reforms which allow Home Care Package subsidies to 'follow' the client... We also encourage similar arrangements in residential care.⁹⁷

- 4.125 This approach would allow the government to continue to manage its fiscal risk by maintaining targets for the provision of residential care, but at the same time encourage a residential care system that is more consumer driven within an overall cap.
- 4.126 Consideration should be given to the ability of the sector to adapt to new supply conditions. In a system where funding is assigned to the consumer, providers will no longer have an exclusive licence to claim a government subsidy. Rather, they will have to compete for each consumer, not only to attract new consumers but also to retain existing residents. And, unlike home care, for residential aged care providers to take advantage of the benefits of a market model they need to create new infrastructure.

⁹⁷ HammondCare submission, p. 5.

- 4.127 In light of this, the sector will require advance notice to ensure they are adequately prepared. For this reason, I suggest the changes should take effect two years after their announcement.

Recommendation 3

That, as soon as possible, the government discontinue the Aged Care Approvals Round for residential care places, instead assigning places directly to the consumers within the residential care cap, with changes to take effect two years after announcement by government.

- 4.128 The sector has identified concerns that implementing a market-based system where places are assigned to the consumer might involve risks to access to services in some locations and/or for some groups of consumers.
- 4.129 This risk is real. Therefore, in removing ACAR, provisions need to be in place to ensure supply continues to grow in areas where markets may not result in an adequate supply of services, e.g. rural and remote areas.
- 4.130 The government should review its existing incentives of capital grants and the viability supplement, and determine whether these alone will be sufficient, whether they need to be expanded, or whether new incentives are required to ensure continuing supply in these areas.

Recommendation 4

That a government announcement on discontinuation of Aged Care Approvals Round (Recommendation 3) be accompanied by appropriate provisions to ensure continuing supply of residential care services in areas with limited choice and competition.

- 4.131 These recommendations are in line with the staged approach to uncapping supply outlined in the Aged care roadmap and steps already taken in home care.

Improving the availability of home care

- 4.132 In total, approximately 70 per cent of home care packages in 2015–16 were levels 1 and 2 (mostly level 2 packages); however, feedback from the sector indicates that demand for level 1 and 2 packages has stagnated, if not reduced, while the level of demand and unmet demand is continuing to rise for levels 3 and 4 home care packages.

- 4.133 Throughout the Review consultation process, there was a strong emphasis on the need for more high level home care packages. For example, Anonymous 2 argued:

*There are not enough packages to keep people living in the community, especially high care – often lesser packages are accepted as a proxy, leaving the person at risk, and also putting extra demand on the care providers... Level 1 packages are a waste of time – they are not being utilised, so the funding for these should go to more Level 4 packages...*⁹⁸

- 4.134 A number of providers, carers, and consumers reported that many consumers have to accept a lower-level package as an interim, while waiting for a higher-level package to become available. For example, Golden Glow Corporation reported that:

*Due to the current restrictions on the number of packages we can have, we frequently commence a client on a Level 2 package while they are waiting for a Level 4 package to become available.*⁹⁹

- 4.135 The Alliance recounted the experience of one of its member organisations:

*...one member of the Alliance has reported constant feedback and complaints about the lack of Level 4 packages across Australia, with many of these clients being left on a Level 2 package while they wait for availability of their assessed level of care needs.*¹⁰⁰

⁹⁸ Anonymous 2 submission, p. 3.

⁹⁹ Golden Glow Corporation submission, p. 3.

- 4.136 Feedback at many of the workshops also raised the difficulty in accessing level 3 and 4 home care packages, with many consumers waiting several months to receive a higher-level package. Some workshop participants reported family members having to wait 12–18 months to access a level 4 home care package.
- 4.137 Further, many consumers argued that level 1 and 2 packages do not present value for money, as they can often receive the same, if not more, services through the CHSP but for a smaller (or zero) contribution. Many providers confirmed this, with some reporting difficulty in filling level 1 and 2 packages.
- 4.138 This suggests that there needs to be a re-balancing in the distribution of home care packages made available at each level to better meet existing unmet demand and better match future demand.
- 4.139 Table 4.9 shows the distribution of home care packages by package level and the corresponding occupancy rates.¹⁰¹ Together they support the sector's view that the demand for higher-level home care packages is continuing to rise.

Table 4.9 Occupancy rates by home care packages level, 2012–13 to 2015–16¹⁰²

YEAR (AS AT 30 JUNE)	HOME CARE					
	LEVEL 1			LEVEL 2		
	Number	% Occupancy	Total occupied packages	Number	% Occupancy	Total occupied packages
2013*	-	-	-	47,158	92.4	43,574
2014	1,303	48.7	635	50,157	88.8	44,539
2015	2,251	48.7	1,096	51,956	85.2	44,267
2016	2,254	68.3	1,539	52,415	81.1	42,509

YEAR (AS AT 30 JUNE)	HOME CARE					
	LEVEL 3			LEVEL 4		
	Number	% Occupancy	Total occupied packages	Number	% Occupancy	Total occupied packages
2013*	-	-	-	13,123	91.0	11,942
2014	1,010	59.9	605	13,679	90.1	12,325
2015	3,815	66.7	2,545	14,680	92.1	13,520
2016	7,369	79.6	5,866	16,918	93.1	15,751

Notes: *Data reported for 2013 are for CACPs (aligned to level 2 home care package) and EACH and EACHDs (aligned to level 4 home care package).

- 4.140 There has been strong growth in the use of level 3 and 4 home care packages (Table 4.9).
- 4.141 A re-balancing seems further justified when considered in light of ACAT assessment approval data. For example, in 2016–17¹⁰³ there were 29,602 approvals for levels 1 and 2 home care packages, compared to 53,762 approvals for levels 3 and 4 home care packages.¹⁰⁴

¹⁰⁰ National Aged Care Alliance submission, p. 7.

¹⁰¹ The occupancy rate is defined as the proportion of available package days that were used for home care.

¹⁰² Department of Health, *Reports on the operation of the Aged Care Act 1997*, 2012–13 to 2015–16, p.37 and 2013–14, p.27, and Department of Health, unpublished data.

¹⁰³ Note numbers represent approvals for the period July 2016 to April 2017.

¹⁰⁴ Department of Health, unpublished ACAP programme data.

- 4.142 Further, the Deloitte modelling projected a steady and increasing level of unmet demand for levels 3 and 4 home care packages and a rapidly declining level of unmet demand for levels 1 and 2 home care packages over the next 10 years.

Recommendation 5

That the government re-balance the distribution of home care packages, by increasing the proportion that are high care packages, without a change in the overall home care ratio.

- 4.143 In addition to Recommendation 5, the Review considered whether the mix of home care packages and residential care places within the Ratio should also be re-balanced, by increasing the home care ratio and reducing the residential care ratio while maintaining a total Ratio of 125 places.
- 4.144 The Review found that this approach would not result in any significant gains. First, the department's modelling indicated that, due to the lag time in operationalising residential care places, there is limited scope to reduce the residential care target below the current target of 78 places in the short to medium term. This is because even if the government immediately stopped allocating any new residential care places, around 40,000 places already provisionally allocated in past ACAR rounds would come online between now and 2021–22. These places would result in a Ratio figure of 76.3 residential care places, which is only marginally lower than the current target of 78 places. To deliver the modest increase in the home care ratio that this would offer would come at the cost of releasing no new residential places for four years. This is clearly unrealistic.
- 4.145 This observation in turn leads to a second reason for not adopting the approach of reducing the residential care target: long-term planning ramifications would result from a move to permanently lower the residential care target by ceasing the release of places over the short term, and then maintaining that lower target over the medium term. The four-year freeze would dampen supply of places into the 2020s, and this in turn would require resetting the residential care target at a significantly higher rate in the mid- to late 2020s, as the first of the baby boomers enter the 80 and over cohort.
- 4.146 Permanently re-balancing the Ratio is unlikely to assist in increasing the supply of home care. However, creating greater flexibility within the Ratio between the use of home care and residential care places may be a more productive approach. This would achieve the desired outcome of providing more high level home care packages in the medium term, while not reducing the allocation of residential care places.
- 4.147 Between now and 2030, the ageing of the baby boomers will markedly increase the number of people in the 70 and over cohort. Through the planning Ratio, this will result in a significant expansion in the absolute numbers of aged care places over this period. However, it is likely that the demand for residential care will grow relatively slowly during this time. This is because the majority of people who access aged care services do so from their early to mid-80s, and the first of the baby boomers will not reach this age until the late 2020s.
- 4.148 As a result, assuming that people continue to enter residential aged care at similar ages to the current pattern between now and the late 2020s, the number of aged care places will rise faster than the rise in the rate of demand. During this period, use of residential aged care is unlikely to exceed 76 places per 1,000 people aged 70 years and over, and may actually fall below 75 places per 1,000 people aged 70 years and over in the mid-2020s.¹⁰⁵ This equates to approximately 12,000 unoccupied residential care places that could be temporarily reallocated as home care packages.
- 4.149 Between now and the early 2020s, the government should allow for greater flexibility in how residential care places are used by allowing an unoccupied residential care place to be temporarily reallocated as an additional high level home care package. The government would manage these arrangements nationally (see Box 4.4).
- 4.150 Residential care would continue to be allocated at levels that maintain a ratio of 78 places, and these places would be used by providers and consumers as usual. However, where those operational residential care places go unoccupied, the government would release more high level home care packages. If demand for residential care grows, the release of new home care packages would be held back to meet that residential care need. This would not impact on the base level of home care packages being released, meaning the minimum 45 places per 1,000 people aged 70 years and over would be maintained.

Box 4.4 A flexible model to manage supply

¹⁰⁵ Department of Health, unpublished modelling.

Assume the current Ratio provides for 125,000 operational aged care places in the system: 78,000 residential care places; 45,000 home care places; and 2,000 restorative care places.

Under this proposal, 93 per cent occupancy is assumed to be the 'fully-utilised' benchmark:

If residential care usage was 93 per cent of operational places under the Ratio (consistent with current rates), there would be 72,540 residential care occupants and 45,000 home care packages in circulation.

If residential care occupancy dropped to 85 per cent, there would only be 66,300 residential care occupants. Therefore, there would be 6,240 residential care places not being used (the difference between usage rates of 93 per cent and 85 per cent), that could instead be assigned to consumers as additional home care packages. This would allow for up to 51,240 home care packages to be in circulation.

However, if residential care occupancy rose to 95 per cent, there would be 74,100 residential care occupants. This would mean there would be no additional home care packages allocated and there would be 45,000 home care packages in circulation.

- 4.151 These arrangements would maintain the cap of 125 aged care places, but allow for the number of home care packages to expand up to what may be around 49 places per 1,000 people aged 70 years and over with the extra places allocated to high level home care packages.
- 4.152 Further, if it is correct that the current supply of residential care is meeting or is close to meeting demand, then by maintaining the current target for residential care, an oversupply of places is likely. The proposed change would test this proposition and help measure the true demand for residential care, providing important information required by government before it can consider uncapping supply. For example, if the demand for residential care is met under these arrangements, the government could be confident it has an accurate measure of demand and could contemplate removing supply caps for residential care. It also provides an opportunity to test the demand limits for home care packages by providing additional packages beyond the current supply restrictions.
- 4.153 In addition, it would be expected that the temporary re-allocation of unused residential care places to home care packages would further reduce demand for residential care services, in line with consumer preferences to remain living at home longer. This would create a feedback loop that would enable the system to move towards matching supply to consumer preferences.
- 4.154 UnitingCare Australia supported changes to the current supply arrangements:

*We encourage a more energetic approach on the part of the Australian Government to increasing the supply of home care packages to achieve the 45/1000 people target, with a view to future repositioning of the current supply ratios to a lower residential figure and greater supply of HCP [home care package] and restorative care services if residential occupancy continues to trend down.*¹⁰⁶

- 4.155 There was also support for a change in the mix:

*Given that expenditure on residential care subsidies far eclipses expenditure on home care subsidies and that consumers demonstrate a preference for home care, it makes sense to increase the proportion of Home Care Packages relative to residential care places... It is noted here that a reduction in the proportion of residential care places would lead to Government savings in the area of accommodation subsidies.*¹⁰⁷

- 4.156 If the recommendation is implemented as I propose, there will be a significant improvement in the availability of higher-level home care, addressing this area of rising demand. It will result in a system that is better able to reflect consumers' preferences and demand, in an environment where demand preferences are not fully understood. In addition, and importantly, it will test whether demand is being met in any area of care, informing future considerations about whether to uncap supply.

¹⁰⁶ UnitingCare Australia submission, p. 7.

¹⁰⁷ Combined Pensioners & Superannuants Association of NSW submission, p. 8.

Recommendation 6

That the government further increase access to high level home care packages to better reflect current demand by allowing for the temporary allocation of a home care package where there is a residential care place that is not being used.

Introduce a level 5 package

- 4.157 In addition, there is merit in introducing a higher-level home care package.
- 4.158 During the workshops, carers and providers noted that consumers with high physical and/or significant care needs arising from dementia were not able to be effectively cared for at home for long periods, despite receiving a level 4 home care package.
In the Sydney workshop, for example, consumers reported that even where a consumer is able to access a level 3 or 4 package, the hours of care provided are not enough to meet the consumer's needs. Consumers are then having to enter residential care to have their needs met.
- 4.159 At a workshop held in Port Augusta, aged care workers also argued that there needs to be better supported living between a level 4 home care package and residential care. In Perth, Melbourne and Sydney, consumers expressed their concern that level 4 home care packages do not provide sufficient care and services to allow consumers with high care needs, and those with advancing dementia, the level of support required to continue living at home.
- 4.160 A level 5 home care package would be well targeted towards providing an alternative to residential care for those consumers with high level care needs whose needs can no longer be supported by existing packages. The level of assistance should be no higher than the average cost of care in residential care, currently around \$63,000.¹⁰⁸
- 4.161 An alternative approach to introducing a level 5 package could be to revalue the four existing levels of home care, with a higher level of assistance for a level 4 package (and possibly a level 3 package) than currently provided and, possibly, lower levels of assistance for levels 1 and 2 packages. This would likely mean that people on existing high level packages would benefit from a greater subsidy; in other words, access to more care and services. As such, it is not well targeted at the specific population group—those with high care needs who would otherwise have to enter residential aged care.
- 4.162 On balance, my preferred approach, at least in the short term, is to introduce a level 5 home care package. This is in line with the objectives outlined in the Roadmap to achieve more seamless movement for consumers between home-based care and residential care.
- 4.163 The new level 5 package should be built into new packages released as part of implementing Recommendations 5 and 6. Together, these recommendations acknowledge and respond to rising levels of demand for high level home care packages, and facilitate consumer preference to remain living at home.
- 4.164 Having said that, a review of the existing packages (both the number of distinct packages and the levels of assistance under each of them) should be considered later as part of the integration of the CHSP and Home Care Packages Programme.

Recommendation 7

That the government introduce a level 5 home care package to allow people with higher care needs to stay at home longer, with the level of assistance being no higher than the average costs of care in residential care.

Residential respite care

- 4.165 The overall intent of Recommendations 5, 6 and 7 is to allow a greater number of consumers, including those with higher care needs, to be supported to remain living at home. In doing so, the needs of informal carers, who often provide significant additional support, should be considered. Government needs to ensure that there are adequate and appropriate respite services to support informal carers in their role.

¹⁰⁸ Department of Health, *Reports on the operation of the Aged Care Act 1997, 2015–16*, p. 47.

- 4.166 There are many types of respite services: community or home-based respite, such as those available under the CHSP or a home care package; and residential respite care, which can be used for planned periods of respite and is also often used in emergency or crisis situations.

Box 4.5 Residential respite care

Residential respite care is used for both planned periods of respite, and in emergency or crisis situations.

Access to residential respite care requires a comprehensive ACAT assessment. Unlike assessment for permanent residential care, approval for residential respite care is given by categories, either high or low level care. Once approved, consumers are eligible for up to 63 days of residential respite care every financial year.

Providers of residential respite care do not have a separate allocation of residential respite places. Rather, the Ratio target for residential care places includes the provision of respite services.

- 4.167 Feedback provided from workshops and from submissions was that often consumers and their carers are finding it difficult to access residential respite care. The Australian Medical Association (AMA), for example stated that:

*The need for respite care usually occurs when the carer has become unwell and/or is temporarily unable to provide care. In these situations, it is often very difficult to access respite care.*¹⁰⁹

- 4.168 However, the extent to which this difficulty has increased over time is unknown.

- 4.169 The LLLB reforms made no changes to residential respite care. However, since implementation of the reforms, the use of residential respite care has increased and the patterns of use have changed.

- 4.170 The sector has put forward that implementation of residential care reforms, particularly means testing and accommodation payment reforms, has resulted in more people entering residential respite care prior to admission to permanent care, with providers and consumers using this time as a 'try-before-you-buy' period.

Consequently, it has become more difficult for consumers with a genuine need for respite to access care. This argument deserves some exploration.

- 4.171 In 2012–13 and 2013–14 (pre-reform) approximately 48,000 people received residential respite care. In 2014–15, post-reform, approximately 53,000 received residential respite care. In 2015–16, this rose to approximately 57,000 people,¹¹⁰ an increase of 9,000 people since the reforms were implemented.

- 4.172 The main reason for the increased usage of respite care is that there was a growth in the number of people entering into permanent residential care either immediately after or within a week of being in respite care. This number has increased by approximately 5,000 people, from around 20,000 people in 2013–14 to 25,000 people in 2015–16.¹¹¹

- 4.173 Overall, there were an additional 4,000 people using residential respite care post-LLLB reforms who were not in respite immediately prior to entering permanent care.

- 4.174 Given this, I am not convinced that residential care reforms implemented under LLLB, and the increase in the 'try-before-you-buy', have made it more difficult for carers and consumers to access residential respite care.

- 4.175 However, irrespective of whether it is more or less difficult to access residential respite care post-LLLB reforms, it is evident that:

The use of residential respite care is increasing and patterns of use have changed.

By increasing access to high level home care packages for people who might otherwise enter residential care, the need for residential respite care will further increase.

- 4.176 The AMA noted that:

¹⁰⁹ AMA submission, p. 8.

¹¹⁰ Department of Health, *Reports on the operation of the Aged Care Act 1997*, 2012-13, p. 6, 2013-14, p. ix, 2014-15, p. 4, and 2015-16, p. xii.

¹¹¹ Department of Health, unpublished data.

*Demand for respite services is likely to increase as the trend towards community care increases and the carer base diminishes.*¹¹²

4.177 Alzheimer's Australia stated:

*With the increasing reliance on home care, it is essential to ensure that there is adequate support for family and carers.*¹¹³

4.178 It will be essential that, in implementing changes to increase access to high level home care, the government ensure that the existing arrangements for residential respite care meet its objectives, and that there is adequate supply and equitable access to residential respite care for carers and consumers.

Recommendation 8

That the government:

- a) In the short term, review the existing respite arrangement to ensure that its objectives are being met.
- b) In the medium term, in discontinuing the Aged Care Approval Round for residential care (Recommendation 3), review how best to ensure adequate supply and equitable access to residential respite care.

Changing the population cohort of the planning Ratio

4.179 The Ratio plays a critical role in the aged care system, allowing growth in the number of aged care places to shadow the growth pattern of the 70 years and over cohort. Over time, changes in the Ratio have been made to the numerator, incrementally increasing the target number of places from 100 to 125.

4.180 However, the denominator—1,000 people aged 70 and over—is also important. Based on the current average age of entry to aged care services (82.0 years for men and 84.5 years for women¹¹⁴) and the age-specific rates of use more broadly (Figure 4.3), continuing to use an age indicator of 70 years and over in the long term will result in a significant under-supply of places.

4.181 Leading Age Services Australia noted this in its submission:

*The current provision ratio for the 70+ age group is an inadequate proxy that does not align with residential care utilisation, which is predominantly used by the 85+ age group.*¹¹⁵

4.182 The department has modelled the cumulative growth in aged care places under three possible Ratios based on the 70 and over, 75 and over and 80 and over populations, and compared this to a projection of the growth required to meet the current level of use by age.¹¹⁶

4.183 The modelling assumed that the starting point would be to change the numerator and the denominator at the same time such that, at the point of conversion (2022–23), the new Ratio would result in the same number of absolute aged care services that is projected under the current Ratio, at 2021–22. This resulted in a figure of 195 places per 1,000 people aged 75 years and over or 347 places per 1,000 people aged 80 years and over.¹¹⁷ The significance is that as the demographic profile of the population ages over ensuing years, the different Ratios produce very different outcomes in terms of the absolute number of aged care services supplied.

¹¹² AMA submission, p. 8.

¹¹³ Alzheimer's Australia submission, p. 7.

¹¹⁴ Department of Health, 2016, *2015-16 report on the operation of the Aged Care Act 1997*, p. xii.

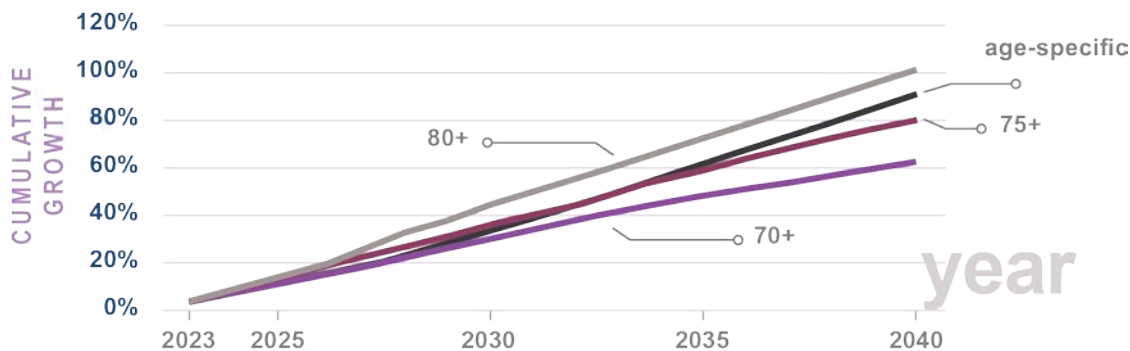
¹¹⁵ Leading Age Services Australia submission, p. 10.

¹¹⁶ "Age-specific" refers to taking the current rates of use of aged care by people at each specific year of age, and then projecting forward the use of aged care if those rates were held constant, allowing the population at each age to vary according to current demographic projections.

¹¹⁷ Department of Health, unpublished modelling.

4.184 Figure 4.5 shows the results of this modelling.

Figure 4.5 Cumulative growth in aged care places, 2023 to 2040¹¹⁸



4.185 The first of the baby-boomer cohort have only just turned 70, meaning that the rapid growth in the 80 and over cohort will begin in about ten years. Figure 4.5 shows that once the baby-boomer cohort enters their 80s (in 2027), a gap develops between the current 70 and over Ratio and the age-specific usage projection. Therefore, the growth under the current planning Ratio will not provide sufficient places to meet the need for care of this group.

4.186 For most of the projection, the denominator that most closely matches the age-specific projections is that for the 75 and over cohort.

4.187 Based on the cumulative growth of places, the department modelled the projected costs after ten years, for each scenario: the 70 and over, the 75 and over and the 80 and over. Table 4.10 shows the results of the cost projections.

Table 4.10 Projected costs under Ratio based on 70 and over, 75 and over and 80 and over, at 2031–32¹¹⁹

	ESTIMATED EXPENDITURE \$ BILLION (NOMINAL)	ADDITIONAL EXPENDITURE FROM BASE CASE \$ BILLION (NOMINAL)	% INCREASE EXPENDITURE FROM BASE CASE
Base case: 125 places/1,000 people aged 70 and over	33.5	-	-
Change to: 195 places/1,000 people aged 75 and over	35.5	2.0	6.0
Change to: 347 places/1,000 people aged 80 and over	38.4	4.9	14.7

4.188 To put this in perspective, current expenditure on residential care and home care accounts for less than 1 per cent of GDP, but it is expected to grow to around 1.35 per cent by 2031–32. The increase in expenditure under the 75 and over planning option would represent an approximate 0.08 percentage point increase in the proportion of GDP, and the increase under the option 80 and over option would be approximately 0.2 percentage points.

4.189 An alternative approach to addressing the increasing number and percentage of people over the age of 80 would be to continue to modify the numerator. If the Ratio denominator were left at 70 and over, the numerator could be raised to an appropriate level to meet expected demand. However, this appears to be a less effective planning approach, requiring more frequent active policy decisions every time the population profile changed. Changing the denominator produces a more robust model for meeting long-term demand, requiring fewer adjustments.

4.190 If the Ratio denominator is changed in 2022–23 from 70 and over to 75 and over to more closely follow the increase in the demand for care long term, and an equal numerator is set (195 places), this shift would result in a requirement for creation of an additional 28,000 aged care places over that decade (2022–23 to 2032–33).¹²⁰

¹¹⁸ Department of Health, unpublished modelling.

¹¹⁹ Department of Health, unpublished modelling.

¹²⁰ Department of Health, unpublished modelling.

- 4.191 Due to the changing demographics, the current planning Ratio will not be adequate to meet future demand. Moving the Ratio population will create additional places and subsequently increase expenditure for government. However, the analysis shows that maintaining the current Ratio will result in a comparative reduction in access to aged care from around 2027–28, even while the system continues to grow in absolute terms. This is not a tenable position and would require an increase in the current target of 125 places at some point.
- 4.192 While there is considerable uncertainty about the exact levels of demand, the long-term need for more aged care resulting from demographic changes is certain and will need to be addressed by government.

Recommendation 9

That the government change the Aged Care Provision Ratio to the population cohort aged 75 years and over, following achievement of the 125 Ratio in 2021–22, to better meet future demand.

- 4.193 Given the additional information that will be gathered from flexibly managing the supply of home care packages and residential care (Recommendation 6), by 2021–22 the government will have a better understanding of the underlying demand for aged care services.
- 4.194 Therefore, at the time of implementing Recommendation 9, there will be scope for the government to consider whether a change in the mix of places is required to better reflect patterns of demand, and/or whether there are further opportunities for removing supply controls.

Recommendation 10

That the government, in implementing Recommendation 9, consider whether a change in the mix of places within the new Ratio is required to better reflect demand, and that it consider further opportunities for removing supply controls.

CONCLUSION

- 4.195 As the first half of this chapter showed, it is difficult to determine the level of demand for aged care services, as well as the extent to which that demand is unmet. For government to consider uncapping supply, it will require a far better understanding of the true demand for aged care services. It is also apparent that, while overall the level of unmet demand may not currently be great, the distribution of services by service type and level is not well matched to consumer demand.
- 4.196 What is certain is that demand will significantly increase with the ageing of the population and it will outstrip supply under the current planning arrangements.
- 4.197 The recommendations in this chapter aim to address these issues.
- 4.198 Similar to the home care package reforms implemented in February 2017, the removal of ACAR will encourage a residential care system that is more responsive to the needs of consumers.
- 4.199 These recommendations also allow for flexibility to better match supply to the areas of aged care where unmet demand appears to exist. The evidence available to this Review indicates that this means increasing the proportion of high level home care packages, including the need for assistance that is greater than currently available under the level 4 home care package.
- 4.200 Implementing a more flexible approach to how aged care places are used within the Ratio will provide an opportunity for government to test the true demand for aged care services, particularly for residential care. Used in conjunction with the information made available through the national prioritisation queue in home care, these changes will provide government with mechanisms to better monitor and measure demand for services. This is essential for government to consider uncapping supply.
- 4.201 Finally, changing the population cohort on which the planning Ratio is based, from people aged 70 years and over to people aged 75 years and over, will allow the overall supply of aged care places to better match the key demand driver in aged care, that is, the ageing of Australia's population.

4.202 These changes are important to better meet existing care needs. The sequencing of when these reforms are implemented is also important. By improving our understanding of the demand for home care and residential care, progressively loosening supply controls, and recognising the need for greater resources in future, implementation of the recommendations in this chapter will represent major steps towards realisation of a consumer demand-driven model for Australian aged care services.

CHAPTER 5

MEANS TESTING IN HOME AND RESIDENTIAL CARE

INTRODUCTION

- 5.1 This chapter responds to matter (d) in the Review terms of reference: the effectiveness of means-testing arrangements for aged care services, including an assessment of the alignment of charges (i.e. consumer contributions) across residential care and home care services.
- 5.2 The chapter describes means testing in aged care, before and after the Living Longer Living Better (LLLb) reforms. It considers the effects of the changes, looking first at home care, and then at residential care. The chapter discusses how the changes have impacted access to care and makes recommendations to improve the transparency, equity and sustainability of the fee architecture.
- 5.3 This chapter and chapter 6 draw on data and analysis contained in the Aged Care Financing Authority's (ACFA's) *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*. While some of the data and analysis is reproduced here, further information can be found in the ACFA report.

MEANS TESTING IN AUSTRALIA'S AGED CARE SYSTEM

- 5.4 Means testing refers to the assessment of individuals' income and assets to determine the type and level of contribution a person can make towards their aged care costs. Means testing plays a role in:
- ensuring equity in consumer contributions so that people with similar financial resources make similar contributions
 - protecting people with low levels of wealth so that they receive the care they need without having to make contributions that they cannot afford
 - contributing to the long-term sustainability of the aged care system by ensuring that those who can afford to contribute to the cost of their aged care do so.
- 5.5 Currently, means testing is restricted to home care packages and residential care. For home care packages, income testing determines consumers' contributions to their care costs (in addition to the basic daily fee, which everyone can be asked to pay). In residential care, combined income and asset testing determines consumers' contributions to their accommodation and care costs. There is no formal means testing in the Commonwealth Home Support Programme (CHSP).¹²¹ In this report 'means testing' is used as a global term to cover both income testing in home care, and income and asset testing in residential care.

¹²¹ The CHSP Client Contribution Framework expects that, while there is no formal means testing, CHSP providers' client contribution policies should take into account a client's capacity to pay and include arrangements for financial hardship.

THE HISTORY OF MEANS TESTING¹²²

Income and asset testing prior to Living Longer Living Better

- 5.6 Prior to the LLLB reforms, home care package providers could charge two fees. The first was a basic fee of up to 17.5 per cent of the single aged pension, which every consumer could be asked to pay. The second fee was means tested according to income. It comprised an additional amount up to 50 per cent of a person's income above the single age pension.¹²³
- 5.7 Income assessments for home care consumers were conducted by providers. They had discretion to charge lower or no fees depending on consumers' financial circumstances, thereby providing informal financial hardship assistance. Government paid the full value of the home care package through subsidies and supplements to the provider. The value of the subsidy was not affected by whether the provider collected any fees.
- 5.8 In residential care, prior to the LLLB reforms, consumers in residential care could be asked to pay a number of payments. The first was a basic daily fee of 85 per cent of the single age pension. The second was an income-tested fee, while the third was a payment for accommodation in the form of either a lump sum accommodation bond (in low care),¹²⁴ or a daily accommodation charge (in high care).¹²⁵
- 5.9 Two separate tests were applied: an assets test, that related to accommodation costs; and an income test, that related to care costs.
- 5.10 A consumer's contribution to their accommodation costs was based on an assessment of their assets undertaken by the Department of Human Services (DHS):
- As is still the case, there was an asset-free threshold (\$45,000 at 20 March 2014). A resident with assets up to this threshold was fully supported and government paid an accommodation supplement on their behalf.
 - Residents with assets above the threshold and up to \$116,136 were partially supported and paid a partial daily accommodation charge (in high care) or a bond of up to \$71,136 (in low care).¹²⁶
 - Residents with assets above \$116,136 paid a daily accommodation charge capped at \$34.20 (in high care) or an accommodation bond (in low care).
- 5.11 A consumer's contribution to their care costs was based on their income, according to an income test conducted by DHS:
- As is still the case, there was a threshold equivalent to the basic single age pension plus pension income-free area¹²⁷ (\$24,731.20 annually at 20 March 2014), below which the consumer did not contribute to care costs.
 - Residents with higher levels of income paid an income-tested fee calculated at five-twelfths of income over the threshold, up to a maximum income-tested fee of \$73.86 per day.
- 5.12 This system of dual tests resulted in income-rich, asset-poor people paying all their care costs and nothing for accommodation, while asset-rich, income-poor people paid high accommodation costs but nothing for care.

¹²² Subsidy rates and thresholds quoted in this chapter for consumers who entered care since the reforms were implemented are as at 20 March 2017. Subsidy rates and thresholds applying to consumers who entered care before the reforms are as at 20 March 2014, unless otherwise specified.

¹²³ Consumers in receipt of a home care package that commenced prior to 1 July 2014 had their fee arrangements grand-parented, meaning their fees continued to be determined under the old rules.

¹²⁴ High-care residents could also be asked to pay an accommodation bond if they were in what was known as an extra service place. Extra service status was granted by the Department of Health and allowed providers to charge an extra service fee for the provision of a significantly higher than average standard of services including accommodation, range and quality of food and non-care services such as recreational and personal interest activities.

¹²⁵ All residents entering an extra service place could be asked to pay an accommodation bond and the extra service amount (the sum of the approved extra service fee and 25 per cent of that fee). The additional 25 per cent accounted for the amount of subsidy reduction (often referred to as the extra service 'clawback') applied to places with extra service status, equivalent to 25 per cent of the approved extra service fee. The subsidy reduction for extra service places was removed for residents who entered permanent care from 1 July 2014.

¹²⁶ The maximum bond payable for a person in this category was the difference between the person's assessed assets, up to \$116,136, and the asset-free threshold of \$45,000 (at 20 March 2014).

¹²⁷ The amount of income that a person can receive per fortnight and still receive the full rate of pension.

Increasing consumer contributions: the Productivity Commission and the Living Longer Living Better reforms

- 5.13 The Productivity Commission (the Commission) made several recommendations related to aged care means testing. These concerned greater consistency in contributions across community and residential care, more comprehensive means testing, lifetime limits on consumer contributions, and the introduction of a government-backed scheme to enable consumers to draw on the equity in their home to pay their aged care costs (including where the residence is occupied by a protected person).¹²⁸
- 5.14 The LLLB reforms made changes to means-testing arrangements in both residential care and home care. They changed the means-testing arrangements for residential care by combining the income and assets test, and introducing annual and lifetime caps on fees. Changes to income-testing arrangements for home care packages formalised the income test with administration by DHS rather than providers, standardised income-tested care fees, and introduced annual and lifetime caps on care fees.
- 5.15 The government did not support the recommendation relating to a government-backed scheme for releasing housing equity.

HOW DOES THE GOVERNMENT ASSESS CAPACITY TO PAY?

- 5.16 Means testing is used to determine whether a consumer is required to make certain payments, and in some cases to determine the level of contribution. Means testing is also used to help determine the level of subsidy that government will pay on a person's behalf. Where an individual has the capacity to contribute, the government will pay less; that is, the subsidy is reduced by the amount of means-tested care fee. Means testing ensures that consumers with similar means make a similar contributions and that those with little means can still gain access to care.
- 5.17 Consumers' means are assessed by DHS at the time of entry to care. Consumers are required to notify DHS of any significant changes to their income and assets or personal circumstances (e.g. a partner entering care), while the need for any changes to their contributions is reviewed quarterly by DHS.
- 5.18 A consumer can choose not to have their means assessed, but they will not then be eligible for government assistance with their fees. They can be asked to pay the maximum care fee based on the cost of their care and an accommodation payment negotiated directly with their aged care home.
- 5.19 Submissions to the Review reflected a range of views about the efficacy of means testing and its role in determining consumers' contributions to aged care costs. For example:

*The means testing has been of benefit to some people, but also puts others who have been savvy with their lifetime savings or who have invested hard earned money at a disadvantage.*¹²⁹

*The means test is the fairest way of establishing the split between government and resident fee payment. We advocate that this is used as a key mechanism to manage governments spending growth rather than cutting core funding through the ACFI.*¹³⁰

*As well as being justified on fairness grounds, increased consumer contributions within life-time contribution protections is essential for securing the affordability of a consumer-driven market-based service industry for aged care which provides consumers with choice and control over services.*¹³¹

¹²⁸ The term 'protected person' is defined in legislation and includes the person's spouse, partner or dependent child. The definition also includes a close relation who lived with the care recipient for five years or a carer who has lived with the care recipient for two years. However, both the carer and close relation must be eligible for a government income support payment for the definition to hold.

¹²⁹ Anonymous 2 submission, p. 4.

¹³⁰ Mercy Aged and Community Care Limited submission, p. 4.

¹³¹ Catholic Health Australia submission, p. 5.

Income testing for home care packages

5.20 From 1 July 2014, DHS commenced income testing for home care packages, with government subsidies reduced by the amount of income-tested care fee. Figure 5.1 illustrates the income thresholds for home care and maximum income-tested care fees that can be charged.

Figure 5.1 Home care income thresholds and maximum income-tested fees, at March 2017¹³²



Notes: *Includes consumers with significant levels of assets but low levels of income. **Includes consumers with significant assets and income within the income range.

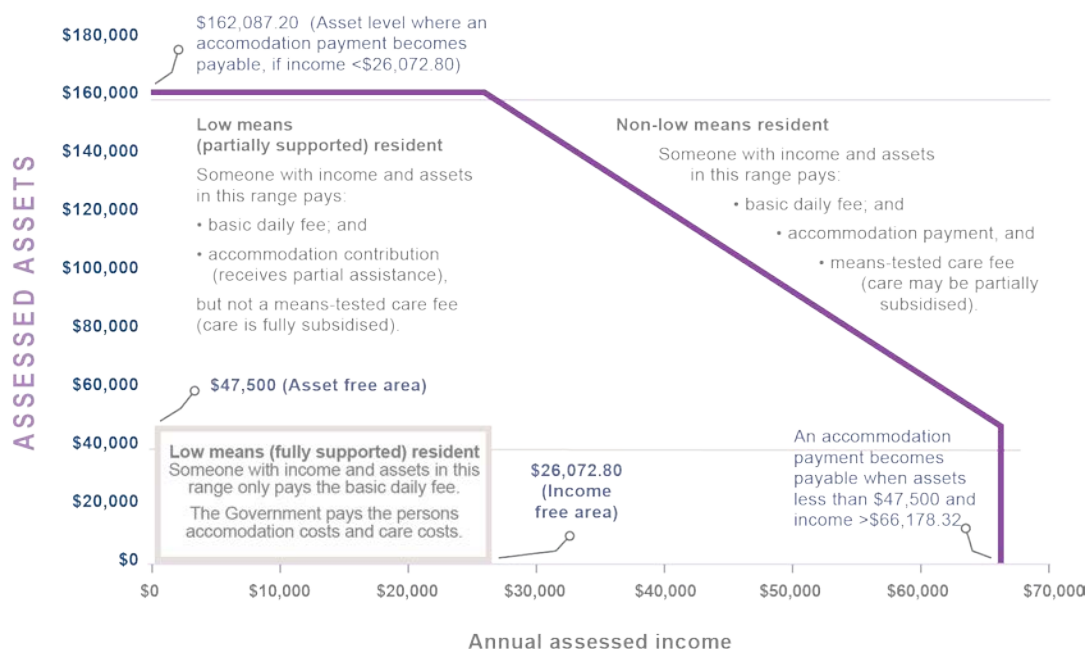
- 5.21 All consumers in receipt of home care packages can be asked to pay a basic daily fee equivalent to 17.5 per cent of the single age pension. In addition, consumers with income above the first income threshold (equivalent to the basic single age pension plus pension income-free area) can be asked to pay an income-tested care fee.
- 5.22 The level of government care subsidy is reduced by the value of the assessed income-tested care fee. This subsidy reduction is applied, even if the income-tested care fee is not paid or collected. Whether or not the provider charges the fee, it is still required to provide services agreed with the consumer up to the value of the subsidy as if the fees had been charged. This provides an incentive to providers to ensure consumers who are able to make a contribution to their cost of care, do so.
- 5.23 Assets are not means tested in home care. In my view, this is appropriate. As their intention is to support individuals to remain in their home, assessing a person's assets, which may largely consist of their home, could put pressure on that person's ability to remain in that home, and would be inconsistent with that intention.
- 5.24 I also note that while there is no asset test, financial assets, which may be a significant portion of an individual's non-home assets, are assessed to some extent by the deeming rules, whereby income is deemed on those assets and included in the income test.

¹³² ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 11.

Combining the income and asset tests in residential care

- 5.25 The LLLB reforms aimed to strengthen means-testing arrangements by combining the income and asset tests in residential care to ensure greater consistency in consumer contributions towards accommodation and care costs. Assets and income are now both counted in the assessment of what a consumer should contribute towards accommodation and care costs.
- 5.26 Depending on the levels of their assets and income, consumers are classified into three tiers of consumer contributions (Figure 5.2; Box 5.1):
- low means (fully supported)
 - low means (partially supported)
 - non-low means
- 5.27 Consumers in the final category pay the market-based accommodation price negotiated directly with the residential care home.
- 5.28 Figure 5.2 shows how assets and income are combined into a single means test for residential care.

Figure 5.2 Residential care assessed income and asset thresholds, March 2017 rates¹³³



- 5.29 The level of government subsidy payable to providers of residential care for accommodation and care costs is reduced by the amount of the consumer's assessed accommodation contribution and means-tested care fee.¹³⁴

¹³³ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 18.

¹³⁴ Multi-Purpose Services (MPS), however, are block funded. Residents of MPS are not eligible to receive a government accommodation supplement and do not make an accommodation contribution. While they do undergo a means test assessment, it is only used to determine their eligibility to pay an accommodation payment.

Box 5.1 Means testing and consumer contributions: how are aged care consumers categorised?¹³⁵

Home care packages

Home care consumers are categorised based on the level of their assessed income.

Full pensioners and those with the income of a full pensioner can be asked to pay a basic daily fee. This includes consumers with significant assets but low income.

Part-pensioners and those with a similar level of income can be asked to pay a basic daily fee and income-tested care fee, up to the first cap. This includes consumers with significant assets and income within the second shaded area in Figure 5.1.

Self-funded retirees can be asked to pay a basic daily fee and income-tested care fee, up to the second cap.

Residential care

Residential care residents are categorised based on the level of their assessed income and assets at the time that they enter care.

Low means (fully supported) residents can be asked to pay a basic daily fee. This would include full pensioners who either do not own a home or whose former home has a protected person in it.

Low means (partially supported) residents can be asked to pay a basic daily fee and accommodation contribution. This would include some full or part-pensioners who either do not own a home, whose former home has a protected person in it, or whose home is under the cap on the value of the home.

Non-low-means (sometimes referred to as non-supported) residents can be asked to pay a basic daily fee, an accommodation payment and a means-tested care fee. This would include some full or part-pensioners who own a home without a protected person in it, or who otherwise have assets that are greater than the first asset threshold in Figure 5.2. Referring to non-low-means residents as 'non-supported' residents can be misleading, because most residents in this category receive some assistance with their care costs.

It is important to note that, in both home care and residential care, a consumer's fee-paying status doesn't always align with their age pension status.

- 5.30 The next two sections consider the effects of the means-testing changes in home care and residential care, respectively. They examine the impacts of the changes on the sustainability of the system and on fairness for consumers.

CHANGES TO INCOME TESTING AND FEES IN HOME CARE

Did the changes improve the sustainability of the aged care system?

- 5.31 The amount of income-tested care fees collected from post-reform (1 July 2014) home care consumers is small in comparison to the amount of subsidies paid for those consumers. Therefore, income-tested care fees are not contributing significantly to the government's fiscal sustainability:
- In 2014–15 \$3.2 million of income-tested care fees were payable with an equivalent subsidy reduction—this represented 1.8 per cent of a government subsidy of \$176 million for post-reform consumers.¹³⁶
- In 2015–16 \$13.1 million of income-tested care fees were payable with an equivalent subsidy reduction—this represented only 2.5 per cent of a government subsidy of \$516 million for post-reform consumers.
- 5.32 This result is partly because there is a large number of home care consumers who are full pensioners (82 per cent at 30 June 2016), and who are therefore not required to contribute any care fee.¹³⁷

¹³⁵ Box 5.1 is a general explanation of the different means-testing categories used to describe aged care consumers, with particular reference to pensioners. It is not complete and does not necessarily reflect how aged care consumers are described in legislation. For a fuller picture this explanation should be read in the context of this chapter and in conjunction with Figure 5.1 for home care and Figure 5.2 for residential care.

¹³⁶ Figures for income-tested care fees payable represent the total assessed income-tested care fees, not necessarily the total fees actually paid.

¹³⁷ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 16

- 5.33 Of the remaining 18 per cent of consumers, a high proportion (15 per cent at 30 June 2016) are part-pensioners, who can only be charged a care fee up to the first cap, an average daily amount of \$6.30. The remaining 3 per cent of home care consumers (self-funded retirees) pay an income-tested care fee up to the second cap, an average daily amount of \$26.80.¹³⁸
- 5.34 The high representation of pensioners in home care is discussed later in this chapter. Measures to increase the amount of income-tested care fee and corresponding subsidy reduction are also discussed.

Did the changes result in more equitable fee arrangements?

- 5.35 There are a number of potential equity issues in the fee arrangements for home care.

Equity issues: basic daily fee

- 5.36 Equity issues arise both where consumers pay varying basic daily fees for the same level of assistance, and where consumers pay the one rate of basic daily fee for all package levels.

Basic daily fee is not charged consistently

- 5.37 There is a question of equity over the inconsistent charging of the basic daily fee. It is not compulsory for a provider to charge the basic daily fee to consumers receiving home care packages. One consumer may be paying no basic daily fee, while another who is receiving a similar package will be paying the maximum amount of \$10.10 per day.
- 5.38 If charged, the basic daily fee must be included in a consumer's individual budget, increasing the total value of the overall package.
- 5.39 ACFA's survey of home care providers¹³⁹ showed that 78 per cent of respondents charge the basic daily fee, but over half of those indicated that they charged less than the maximum amount. Of the services that advised that they do not charge a basic daily fee, a common reason was that this was "...a business decision as it was felt that the consumer couldn't afford to pay this fee."¹⁴⁰
- 5.40 A person who enters a home care package after 1 July 2014 can apply for financial hardship assistance from the government. The hardship supplement is available to home care recipients who are in genuine financial hardship and are unable to pay their costs of care due to circumstances beyond their control.¹⁴¹
- 5.41 I consider that the basic daily fee should be a minimum consumer payment to access the government-subsidised home care system and should therefore be mandatory for all home care consumers. Those consumers who are unable to afford such a payment would be eligible to apply for financial hardship assistance. This should be the vehicle for addressing genuine need, rather than providers exercising discretion in charging fees.

Should the level of basic daily fee be the same for all consumers?

- 5.42 A related issue is whether it is equitable that consumers are asked to pay the same level of basic contribution regardless of assessed care needs (that is, their package level). A consumer on a level 1 package of \$22.04 per day (excluding the basic daily fee) and a consumer on a level 4 package of \$133.99 per day (excluding the basic daily fee) may both be asked to pay a basic daily fee of \$10.10. Therefore, the basic daily fee represents a much higher proportion of a level 1 package than a level 4 package (Table 5.1).

¹³⁸ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 16

¹³⁹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, Appendix B.

¹⁴⁰ Further information on and from the survey is in Appendix B of ACFA, 2017, *Report to inform the 2016-17 review of amendments to the Aged Care Act 1997*.

¹⁴¹ See My Aged Care, Financial hardship assistance, <https://www.myagedcare.gov.au/costs/financial-hardship-assistance>

Table 5.1 Basic daily fee as proportion of home care package value (per day)¹⁴²

	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4
Total package value (basic subsidy + basic daily fee)	\$32.14	\$50.19	\$98.24	\$144.09
Basic daily fee (%)	31	20	10	7

- 5.43 It is likely that the relatively high proportion of the basic daily fee in lower-level packages is contributing to the lack of uptake of those packages. The Combined Pensioners and Superannuants Association of NSW argued that:

*The Department should review the affordability of the basic daily fee payable by Home Care Package recipients for full-rate Age Pensioners, and the affordability of the basic daily fee payable by residential aged care recipients for full-rate Age Pensioners.*¹⁴³

- 5.44 More broadly, the NSW Ministry of Health observed that:

*The current fee structure for services in the home (CHSP and home care packages) is not balanced or equitable. The fee structure does not provide an incentive for consumers to move through the system from lowest level of support to highest levels of support as their needs increase, contributing to blocks at every level.*¹⁴⁴

- 5.45 To correct this inequity, the value of the basic daily fee should be changed so it is proportionate to the value of the home care package. I am conscious that the basic daily fee itself should not act as a barrier for individuals to receive home care and recommend that the current value of the basic care fee (17.5 per cent of the single age pension) is retained for consumers receiving level 4 packages. The value of the basic care fee for other packages (levels 1–3) would be set at a rate which is in proportion to their subsidy value. This could, for example, set the basic care fee for a level 1 package at around \$1.66 per day.
- 5.46 This approach would reduce any ‘fee shock’ or disincentive for a consumer who transitions from receiving CHSP services to receiving a home care package. In addition, it would maintain the link between the fee and the age pension, ensuring that the fee increases when pensions increase.

Equity issues: income-tested care fee

- 5.47 Equity issues arise when consumers do not pay, or do not pay the full amount of their assessed income-tested care fee.
- 5.48 As is the case for the basic daily fee, providers are not required to charge consumers the full income-tested care fee. ACFA’s survey of home care providers showed that 83 per cent of respondents charged an income-tested care fee.¹⁴⁵
- 5.49 Whether providers actually collect income-tested care fees does not directly impact government expenditure. This is because the package subsidy is reduced by the value of the assessed income-tested care fee, regardless of whether it is actually charged to the consumer.
- 5.50 However, the decision of providers not to charge some fees does raise questions about the impact on provider viability, and equity in consumer contributions. Some consumers are paying income-tested care fees and others in similar situations—with the same financial circumstances and care needs—are not, but are receiving the full value of the package. The discretion providers have around charging the fee also contributes to consumers’ confusion about fees payable.
- 5.51 The fact that providers may not be charging the full income-tested care fee raises the questions of whether:
- providers are absorbing the cost of the subsidy reduction

¹⁴² Department of Health, 2017, *Schedule of subsidies and supplements effective 1 July 2017* and *Schedule of fees and charges as at 1 July 2017*.

¹⁴³ The Combined Pensioners and Superannuants Association of NSW submission, pp. 10–11.

¹⁴⁴ New South Wales Ministry of Health submission, p. 5.

¹⁴⁵ ACFA, 2017, *Report to inform the 2016-17 review of amendments to the Aged Care Act 1997*, Appendix B.

- consumers are receiving a lower level of care and services than those for which they have been assessed
- consumers have negotiated to purchase fewer services and avoid paying the income-tested care fee, despite the fact that providers are not permitted to reduce the value of a package in this way.

5.52 It is also possible that the financial impact of not charging income-tested care fees is being lessened by providers charging higher administration, case coordination or exit amounts, or by increasing hourly rates for care and services. If this is occurring, it will be reducing the amount of care and services provided.

Should consumers be required to pay their assessed income-tested care fees?

5.53 The fact that some consumers are receiving subsidised care and services without contributing when they could otherwise afford to do so challenges the principle that consumers, where able, are expected to contribute to the costs of their care. This principle is central to the future viability and sustainability of the aged care system more broadly.

5.54 Therefore, I consider that payment of income-tested care fees should be mandatory. As is the case for the basic daily fee, those consumers who are unable to afford such a payment because of their unique circumstances are eligible to apply for financial hardship assistance from the government.

5.55 I considered an alternative approach, suggested by some industry members, which was that government determine the subsidy it will pay depending on a consumer's care needs and financial capacity (much as it does under current means-testing arrangements), but enable consumers to decide how to obtain the remainder of the assessed care needs. In this way, government would still conduct a needs assessment and income test to determine eligibility and subsidy level, but would allow the consumer discretion to top up the value of services with that provider, purchase those services from another provider, or meet that need through informal care arrangements.

5.56 I have a number of concerns with this approach. Government would lose 'line of sight' between a person's assessed care need and the level of care that they are actually provided. Moreover, given the possibility that the non-subsidised component of care may not be obtained, it would not be consistent with the broader principle that consumers contribute to the cost of their care where they can afford to do so, nor with my Recommendations 12 and 14, which both require that consumers should be asked to make a minimum contribution towards the cost of accessing government-subsidised care at home. At the same time, this proposal would reduce transparency of government and consumer contributions and also make it harder to protect low-income earners (who could be asked to pay a fee in addition to a basic care fee).

5.57 This is an area that the government and the sector should continue to monitor to ensure that the fee and contribution arrangements continue to protect consumers while also supporting the viability of the sector and the sustainability of government funding.

Are fees transparent and understood?

Administration fees are unclear

5.58 The Home Care Packages Programme offers a coordinated package of services to consumers, who have an individual budget from which to pay for these services.

5.59 There is a range of administrative tasks that any provider must undertake to operate effectively, and the cost of these administrative activities is part of the cost of the service. Administration of home care packages includes establishing and maintaining care plans and agreements, staff recruitment and screening, complying with reporting requirements, and paying employees who make the calls and bookings that coordinate a consumer's complex care. Administration costs may not only be legitimate provider expenses, but will often be essential to the provision of care.

5.60 The government's approach to whether and how aged care providers may include administration costs in consumer's individual budgets was summarised in late 2016:

The Department does not set a limit on administrative charges for home care, however expects them to be kept to a minimum so that consumers can receive the care and support they need.

[From February 2017] Providers will be able to make a range of new information available [on My Aged Care], including information about their fees and charges.¹⁴⁶

- 5.61 The government's approach reflects both the legitimate nature of administrative expenses, and the expectation that increased consumer choice in home care will drive increased competition between among providers, ensuring that costs and charges will be efficient.
- 5.62 However, there is no standard approach to charging for administrative overheads in the sector. In workshops, stakeholders regularly raised issues around the transparency and comparability of fees, particularly administration fees in home care packages. Consumers reported cases of administration fees exceeding 30 per cent of the value of their package, which appeared excessive and did not obviously reflect costs of the services they were receiving:

It was explained that a \$14,000 package may have admin and Case Management that is equivalent to 40 to 50% of the package leaving only \$7 8000 for services. You would contribute \$4000...Maybe I would have more control by spending my own money.¹⁴⁷

- 5.63 A consumer observed:

...community providers...are very reluctant to give a breakdown of costs, many working on "what fits in" a particular level of care budget rather than explaining individual costs such as administration fees, coordination and care costs, contingency, etc.¹⁴⁸

- 5.64 Another said:

The fees and charges vary dramatically across Aged Care Providers. In my experience I did not find anywhere that I could adequately understand what charges would be involved in my Parent(s) care until I interviewed the many Care Providers individually.¹⁴⁹

- 5.65 The evidence and other feedback from consumer peak bodies indicates, that there may currently be a lack of transparency and of comparability.
- 5.66 The lack of transparency arises because, where administrative costs are charged as a stand-alone item, consumers cannot see how those costs relate to the provision of the services they receive. The lack of comparability arises both because providers are not necessarily publishing their fees and charges, and because the widely divergent practices of different providers makes it difficult or impossible for consumers to compare the actual costs of care provided by different services.
- 5.67 In some areas of aged care, government has addressed the issue of ensuring information is available by mandatory publishing of particular fees or prices, particularly in accommodation pricing. In other areas of the economy, such as telecommunications or banking, it has required publishing of key service prices or comparison pricing. However these can be cumbersome and complex solutions.
- 5.68 I note that the February 2017 reforms allow consumers to take their package to a provider of their choice (and to move between providers if dissatisfied) create a significant increase in competition in the home care market. However, it will take more time before the full impact of this increased competition on administration fees will be seen. It is therefore unclear whether competitive forces will adequately deal with the lack of comparability of administration fees.
- 5.69 The government and provider peak bodies should work together to determine how best to ensure comparability of pricing for consumers, and how best to publish this information on My Aged Care. Providers should ensure that administrative costs are modest and, where possible, attributed to the care services that consumers receive.

¹⁴⁶ Department of Health, 2016, Senate Community Affairs Committee estimates answer to question on notice, SQ16-000730.

¹⁴⁷ Council on the Ageing submission, p. 16.

¹⁴⁸ Anonymous 2 submission, p. 4.

¹⁴⁹ Anonymous 19 submission, pp. 4–5.

5.70 If the sector cannot develop better practices around administrative fees, government should intervene more directly.

Recommendation 11

That government and providers work together to determine how to ensure comparability of home care pricing for consumers and how best to publish on My Aged Care.

Changing the name of the basic daily fee

5.71 The term 'basic daily fee' has been carried over from residential care and does not readily apply to home care. In residential care, the basic daily fee is paid for daily living expenses such as meals, utilities and cleaning and is distinct from means-tested care fees, which are for care. In home care packages, all services are care-related. Having an income-tested care fee and a basic daily fee leads to questions about what the basic daily fee is for if not for care, and there are some misconceptions about it being an administrative fee. During workshops, for example in Hobart, it was indicated that it was difficult to understand the fees in home care, especially the basic daily fee, with workshop participants suggesting that the administration fees charged by providers are doubling up with the basic daily fee. Furthermore, home care consumers do not necessarily receive services daily, which leads to questioning why they are paying a 'daily' fee.

5.72 The name of the fee should be changed to better reflect that it is a basic fee for home care services.

Recommendation 12

That the government revise the naming and structure of home care fees to:

- a) Rename the 'basic daily fee' as a 'basic care fee' in home care.
- b) Require that providers charge the 'basic care fee' in home care.
- c) Require that providers charge the income-tested care fee in home care.
- d) Make the value of the basic care fee proportionate to the value of the home care package, retaining an upper limit related to the value of the single aged pension.

CHANGES TO MEANS TESTING AND FEES IN RESIDENTIAL CARE

Did the changes improve the sustainability of the aged care system?

5.73 The LLLB reforms to means testing were intended to increase consumer contributions from residents who can afford to make a greater contribution to the cost of their aged care, thereby reducing the overall cost of aged care for taxpayers. One way of assessing whether the reforms were successful in this regard is to compare the fee-paying status of residents who have entered care since the reforms commenced with that of residents who were in care under the pre-reform arrangements. Changes in fee-paying status gives an indication of whether more residents are contributing to the cost of their care and accommodation.

How has the fee-paying profile of residents changed?

5.74 To understand whether the profile of residents has changed as a result of the reforms, the Review compared the fee-paying status of residents in care on 30 June 2014, before the reforms commenced, with the fee-paying status of residents who entered care after the reforms.¹⁵⁰ Results show that the proportion:

- that **paid only the basic daily fee** was the same for both groups, about a quarter of all residents
- for whom **government did not pay any accommodation supplement** was the same for both groups, around 60 per cent of all residents¹⁵¹

¹⁵⁰ Department of Health, unpublished data. Fee-paying status of post-reform residents is for those residents who entered permanent residential care on or after 1 July 2014 and were still in care on 30 June 2016.

- that **contributed to their care costs** was higher for residents who entered care after the reforms (44 per cent) than for residents in care immediately before the reforms (34 per cent).

5.75 The increase in the proportion of residents contributing to their care costs is an intended result of the change to the means test, and indicates a modest improvement to the sustainability of the aged care system. However, the positive impact on government fiscal sustainability is limited because the number of residents paying their full accommodation costs has not increased. There may also be an improvement for providers as they may be receiving greater revenue through accommodation payments (this is discussed further in chapter 6 on accommodation payments in residential aged care).

How has the overall cost burden changed?

5.76 The effectiveness of means-testing changes for improving sustainability of residential aged care can also be assessed by measuring whether the reforms reduced the proportion of overall costs paid for by government (i.e. taxpayers), compared with costs paid for by consumers. This can be measured by comparing the outcome of the two different tests (i.e. post-reform means test and the pre-reform income and assets test) if applied to the income and assets of consumers who have entered care since the reforms.

5.77 This analysis shows that the means-testing reforms have marginally improved sustainability by shifting a small proportion of the costs of care and accommodation to the consumer. As might be expected, most of this shift is in relation to care fees:

- Government's share of the cost of care has reduced to 94 per cent under the new means-testing arrangements, compared with 98 per cent under the pre-1 July 2014 arrangements.
- Government's share of the cost of accommodation has reduced to 42 per cent under the new arrangements, compared with 43 per cent under the pre-1 July 2014 arrangements.¹⁵²

5.78 Overall, the effectiveness of the means-testing changes has been very modest.

The treatment of the former principal residence in the assets test

5.79 The LLLB reforms changed the way that the means test works in relation to the residents' former principal residences (homes). Previously, the former home was counted as an asset for the purposes of determining a resident's contribution to their accommodation costs, and was not considered when determining their eligibility to contribute to their care costs.

5.80 Under the LLLB reforms, both income and assets are now included in the means test used to determine the resident's contribution towards their accommodation and care costs. A resident's home is included in the asset test up to a capped value of \$162,087.20, if unoccupied by a protected person.¹⁵³

5.81 Including and capping the value of the home under the combined income and assets test has effectively maintained the pre-reform concept that a person's home will be counted only towards their accommodation costs and not their care costs. Assets of \$162,087.20 are enough to extinguish eligibility for government subsidies for accommodation (i.e. residents are required to pay the full cost of their accommodation).

5.82 A person whose only asset is their house and whose income is below the income-free threshold will pay the full cost of their accommodation but no means-tested care fee, e.g. a full pensioner whose only asset is a former home without a protected person in it.

5.83 The overall effect of this reform is that any other assets (and any income above the income-free threshold) will be counted towards a resident's means-tested care fee.

¹⁵¹ This includes low-means residents who are paying the maximum accommodation contribution and residents paying an accommodation payment agreed with the provider.

¹⁵² Department of Health, unpublished data.

¹⁵³ A definition of protected person is provided at footnote 8

- 5.84 Of post-reform residents, approximately 30 per cent had the net value of their home included at a capped amount under the aged care means test. According to ACFA's analysis, the majority of these residents paid an accommodation payment and means-tested care fee.¹⁵⁴
- 5.85 However, the cap means that consumers with a greater proportion of their wealth in a home will contribute relatively less to the cost of care than a person with wealth in other assets.
- 5.86 Furthermore, it is inequitable for residents whose homes have a lower market value than others. For example, the cap represents 50 per cent of the value of a home worth \$320,000, compared with 18 per cent of a home worth \$900,000 (or to put it another way, the cap provides a greater benefit to people with more valuable houses). This differential may be even greater for consumers in rural and regional areas where house prices are generally lower than in metropolitan areas. Someone with a \$900,000 home has significantly greater means than someone whose home is worth \$320,000, yet their contribution is the same because of the cap, all else being equal. In its submission to the Review, Council on the Ageing ACT observed that:
- It is possible to recognise that the argument against family home exemption from means testing carries weight in some instances, without attempting to make home equity the basis of a reorganisation of the whole aged care funding system. It would not be fair to expect an older pensioner in a rural location to use up the entirety of their home equity to pay for a given set of basic care services, when a city pensioner whose house happens to be worth ten times as much, might be able to pay the same amount with 90 per cent of their equity untouched.*¹⁵⁵
- 5.87 Moreover, it is inequitable for residents who are not homeowners and have invested in other assets, which are fully assessable.
- 5.88 To achieve equitable treatment between different types of wealth and between homeowners and non-homeowners, and to ensure that consumers are contributing an appropriate amount to the cost of their care based on their means, the full value of the home should be included in the residential care means test.
- 5.89 By including the full value of the home in the means test, residents with a home with a net value greater than the current cap will pay more in means-tested care fees. Arguably this would reduce the balance of funds available for consumers to pay other fees, such as accommodation payments or additional services fees, that are negotiated with and paid directly to providers. However, this is not a significant concern, as the taper rates are low at 1 and 2 per cent.¹⁵⁶

Recommendation 13

That the government include the full value of the owner's home in the means test for residential care when there is no protected person in that home.

Would inclusion of full value of the home increase the need for home equity release products?

- 5.90 It is possible that including the full value of the home in the means test may impact demand for equity release products, as consumers may require access to additional equity to pay means-tested care fees.
- 5.91 However, in my view, including the full value of the home in itself would not result in significant additional need for financial products to assist consumers to release the equity in their homes. This is because those consumers affected by Recommendation 13—i.e. those with a home with no protected person—would likely already have needed to access that equity in some way to pay an accommodation payment.
- 5.92 This would particularly be the case if the home was their only major asset.¹⁵⁷

¹⁵⁴ ACFA, 2017, *Report to inform the 2016-17 review of amendments to the Aged Care Act 1997*, p. 23

¹⁵⁵ Council on the Ageing ACT submission, p. 7.

¹⁵⁶ 1 per cent of assessable assets between the value of \$162,087.20 and \$391,261.20, and 2 per cent of any value above that are payable as care fees for a full year.

¹⁵⁷ It is worth noting that the need to pay an accommodation payment is not the only use for an equity release product in the aged care context; consumers may seek financial equity release products to pay for costs associated with care at home. The Deloitte 2014 Reverse Mortgage Survey estimates that 'aged care purposes' account for around 4 per cent of the use of proceeds from reverse mortgages, although it does not state whether for costs related to home-based or residential care. Reference: Deloitte Touche `Tohmatsu, 2015, *The Deloitte 2014 Reverse Mortgage Survey*, p. 21.

- 5.93 Furthermore, removing the preferential treatment of the home would lessen the incentive to hold wealth in that asset.
- 5.94 I note too that equity release products do not appear to be widely used to fund aged care costs, although some providers offer products tailored to aged care. According to industry statistics from the Deloitte reverse mortgage survey, only 4 per cent of the proceeds of reverse mortgages in 2014 were used for aged care purposes.¹⁵⁸
- 5.95 As the Commission has pointed out, current loan-to-value restrictions (LVRs) on reverse mortgages may also prevent further use of reverse mortgages for funding aged care costs, particularly refundable deposits.¹⁵⁹ This is because the restrictions on LVRs prevent older people from accessing a larger amount of equity unless their property value is already very high. For example, a person aged 83 years (just under the average age at first admission to residential care), would be restricted to borrowing no more than 43 per cent of the value of their home. They would thus need to have a property worth over \$900,000 to fund a refundable deposit of \$391,000 (the average accommodation price published on My Aged Care at 1 February 2017) entirely through proceeds from a reverse mortgage.

Box 5.2 What are equity release products?

Equity release products allow people to access the equity in their home by converting some of its value into cash payments, which can be used for a range of purposes such as home improvements, regular income, debt repayment, aged care and medical treatments.

There are two types of home equity release products available in Australia, as well as the Australian Government pension loans scheme.¹⁶⁰

Home equity conversion loans (also known as reverse mortgages) allow a person to borrow against the equity in their home, with the option of deferring repayments so the loan plus interest is repaid when the home is sold, transferred or passed to the estate of the last surviving borrower.

Home reversion schemes allow a person to sell a proportion of the equity in their home while they continue to live there; they receive a lump sum payment in exchange for a fixed proportion of the future value of their home. When the house is sold, the reversion scheme provider receives a portion of the proceeds of the sale according to the proportion of equity agreed with the person.

How widespread are equity release products?

Uptake of equity release products is generally low, although reverse mortgages represent a much greater market share than home reversion schemes. At 31 December 2014 there were approximately 40,000 reverse mortgages in Australia worth a total of \$3.6 billion.¹⁶¹ In contrast, Homesafe (the sole home reversion scheme provider) held \$482 million in residential equity at June 2015.¹⁶²

According to the Productivity Commission, reverse mortgages represent only 0.4 per cent of the home equity of older Australians, while the proportion of seniors who have a reverse mortgage has remained steady at around 1–2 per cent.¹⁶³

While the reverse mortgage market expanded during the mid-2000s, growth slowed substantially following the global financial crisis and has since flattened out. In 2015 the Productivity Commission suggested that there had been a modest revival in the market, and that a number of providers are now offering products specifically for aged care purposes, demand

¹⁵⁸ Deloitte Touche` Tohmatsu, 2015, The Deloitte 2014 Reverse Mortgage Survey, p. 21.

¹⁵⁹ Productivity Commission, 2015, *Housing decisions of older Australians*, p. 158.

¹⁶⁰ The pension loans scheme allows self-funded retirees and part pensioners to access the equity in their homes or properties through regular payments made by the Australian Government. The payments can be made for a short time or an indefinite period, and can be up to the maximum rate of age pension. The loan can only be taken as an income stream (rather than a lump sum), and cannot exceed the maximum pension, or the difference between the person's part pension and the maximum pension amount. For eligibility requirements and other information, see the Department of Human Services website at <https://www.humanservices.gov.au/customer/services/centrelink/pension-loans-scheme>

¹⁶¹ Deloitte Touche` Tohmatsu, 2015, The Deloitte 2014 Reverse Mortgage Survey, p. 4.

¹⁶² Productivity Commission, 2015, *Housing decisions of older Australians*, p. 152.

¹⁶³ Productivity Commission, 2015, *Housing decisions of older Australians*, p. 150.

for which appeared to be slowly growing since the 2014 reforms to aged care.¹⁶⁴ Similarly, in 2016 the Australian Centre for Financial Studies observed that there appeared to be some new entrants to the market.¹⁶⁵ However, more recent industry observations suggest that the number of providers of equity release products has started declining.¹⁶⁶

Why are equity release products not used more widely?

Commonly cited barriers to the uptake of equity release products include:¹⁶⁷

- low consumer demand, impacted by low levels of financial literacy and limited awareness of equity release products
- negative perception of cost and risk associated with equity release products, particularly reverse mortgages
- consumer preferences, such as precautionary saving and debt aversion, and a desire to retain the family home as an inheritance for their children
- preferential treatment of the home under age pension and aged care asset tests. While the home is exempted from the aged pension test and either exempt from or capped for the aged care asset test, amounts received from equity release products can be counted as assets.

Commonly cited factors impacting the supply of equity release products include:

- longevity risk and no negative equity guarantee, including uncertainty about timing and amount of return
- reputational risk
- capital adequacy regulations—higher risk weighting applied to reverse mortgages compared with standard mortgages, requiring lenders to hold more capital
- inconsistent regulatory framework for home reversion schemes compared with reverse mortgages.

Basic daily fee

5.96 Unlike home care, in residential care there appears to be almost universal charging of the basic daily fee.¹⁶⁸ In 2014–15, total provider revenue from basic daily fees was \$3.0 billion. Based on the maximum basic daily fee, residential care providers could have charged an estimated \$3.1 billion in basic daily fees in 2015–16.¹⁶⁹

5.97 There are suggestions from industry that the amount of the basic daily fee, \$49.07, is not sufficient to cover the cost of the daily living expenses to which it relates:

*In 2007 the gap between a client's daily living expenses and the income received from the basic daily care fee was \$16.10 per day. Some 10 years later that gap has doubled to \$32.12 per day...*¹⁷⁰

5.98 Feedback from workshops with providers indicated that there ought to be more flexibility with the basic daily fee in residential care, so that providers are able to compete based on quality and price in this area.

5.99 I note that currently providers are limited to differentiating their product in terms of accommodation and additional or extra services. Uncapping the amount of the basic daily fee and allowing providers to differentiate on the basis of basic daily

¹⁶⁴ Productivity Commission, 2015, *Housing decisions of older Australians*, p. 150.

¹⁶⁵ Australian Centre for Financial Studies, 2016, *Home equity release: challenges and opportunities*, p. 12.
<https://australiancentre.com.au/publication/home-equity-release-challenges-opportunities/>

¹⁶⁶ Representative body SEQUAL – also known as Senior Australians Equity Release Association of Lenders – discontinued its operations on 31 January 2017.

¹⁶⁷ For a more detailed description of the demand and supply side factors, see Productivity Commission, 2015, *Housing decisions of older Australians*, especially pp. 153-160, and Australian Centre for Financial Studies, 2016, *Home equity release: challenges and opportunities*, especially pp. 15-25.

¹⁶⁸ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 20.

¹⁶⁹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 20.

¹⁷⁰ Reid, Patrick, 'Gap doubles between basic living costs and daily care fee', *Inside Ageing*, 31 January 2017.

living services and price should be beneficial in that it would encourage innovation and improve choice and quality. However, there would need to be certain safeguards to protect access to care and provide transparency.¹⁷¹

- 5.100 To ensure that the basic daily fee remains affordable for all residents, a higher basic daily fee would only be applicable for non-low-means residents. For those with low means, the basic daily fee should continue to be capped at the current level,¹⁷² so that they have funds remaining for other expenses:

*An important context for this approach would be to ensure a floor price remains at 85% of the single pension to ensure that those without means, undertaking respite or enduring hardship have a suitable safety net to fall back on.*¹⁷³

- 5.101 To provide transparency and to encourage innovation, choice and quality, providers should be required to publish their maximum basic daily fee for non-low-means residents on My Aged Care, on their own website and in written materials to be given to prospective residents.
- 5.102 In addition, I propose that, if a provider proposes to charge an amount greater than \$100 per day, the provider must receive approval from the Aged Care Pricing Commissioner (Pricing Commissioner). The Pricing Commissioner currently performs this role in relation to accommodation payment prices over a lump sum equivalent of \$550,000 and for extra service fees.
- 5.103 The basic daily fee should continue to be paid for day-to-day hotel and living costs such as meals, cleaning, laundry, heating and cooling. While I have suggested that uncapping the basic daily fee will enable providers a further point of differentiation and will encourage innovation and improve choice and quality, government might also consider whether providers would need to demonstrate the additional benefit received for a higher basic daily fee over and above that received for the lower rate.
- 5.104 In addition, consideration should be given to providing additional protection to those residents whose assets place them within the non-low-means category, but who otherwise have limited income and assets (e.g. full pensioners whose only major asset is their former home, where unoccupied by a protected person, with a value that is not significantly higher than the first asset threshold).
- 5.105 Under current arrangements, these residents can be asked to pay an accommodation payment but no or very little means-tested care fee. Allowing providers to charge higher basic daily fees could have a disproportionate impact on this group compared with other non-low-means residents. While part-pensioners can be asked to pay a means-tested care fee, this is limited by their means, whereas a higher basic daily fee would not be means tested. Consumers could elect to pay a higher fee by drawing down on their lump sum accommodation deposit (if available) but this option is at the discretion of the provider. Protection will be required for those consumers within this group who do not have financial capacity to pay a higher basic daily fee.

Recommendation 14

That the government:

- a) require that providers charge the minimum basic daily fee in residential care
- b) retain the cap on the value of the basic daily fee in residential care for low-means (fully and partially supported) residents
- c) allow providers to charge a higher basic daily fee to non-low-means residents, with amounts over \$100 to be approved by the Aged Care Pricing Commissioner
- d) require that the maximum basic daily fee be published on the My Aged Care website, the provider's website and in written materials to be given to prospective residents.

¹⁷¹ Further information is in table 2.4 of part 1 of ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*.

¹⁷² Approximately a quarter of all postreform residents are fully supported by government in their accommodation costs, and are paying only the basic daily fee. A further 17 per cent are partially supported residents paying some accommodation contribution (with a further 2 per cent also paying a means-tested care fee).

¹⁷³ Reid, Patrick, 'Gap doubles between basic living costs and daily care fee', *Inside Ageing*, 31 January 2017.

ARE THE ANNUAL AND LIFETIME CAPS EFFECTIVE?

- 5.106 Annual and lifetime caps apply to income-tested care fees paid by home care consumers and means-tested care fees paid by residents of residential care homes.
- 5.107 In home care, there are two annual caps depending upon the consumers' assessed income level. A cap of \$5,276.08 per year applies to part-pensioners, while a cap of \$10,552.18 per year applies to self-funded retirees. In residential care, the annual cap is \$26,380.51.¹⁷⁴
- 5.108 The lifetime cap of \$63,313.28 applies to income- and means-tested care fees paid for both home and residential care. Any care fees a person has paid in home and/or residential care will count towards their lifetime cap. Neither basic daily fees nor accommodation costs are counted towards the annual and lifetime caps.

How many consumers have reached the annual and lifetime caps?

- 5.109 In home care, the annual caps are calculated daily, which means in effect that any part-pensioners or self-funded retirees paying the maximum income-tested care fee per day (\$14.49 and \$28.98 respectively) will reach the annual cap if they are in care for an entire year. Data from the department shows that as at 30 June 2016, 17.9 per cent of all home care package recipients were paying an income-tested care fee, of which 2.4 per cent were part-pensioners reaching the first cap and 1.1 per cent were self-funded retirees reaching the second cap.¹⁷⁵
- 5.110 Similarly, only a very small proportion of residential care residents have met the annual cap on care fees. Table 5.2 shows the proportions who had reached the annual cap on income- and means-tested care fees in the two years after the caps were implemented.

Table 5.2 Residential care consumers reaching annual cap on care fees¹⁷⁶

	% OF NON-LOW-MEANS RESIDENTS	% OF ALL RESIDENTS
30 June 2015	1.4%	0.8%
30 June 2016	3.6%	2.0%

- 5.111 Only 2 per cent of all residents had reached the annual cap on means-tested care fees at the end of June 2016. No residents had reached the lifetime cap at 30 June 2016, as it would take longer than two years to reach that cap.
- 5.112 Analysis by the department, also reported by ACFA, estimates that around 10 years after the commencement of the reforms, once residents who entered care before the reforms took effect have left, the annual and lifetime caps will reduce the funds generated by means-tested care fees by around \$0.3 billion per annum. The caps are estimated to be reached by approximately 5 to 6 per cent of permanent residents.¹⁷⁷
- 5.113 Those benefiting from the annual and lifetime caps are consumers with higher levels of wealth. Therefore, there is a question about the equity of the annual and lifetime caps. The caps limit the amount that wealthier consumers contribute to their care costs, after which taxpayers effectively subsidise the full cost of their care. This raises the question of whether consumers with sufficient wealth to benefit from the caps could be asked to contribute more, proportionate to their financial capacity. The Association of Age Service Professionals Inc., for example, argued that:

The current limitations on annual and lifetime caps for contributions do not reflect a “true capacity to contribute”.¹⁷⁸

¹⁷⁴ Department of Health, Schedule of fees and charges for residential & home care, 20 March 2017.

¹⁷⁵ For a more detailed breakdown of the proportion of part-pensioners and self-funded retirees reaching the annual caps, see Appendix A of ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*.

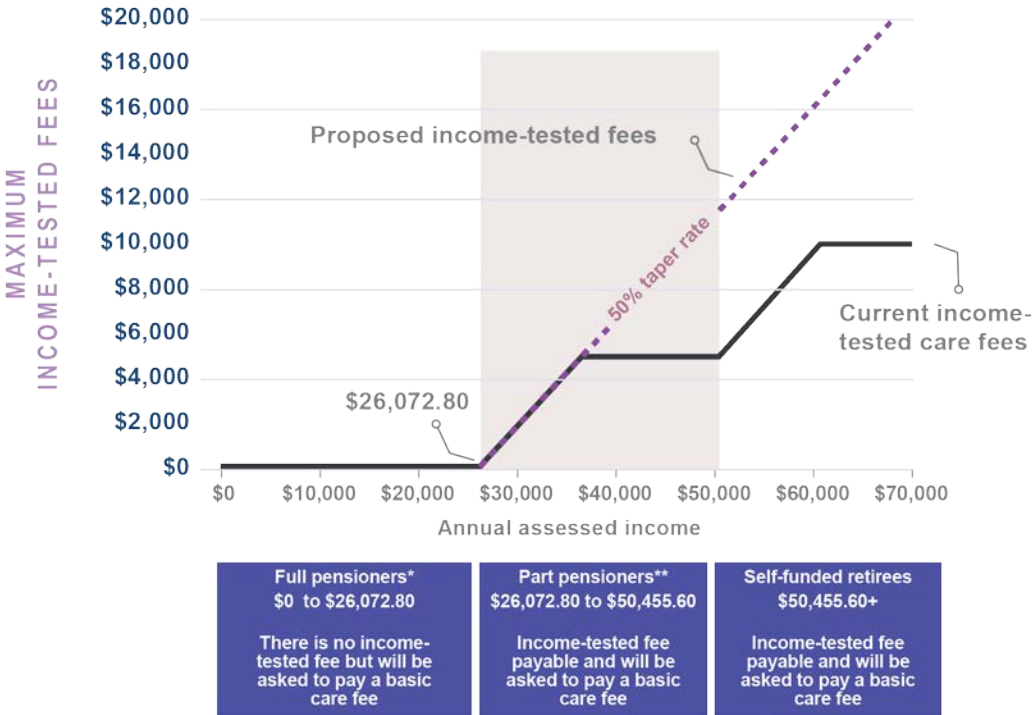
¹⁷⁶ Department of Health, unpublished data.

¹⁷⁷ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, pp. 26–27.

¹⁷⁸ Association of Age Service Professionals Inc. submission, p. 4.

- 5.114 ACFA has made the point that it appears inconsistent for the basic daily fee in home care not to be counted towards the caps, as the basic daily fee (if charged) must be included in the person’s individualised budget and can therefore be counted towards the overall package funds available for the person’s care.¹⁷⁹ Removing the caps would remove this inconsistency.
- 5.115 Given this analysis, I consider that equity would be improved if the annual and lifetime caps were removed. This would ensure that wealthier consumers would continue to contribute towards their care costs while they remain in receipt of services, proportionate with their financial capacity.
- 5.116 I considered the option of retaining but increasing the lifetime cap, to protect those residents who may receive residential care for a long period of time (e.g. those with early-onset dementia). However, other existing protections deal appropriately with these cases. Residents’ means are re-assessed over time, which means that their contributions will decrease as their income and/or assets decrease. Removing the annual and lifetime caps would ensure that care recipients contributed to the costs of their care commensurate with both their care needs and relative financial capacity.
- 5.117 Abolishing the annual and lifetime caps would support greater simplicity and consistency in treatment of fees across the CHSP, home care packages and residential care (discussed further below).
- 5.118 The impact on income-tested care fees for home care is illustrated in Figure 5.3.

Figure 5.3 Income-tested fees for home care packages under Recommendation 15¹⁸⁰



Note: * Would also include those people with significant levels of assets and low levels of income. ** Would also include those people with significant levels of assets and income with the income range.

- 5.119 I acknowledge, however, that removing the caps will not fully address inequities in the level of income-tested care fees paid by home care package consumers as a proportion of the package value. That is, maintaining a 50 per cent taper rate regardless of package level means that consumers with the same income will pay care fees at a higher proportion of a level 2 package, for example, than a level 4 package. This may mean that higher-level packages continue to be more attractive to consumers with greater means, as they will get better value from a higher-level package.

¹⁷⁹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, pp. 13–15.

¹⁸⁰ Department of Health, unpublished figure generated for the purposes of the Review.

Recommendation 15

That the government abolish the annual and lifetime caps on income-tested care fees in home care and means-tested care fees in residential care.

EFFECTIVENESS OF CHANGES TO MEANS TESTING AND FEE ARRANGEMENTS: IMPACTS ON ACCESS TO CARE

5.120 A particular focus of this chapter (and the Review more broadly; see also chapter 9 on equity of access) is whether the LLLB changes to means testing affected access to care, and the adequacy of safeguards for those who can least afford to pay.

Access to home care packages

5.121 There is some evidence to suggest that the changes to income testing and fees for home care packages have impacted how consumers are accessing this type of care.

5.122 Data from the department, reported by ACFA, show that a large majority of home care consumers are full pensioners.¹⁸¹ Of all post-reform consumers receiving a home care package at 30 June 2016:

- 82 per cent were assessed as being full pensioners
- 15 per cent were assessed as being part-pensioners
- 3 per cent were assessed as being self-funded retirees.

5.123 However, there is a noticeable pattern in the proportion of each group accessing the different levels of care. Table 5.3 shows the fee-paying status of post-reform home care consumers, based on income test assessments conducted by DHS.

Table 5.3 Home care consumers' pension and fee-paying status, 2015–16¹⁸²

HOME CARE PACKAGE LEVEL	PENSIONER	PART-PENSIONER*	SELF-FUNDED RETIREE^
	Basic daily fee (BDF) only	BDF + income-tested care fee (up to 1st cap)	BDF + income-tested care fee (up to 2nd cap)
1	85%	14%	1%
2	78%	20%	2%
3	77%	19%	4%
4	73%	22%	5%

Notes: *This includes any home care consumers with assessed income greater than the income-free area (\$26,072.80 at March 2017) up to the income threshold (\$50,455.60 at March 2017). ^This includes any home care consumers with assessed income greater than the income threshold. This data is for post-1 July 2014 recipients of home care subsidies in 2015-16. Income is each recipient's most recent income test amount. For recipients that had no income test, their income was set as: \$2300 per fortnight for those recipients that had a means not disclosed (MND) record (this income equates to the maximum means contribution); \$0 for recipients with no means test records (they are assumed to be protected). Figures in Table 5.3 differ from those presented elsewhere in the report (e.g. number of home care recipients meeting annual and lifetime caps), as these are for all recipients in a home care package in the 2015-16 financial year, whereas other figures are at 30 June 2016.

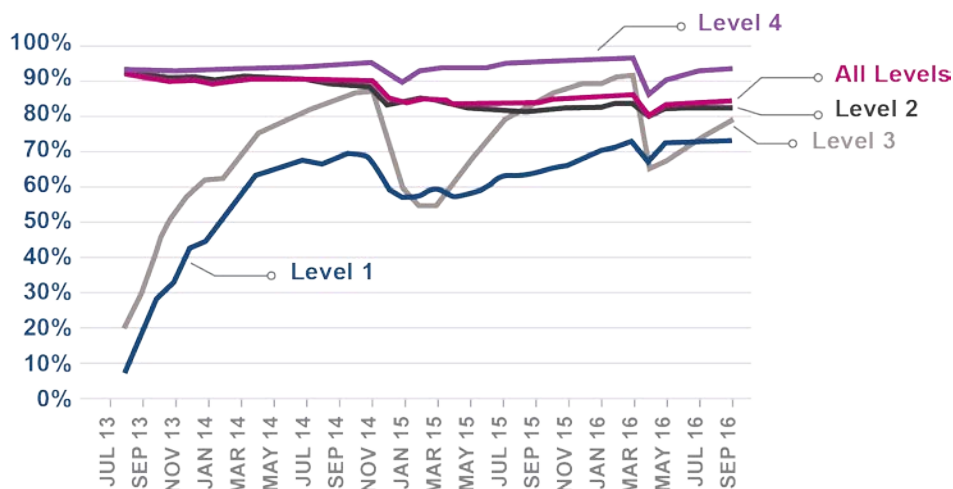
5.124 There is a clear correlation between home care consumers' average assessed income and their care package level (Table 5.3). Level 1 packages have the highest proportion of pensioners and the lowest proportion of part-pensioners and self-funded retirees. Conversely, level 4 packages have the lowest proportion of pensioners, but the highest proportion of part-pensioners and self-funded retirees.

¹⁸¹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, especially section 2.2.3 and Appendix A.

¹⁸² Department of Health, unpublished data.

- 5.125 Lower-level packages appear to be less attractive to consumers with higher levels of wealth. As ACFA has suggested, this may be a result of the level of fees payable by part-pensioners and self-funded retirees in lower-level packages.¹⁸³ For example, the maximum fees payable by a self-funded retiree in a level 1 package would represent 100 per cent of the total package value (i.e. subsidy and basic daily fees), while the maximum fees for a part-pensioner would be 76 per cent of the package value, and 31 per cent for a full pensioner. In contrast, the maximum fees payable by a self-funded retiree in a level 4 package would represent just 27 per cent of the package value, 17 per cent for a part-pensioner, and only 7 per cent for full pensioners, with the government subsidising the rest. As such, individuals with higher means may be more likely to take up higher-level packages because they perceive them to offer better value for money.
- 5.126 This suggests that the current arrangements set consumer contributions at price points that, relative to the amount of government subsidy, discourage consumers with higher levels of wealth from accessing low-level home packages. This leaves open the question of whether wealthier consumers in need of low-level care are obtaining it elsewhere, for example through the private market, through informal care arrangements, or through the CHSP. Merri Health observed that:
- Some clients with assessed needs for a home care package are choosing to not take up a package and choose to use CHSP services as a result of the financial disadvantage they would experience under the current arrangements.*¹⁸⁴
- 5.127 It may be that having fees set at such a price point may be desirable from government's perspective, as it may mean that taxpayer subsidies are being directed to consumers with lower-means. However, this would only be the case if higher-means consumers are not receiving services through the CHSP instead. This is addressed below.
- 5.128 Finally, it should be noted that occupancy figures for home care packages suggest that higher-level packages are generally more attractive than lower-level packages (Figure 5.4). The occupancy rate for level 1 packages has generally remained markedly lower than for other packages, at no point rising above 72 per cent.

Figure 5.4 Home care package occupancy rates¹⁸⁵



Notes: Occupancy in home care packages is measured as the total number of days a package was actually being used by a consumer (occupied place) as a proportion of the number of days a package was available to be offered to a consumer by a provider (available/operational place). In this calculation, the numerator is the number of claim days (the days in which a consumer is enrolled in the home care package) during a period, and the denominator is the number of place days (the days over which the package was operational) during the same period. So while this measure of occupancy may not directly reflect the way in which home care is delivered, it does reflect the fact that government pays home care subsidy on a per diem basis as a measure of the proportion of total subsidy revenue the provider could have received for that package over the period.

- 5.129 In comparison, occupancy for level 4 packages has remained relatively stable at around 92 per cent, while occupancy in level 2 packages has gradually trended downwards, dropping from around 92 per cent in August 2013 to 81 per cent in

¹⁸³ ACFA, 2017, *Report to Inform the 2016-17 Review of Amendments to the Aged Care Act 1997*, see especially section 2.3.2.

¹⁸⁴ Merri Health submission, p. 4.

¹⁸⁵ ACFA, 2017, *Report to inform the 2016-17 review of amendments to the Aged Care Act 1997*.

September 2016. Occupancy in level 3 packages has varied, climbing to 87 per cent in November 2014 and 91 per cent in March 2016. While there have been sharp declines due to new packages being released, level 3 package occupancy has always trended upwards.

- 5.130 While more consumers overall are able to access home care with the release of additional packages, these occupancy figures (Figure 5.4) suggest that the income testing and fee changes in home care have had some impact on the uptake of packages. Perceived inequities in fee arrangements for home care packages have impacted both providers' fee-charging practices and the proportion of part-pensioners and self-funded retirees in receipt of lower-level packages.

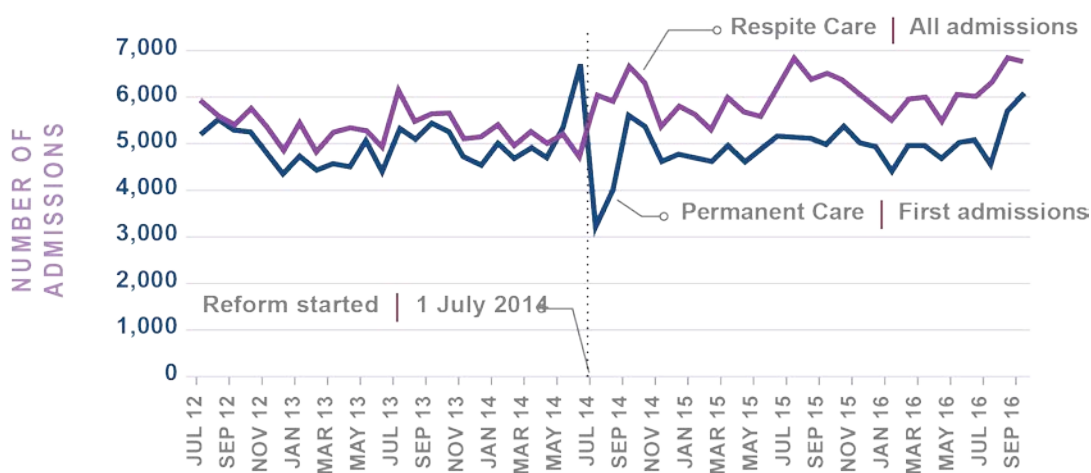
Access to residential care

- 5.131 The changes to means-testing arrangements and fees in residential care do not appear to have negatively impacted consumer access. Analysis by ACFA shows that overall the proportion of pensioners, part-pensioners and self-funded retirees entering residential care since 1 July 2014 has not changed significantly compared to admissions prior to 1 July 2014.¹⁸⁶ Similarly, there has been no substantial change in the average income of new entrants to residential care in the years after the reforms compared with those who entered before. This suggests that the new means-testing arrangements are not impacting access to residential care for residents in different income ranges.
- 5.132 However, there is some evidence to suggest that the reforms may be influencing how consumers are accessing respite care and its relationship to permanent residential care more broadly.

How has the use of respite care changed?

- 5.133 Admissions data for respite and permanent residential care (Figure 5.5) show a clear change in admissions prior to 1 July 2014 compared with admissions following the changes.

Figure 5.5 Admissions to permanent and respite care, July 2012 to September 2016¹⁸⁷



- 5.134 There was a spike in admissions to permanent residential care immediately prior to the reforms, followed by a significant drop in July and August 2014, after which admissions started to return to the broad pre-reform trend.
- 5.135 Admissions to residential respite care, however, increased after 1 July 2014 and have remained higher, both in comparison with pre-reform respite admissions and with post-reform admissions to permanent care.
- 5.136 Analysis conducted for the Review by the department shows that there are two key factors influencing the increased use of respite care:
- a higher number of people are entering respite care immediately preceding (i.e. within a week of) entry to permanent care
 - consumers of respite care are staying longer in care.

¹⁸⁶ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, pp. 61–62.

¹⁸⁷ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 57.

- 5.137 It should be noted that most of the increase in people entering respite immediately preceding entry to permanent care is for people receiving high-level respite care.¹⁸⁸ In addition, consumers receiving respite care who then immediately enter permanent care stay in respite on average twice as long as those who return home.
- 5.138 The consistently higher rate of respite care usage suggests that the reforms have had an ongoing influence on consumer behaviour. Several explanations have been proposed:
- consumer and provider uncertainty about the financial implications of the changes
 - residents' and/or providers' preference for individuals to delay entry to permanent residential care while their financial arrangements are settled
 - using respite care to complement home care packages.¹⁸⁹
- 5.139 For further discussion of respite care see chapter 4 on demand and supply, and Recommendation 8.

Administration of means testing

- 5.140 Processing of income and assets assessments for home care packages and residential care is conducted by DHS. DHS began administering income assessments for home care packages on 1 July 2014, prior to which home care providers conducted their own informal income assessment.

Timeliness of assessments

- 5.141 The timeliness of and apparent delays in completion of means tests were raised in a number of submissions to the Review.

*The means testing assessment/s also take too long to happen/process.*¹⁹⁰

*The problem is in the delivery of the assessments which is still riddled with errors and inconsistencies over 2 years into the new rules.*¹⁹¹

*The time it takes to receive information about the outcome of assessments can be protracted and has caused financial disadvantage for some clients who are charged full means tested fees until the notification comes through.*¹⁹²

*The advice of the level of fees is not being provided to the recipient in a timely manner. Many services are charging the maximum fee amount until receiving notification from DHS. This delay in informing the service providers puts additional stress on the person in care and their family.*¹⁹³

- 5.142 Data from DHS indicate that the majority of means tests (approximately 60 per cent in 2014–15 and 65 per cent in 2015–16) are processed on the day of receipt. This is mostly due to the number of pensioners or part-pensioners (particularly for home care) whose information is already held by DHS.
- 5.143 It is important to note, however, that the information may not be received by DHS until sometime after the person has entered care. For example, if a pensioner enters home care, they are not required to submit a means test to DHS because DHS holds the relevant income information by virtue of the person being a pensioner. The provider then has up to 28 days in which to advise DHS that the person has started receiving care. It can therefore be 28 days from the date of entering care to the 'day of receipt'.

¹⁸⁸ Consumers are approved for either low-level respite care or high-level respite care. The subsidy paid to the provider for this care is different for each level.

¹⁸⁹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, pp. 57–58.

¹⁹⁰ Anonymous 17 submission, p. 4.

¹⁹¹ Sunnyside Lutheran Retirement Village submission, p. 4.

¹⁹² Advocare submission p. 4.

¹⁹³ Aged and Disability Advocacy Australia and Aboriginal & Torres Strait Islander Disability Network of Queensland submission, p. 4

5.144 DHS estimates that the average time between receipt of a complete application and generation of an assessment notice was on average 8.3 days in 2014–15 and 7.7 days in 2015–16. Table 5.4 provides a summary of the number of assessments and the timeframe in which they were processed.

Table 5.4 Ranges of time for completing assessments¹⁹⁴

	WITHIN 28 DAYS	WITHIN 29 TO 56 DAYS	OVER 56 DAYS	TOTAL ASSESSMENTS COMPLETED
2014–15	101,397	8,426	4,175	113,998
2015–16	128,349	7,518	8,267	144,134

5.145 According to information from DHS, the vast majority of assessments taking over 28 days to complete are due to incomplete information from consumers or their nominees. DHS has noted a number of factors influencing processing timeframes:

- Some consumers are unable to complete forms, and sometimes no nominee is in place to act on their behalf.
- Nominees do not have access to complete financial information, or power of attorney is required to access complete financial information.
- Consumers have complex financial arrangements, especially as more consumers have superannuation and multiple sources of income.

Information and support to complete assessments

5.146 A number of submissions to the Review suggested that clearer communication and additional support is needed to assist consumers or their representatives to complete the assessments.

There is confusion by both consumers and providers about the process for applying for a means test, be it for assets and income for residential services, or income for home care. ...Better communication is needed to support the consumer to know what information is required and how it is provided to DHS.¹⁹⁵

People do not understand what means testing is or the process they have to follow, and there is a lack of support to assist people to complete their income and assets form for Centrelink. If you provide the incorrect information it is very difficult and time consuming to get it reviewed. Older people need face-to-face or telephone consultation.¹⁹⁶

5.147 I agree with this assessment. The departments of Health and Human Services should continue to work to improve communication and clarify the means-testing rules and assessment process. The recommendations in chapter 8 on the introduction of an aged care navigator and outreach service will also assist consumers with means testing issues.

How aligned are charges across the different care settings?

5.148 There is limited alignment in consumer contributions across home care packages, residential care and the CHSP, in that the basis for determining consumer contributions in each are significantly different. The LLLB reforms made some improvements to the alignment of consumer contributions between home care packages and residential care by extending subsidy reductions for income-tested care fees to home care packages.

5.149 More broadly, however, there remain significant differences in the extent of means testing and levels of consumer contributions among the different care settings. These differences include:

Consumer contributions in home care packages are based on a person's income only, while contributions to residential care take into account a person's income and assets.

¹⁹⁴ DHS, unpublished data.

¹⁹⁵ Leading Aged Services Australia submission, p. 15.

¹⁹⁶ Advocare submission, p. 4.

The levels and application of the annual caps in home and residential care result in differences in the extent to which contributions reflect care needs as well as capacity to pay.

Fees charged in CHSP are not based on means testing, nor are they required under regulation.

CHSP Client Contribution Framework

- 5.150 The LLLB reforms intended that, consistent with the recommendations of the Commission, there would be consumer contributions across all forms of care, including the CHSP. The government released a consultation paper on fees in the CHSP in March 2015. The paper focused on providing a framework for the collection of fees in the CHSP. This would help ensure the financial sustainability of the CHSP through client contributions, and address potential financial disincentives for consumers to move from CHSP services into home care packages. The discussion paper also proposed providing appropriate safeguards for those least able to contribute to the cost of their care.
- 5.151 As a result of sector resistance to the fees proposal, a uniform, mandatory fee structure for home support was set aside, replaced instead with a principles-based Client Contribution Framework (CCF). The CCF was introduced in October 2015, and does not include a mandatory fees schedule. Instead it outlines the principles service providers can adopt in setting and implementing their own client contribution policy. There is also an expectation from the government that client contributions collected should gradually increase from 10 per cent to a minimum of 15 per cent of the service provider's grant revenue.
- 5.152 In April 2017, the department undertook a national survey of CHSP providers to better understand the uptake and effectiveness of the CCF to date, including any implementation issues. When available this information will be essential for considering any changes to the CHSP.

Alignment of CHSP client contributions with consumer contributions for home and residential care

- 5.153 Client contributions for the CHSP in particular are not well aligned with those for home care packages and residential care. As the National Aged Care Alliance has pointed out, there is:

*Inequity of contributions paid by consumers towards their care across the various aged care programs. For the same level of service, the client contribution paid in the Home Care Packages Program compared with the Home Support Program are greatly different.*¹⁹⁷

- 5.154 Similarly Macarthur Diversity Services Initiative observed that:

*Clients are already paying a client contribution and the addition of the income test fee for applicable clients has resulted in clients refusing [to] take up packages. Services provision for aged care should be provided to all clients at a set price and anything to link to income assessability should be left to Centrelink. We need to separate services provision and means testing. Our experience is that clients do not want to take up services that they must pay [for] under HCP [home care package] which is more expensive than CHSP. This impacts on the health of the client and then we defeat the purpose of healthy ageing.*¹⁹⁸

- 5.155 In terms of consumer contributions in the CHSP, the CCF:¹⁹⁹
- expects that those who can afford to contribute to the cost of their care will do so while providing safeguards for those consumers with limited financial means
 - aims to move towards national fairness and consistency in client contributions and to improve the sustainability of the CHSP over time
 - expects that, while there is no formal means testing, CHSP providers' client contribution policies should take into account a client's capacity to pay and include arrangements for financial hardship.

¹⁹⁷ National Aged Care Alliance submission, p. 11.

¹⁹⁸ Macarthur Diversity Services Initiative submission, p. 4.

¹⁹⁹ The CCF was introduced from 1 July 2015 and established a principles-based approach for providers to set and implement their own client contribution policy. There is a national guide to the CCF, intended to help providers with the establishment of client contribution arrangements that align to the CCF. The guide states that "there is no 'one size fits all' approach to client contribution arrangements across the CHSP and providers can flexibly implement the Framework to best meet their clients' and their organisational needs."

- 5.156 However, there is no requirement that providers charge consumer contributions for services delivered under the CHSP and some consumers are charged little or no fees. This creates a disincentive for consumers to take up a home care package, for example when their care needs increase, as fees for home care packages may appear relatively high in comparison. The low occupancy rates in level 1 and 2 packages appear to support this. The discrepancy in fees also has broader implications for consumer perceptions about the cost of aged care services and the sustainability of the aged care system overall.
- 5.157 In my view, these concerns should be addressed by making fees in CHSP mandatory and aligned to a consumer's income. Fees should be based on an individual's financial capacity and aligned as closely as possible with the income-testing arrangements for home care.

Recommendation 16

That the government introduce mandatory consumer contributions for services under the Commonwealth Home Support Programme. Consumer contributions should be standardised according to an individual's financial capacity.

Community awareness of the extent of government funding

- 5.158 I note, finally, that there is a need to improve consumers' understanding of the cost of the care and services they receive through the government-funded aged care system, and the degree to which those care services are subsidised. Developing consumer and community awareness will inform and assist future policy discussion about how to fund and maintain the aged care system, and the role of consumer contributions in ensuring sustainability.

Recommendation 17

That the government inform consumers of the value of the subsidy that is provided for their care.

CONCLUSION

- 5.159 Means testing remains an effective mechanism for determining consumer contributions for home care packages and residential care. The LLLB reforms to means testing have resulted in very modest improvements to the sustainability of the aged care system for government by increasing consumer contributions, without adversely affecting consumers' access to aged care overall.
- 5.160 However, I believe that further changes to these arrangements, as outlined in my recommendations, are required to improve the effectiveness of consumer contributions and means testing. Better targeting and a more inclusive approach to assets will improve transparency for consumers, support provider viability, and further improve the long-term sustainability of the system.
- 5.161 My recommendations are also consistent with the vision of the Roadmap. They would increase consistency of fee arrangements within and across care types and improve the equity in treatment of different forms of income and assets.

CHAPTER 6

ACCOMMODATION PAYMENTS IN RESIDENTIAL CARE

INTRODUCTION

- 6.1 This chapter responds to matter (e) in the Review terms of reference: the effectiveness of arrangements for regulating prices for aged care accommodation. It covers payments by residents for the costs of accommodation in a residential care home and the funding provided by government for those who cannot afford to pay their own accommodation costs.
- 6.2 The chapter briefly reviews the history of accommodation payments and explains the changes introduced under Living Longer Living Better (LLLBB) reforms. The impact on residents is considered, particularly whether the LLLBB reforms have increased consumer choice and control. The impacts of reforms to accommodation payments on providers are also considered, including the adequacy of government subsidies for encouraging investment and developing additional residential capacity. Finally, the existing regulatory arrangements are considered.
- 6.3 As with chapter 5 on means testing, this chapter draws on data and analysis contained in the Aged Care Financing Authority's (ACFA) *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*. Relevant data and analysis is reproduced here, and further information can be found in that report.

PAYMENTS FOR ACCOMMODATION IN RESIDENTIAL CARE HOMES

- 6.4 In residential care, accommodation is treated as a distinct cost component separate from the costs of care. Government pays a specific subsidy—the accommodation supplement—to cover the cost of accommodation for residents with limited means. Those with the means are required to pay the full cost of their accommodation, which is based on market prices and negotiated directly with the provider. The means test discussed in chapter 5 is used to determine which residents are eligible to receive full or partial assistance through the accommodation supplement.
- 6.5 Accommodation payments, especially in the form of lump sums, play a central role in funding capital investment in residential aged care. As ACFA noted:

*Lump sum accommodation payments have a critical role in the capital financing of the residential aged care sector. For many decades, residential aged care providers have been able to receive upfront lump sum accommodation payments from consumers. These have served as interest-free loans to support the provision of their accommodation. These payments have assisted the sector to create and renew the building stock required to support the current and future demand for services.*²⁰⁰

²⁰⁰ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 11.

HISTORY OF PAYMENTS FOR ACCOMMODATION IN RESIDENTIAL CARE HOMES

- 6.6 Prior to 1 July 2014, providers could only accept lump sum accommodation bonds from residents in a low-care place, or from residents in a high-care place with extra service status²⁰¹. Residents in a high-care place (without extra service status) could only be asked to pay a daily accommodation charge (capped at \$34.20 per day at 20 March 2014).²⁰²
- 6.7 There were minimal restrictions on the amount of accommodation bond a provider could charge a low care or extra service resident, aside from the requirement that the resident be left with a certain amount of assets (the asset-free threshold of \$45,000 at 20 March 2014).²⁰³ Accommodation bonds were based primarily on a resident's assets, and did not necessarily reflect the cost or quality of accommodation.
- 6.8 Residents did have the option of negotiating to pay some or all of their accommodation bond by periodic payments, but this payment option was not favoured by most providers.
- 6.9 Providers could also deduct a regulated retention amount from accommodation bonds. Retention amounts did not have a specified purpose and formed part of providers' general revenue.
- 6.10 The government paid an accommodation supplement to providers on behalf of residents who could not meet the full cost of their accommodation in a residential care home. Prior to the reforms, eligibility for the accommodation supplement was calculated based on a person's assessed assets. A person could receive the full accommodation supplement if they had assessed assets below a threshold, or a partial accommodation supplement if they had assessed assets greater than the first threshold but below a second threshold.

Changes under the Living Longer Living Better reforms

- 6.11 In its 2011 report, the Productivity Commission (the Commission) found that the existing arrangements for accommodation pricing in residential care homes were inequitable, with accommodation bonds bearing little relation to real costs or the quality of the accommodation. Pricing restrictions and subsidy levels were also found to be a barrier to investment and building activity in the sector.²⁰⁴
- 6.12 In response, the broad policy objectives of the LLLB reforms were to:
- increase choice, transparency and flexibility for residents in how they pay for their accommodation
 - prevent providers from choosing which residents to admit on the basis of their ability to pay a lump sum
 - broaden the potential pool of lump sum payments for providers by allowing residents to choose this payment method irrespective of care level.
- 6.13 The LLLB reforms included:
- removal of the cap on daily accommodation charges in high care (that is, allowing market-based pricing, where providers set and publish accommodation prices that can be paid by non-low-means residents)²⁰⁵
 - allowing lump sum accommodation payments to be accepted across all residential care (associated with the removal of the distinction between low and high care places)

²⁰¹ Extra service status places are granted to residential aged care providers that provide a significantly higher than average standard of services including accommodation, range and quality of food, and noncare services such as recreational and personal interest activities. They are able to charge an extra service fee to a resident in an extra service place, and if that resident is in a high-care place the provider can accept an accommodation bond.

²⁰² Department of Social Services, Schedule of resident fees and charges for pre 1 July 2014 residents: from 20 March 2014, <https://agedcare.health.gov.au/aged-care-funding/aged-care-fees-and-charges/archive-residential-care-fees-and-charges>

²⁰³ The concept of a 'minimum permissible asset value' was first introduced with accommodation bonds in the 1997 reforms. At that time, the minimum permissible asset amount was set at 2.5 times the basic age pension (about \$22,500 in 1997).

²⁰⁴ Productivity Commission, 2011, *Caring for older Australians*, vol. 2, pp. 30–33.

²⁰⁵ See chapter 5 for definition of non-low means.

- giving residents the choice of accommodation payment types, between lump sum payments [Refundable Accommodation Deposit (RAD) or Refundable Accommodation Contribution (RAC)], daily payments [Daily Accommodation Payments (DAP) or Daily Accommodation Contributions (DAC)], or a combination of both²⁰⁶
- giving residents 28 days after entry into residential care to choose their payment method
- setting a formula to ensure that consumers paying for accommodation via a lump sum payment and those paying daily payments were making equivalent contributions
- removal of providers' ability to deduct retention amounts
- introduction of a maximum accommodation payment amount set by the minister above, which providers are required to apply for approval by a newly established Aged Care Pricing Commissioner (the Pricing Commissioner) requirement for providers to publish their maximum accommodation prices, quoted as both lump sum and daily amounts.

6.14 The government also increased the maximum level of accommodation supplement paid on behalf of partially and fully supported residents. The higher supplement amount was restricted to newly built (on or after 20 April 2012) and significantly refurbished residential care homes. The intent of the measure was to improve access to care for residents with limited financial means, encourage the development of additional capacity in the residential care sector and enhance the quality and amenity of accommodation for care recipients.²⁰⁷

HAVE THE CHANGES IMPROVED FLEXIBILITY AND CHOICE FOR CONSUMERS?

Has the requirement to advertise accommodation prices improved transparency?

- 6.15 The LLLB reforms were intended to improve transparency and encourage greater competition between providers, requiring providers to publish maximum accommodation prices prior to agreeing and charging accommodation payments to residents.
- 6.16 Providers must publish the maximum accommodation price that they propose to charge for each room (or bed in a shared room) on My Aged Care, on their own websites (if they have them) and in written materials given to prospective residents and their families. They must also include information describing the rooms and common areas of the facility, any specific design features (e.g. a dementia wing), amenities or other items included in the price and available to residents. The published price is the maximum price that can be charged, but residents and providers can agree a lower amount. The accommodation price must be agreed before entry and recorded in writing.²⁰⁸
- 6.17 Since 1 July 2014, a consistent 96 per cent of providers have published accommodation prices on the My Aged Care website.²⁰⁹ A minority of providers—such as some multi-purpose services or those specialising in services for residents with low means—have not published their accommodation prices, primarily because they do not charge their residents accommodation payments.²¹⁰
- 6.18 In their submission, Aged and Disability Advocacy Australia and Aboriginal & Torres Strait Islander Disability Network of Queensland noted that they considered:

²⁰⁶ Refundable Accommodation Deposits (RAD) and Daily Accommodation Payments (DAP) are payments for accommodation made by post-1 July 2014 non-low means residents, who negotiate an accommodation price directly with the aged care home. Refundable Accommodation Contributions (RAC) and Daily Accommodation Contributions (DAC) are the equivalent payment types for post-1 July 2014 low-means (partially supported) residents who have been assessed by the Department of Human Services (DHS) as eligible for some assistance with their accommodation costs. DHS advises residents of the maximum DAC they can be asked to pay, based on their means.

²⁰⁷ Department of Health, 2014, Higher Accommodation Supplement, <https://agedcare.health.gov.au/aged-care-funding/higher-accommodation-supplement>

²⁰⁸ Although in principle all residents agree an accommodation price with their residential care home prior to entry, residents subsequently determined to be of low means and eligible for support with their accommodation costs cannot be asked to pay this agreed amount. They can only be asked to pay the accommodation contribution amount determined by DHS based on their means assessment.

²⁰⁹ Department of Health, unpublished data.

²¹⁰ Department of Health, unpublished data.

...the regulation of accommodation prices as a valuable change made to the Act. The regulation provides consumers with transparency and allows them to easily compare services and make a decision based on value and quality. Regulating pricing gives the person choice and control about where they may like to go and what that looks like for each individual.²¹¹

- 6.19 On one hand, the requirement to publish accommodation prices has improved transparency. On the other hand, a number of submissions pointed out that providers are not publishing other costs or fees that residents may be asked to pay. For example, the Ethnic Communities' Council of NSW stated that:

*There needs to be greater transparency in the way in which residential care providers advertise and promote their accommodation prices. This includes transparent information about hidden costs such as exit costs, additional service costs, basic services vs options, room sharing, additional aged care therapy's such as physiotherapy or hydrotherapy, alternative meals and activity options.*²¹²

- 6.20 Similarly, the Association of Age Service Professionals Inc. observed that:

*Providers are not advertising their total price on either the My Aged Care website or their own. Some are not advertising the additional service fees and none are advertising the capital refurbishment fees. Consumers are unable to compare one facility to the next nor are they able to understand what fees they will be up for until they sign the agreement. More transparency is needed.*²¹³

- 6.21 While there were no specific changes to aged care legislation related to fees for additional services as part of LLLB reforms, many submissions made the point that these fees should have the same degree of transparency as accommodation prices. I agree that transparency of aged care costs should be enhanced. This would be achieved by requiring the publication of fees that providers may be permitted to charge under aged care legislation. Similar to accommodation payments, providers would be required to provide a description and a value for these fees in a format that would be easy for consumers to compare.

Recommendation 18

That the government improve the transparency of fees for residents by requiring providers to publish information on My Aged Care in a way that assists informed choice by consumers.

Have accommodation prices increased?

- 6.22 The changes to the rules for accommodation payments and data limitations mean that accommodation prices cannot be compared on a like-for-like basis with pre-reform accommodation bond amounts. Pre-reform payments could only be made in one lump sum whereas post-reform payments can be made as a single lump sum payment or a smaller lump sum payment in combination with a daily payment. However, the average accommodation prices agreed between providers and post-reform residents can be compared with average accommodation bonds received prior to the reforms.
- 6.23 According to analysis by ACFA, accommodation prices appear to have increased. An average accommodation bond in 2013–14 was \$296,000 for new entrants.²¹⁴ In 2014–15 the average agreed accommodation payment for those entering care had increased to around \$334,000,²¹⁵ up 13 per cent on the previous year. The average agreed accommodation

²¹¹ Aged and Disability Advocacy Australia and Aboriginal & Torres Strait Islander Disability Network of Queensland submission, p. 5.

²¹² Ethnic Communities' Council of NSW submission, p. 6.

²¹³ The Association of Age Service Professionals Inc. submission, p. 4.

²¹⁴ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p.27 in Appendix C.

²¹⁵ This data is indicative only. Agreed accommodation prices are reported by aged care homes through the Aged Care Entry Record (ACER). The ACER must be completed within 28 days of a resident's entry to permanent residential care. In some instances the provider may complete the ACER before the resident has elected their payment method. The ACER is also completed for supported residents. This means that the data may include prices agreed with supported residents prior to their fee advice letter (and subsequently unpaid).

price has since gradually increased, reported as \$350,000 at 1 February 2017.²¹⁶ However, this is significantly lower than the average accommodation price published on My Aged Care at that date, which was \$391,000.²¹⁷

- 6.24 The affordability of accommodation payments was raised with the Review by some stakeholders. The Victorian Commonwealth Home Support Programme (CHSP) Carer Programs Network, for example, said:

*Accommodation prices are expensive. The assumption seems to be that every person owns a home that has significant financial value, however the many homes in rural and remote areas will not attract anywhere near the hundreds of thousands of dollars needed to pay an accommodation bond.*²¹⁸

- 6.25 Affordability and diversity in accommodation options are key enablers of consumer choice. While ACFA has reported that accommodation prices are reasonably diverse nationally,²¹⁹ there may be less diversity in accommodation and pricing in rural and regional areas.
- 6.26 The LLLB reforms did introduce additional flexibility for residents by enabling 'draw-down' of daily payments from lump sums. In practice this means that a resident could pay a partial lump sum payment and then agree to a daily payment to pay the remainder of the accommodation cost. The daily payment could be 'drawn-down' from the lump sum payment, meaning that its value would decrease over time. This means that residents may be able to access accommodation that their assets alone would not afford them. I note, too, that the existing financial hardship provisions include provisions for recognising unrealisable assets, which may be of particular use to residents in rural and remote areas who may experience difficulty in selling or borrowing against their homes.²²⁰

Choice of accommodation payment type

- 6.27 The changes to accommodation payments aimed to give residents greater choice and flexibility in how they paid for their accommodation. Residents would be given a choice between payment types, and a 'cooling-off' period after they entered care in which to make that decision.
- 6.28 Analysis by ACFA shows that lump sum accommodation payments remain the most common payment method for non-low-means residents (52 per cent), followed by a combination payment (partial lump sum and daily payments) (26 per cent) and daily payments (22 per cent) (Figure 6.1).²²¹
- 6.29 In contrast, 80 per cent of partially supported residents chose to make daily contributions. However, partially supported residents are advised of their accommodation contribution amounts by the Department of Human Services (based on the person's means test) as a daily contribution amount so daily contributions could be seen as a 'default' form of payment.

Figure 6.1 Consumer choice of accommodation payment type, 2015–16²²²

²¹⁶ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 43.

²¹⁷ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 41.

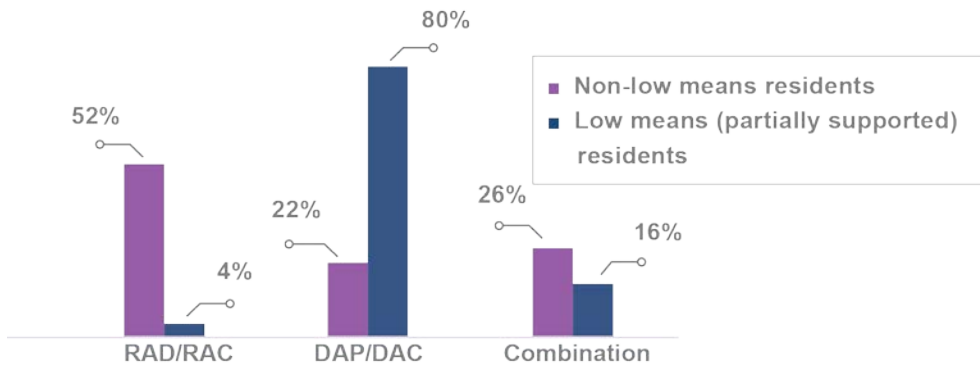
²¹⁸ Victorian CHSP Carer Programs Network submission, p. 5.

²¹⁹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 28 in Appendix C.

²²⁰ Department of Health, Financial hardship assistance, <https://www.myagedcare.gov.au/costs/financial-hardship-assistance> and DHS, Financial hardship assistance for Residential Aged Care form (SA461), <https://www.humanservices.gov.au/customer/forms/sa461>

²²¹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 37

²²² ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 37.



6.30 Prior to the reforms, accommodation bonds were the default form of payment for residents in low care, although residents were able to negotiate with their provider to pay the bond by periodic payments or a combination of bond and periodic payments. In 2013–14, just over 87 per cent of all bond-paying new residents paid by lump sum only, while only 4 per cent paid by periodic payments and around 9 per cent by a combination of the two.²²³ In comparison, post-LLLB reform payment choices are now more evenly distributed across payment types, particularly for non-low-means residents, indicating that residents are exercising their right to choose.

6.31 However, one submission to the Review indicated that not all providers are supporting full choice of payment by the resident but are showing preference for lump sums over daily payments.

*The accommodation charge can now be paid in instalments (daily accommodation payments) rather than by a lump sum (refundable accommodation deposit). This enables more clients to enter residential care who have minimal assets but a regular income. However, the reality is that few residential age care facilities will mention the option of paying by DAP and only mention the RAD option.*²²⁴

6.32 One industry submission gave a different provider perspective on consumer choice of payment, suggesting that:

*Providers should have a clear understanding of the methods by which they are paid by consumers prior to admission. As such, the 28-day rule for a decision to pay a RAD or DAP should be abolished to require the decision to be made up front.*²²⁵

6.33 This raises an issue similar to those raised by providers in submissions to the Senate inquiry into LLLB. Providers were concerned that residents' choice of payment would lead to a preference for daily payments over lump sums, posing a liquidity risk and potentially curtailing investment.²²⁶ Based on the data reported by ACFA, this has not eventuated and non-low-means residents continue to favour lump sum payments. It does appear, however, that some providers are still of the view that they should determine the form of payment appropriate to their business. Overall, I consider that existing arrangements strike an appropriate balance between the interests of consumers and providers.

HOW HAVE THE CHANGES IMPACTED PROVIDERS?

Funding accommodation for residents with low means

6.34 The LLLB reforms increased the funding available to support the accommodation costs of residents with low means by increasing the accommodation supplement paid to providers if the facility was newly built or significantly refurbished.

²²³ Department of Health, 2014, *2013–14 report on the operation of the Aged Care Act 1997*, p. 47.

²²⁴ Charles Penheiro, submission one, p. 4.

²²⁵ Illawarra Retirement Trust Group submission, p. 6.

²²⁶ Senate Standing Committee on Community Affairs, 2013, *Report on Aged Care (Living Longer Living Better) Bill 2013 [Provisions] and related bills*, particularly pp. 62–66.

How many services are eligible for the higher rate of accommodation supplement?

- 6.35 As at 30 September 2016, an estimated 757 residential care homes (28 per cent of all homes) were eligible or potentially²²⁷ eligible for the higher accommodation supplement.²²⁸ This included 630 homes eligible or potentially eligible due to significant refurbishment (24 per cent of total residential care homes), and 127 newly built facilities (5 per cent of total homes).
- 6.36 While payment of the higher accommodation supplement commenced on 1 July 2014, relevant investment that was completed on or after 20 April 2012 was eligible for the supplement. The industry saw an increase of 69 per cent of the value of investment completed in 2013–14 over the previous year²²⁹, an indication of the investment in improving existing homes and creating additional capacity encouraged by the higher rate of supplement.
- 6.37 The estimated completed refurbishment spend per residential care home averages \$3.9 million, with a median of \$1.7 million and total estimated expenditure of \$2.45 billion across the sector between 1 July 2014, when the higher rate was introduced, and 30 September 2016.

Is government funding of accommodation for residents of low means adequate?

- 6.38 ACFA's analysis compared the level of government funding for accommodation with the average agreed prices charged by providers. ACFA found that the higher rate of accommodation supplement (\$55.09 per day at 20 March 2017) paid on behalf of low-means residents in new or significantly refurbished homes is broadly in line with average prices paid by those residents contributing their own accommodation costs.²³⁰

The overall average agreed accommodation payment of \$350,000 RAD (equivalent DAP of \$55.23) is broadly equivalent to the higher rate of supplement of \$55.09 per day (\$349,095 lump sum equivalent).²³¹

- 6.39 This indicates that, on average, the value of the accommodation supplement that the government provides for low-means residents is reasonable for supporting providers to invest in accommodation.

Investment and building activity

- 6.40 The impact of accommodation payment changes on the pool of lump sums, and ability of providers to refund outgoing lump sums, were key industry concerns prior to commencement of the reforms. However, data from the Department of Health (the department) and analysis by ACFA shows that the overall pool of lump sums has steadily increased since 1 July 2014.
- 6.41 In 2015–16, the total pool of lump sums (including both accommodation bonds and refundable deposits) held by residential care providers increased to \$21.73 billion (Figure 6.2).²³²

Figure 6.2 Total pool of lump sums held, 2011–12 to 2015–16²³³

²²⁷ Figures are based on the total number of significantly refurbished services for which standard and confirmation of pre-approval applications have been received (excluding withdrawn, incomplete and newly built). 'Potentially' includes applications that were not initially successful but may be approved upon review including through the Administrative Appeals Tribunal.

²²⁸ Based on count of 2,669 operational services nationally at 30 June 2016. Department of Health, *30 June 2016 Stocktake of Australian Government subsidised aged care places*.

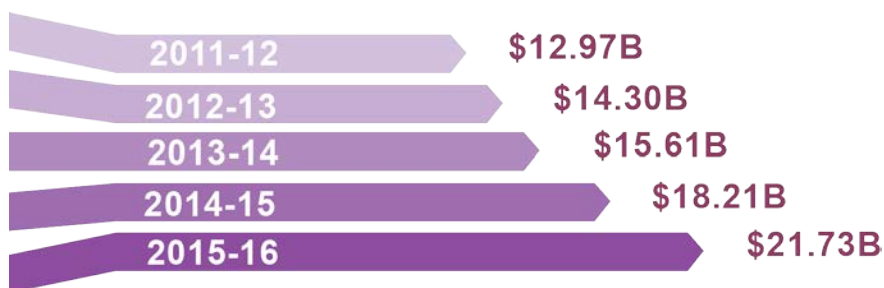
²²⁹ ACFA, 2015, *Annual report on the funding and financing of the aged care sector*, p. xvii.

²³⁰ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, pp. 41–44.

²³¹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 43.

²³² ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 42.

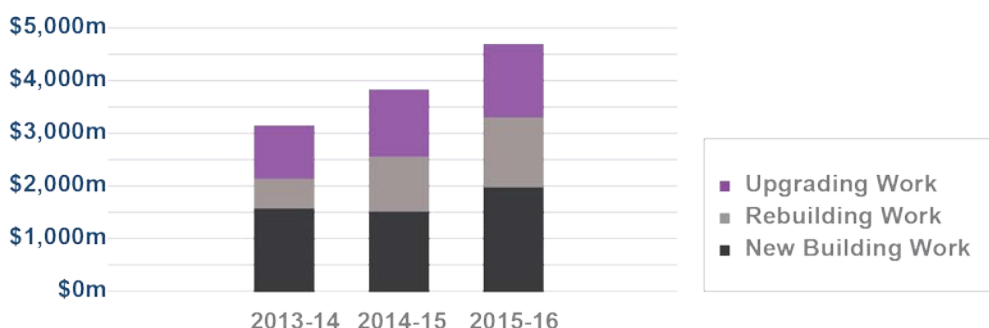
²³³ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 42.



- 6.42 The increase in the lump sum pool held by providers has been driven by three factors:
- the larger potential pool of lump sums, an intended outcome of the removal of the distinction between high and low care that had previously restricted consumers' payment choice options
 - the apparent preference of many non-supported residents to pay for their accommodation by lump sum payments over daily payments
 - an increase in the average value of accommodation payments compared with the value of accommodation bonds prior to the LLLB reforms.

6.43 Building activity has generally increased since the LLLB reforms commenced, suggesting that investors are responding positively to the reforms. The 2016 Survey of Aged Care Homes estimates total building activity to the value of \$4.7 billion in 2015–16²³⁴, compared with \$3.8 billion in 2014–15²³⁵ and \$3.1 billion in 2013–14 (Figure 6.3).²³⁶ This includes new building, rebuilding and upgrading work both completed during the year and in progress at the end of the year.

Figure 6.3 Residential aged care building activity, 2013–14 to 2015–16²³⁷



- 6.44 Two factors are likely to have contributed to the increase in investment and building activity. They are the increased flexibility to charge lump sums, and the increase in the maximum accommodation supplement.

Impact of regulatory changes

Removal of retention amounts

- 6.45 The removal of retention amounts has provided greater transparency and choice in accommodation payments. Providers cannot deduct amounts from the resident's lump sum without the resident's agreement, and the calculation of the amounts to be deducted is transparent.
- 6.46 While consumers support the removal of retention amounts, anecdotally some recent changes in additional services fees have been attributed to a desire to receive de facto retention amounts. These relate to increased accommodation prices and to increased prevalence of additional service fees. In September 2016 the department provided additional

²³⁴ Department of Health, 2016, *2015–16 report on the operation of the Aged Care Act 1997*, p. 51.

²³⁵ Department of Health, 2015, *2014–15 report on the operation of the Aged Care Act 1997*, p. 73.

²³⁶ Department of Health, 2014, *2013–14 report on the operation of the Aged Care Act 1997*, p. 48.

²³⁷ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 43.

information to providers about their responsibilities when charging fees for additional services to clarify their use, including additional service fees described as 'capital refurbishment fees' or 'asset replacement contributions'.²³⁸

- 6.47 Recommendation 14 on the basic daily fee in residential aged care proposes to give providers significantly more flexibility over the contributions that they can ask consumers to pay. It is important, however, that all parts of the aged care sector recognise that many elements of aged care reforms have to balance the competing needs of consumers and providers. Once a balance is achieved through policy debate and legislation it is important that the law and spirit of the solution is adhered to. Embracing the spirit of the LLLB reforms is important in relation to the issue of retention amounts and it will be important for the implementation of many of the recommendations of this report, which also seek to balance the interests of consumers and providers. I therefore conclude that the Pricing Commissioner's role should be expanded in this case, as outlined in Recommendation 19.

Equivalence method and use of the maximum permissible interest rate

- 6.48 In order to provide residents with choice of accommodation payment (that is, RAD, DAP or a combination of both) it was considered necessary to ensure that there was financial equivalence between the RAD and DAP so that neither residents nor providers would be financially disadvantaged by the resident's choice of payment method.
- 6.49 This was ensured by adopting the pre-reform formula used for determining periodic payments. A provider first sets their maximum lump sum payment. An interest rate is then used to determine the equivalent daily rate of payment. The maximum permissible interest rate (MPIR), which was already used in aged care legislation,²³⁹ was adopted to convert a lump sum deposit into an equivalent daily payment.²⁴⁰ The MPIR is typically three to four percentage points higher than the official cash rate.
- 6.50 The MPIR is intended to ensure that the daily payment provides a provider with an income stream broadly equivalent to what they might earn if the consumer had instead provided them with a lump sum payment or sufficient to cover the cost of borrowing that capital funding. Using a specified, consistent interest rate ensures that one form of payment cannot be made more attractive to residents than another, and supports consumers to more easily compare accommodation prices across different rooms and aged care homes.
- 6.51 The rate is determined through legislation with reference to the Australian Tax Office's General Interest Charge (which in turn is based on the 90-day bank bill rate), but set lower to reflect borrowing costs. On 30 June 2017 the rate was 5.78 per cent.
- 6.52 While the lump sum form of an accommodation payment is consistently the most common, chosen by around half of non-low-means residents, there are still around half who are paying part or all of their agreed accommodation price as a daily payment (either fully by daily payment or a combination of daily payment and lump sum).
- 6.53 While many factors are considered when determining how to pay the accommodation payment (e.g. expected length of stay and/or personal financial circumstances), the continued use of daily payments suggests that the MPIR is not punitive for residents given their alternatives.
- 6.54 I agree with ACFA's conclusion that:

*...under the current policy settings the policy of equivalence between lump sums and daily payments should remain, the MPIR is an appropriate rate to be used to determine equivalency and that lump sums should remain as the anchor point from which to convert to daily payments.*²⁴¹

²³⁸ Department of Health, Charging fees for additional care and services in residential aged care, including 'capital refurbishment' type fees, <https://agedcare.health.gov.au/programs/residential-care/charging-fees-for-additional-care-and-services-in-residential-aged-care-including-capital-refurbishment-type-fees>

²³⁹ As detailed in the *Fees and Payments Principles (No. 2) 2014*.

²⁴⁰ The MPIR is also the rate used to determine the amount of interest to be paid by providers on overdue refunds of lump sum accommodation payments.

²⁴¹ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 44.

HAVE THE CHANGES IMPROVED THE SUSTAINABILITY OF RESIDENTIAL AGED CARE?

- 6.55 There are two aspects to sustainability of residential care that need to be considered in the context of this chapter: first, the cost of residential care to taxpayers and the long-term fiscal sustainability of the aged care system; and second, the capacity of the sector to prepare for and meet future need and demand for residential care services.
- 6.56 The LLLB reforms to accommodation payments have not contributed to a reduction in government expenditure, as the overall proportion of residents paying the full cost of their accommodation (i.e. those for whom the government is not paying any accommodation supplement) has not increased. ACFA's analysis shows that when the fee-paying status of residents in care on 30 June 2014 is compared with the fee-paying status of post-reform residents in permanent residential care at 30 June 2016:²⁴²
- the proportion for whom government did not pay any accommodation supplement was the same for both groups at around 60 per cent of all residents
 - the proportion for whom government paid a full accommodation supplement was virtually the same for both groups at about a quarter of all residents.
- 6.57 While the overall proportion of residents for whom the government is not paying any accommodation supplement has not increased, it should still be noted that the steady 60 per cent represents a significant cost avoidance for government (in that the government does not have to subsidise the accommodation costs of the non-low-means group).
- 6.58 The overall pool of lump sums has expanded significantly following the LLLB reforms, which is likely contributing to increased building activity. Similarly, the level of the higher accommodation supplement appears to be sufficient for generating investment and development of additional residential accommodation capacity. In chapter 4 on demand and supply it was observed that the rate of growth of demand for residential care in the medium term is reducing. However actual growth in places needs to be maintained in order to respond to the overall growth in the ageing population.
- 6.59 The existing lump sums pool will not meet all future building requirements. ACFA has reported that based on current assumptions about service provision targets and the costs of construction, the investment requirement of the sector over the next decade will be in the order of \$33 billion, noting that this is almost equal to the total asset value of the industry at 30 June 2015 (\$36.6 billion).²⁴³ However, the increase in the asset value of the sector since the LLLB reforms is an encouraging sign.

IS THE MAXIMUM ACCOMMODATION PAYMENT AN EFFECTIVE MECHANISM FOR REGULATING ACCOMMODATION PRICES?

- 6.60 The maximum accommodation payment and the requirement that providers seek approval from the Pricing Commissioner for accommodation prices in excess of the maximum were introduced as central mechanisms in the regulation of accommodation prices. Their effectiveness can be measured by the impact on market pricing and the degree of consumer protection they provide.
- 6.61 On commencement of the changes to accommodation payments on 1 July 2014, the maximum accommodation payment was set as a refundable deposit of \$550,000, with an equivalent daily payment of \$100.80.²⁴⁴
- 6.62 The maximum accommodation payment has not changed since implementation, although the daily payment equivalent has fluctuated as a result of changes in the MPIR. For example, the equivalent DAP was \$86.79 on 1 February 2017.

²⁴² ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, pp. 24–26 and p. 45.

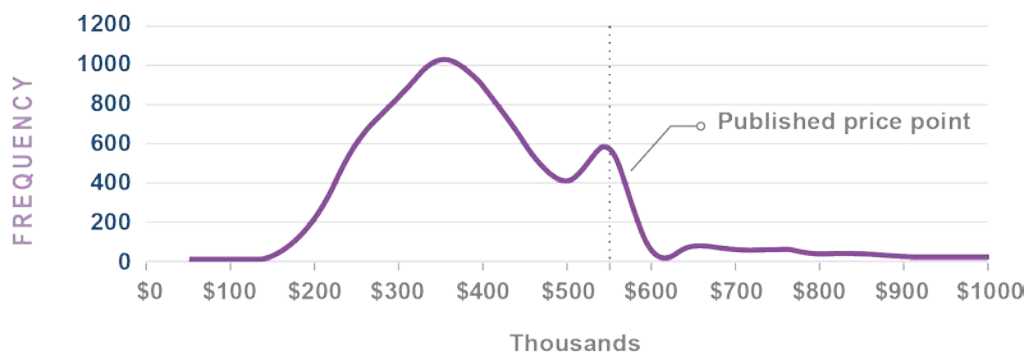
²⁴³ ACFA, 2016, *Annual report on the funding and financing of the aged care sector*, p. 125.

²⁴⁴ Calculated using the MPIR current on 1 July 2014 of 6.69 per cent.

How has the maximum accommodation payment impacted prices?

- 6.63 Analysis by the department, of accommodation prices published on My Aged Care at 1 February 2017 (Figure 6.4) shows that:
- the majority of accommodation prices (approximately 85 per cent) are below \$550,000
 - 8 per cent were equivalent to the maximum payment
 - only 7 per cent were greater than \$550,000.
- 6.64 The proportion of providers publishing accommodation prices equivalent to and above the maximum payment amount has not changed significantly since July 2014. At 30 June 2015, approximately 7 per cent were equivalent to and 6 per cent were greater than the maximum payment amount.

Figure 6.4 Spread of published accommodation prices at 1 February 2017²⁴⁵



- 6.65 The percentage of accommodation prices agreed between residents and providers that are above the maximum payment of \$550,000 is relatively low.²⁴⁶ At 1 February 2017 only 5 per cent of agreed prices were greater than the maximum amount, while 5 per cent were equal to the maximum amount. This is only slightly greater than at 30 June 2015, when approximately 4 per cent were greater than the maximum amount and 4 per cent were equal to the maximum amount.
- 6.66 It appears that while average accommodation prices published on My Aged Care and agreed between resident and providers are increasing, the proportion of published and agreed prices at or above the maximum accommodation price have not increased to the same extent. Therefore, the maximum accommodation price is affecting pricing by limiting higher prices, but is not affecting the majority of accommodation prices below the threshold.

Is the requirement to seek approval from the Aged Care Pricing Commissioner an effective mechanism for protecting consumers?

Applications received by the Aged Care Pricing Commissioner

- 6.67 In the period between 31 January 2014, when the Pricing Commissioner started accepting applications, and the end of 2016, 1,082 individual applications were made for the approval of accommodation prices above the maximum amount. Of these, 91 per cent (986 applications) were approved, representing 16,824 residential places.
- 6.68 There have been no formal rejections to date. The stated approach of the Pricing Commissioner has been to work openly with applicants where prices appear not to be justifiable so that they may reach a position where prices are acceptable. The Pricing Commissioner estimates that approximately 13 per cent of initial applications would otherwise have been refused, had they not been withdrawn by applicants or substantially reframed.²⁴⁷

²⁴⁵ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 38.

²⁴⁶ This data is indicative only. See comment at footnote 15.

²⁴⁷ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 40.

Approved higher accommodation prices

- 6.69 At 31 December 2016, around 9 per cent of residential care places had an approval for an accommodation price above the maximum amount.²⁴⁸ These were distributed across 9 per cent of residential aged care homes.
- 6.70 Looking at approved prices across different price bands (Table 6.1), around 38 per cent of rooms with an approval from the Pricing Commissioner have an approved price between \$550,001 and \$700,000. A further 36 per cent are approved in the range \$700,001 to \$850,000. Only about 9.5 per cent of all rooms approved exceed \$1 million, which represents a small proportion (approximately 1 per cent) of the total number of residential aged care places nationally.

Table 6.1 Distribution of rooms with an approval by price band, 31 December 2016²⁴⁹

PRICE BAND	PROPORTION OF ROOMS WITH AN APPROVAL (TOTAL)
\$550,001 to \$700,000	38.2%
\$700,001 to \$850,000	36.0%
\$850,001 to \$1,000,000	16.3%
\$1,000,001 to \$1,250,000	4.5%
\$1,250,001 to \$1,500,000	2.6%
\$1,500,000 and above	2.4%

Issues and discussion

- 6.71 A number of submissions to the Review queried whether ongoing regulation of prices through the maximum accommodation payment and approval of higher prices by the Pricing Commissioner is necessary, especially in the context of future reform. The Aged Care Guild argued, for example, that:

*A consumer driven market should not involve the level of pricing regulation that currently exists in the market. The Guild supports increased competition and with it consumer driven accommodation pricing, whereby consumers determine what they are willing and able to pay and providers respond accordingly.*²⁵⁰

- 6.72 Aged and Community Services Australia (ACSA) made a similar point:

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

*Consistent with this, ACSA does not see the need for Government to regulate to protect wealthy older people, as currently occurs, via the requirement to seek Aged Care Pricing Commissioner approval of RADs above \$550,000.*²⁵¹

- 6.73 ACSA perceives that the regulatory mechanism of a maximum accommodation price (and approval of higher prices by the Pricing Commissioner) primarily protects wealthier residents, an observation also made by ACFA.²⁵² I agree with ACFA's analysis, however, that it is likely that the application and approval process is having a broader influence on prices, with providers needing to justify their pricing, thus encouraging better quality and amenity. ACFA observes that providers appear to be pricing their accommodation appropriately, given that around 87 per cent of applications to the Pricing Commissioner were approved in the first instance.

²⁴⁸ Aged Care Pricing Commissioner, unpublished data based on a count on 30 June 2016 of a total of 195,825 residential care places, with 2,669 services (residential aged care facilities), operated by 949 approved aged care providers nationally.

²⁴⁹ Aged Care Pricing Commissioner, unpublished data.

²⁵⁰ Aged Care Guild submission, p. 10.

²⁵¹ ACSA submission, p. 10.

²⁵² ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*, p. 40.

6.74 While I note these observations, it is my view that the Pricing Commissioner and approval of higher prices will remain a necessary regulatory mechanism for the medium term while residential care continues to be delivered in a supply-constrained environment. The National Aged Care Alliance has argued:

*Future changes towards an uncapped, consumer-driven market-based system will require changes to the regulation of aged care prices, including accommodation, if a truly market system is to be developed. The Pricing Commissioner provides a pivotal role until such time this occurs. The principle of ensuring transparent, easily accessible information about all costs, including accommodation prices should continue to be at the forefront of any reforms in this area in the future.*²⁵³

6.75 However, while I support retaining the maximum accommodation payment and role of the Pricing Commissioner, I recommend several changes to ease this aspect of the regulatory framework for accommodation prices for the next stage of reforms.

6.76 First, I recommend increasing the maximum accommodation payment from a refundable deposit of \$550,000 to \$750,000. This would reduce the number of applications that providers would need to submit to the Pricing Commissioner, thereby reducing regulatory burden for providers while retaining a consumer protection mechanism. According to data from the office of the Pricing Commissioner:

- approximately 36 per cent of rooms (at December 2016) with an approved higher accommodation price have an approved price of \$751,000 or higher
- the majority of rooms with an approved higher accommodation price (64 per cent) have an approved price between \$550,000 and \$750,000.

6.77 There may be some flattening of the peak/cluster of prices currently published at the \$550,000 threshold (Figure 6.4), with some providers potentially increasing the published price of these rooms into the \$550,000 to \$750,000 bracket.

6.78 Second, the threshold should not be static, but should reflect changes over time in the residential real estate market. This would provide an appropriate transition to further market-based pricing. Government could consider options for best reflecting movement in house prices by linking periodic movements in the threshold to an appropriate index. Government could further consider options for varying the maximum payment by location, as real estate values can vary markedly across regions. However, this would be administratively burdensome.

6.79 Third, the government should consider options for expanding the role of the Pricing Commissioner to include independent assessment of other uncapped fees in residential care. As previously noted, there is some evidence that these fees are not being used as they were intended. An expansion of the Pricing Commissioner's role in this area would provide additional transparency and greater protection for consumers. This includes independent assessment and monitoring of uncapped basic daily fees for non-low-means residents in residential care (as proposed under Recommendation 14). Government could also include fees for other care and services charged by residential care providers.

6.80 This expansion of the Pricing Commissioner's role would also provide additional protections for residents if regulatory controls were relaxed but the overall supply of residential care places remained capped.

Recommendation 19

That the Government retain and reform the role of the Aged Care Pricing Commissioner by:

- a) increasing the maximum accommodation payment, above which approval by the Pricing Commissioner must be sought, from a refundable deposit of \$550,000 to \$750,000 (or equivalent daily payment)
- b) implementing an automatic link between the future maximum accommodation payment and median house prices
- c) expanding the Pricing Commissioner's role to include providing independent assessment of other fees, e.g. additional service fees and uncapped basic daily fees.

²⁵³ National Aged Care Alliance submission, p. 12.

CONCLUSION

- 6.81 The arrangements for regulating prices for aged care accommodation are generally effective. Changing the way that accommodation prices are determined has increased transparency for consumers, allowing them to compare the value of accommodation offered by different providers. Providing more payment options for consumers has positively impacted on the sustainability of the sector, with the pool of lump sum deposits continuing to grow, while building work has increased over time.
- 6.82 Further steps can be taken to both reduce some of the regulatory restrictions on accommodation prices and improve consumers ability to compare aged care fees.

CHAPTER 7

THE PROTECTION OF LUMP SUM ACCOMMODATION PAYMENTS

INTRODUCTION

- 7.1 This chapter responds to matter (h) in the Review terms of reference: the effectiveness of arrangements for protecting refundable deposits and accommodation bonds.
- 7.2 Many people entering residential care contribute to the costs of their accommodation. This contribution is often made by paying a lump sum accommodation payment to the residential care provider upon entry, called a refundable accommodation deposit (RAD) or accommodation bond (referred to in this chapter as a lump sum payment). These lump sum payments are returned to residents (or their estates) when they leave residential care.
- 7.3 Lump sum payments typically represent a large proportion of a resident's wealth, so it is vital that their money is safe. There are two elements of aged care regulation that aim to ensure residents' money is protected: prudential regulation and the Accommodation Bond Guarantee Scheme (the Scheme).²⁵⁴ Both these elements are examined in this chapter.
- 7.4 A range of protections included in aged care law provide prudential regulation. These protections regulate the financial operation of aged care providers in respect of the lump sum payments they hold and are set out in the *Aged Care Act 1997* (the Act), the *User Rights Principles 2014* and the *Fees and Payment Principles 2014*. They are monitored and enforced through prudential standards and overseen by the Department of Health (the department).
- 7.5 The Scheme is the second element of protection. It is a safety net that protects residents' lump sum payments in the event of provider insolvency. The central feature of the Scheme is a government guarantee contained in legislation.²⁵⁵ If a provider becomes insolvent and the residents cannot get their money back, the government will pay the sum owing to them. The Scheme also includes a mechanism²⁵⁶ allowing the Minister to impose a levy on approved residential aged care providers to recover any costs to the government, including administrative costs from repaying money owed to residents. While the Scheme has been used to repay residents, the government has never applied any levy on providers to recoup the costs incurred.

THE APPROACH TAKEN BY THE REVIEW

- 7.6 The Review's consideration of this term of reference has been assisted and influenced by two parallel reviews, completed this year, of the protection of lump sum payments: the Aged Care Financing Authority (ACFA)'s study of the Scheme; and an independent review by Ernst & Young (EY) of prudential regulation and monitoring.
- 7.7 In November 2015, ACFA was tasked by the Minister for Health to review the Scheme, including examining alternative arrangements or methods for achieving the Scheme's purpose—the guaranteed return of lump sum payments to residents. ACFA's study evaluated the existing Scheme and potential alternatives against a set of principles, and drew on expert opinion, quantitative actuarial modelling and qualitative assessments.
- 7.8 ACFA has worked collaboratively with this Review, with the intention that its work would substantially inform the Review's consideration of how lump sum payments are protected. ACFA's study was published on 29 May 2017.

²⁵⁴ Aged care consumers have other important protections under consumer, contract, and corporation laws. These are not considered in this Review, but their important role has been outlined in ACFA's 2017 report on the Scheme, *The protection of residential aged care lump sum accommodation payments*.

²⁵⁵ *Aged Care (Accommodation Payment Security) Act 2016*

²⁵⁶ In the *Aged Care (Accommodation Payment Security) Levy Act 2006*

- 7.9 The task for this Review is broader than ACFA's study, as it includes consideration of prudential standards. In this respect, the Review was greatly assisted by EY's independent review, which evaluated the adequacy of existing legislation and prudential standards in protecting the interests of residents in aged care homes. It also considered whether current regulation supported the effective management of the risk underwritten by the government in protecting the lump sum payments of those residents.
- 7.10 This chapter does not reproduce all the arguments and information in the ACFA study and EY review. However, this chapter does refer to the reports, and quotes the ACFA study extensively where relevant. Further information can be found in the respective reports.²⁵⁷
- 7.11 Of the 145 submissions received by the Review, 50 commented on the protection of lump sum payments. Relevant submissions came from a wide variety of stakeholders, including carers and the relatives of residents (11), consumer advocacy and peak bodies (11), individual service providers (16), major providers (3), an aged care sector peak body (1), a community organisation (1), aged care and health professionals' advocacy groups (4), a state government consumer protection agency (1), and financial services companies (2). ACFA also received 26 submissions as part of its review process.

THE IMPORTANCE OF LUMP SUM PAYMENTS AND THEIR PROTECTION

- 7.12 Lump sum payments provide a significant source of capital funds to the residential care sector. As ACFA noted:

*Lump sum accommodation payments have a critical role in the capital financing of the residential aged care sector. For many decades, residential aged care providers have been able to receive upfront lump sum accommodation payments from consumers. These have served as interest-free loans to support the provision of their accommodation. These payments have assisted the sector to create and renew the building stock required to support the current and future demand for services.*²⁵⁸

- 7.13 The amounts of money involved are large. ACFA noted that "at 30 June 2016, the residential aged care sector held lump sum accommodation payments of approximately \$21.7 billion, with an average new payment of \$370,000".²⁵⁹ This figure is rising each year. Ensuring that these funds, which play a significant role in financing the industry, continue to be available has long been important to policy-makers and the sector. They are a vital and distinctive feature of aged care. At the same time:

*Because lump sum accommodation payments are large sums, and may represent the majority of a resident's wealth, it is vital that these investments are secure. For this reason, their refund is guaranteed in the event that the provider that holds them becomes insolvent. This guarantee is what the Scheme provides.*²⁶⁰

- 7.14 As ACFA demonstrates in its report,²⁶¹ policies designed to guarantee the return of lump sum payments to residents or their estates in the event of provider insolvency extend back to the 1990s. This Review is the latest to contribute to the discussion of how best to provide a guarantee for consumers' money and, in particular, how best to pay for that guarantee.

²⁵⁷ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, <https://agedcare.health.gov.au/reform/the-protection-of-residential-aged-care-accommodation-lump-sum-accommodation-payments>
EY's report *Review of aged care legislation* which provides for the regulation and protection of refundable accommodation payments residential aged care, <https://agedcare.health.gov.au>

²⁵⁸ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 11.

²⁵⁹ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 11.

²⁶⁰ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 11.

²⁶¹ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, pp. 27–39.

The history of lump sum payment protection

- 7.15 The introduction of the legislation that remains the cornerstone of Australia's aged care system—the *Aged Care Act 1997*—included the government's first systematic protection of what were then called bonds.²⁶² The Act provided a framework for a contributory trust that would protect bonds paid by residents in aged care homes. A trust was established in October 1997 but closed after only a few weeks of operation following a change in government policy.
- 7.16 The 2004 *Review of pricing arrangements in residential aged care* (the Hogan report)²⁶³ called for the establishment of a guarantee fund supported by a levy on providers. This was initially supported by the government, but further work resulted in the government concluding that it preferred a “post-payment” approach over Hogan's proposed “pre-payment” approach. In addition to requiring less administration, the government's argument at that time highlighted the concern, always present in the sector, that capital was scarce, and a policy priority remained to ensure there were no impediments to capital being used as effectively as possible.
- 7.17 Legislation was subsequently introduced providing a government guarantee of the return of lump sum payments to residents in the event of provider insolvency. The government's preferred “post-payment” approach was implemented via complementary legislation, giving it the ability to recoup the costs of that guarantee via a levy on providers. The relevant Acts were:
- Aged Care (Accommodation Payment Security) Act 2006
 - Aged Care (Accommodation Payment Security) Levy Act 2006.
- 7.18 In its report of 2011, the Productivity Commission (the Commission) noted²⁶⁴ the costs associated with providing the guarantee of returning lump sum payments to residents in the event of aged care provider failure.
- 7.19 The Commission further noted that the government had not sought to impose a levy on providers despite being able to do so since 2006. As a result, the cost of the guarantee was borne by government, and therefore taxpayers, rather than the key beneficiaries of the guarantee, lump sum deposit-paying residents in aged care homes and providers:
- There is also the prudential risk from the accommodation bond regime that is currently taken up by the Australian Government, as it acts as an unsecured creditor for residential care providers (and in turn provides a guarantee to older Australians purchasing a bond). These arrangements impose further costs on taxpayers.²⁶⁵*
- 7.20 The Commission, like Hogan before it, argued that there should be a system by which the cost of the guarantee should be paid by its beneficiaries:
- ...in the Commission's view the cost of the Australian Government guarantee of accommodation bonds should be borne by the providers through the setting of a fee (recommendation 7.4). Arguably, the cost of prudential regulation should also be borne through the setting of a fee arrangement. Conceptually, both these fees could vary according to the risk of the provider. In practice, however, such an arrangement is likely to be too complicated. Nonetheless both a charge on the prudential regulation and the Government guarantee would more fully reflect the cost of bonds.²⁶⁶*
- 7.21 In terms of the second element of protecting lump sum payments—prudential regulation—the Commission recommended the establishment of a new Australian Aged Care Commission (AACC). The AACC would have a significant role in prudential regulation, and the (then) Department of Health and Ageing could therefore cease its regulatory activities, while retaining regulatory policy responsibilities. The costs of regulation, the Commission argued, should be borne by providers.

²⁶² ACFA's work on the history of capital financing in aged care in Australia provides a comprehensive account of the increasing importance and support for residential aged care financing, in the form of government grants and subsidies. This section of the Review is based on that history.

²⁶³ Department of Health and Ageing, 2004, *Review of pricing arrangements in residential aged care*, p. xx.

²⁶⁴ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, p. lxxv, vol. 2, p. 43.

²⁶⁵ Productivity Commission, 2011, *Caring for older Australians*, vol. 2, p. 43.

²⁶⁶ Productivity Commission, 2011, *Caring for older Australians*, pp. 407–408.

- 7.22 The government did not support this recommendation, suggesting the benefits of an independent agency were unlikely to outweigh its substantial establishment costs. However, the government did not close the door on the idea, indicating that it was prepared to give it further consideration, once the implications of the reforms for governance became clearer.²⁶⁷
- 7.23 With the introduction of the Living Longer Living Better (LLLBB) reforms in 2012, the government indicated in-principle support for a charge on providers for the guarantee protecting lump sum payments, but suggested an alternative approach to that outlined by the Commission:
- From 1 July 2014, all aged care providers will be required to insure any new accommodation bonds that they are paid by residents for entry to care. This approach is more efficient and involves lower administration costs than the Commission's approach.*²⁶⁸
- 7.24 The aged care sector had concerns about this approach, including that there was a lack of a developed private insurance market. After consulting with industry and consumers, the government changed its position, and decided not to introduce requirements for private insurance arrangements for lump sum payments. The lack of a developed private insurance market was believed to create significant uncertainty around costs for providers and potential flow-on costs to residents in aged care homes.²⁶⁹
- 7.25 Instead of insurance, the government decided to extend the existing government-backed Scheme to continue to cover lump sum accommodation payments under the reforms. The changes came into effect on 1 July 2014.
- 7.26 When the government decided to extend the Scheme, it also included in the terms of reference for this Review a requirement that the effectiveness of arrangements for protecting lump sum payments be assessed in 2016–17.
- 7.27 A year after the reforms had been introduced, the government's Commission of Audit²⁷⁰ recommended that the government introduce a fee for aged care providers to access the guarantee for accommodation bonds, or use a transition period to cease operating the guarantee and require providers to source insurance from the private sector.
- 7.28 The Commission of Audit acknowledged concerns expressed earlier among providers that the private bonds insurance market was underdeveloped. However, in the Commission of Audit's view, the market would develop quickly to respond to the new and substantial demand for appropriate insurance products.
- 7.29 In the latest report on the Scheme, ACFA also outlined a range of options for how the Scheme could be maintained in future, and argued:
- ...before the Scheme's beneficiaries should contribute to the costs of the guarantee. This would bring the existing Scheme into line with other similar systems, such as building completion warranty, medical indemnity and student tuition fee protection. It would also limit the Commonwealth's liability. This should be the case whether the existing Scheme is retained, or another model is implemented.*²⁷¹
- 7.30 The history of the Scheme highlights two key elements. First, there is a strong consensus that a system for guaranteeing lump sum payments must continue to exist. I share this view. Second, there should be a mechanism by which the sector pays for the costs of the Scheme, but there has never been consensus reached on how that should occur, with the result that costs incurred by the government have never been recovered.

²⁶⁷ Department of Health and Ageing, 2013, *Australian Government response [to] Productivity Commission's Caring for older Australians report*, p. 33.

²⁶⁸ Department of Health and Ageing, 2013, *Australian Government response [to] Productivity Commission's Caring for older Australians report*, p. 6.

²⁶⁹ Department of Health and Ageing, 2013, *Australian Government response to Senate Community Affairs Legislation Committee Report on the Aged Care (Living Longer Living Better) Bill 2013 and related bills*, p. 7.

²⁷⁰ National Commission of Audit, 2014, *The report of the National Commission of Audit*, p. xlvii.

²⁷¹ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 66.

Use of the Scheme to date

7.31 In assessing the existing Scheme, ACFA examined the occasions on which the Scheme has been triggered by the insolvency of a provider, the providers involved, and the amount of lump sums that were returned to residents or their estates.

7.32 ACFA found that:

To March 2017, the scheme had been triggered ten times, in relation to eleven aged care facilities.²⁷² Refunds under the scheme finalised to that date totalled approximately \$43 million, comprising refunds on 258 accommodation payment balances totalling \$41.2 million, with additional interest payable to the resident or their estate totalling \$1.7 million. The largest single trigger event to date was in 2014, and comprised \$10.8 million for 59 accommodation payment balances.²⁷³

7.33 Following review of information from the department, ACFA explained:

Default events are usually complex situations, and can be occasionally compounded by a lack of cooperation by the provider. The priority for the Department is ensuring the safety and welfare of residents in cases where a facility is not only bankrupt, but also closing down. A declaration of a default event can only be made when one of the legal criteria in the Payment Security Act has been met, so it is necessary for the Department to obtain appropriate evidence to determine whether that has occurred.

Once a default event has been declared, the Department has to then determine through the records that are available whether each resident is owed money, and how much. If current or past residents are found to be entitled to refunds then the processes of the Scheme are set in motion. The individuals legally entitled to the refund have to be located, which can be challenging in those cases where a resident is deceased and the refund needs to be directed to an estate.²⁷⁴

7.34 Based on the information provided, ACFA formed the view that, despite its operational challenges, the department has managed the existing Scheme well:

Despite these potential complexities, the Scheme appears to be administered in an efficient manner. Analysis of data from the default events to date shows that on average it took 19 calendar days from a provider being insolvent to the official declaration made under the Payment Security Act, and 36 days from that declaration to the first refunds being made to residents (or their estates). The fastest official declaration was just six days after bankruptcy, while the fastest repayment after declaration was 22 days.

Given the number of steps and potential complications involved in what are always unplanned and difficult situations, ACFA concludes that the Scheme has been implemented in a timely manner, as well as being effective in ensuring every eligible person receives the return of their lump sum contribution.²⁷⁵

ASSESSMENT OF THE SCHEME

7.35 ACFA's approach to assessing the existing Scheme was based on eight principles. Each was examined from the perspective of the Scheme's primary stakeholders: lump sum-paying residents, residential care providers, and government. This Review has adopted ACFA's approach, and considered the eight principles using ACFA's analysis, as well as other information such as submissions provided to the Review.

²⁷² The Scheme is triggered by the insolvency of a provider. The number of facilities is larger than the number of triggers, as one of the insolvent providers operated more than one facility.

²⁷³ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 57.

²⁷⁴ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 58.

²⁷⁵ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 59.

- 7.36 The principles and measures are listed below. ACFA considered 'effectiveness' as the extent to which the Scheme guaranteed all payments in all circumstances. It placed this criterion alongside seven others that looked at other aspects of the Scheme's operation. ACFA posed a number of questions for each principle, to clarify what the key issues were. This section follows the same format.

Effectiveness

- 7.37 The first and fundamental principle that ACFA considered was effectiveness: is every resident's lump sum payment fully guaranteed as the Scheme intends? Is every provider fully covered? Is government only being called upon when all other avenues are exhausted?
- 7.38 The Scheme has consistently returned lump sum accommodation deposits to residents affected by their provider's insolvency and so fulfilled its purpose as a 'guarantee'.
- 7.39 Consumer peak body Aged and Disability Advocacy Australia considered the Scheme provided appropriately comprehensive coverage:

ADA [Aged and Disability Advocacy] Australia agrees that the current arrangements within the Act that protect the refundable deposits and accommodation bonds is an important protection for people paying the deposit or bond. This provides protection of their asset; offers peace of mind and gives people a sense of security that their funds are secure. In this regard, this part of the Act should remain legislated.²⁷⁶

- 7.40 A peak group representing some of the largest providers, Catholic Health Australia, expressed a similar view:

From a provider perspective, there is no reason to question the effectiveness of the current Bond Guarantee Scheme and prudential standards, as implemented to date.²⁷⁷

- 7.41 I noted ACFA's comments about the forms of consumer law that currently serve to protect resident entitlements, including the return of their lump sum payments.²⁷⁸ ACT Disability, Aged and Carer Advocacy Service submission highlighted the value to the sector of the government's guarantee of protection through the Scheme:

The Australian Government scheme of protecting bonds is a positive one and ensures that consumers are not left in a vulnerable position in the event that an aged care provider becomes insolvent. We agree that this scheme should continue as it is in the best interests of older Australians.²⁷⁹

Efficiency and cost

- 7.42 The second principle was efficiency and cost: if residents or providers are contributing to the cost of protecting lump sum payments, are they getting value for money? Is any cost borne by taxpayers appropriate?
- 7.43 The Scheme as implemented to date has been administered at no cost to providers and residents. This is perhaps the Scheme's most significant weakness. For government and taxpayers, the Scheme's costs since 2008 have totalled almost \$43 million.²⁸⁰ This is the cost of lump sum payments returned to residents and does not include administrative expenses incurred by government. The Scheme is thus not efficient in sharing costs among its beneficiaries.
- 7.44 Aged care providers, in particular, appreciate that the full cost of the Scheme is not currently borne by those who benefit from it. Shepparton Retirement Villages (SRV), for example, observed:

Looking to the future, SRV recognise that the underwriting of RADs is a significant contingent liability for the Government and there is an incentive to levy the industry or introduce mandatory insurance arrangements.²⁸¹

²⁷⁶ Aged and Disability Advocacy Australia & Aboriginal and Torres Strait Islander Disability Network of Queensland submission, p. 7.

²⁷⁷ Catholic Health Australia submission, p. 8.

²⁷⁸ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, pp. 41–43.

²⁷⁹ ACT Disability, Aged and Carer Advocacy Service submission, p. 6.

²⁸⁰ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 57.

²⁸¹ SRV submission, p. 7.

- 7.45 At the same time, a number of respondents pointed to the government's ability to recoup costs from providers via the *Payment Levy Act* and the decisions of successive governments not to do so. Peak organisation Aged and Community Services Australia said:

*The Guarantee Scheme has to date paid out to care recipients the liabilities owed to them on a number of occasions without imposing a levy on the sector. ACSA [Aged and Community Services Australia] understands that as the national pool of refundable accommodation deposits, including bonds, grows (\$18 billion in 2015 – up from approximately \$15.6 billion in 2014) that the Government is going to want to reduce its risk exposure, notwithstanding that it currently is able to recoup this from the sector via imposition of a levy.*²⁸²

- 7.46 Another provider peak body, the Aged Care Guild (the Guild), agreed:

*It can be argued that there is no cost [to Government] and, with the levy in place, no real risk to the Commonwealth in providing this guarantee. The Commonwealth has the statutory capacity to levy the industry to recover any losses incurred by failures within the industry.*²⁸³

- 7.47 A consumer representative organisation made the same point as the providers:

*In relation to the second point [the financial risk of approved service providers becoming insolvent], the remedy is to put into operation the Accommodation Bond Levy legislation that has been available for several years but never used. This would allow the Government to impose a levy on the industry to fund the Scheme, and resource its administration. While it is 'interventionist' (requires Government to play the role of levy imposer/collector, banker and investor) the compensatory benefits justify the approach.*²⁸⁴

- 7.48 The question of whether and how the costs of the Scheme should be shared is a longstanding one, with the sector mostly advocating for the status quo. However, as previous reviews have noted, 'cheap' for one group of stakeholders does not mean 'efficient'.

Simplicity

- 7.49 The next principle is simplicity: how easy is it for residents to ensure their money is protected, and for them to recover the funds in the event of a provider default? Can providers ensure coverage with a minimum of administration? Can government ensure coverage, and have sufficient information to know the system is working, with a minimum of administration?

- 7.50 The existing Scheme is set in motion by the department following a trigger event. All providers are automatically covered by the Scheme and while they do have reporting requirements related to their prudential management, they are not required to maintain any ongoing administration or communication with the department about the Scheme itself. Similarly, there are no requirements for lump sum-paying residents. The Scheme is therefore administratively simple for providers and residents of aged care homes.

- 7.51 While the department must manage the Scheme following a trigger event, the administrative burden at other times is limited to its underlying prudential monitoring. In addition to being necessary for good sector governance, the government's prudential monitoring also reduces the chance of calls on the Scheme.²⁸⁵

- 7.52 As pointed out by some respondents, there may be a small number of cases where residents or their estates find recovery of their lump sum payments to be complex. However, it is not clear whether this means there are deficiencies with the Scheme that can be remediated:

²⁸² Aged and Community Services Australia submission, p. 15.

²⁸³ Aged Care Guild submission, p. 12.

²⁸⁴ Council on the Ageing ACT submission, p. 10.

²⁸⁵ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, pp. 46–47.

The legally prescribed conditions for the triggering of the refund scheme were not adequate to address a case where a rogue operator resisted declaration of insolvency. This resulted in a situation where residents and their families were in a stressful state of uncertainty for several months until one of them, independently of the Department, brought on a successful insolvency action through the courts.

The remedy here is to change the procedures under which the Scheme and the Department operates, not to abandon the Guarantee Scheme.²⁸⁶

7.53 Insurance provider Australian Unity mentioned one case as well:

The intent of the scheme is working well, however the reality is slightly different. We currently have an issue where an Approved Provider that was declared bankrupt and shut down is fighting the bankruptcy case in court. As a result due to the outcome of the bankruptcy case still being undecided the funds cannot be distributed out of the Scheme to the Providers that the residents were transferred to at the time of closing.

This is a significant failing in the system to the new Provider and we would recommend a review into the tightening of how and when funds are transferred in such circumstances moving forward.²⁸⁷

7.54 These situations do not appear to be the usual experience. They may point to a need for a review of some legal arrangements. Such situations, while rare, may also be further reduced by fostering greater awareness by residents of their rights under laws protecting them, and laws governing corporations.

Sustainability

7.55 One of the key principles discussed in relation to the Scheme is sustainability: are any costs passed on to consumers fair and equitable as the industry evolves over time? Are any costs borne by providers manageable as the industry evolves? Are any costs to government appropriate, sustainable and predictable?

7.56 As ACFA noted, the Scheme represents a significant contingent liability for the government, should a large provider become insolvent. The modest costs of the Scheme reflect the fact that none of the insolvency events to date has been of a large, multi-service aged care provider. Nevertheless, costs have been highly variable. ACFA noted:

While this expense has been manageable for the Commonwealth, a different picture may emerge in terms of the predictability of sector responses to reform in the future. While payments have been modest, their pattern has been inconsistent. Annual costs for payments incurred by the Commonwealth have varied from zero in several years, to nearly \$20 million in others. This volatility makes meaningful budget planning unrealistic.²⁸⁸

7.57 As the lump sum payment pool grows, and the number of providers shrinks as a result of gradual industry consolidation, the risk of a default being much more costly for government would increase. Under such a scenario, the Scheme as currently implemented, with no cost recovery from the sector, may be becoming increasingly uncertain for all stakeholders, and less sustainable for government.

7.58 The National Seniors Australia submission to the Review captured the challenge in achieving a sustainable balance between the costs borne by key stakeholders:

Providers should also bear a degree of the cost of providing a guarantee because this will encourage the sector to strengthen their financial management practices. It is important that the cost to providers is kept low to ensure that this does not shift the financial burden onto aged care consumers; providers are already facing cost pressures as a result of recent moves to withdraw funding from the sector and therefore government should be cautious about increasing this burden as this will ultimately increase the risk of default.²⁸⁹

²⁸⁶ Council on the Ageing ACT submission, p. 10.

²⁸⁷ Australian Unity submission, p. 8.

²⁸⁸ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 62.

²⁸⁹ National Seniors Australia submission, pp. 14–15.

- 7.59 ACFA considered the results of modelling the costs of a retrospective levy, and noted that they were likely to be modest—less than 0.2 per cent of the value of the lump sum payments. It would appear unlikely that such a small burden on providers' finances would contribute to provider default.

Equity

- 7.60 ACFA's fifth principle was equity: do all residents have access to protection of their lump sum payments, regardless of their circumstances? Does every provider have access to protection of the payments they hold? Is government able to be certain that every resident has equal protection? Are those who are paying for the Scheme the ones who benefit from it?
- 7.61 The existing Scheme provides access to the guarantee for all residents and providers, regardless of their circumstances. As ACFA explained:

All providers and all lump sum accommodation payment-paying consumers are treated equally, in that they all have received protection of their investments and capital for no charge. Protection of lump sums is not affected by the location of a resident, their means, or the kind of provider they choose.

Providers receive equal protection, regardless of size, the market in which they operate, their ownership structure, or their profitability.²⁹⁰

- 7.62 Government decisions to date have meant that the costs of the Scheme have not been shared with residents or providers. This is not equitable for taxpayers, who have paid all the default costs over the decade of the Scheme's operation, though they are not direct beneficiaries of its operation.
- 7.63 It would be more equitable if the beneficiaries of the Scheme contributed to its costs.

Operability

- 7.64 There are important practical questions to be considered about any proposed change to the Scheme's operability: would any change to the Scheme be achieved without affecting resident or provider protections during the transition? Would the change be easy for residents and providers to understand and accept? How much alteration to providers' business systems and processes would the change require? How much alteration to legislation and government business systems and processes would the change require? Would new stakeholders, such as insurance companies or brokers, be required to become involved?
- 7.65 As set out earlier, the existing Scheme has returned lump sum payments to more than 250 residents or their beneficiaries since 2008. There has been no instance where the Scheme has not returned a lump sum to an eligible resident. There is no evidence that there are current difficulties with running the Scheme.
- 7.66 If the government elected to implement an alternative, it is likely that legislative change would be required. It might also necessitate alterations to providers' business support systems. The existing Scheme is attractive from the point of view of operability; however, implementing a levy alongside the existing Scheme would appear fairly straightforward with the legislative framework already in place.

Encouraging right behaviour

- 7.67 A seventh principle is encouraging right behaviour: is lump sum protection provided without significant changes in provider risk levels and behaviour? Does the Scheme give government and providers the incentive to maintain appropriate prudential controls and to manage against the risk of insolvency?
- 7.68 One consumer organisation supported the existing Scheme, arguing it encourages the government's effective scrutiny of the sector. The Health Care Consumers Association suggested that shifting from the current Scheme might reduce government's prudential monitoring, and therefore weaken safeguards for residents:

If the changes envisaged under the [Aged Care] Roadmap are seen to reduce government's financial responsibility for aged care, there may be less justification for prudential monitoring of care providers' financial operations. The incentive

²⁹⁰ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, pp. 62–63.

*then would be for the Department of Health to reduce its administrative costs by winding down its monitoring operation, which would no longer be able to provide advice informing the targeting of providers presenting service quality or financial risk. Without this alert mechanism, aged care residents would in turn be placed at increased risk of poor quality service or the stress of a sudden need to relocate.*²⁹¹

- 7.69 While the current Scheme encourages appropriate behaviour on the part of government, it is less clear that it has the desired effect on residents or providers, as they incur no costs under the Scheme. ACFA noted:

*Conversely, the Scheme does not create incentives for consumers to scrutinise the prudential standards of providers or to choose providers based on the level of protection offered on their investment, as all accommodation payments are automatically provided with a guarantee that has no cost.*²⁹²

- 7.70 Similarly, the current Scheme also creates no incentives for providers to avoid risks that might result in default. Under some alternative options, ACFA noted, risk-rating of providers could be introduced. This could help consumers understand the level of financial security of providers, and would give providers a price signal about their level of risk. However, whether this would have any effect on provider behaviour is debatable. As ACFA put it:

*It could be argued however that providers do not need an insolvency insurance charge to motivate them to avoid bankruptcy, as that would be a fundamental objective of their activities in any case. It is therefore not clear whether scheme design plays a significant role in influencing provider behaviour around maintaining solvency.*²⁹³

- 7.71 Rather than using the Scheme to influence provider behaviour, most submissions focused on prudential arrangements, suggesting they could be strengthened to address a perception of rising levels of future risk within the sector. The Guild suggested that the department needed to better understand the various ways in which organisations might arrange their interconnected, but divergent, business structures, including their residential provider entities:

*The Guild supports increased prudential supervision of the industry, which will increase the Commonwealth's understanding of risk (e.g. freehold vs. leasehold).*²⁹⁴

- 7.72 Other providers, for example SRV, focused on the capacity of prudential regulation to prevent insolvency:

*SRV's preferred approach is that the Government undertake a more rigorous oversight of the industry, especially in relation to provider solvency as a means of identifying and limiting potential problems in the future.*²⁹⁵

- 7.73 The Guild was supportive not only of maintaining, but tightening, prudential requirements:

*At present, it is in the industry's interests to maintain quality and tighten prudential requirements, which ensures a stable industry.*²⁹⁶

- 7.74 This Review returns to prudential regulation, and its effect on provider behaviour, later in this chapter.

Certainty

- 7.75 The final principle that ACFA considered was certainty: how certain can residents, providers and government be that lump sum payments are protected in all circumstances? Will the Scheme support investor confidence in the sector?

- 7.76 The existing Scheme is guaranteed by the government. The Scheme's record of delivering on this guarantee gives both the residential sector (including its financiers) and residents a high level of comfort. As the Provider Assist organisation indicated:

²⁹¹ Health Care Consumers Association submission, p. 15.

²⁹² ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 63.

²⁹³ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 63.

²⁹⁴ Aged Care Guild submission, p. 13.

²⁹⁵ SRV submission, p. 7.

²⁹⁶ Aged Care Guild submission, p. 13.

The Commonwealth's guarantee on amounts of refundable accommodation deposits and accommodation bonds provides much needed stability to capital funds for Aged Care Providers.²⁹⁷

7.77 ACFA expressed a similar view:

The Payment Security Act requires that an insolvency event...such as an order for a company to be wound up, must trigger the requirement that the Commonwealth step in and refund unpaid accommodation payment balances to consumers. In addition, the Minister can trigger refunds in circumstances where an insolvency has not legally yet occurred but a consumer is owed an accommodation payment balance. These provisions mean consumers can be certain their money will be secure.²⁹⁸

7.78 While there is certainty for residents, this is not the case for providers. ACFA analysed and explained this in detail:

The Scheme currently contains one significant uncertainty, noted during discussion with stakeholders. This is the Minister's discretionary decision as to whether to levy the aged care sector to recover the costs of past default events it has incurred. The legislation allows the Minister to recover the cost of default events, including the administrative costs.

There is no time limit on the Minister's decision.

A future Minister could legally levy providers for default events that occurred throughout the last decade, though this would be controversial.

The Minister can choose to recover any proportion, up to 100 per cent, of the cost – again, the proportion is discretionary.

Finally, the Minister can make regulations that set different rates of contribution to a levy from different "classes" of provider, and can set the contribution of a class of providers at zero. Thus it is possible that some providers could find they are subject to a levy, while others are exempt.

The discretionary nature of the levy and its design means providers are unable to plan to meet possible costs of a scheme.

ACFA understands that the largest provider, if the government were to levy the full cost of all insolvency events since 2006, would face a bill in excess of a million dollars. While this would be a small proportion of their annual operating budget, it is a large amount to be unable to predict and budget.²⁹⁹

7.79 Given the high level of uncertainty faced by providers regarding a possible levy, it is surprising that only a minority of them considered this to be an issue. This appears most likely to be because the government has not, to date, implemented a levy, encouraging a perception that, in practice, it is unlikely they would incur a cost.

Alternative approaches considered by ACFA

7.80 ACFA undertook an extensive assessment of alternative approaches to the existing Scheme. After consulting experts and organisations that administer other types of guarantee schemes, ACFA concluded neither insurance-based approaches nor bank guarantees were likely to be viable.

7.81 In addition to the existing Scheme, two options that ACFA did consider as viable were a compulsory retrospective levy, and a prospective levy to finance a guarantee pool fund.

7.82 The first option, a compulsory retrospective levy, would involve implementing the existing levy mechanism but removing the requirement that the Minister must authorise its use. The second option of a prospective levy would be more complex to implement and would be based on significant actuarial modelling to define the total pool required and the size of annual levies. However, once established, the ongoing operation of the fund with a prospective levy could be straightforward.

²⁹⁷ Provider Assist submission, p. 15.

²⁹⁸ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 64.

²⁹⁹ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 64.

- 7.83 In its report, ACFA commented that “a levy or other cost-sharing mechanism should only be implemented if the benefits of doing so outweigh the costs.” Collecting a levy would require the government to put additional resources into the Scheme. If all non-government³⁰⁰ providers that hold lump sum payments were to be levied, the cost would be spread across nearly a thousand aged care providers.
- 7.84 ACFA provided an example of the value of a retrospective levy that could be applied to recoup a default event of \$10.2 million, an amount similar to the largest default event that has occurred to date. The cost of repayment was spread over three years.³⁰¹ Assuming the total pool of lump sum payments was around \$20 billion, this would result in a levy of around \$0.17 per \$1,000 each year for three years.³⁰² A service holding 100 lump sums valued at the average agreed price of \$342,000 per place could pay an annual levy of \$5,814.
- 7.85 For small default events, this would mean issuing a large number of very small invoices, perhaps for only a few hundred dollars per provider and, in the case of providers with only a few residents holding lump sum payments, possibly significantly less.
- 7.86 For these reasons, I agree with ACFA that a levy should only be charged when the total costs are sufficiently significant that it is effective to do so, for example above a threshold of a total value of over \$5 million.

Conclusions regarding the Scheme

- 7.87 The evidence indicates that the Scheme is in large part simple and operates well. It has always delivered on its primary objective: the return of residents’ lump sum payments in the event of provider failure. By absorbing all of the Scheme’s costs to date, the government has carried all of the risk, with no sharing of costs across the Scheme’s beneficiaries: providers and lump sum-paying residents. Certainty under the Scheme is available to residents, but not to government or to providers, who have been given no guidance on whether they need to plan for the costs of a levy in the event of provider defaults.
- 7.88 I concur with ACFA that a mandatory retrospective levy would share costs, be as effective as the existing Scheme, and would make the Scheme more sustainable. It would reduce uncertainty for providers to some extent, though levies would remain less predictable than under the prospective levy option.

Recommendation 20

That the government maintain the Bond Guarantee Scheme, but reform it to improve certainty and to ensure that aged care providers make contributions where the benefits outweigh the costs. This would include that the government:

- announce a date after which it will require that non-government residential aged care providers be levied to recoup all of the costs of default events, where the total amount of those events exceeds, say, \$5 million in any fiscal year
- introduce a formal process for notifying the sector of defaults that have occurred that exceed that threshold, and the cost of the levy that will be applied
- declare that the costs to the Scheme of provider insolvency events that were triggered prior to the reform commencement date will not be recouped.

OTHER ASPECTS OF IMPROVING PROTECTION OF LUMP SUM PAYMENTS

- 7.89 While generally effective, the Scheme and its arrangements could be improved through the provision of better and more timely information to all parties. Recommendation 20, for example, proposes improvements to how government communicates about defaults and levies. This Review argues that benefits can be gained from greater transparency for aged care consumers, including in relation to lump sum payments.

³⁰⁰ There are a small number of state government-operated residential care homes. It is unlikely that these homes would trigger the Scheme, as the state government would have capacity to fund their refunds.

³⁰¹ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 68.

³⁰² ACFA, 2016, *Fourth report on the funding and financing of the aged care sector*, p. 27.

- 7.90 It is important that residents and their advocates have consistently reliable information about the management of the lump sum payments. This is worthwhile to improve consumer understanding of the service and protection they are receiving, but also to significantly improve their understanding of their consumer rights and avenues to ensure those rights are respected. A financial planner observed:
- Residents are very appreciative that the amount of the RAD is 100% backed by the government. However not many of them are aware of this.*³⁰³
- 7.91 Submissions and conversations with people experienced in the sector have indicated that information and choices around paying for accommodation are not always as transparent and accessible as they could be. The Australian Blindness Forum wrote:
- ...that any arrangements for protecting refundable deposits and accommodation bonds need to have adequate transparency and disclosure to consumers. In addition, it is imperative that any contracts, documents or other material that are required or made available to consumers in relation to these arrangements are provided in the consumer's preferred format.*³⁰⁴
- 7.92 Alzheimer's Australia made a similar point:
- The current arrangements are seen to be reasonably effective in terms of legislation and regulation. However, consumer understanding of the rights and responsibilities of providers and consumers, and appropriate adherence needs to be closely monitored and transparent.*³⁰⁵
- 7.93 ACFA noted in its report that "legal protections afforded by consumer law and contract law are important in guiding the expectations and good practice of providers" and:
- Under the User Rights Principles, there are provisions to ensure that rights and protections are understood, such as the legal onus placed on providers to assist the care recipient to understand the information they are given (S. 11), and for the information to be expressed in plain language and be readily understandable by the care recipient (s. 15).*³⁰⁶
- 7.94 In addition, the disclosure standard, with which providers must comply, requires that they give residents information demonstrating their level of compliance with the liquidity standard and the records standard, as well as information that describes their most recent financial standing, such as a report.³⁰⁷
- 7.95 During consultations, ACFA raised the possibility that many resident agreements are not transparent or clear enough to be considered fully compliant with the *User Rights Principles 2014*, and do not adequately communicate to residents their rights under consumer law generally. It was also queried whether residents are receiving the reports on refundable lump sum payments that must be provided.³⁰⁸ This Review did not receive significant evidence on whether contracts and agreements are accessible and flexible, or whether new residents are being effectively supported to understand them. There may be merit in the department being more active around the compliance with the *User Rights Principles 2014* of residential agreements and the provision of information to consumers as one element of a broader re-balancing of the consumer-provider relationship.
- 7.96 Improved prudential management and oversight should also strengthen the ability of residents to negotiate and understand agreements, as well as result in an overall reduction in the risk of provider insolvencies.

³⁰³ Charles Penheiro, submission two, p. 6.

³⁰⁴ Australian Blindness Forum submission, p. 9.

³⁰⁵ Alzheimer's Australia submission, section 2.8.

³⁰⁶ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 43.

³⁰⁷ ACFA, 2017, *The protection of residential aged care lump sum accommodation payments*, p. 45.

³⁰⁸ Department of Health, Aged care accommodation bonds — disclosure standard — information for providers, <https://agedcare.health.gov.au/aged-care-accommodation-bonds-disclosure-standard-information-for-approved-providers>

PRUDENTIAL CONTROLS

- 7.97 As outlined at the start of this chapter, lump sum payments are protected through the prudential requirements set out within s52M-1 of the Act and the prudential standards within Part 5 of the *Fees and Payments Principles 2014*.
- 7.98 The prudential regulation of aged care continues to evolve, reflecting changes in business practices. The last substantive round of changes followed the release of a report by the Australian National Audit Office in 2009, and consultation with the sector in 2010–11. Both highlighted the need to strengthen regulation of how providers manage lump sum payments. As a result, amendments were made to the Act and to the supporting Principles.
- 7.99 The amendments to the Act clarified how providers could legitimately use lump sum payments and strengthened the department's monitoring of compliance, as well as introducing criminal penalties for misuse of lump sum payments.
- 7.100 In addition, the introduction of a governance standard meant that providers had to ensure that their own governance systems included compliance with the responsibilities of managing lump sum payments. This new standard complemented those introduced in 2006: the liquidity, records and disclosure standards.
- 7.101 However, the sector has evolved significantly since that time, major reform has taken place as a result of the LLLB package, and the pool of lump sum payments has almost doubled since 2011.

Review of prudential standards

- 7.102 In late 2016, the department engaged EY to review the prudential standards in the context of protecting the interests of residents, as well as the current controls supporting the management of the risk underwritten by the government.
- 7.103 The EY review was based on four principles:³⁰⁹
- protection of residents
 - protection of the government and its reputation when a provider is non-compliant, and reduction of reliance on and use of the Scheme
 - limiting the compliance burden on providers
 - support of the long-term financial sustainability of the sector.
- 7.104 In undertaking the review, EY considered the financial services sector's regulatory practices, the department's risk assessment approach in evaluating provider non-compliance, and the need to foster stability and financial sustainability of the aged care sector.

Prudential review findings

- 7.105 As part of their review, EY compared the prudential standards against the prudential regulation of other industries. They found two main gaps that diminish the department's regulatory efficacy as well as its ongoing ability to assess providers' compliance with their prudential requirements overall.
- 7.106 First, the data the department receives from approved providers is inadequate to assess their compliance with the prudential standards and to ensure they are engaging in low-risk uses of accommodation payments. As the business structure of providers can vary considerably, it is difficult for the department to analyse the financial risks based on the data provided.³¹⁰
- 7.107 Second, current gaps in the prudential requirements within the aged care legislation do not align with prudential regulatory practice outside aged care. For example, providers are currently able to set their own liquidity standard that is often lower than the standards used in the financial sector. As a result, the capacity of the department to assess and

³⁰⁹ EY, 2017, *Review of aged care legislation which provides for the regulation and protection of refundable accommodation payments in residential aged care*, p. 5.

³¹⁰ EY, 2017, *Review of aged care legislation which provides for the regulation and protection of refundable accommodation payments in residential aged care*, p. 5.

determine that providers are adequately capitalised, and have sufficient liquidity to repay lump sum payments, is limited.³¹¹

Prudential review recommendations

- 7.108** The EY review recommended amending the current legislation to change the prudential standards, including the disclosure standard and liquidity standard. This included:³¹²
- changes to the disclosure standard to improve provision of information to consumers
 - changes to the disclosure standard to require disclosure of corporate structures to the department
 - changes to the liquidity standard to introduce a liquidity threshold.
- 7.109** Specifically, the EY review found that there was a need for greater transparency of information about providers, including their corporate group structures, shareholders and ultimate owners, and any changes in ownership and related transactions. The review recommended limiting or phasing out discretionary trusts, which would contribute to achieving this level of transparency.
- 7.110** EY advised that the benefits of these changes could include:
- introduction of an early-warning system which indicates when a provider might be unable to repay lump sum payments
 - clarity for providers regarding what is required under the prudential standards
 - an easier test to monitor compliance with prudential standards.³¹³
- 7.111** In addition to changes to the prudential standards, EY recommended the introduction of a capital adequacy requirement. This would require providers to show they had levels of capital available consistent with maintaining the security of lump sum payments.
- 7.112** The EY review further recommended retaining the requirement for an independent auditor to verify that providers are complying with the prudential standards. This independent verification provides an independent, fair and accurate assessment of an approved provider's compliance with their prudential standards obligations. EY highlighted that independent auditing, by way of independently verifying compliance, is a requirement in other sectors, including the financial services sector. Continuing this requirement would keep the department in step with generally accepted good corporate governance.
- 7.113** I consider that the findings of the EY report make it apparent that strengthening the prudential standards offers a substantial benefit for all the Scheme's stakeholders. Implementing their recommendations could reduce the likelihood of provider failure and the imposition of the levy on all providers. It would also bring aged care prudential compliance in line with other financial sector regulatory requirements. In addition, it would assist further the government's efforts to identify providers that may be unable to repay residents' lump sum payments, providing better protection for residents.
- 7.114** I support the recommendations made by EY that the prudential standards be changed in a phased approach to minimise the disruption to the provider market.

³¹¹ EY, 2017, *Review of aged care legislation which provides for the regulation and protection of refundable accommodation payments in residential aged care*, p. 5.

³¹² EY, 2017, *Review of aged care legislation which provides for the regulation and protection of refundable accommodation payments in residential aged care*, pp. 9–11.

³¹³ EY, 2017, *Review of aged care legislation which provides for the regulation and protection of refundable accommodation payments in residential aged care*, p. 13.

Recommendation 21

That the government reform prudential standards and oversight, taking account of the recommendations in the independent review of prudential standards conducted by Ernst & Young to:

- correct gaps in prudential information received by the government
- strengthen the standards to improve liquidity, capital adequacy and disclosure requirements
- strengthen governance standards.

Financial sustainability of prudential controls

- 7.115 The department advised that the operation of the current Scheme and the existing prudential controls costs approximately \$1.8 million per annum. These costs increase when the Scheme is triggered—by an average of \$1.1 million per event—and can be higher, depending on the complexity of the trigger event.³¹⁴
- 7.116 The 2011 Productivity Commission report argued that the costs of prudential oversight should be borne by the sector:
- Arguably, the cost of prudential regulation should also be borne through the setting of a fee arrangement...both a charge on the prudential regulation and the Government guarantee would more fully reflect the cost of bonds.*³¹⁵
- 7.117 Recommendations 20 and 21 would improve the certainty of the financial and prudential oversight at little cost. However, I believe the government should monitor whether the costs of prudential oversight of providers should be recouped from providers.

CONCLUSION

- 7.118 The existing Scheme and its arrangements are generally effective. The simplest way to improve its efficiency, certainty and sustainability would be to remove the government's discretion over applying a levy, and thereby ensure that the sector contributes to the cost of the protections that the Scheme affords. This could be determined relatively simply, for example calculating it as a flat percentage of the total value of the lump sum payments held by each provider. However, this should only occur when it is cost effective and should only apply to any future default events, extinguishing any claims the government may have on recouping the cost of past default events.
- 7.119 Strengthening the department's prudential monitoring of providers will enhance this critical aspect of the system. For this reason, I suggest that changes to the Scheme (Recommendation 20) should not be implemented prior to the prudential reforms (Recommendation 21) though the two could be done contemporaneously.

³¹⁴ Advice provided by Department of Health

³¹⁵ Productivity Commission, 2011, *Caring for older Australians*, vol. 2, pp. 407–408.

CHAPTER 8

ACCESS TO SERVICES

INTRODUCTION

- 8.1 This chapter responds to matter (i) in the Review terms of reference: the effectiveness of arrangements for facilitating access to aged care services. It focuses on the availability of information and the assessment process, centred on the single entry point for information and access to aged care services: My Aged Care.
- 8.2 The transition to My Aged Care as part of the Living Longer Living Better (LLLBB) reforms was a significant shift in how information, assessment and referral to access aged care services took place. This chapter considers the particular circumstances that led to the establishment of My Aged Care and considers the issues most relevant to its performance and possible future direction under the topics of entry, information and assessment. It considers implementation issues, the key assessment processes, the Regional Assessment Services (RAS) and the Aged Care Assessment Teams (ACATs), and how they are supporting access to care.

THE PRODUCTIVITY COMMISSION AND THE ESTABLISHMENT OF MY AGED CARE

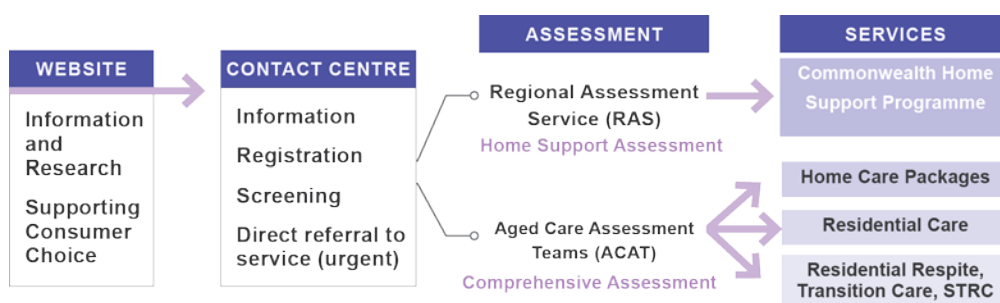
- 8.3 Prior to the establishment of My Aged Care, there was no central pathway for older people to access information and services. The Productivity Commission (the Commission) in 2011 outlined that consumers faced a complex and confusing array of entry points into the aged care system and multiple sources of information about ageing. The Commission also noted that the system emphasised services to address symptoms of functional decline rather than focusing on halting or reversing decline.
- 8.4 The Commission recommended establishing a central gateway for older Australians to find out about and access aged care services. The Commission envisaged that the gateway would include:
- a platform to provide information allowing people to better navigate their way through the aged care system, to find out about services and how to access them
 - assessment of aged care needs and financial capacity to make contributions to care
 - initial care coordination in some cases, and referrals or access to a care entitlement based on assessment
 - facilitating access for people with language and cultural needs.³¹⁶
- 8.5 The Commission saw the gateway as a platform for accessing many other aspects of aged care. For example, it proposed the introduction of an intensive time-limited reablement service,³¹⁷ with eligibility and entitlement assessed by the gateway. The main benefit of the gateway would be a greater focus on independence for the aged, emphasised through the holistic assessment of consumer needs and goals by independent assessment workforces.
- 8.6 The government supported the recommendation and in response established an aged care gateway, now known as My Aged Care. My Aged Care is designed to create a single pathway into, and through, the aged care system. Following significant expansion in 2015, My Aged Care now includes a contact centre and website, central client records to facilitate the collection and sharing of information, holistic needs assessment through a national standardised assessment form, online referral management and web-based portals for clients, assessors and service providers.

³¹⁶ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, pp. lxiv, lxvii, lxviii.

³¹⁷ "Reablement involves time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss or regain confidence and capacity to resume activities." Australian Government, My Aged Care, *Linking support and reablement*, <https://agedcare.health.gov.au/support-services/my-aged-care/fact-sheet-linking-support-and-reablement>

- 8.7 My Aged Care allows older people and their support networks to find out about aged care services. For those who wish to be assessed for care, My Aged Care will assess a consumer's needs for services and make an appropriate referral for services intended to reflect their needs, goals, motivations and preferences.
- 8.8 Many stakeholders access My Aged Care for information only. For consumers seeking access to services, the contact centre begins with screening. Depending on the outcome of screening, a consumer moves through to one of the two face-to-face assessment workforces:
- RAS for home support assessment and access to entry-level services delivered through the Commonwealth Home Support Programme (CHSP)
 - ACATs for comprehensive assessment and access to home care packages, residential care, residential respite, transition care, short-term restorative care or other forms of flexible care.
- 8.9 At the point of assessment, a consumer will be considered for a reablement intervention which can reduce or eliminate their need for ongoing service. Reablement interventions may include advice and/or referral for service on the provision of aids and equipment, home modifications, allied health and therapy, retraining and education.

Figure 8.1 Overview of the journey through My Aged Care



- 8.10 To help facilitate access across consumers with diverse needs, the My Aged Care website includes information that has been translated into 18 languages. People who speak a language other than English can use the Translating and Interpreting Service (TIS). TIS staff can facilitate a call to the My Aged Care contact centre on a person's behalf, or the My Aged Care contact centre can facilitate a call to TIS to assist with communicating with a consumer over the phone. TIS can converse in more than 160 languages. The My Aged Care contact centre can also connect with the National Relay Service, a phone service for people who are deaf or have a hearing or speech impairment.

Implementation of My Aged Care

- 8.11 The implementation of My Aged Care commenced in 2013 with the introduction of a national contact centre and the website (My Aged Care Stage 1). The contact centre was initially an information-only service for people to learn about aged care processes and services over the phone.³¹⁸
- 8.12 In July 2014, online fee estimators for residential and home care were launched on the My Aged Care website. The fee estimators allow consumers to estimate what costs their service provider may ask them to pay.³¹⁹
- 8.13 My Aged Care was significantly expanded from 1 July 2015³²⁰ (My Aged Care Stage 2) to become the gateway through which consumers access government-funded aged care services. The changes at this point included:³²¹
- a central client record
 - extending the role of the contact centre, from information provision to also include:
 - registration and screening of consumers

³¹⁸ Department of Social Services, 2015, *My Aged Care concept of operations*, p. 9.

³¹⁹ There are also safeguards in place for consumers who are financially disadvantaged and are unable to pay the contribution. See chapter 9 on equity of access.

³²⁰ Different arrangements initially applied in Victoria and Western Australia with Victoria completely transitioning to My Aged Care in August 2016 and Western Australia scheduled to fully transition from July 2018.

³²¹ Information on the My Aged Care changes in 2015 can be found at <https://agedcare.health.gov.au/programs-services/my-aged-care/about-my-aged-care>

- referring eligible consumers for a face-to-face assessment by either the RAS or an ACAT³²²
- assisting consumers to find available and appropriate government-funded aged care services, where required
- the National Screening and Assessment Form (NSAF), used by the contact centre, RASs and ACATs to ensure a nationally consistent and holistic screening and assessment process
- the RASs, regionally-based services whose main function is to conduct face-to-face assessments for those who seek entry-level support at home, provided under the CHSP
- match and refer capability—an electronic system to support assessors to identify and assist in matching eligible consumers to service providers in their local area
- web-based My Aged Care portals for clients, assessors, service providers and the contact centre
- the ability for service providers to self-manage information about the services they deliver.

8.14 From 1 July 2015, most ACATs received referrals via My Aged Care but then undertook assessment using other legacy systems. In February 2016, ACATs started full transition to using the My Aged Care system. This included completing assessments and consumers support plans and matching and referring consumers for services.³²³

8.15 In April 2016, the department streamlined the screening process used in the contact centre³²⁴ and introduced new system functionality to reduce the time it took to complete screening, improve the consumer experience and lessen the number of incorrect referrals. These reduced the average time for a consumer to be registered and screened by contact centre agents from 40 minutes to approximately 15 minutes.

8.16 In June 2016, a webform for use by health professionals was introduced. This enabled electronic referrals, to simplify and speed up the referral process to assessment services in My Aged Care and to draw on health professionals' expertise and knowledge of the consumer.

Implementation challenges

8.17 Significant implementation and operational challenges followed the launch of My Aged Care Stage 2 in mid-2015 and transition of assessment and referral processes to My Aged Care. While the department had identified the risks, the convergence of so many of the implementation risks and the scale at which many of them occurred was not anticipated.

8.18 For service providers, this was a demanding time and required them to actively and quickly adapt to a major new IT system and processes. As could be expected, there were challenges for stakeholders adapting to the new arrangements. However, as My Aged Care has become established, more stakeholders, particularly providers, now realise that it is at the centre of accessing government-funded aged care and are changing their business processes accordingly.

8.19 Feedback from a range of stakeholders (including assessors and providers) indicated that the department should more actively promote the use of the portal by various employees in service provider organisations, and that provider organisations should ensure that relevant staff have appropriate access to assist consumers as effectively as possible.

8.20 The department continues to work with aged care stakeholders to improve My Aged Care. This includes regular release of IT system changes to enhance the current functionality.

8.21 In addition, the department worked with stakeholders in 2016 to identify opportunities for improvements to My Aged Care policy, processes and IT systems. In consequence, the department has developed a work plan of enhancements to increase process efficiency and system capacity, improve consumer choice, and reduce duplication. This was noted by some stakeholders:

...DoH have continued to respond to concerns raised about access to aged care information and services, particularly over the last six months.³²⁵

³²² At this time ACATs were only able to accept/reject referrals on My Aged Care, not conduct their comprehensive assessment in the system.

³²³ Information on the ACAT transition to My Aged Care can be found at <https://agedcare.health.gov.au/programs-services/my-aged-care/acat-transition-to-my-aged-care>

³²⁴ Information on the changes to the screening process can be found at <https://agedcare.health.gov.au/programs-services/my-aged-care/changes-to-the-screening-process>

³²⁵ Baptist Care Australia submission, p. 8.

- 8.22 The work plan includes process and policy changes to support access to My Aged Care for consumers with diverse needs, support for health professionals to engage with My Aged Care, guidance to improve the consistency of assessment processes and the improved integration of specialised assessments with My Aged Care processes. Some of the changes to system functionality in the work plan are scheduled for implementation from July 2017. The changes have been positive, but need to be continued:

*...The system is progressively being improved. However, consumers are not yet experiencing a seamless journey through the system.*³²⁶

- 8.23 Further work is necessary by both government and providers to ensure that My Aged Care operates in the most efficient and effective manner, and that the journey for a consumer is facilitated without them having to repeat their story, or feel they are experiencing multiple assessments. Later in the chapter I address what government needs to do, which will require further investment. Providers need to ensure that they are fully engaging with and using My Aged Care to support access for consumers.

Evaluation of My Aged Care

- 8.24 One of the important sources of information available to the Review has been an independent evaluation of access commissioned by the department. The evaluation, by AMR, investigated experiences and perceptions of the aged care system and My Aged Care. The research identified several strengths as well as opportunities to improve and enhance processes.

- 8.25 AMR conducted research among:

- consumers
- carers
- assessors
- service providers
- health professionals.

- 8.26 AMR established a baseline of data prior to the July 2015 implementation, then undertook two rounds of engagement. Wave 1 of this research was conducted from January to March 2016, while wave 2 of the AMR research took place in January to March 2017.

- 8.27 When wave 1 was undertaken, the system had been in operation for a maximum of eight months for any participant and was not fully rolled out nationally. The results of the wave 1 research reflect some of the implementation challenges that had been experienced at that stage. On satisfaction with the aged care system overall, AMR reported:

Satisfaction with the aged care system in Australia was moderately high among the general public. Just under half of consumers (48%) were satisfied with the way they were able to navigate and utilise the system. This outcome is consistent with the baseline findings.

Care recipients were significantly more satisfied with the aged care system overall than were carers (72% vs. 43%)... However, carers' satisfaction had risen significantly since the baseline wave from 36%.

43% of service providers indicate some degree of satisfaction with the aged care system, representing a decline since the 61% recorded at the baseline.

50% of assessors indicated that they were either 'fairly' or 'very' satisfied with the aged care system, with only 21% expressing dissatisfaction with the system on the whole.

*The lowest satisfaction with how the aged care system functions overall was the 38% recorded among health professionals. This result was driven by a significantly lower rating of 12% among hospital-based professionals versus 50% among GPs.*³²⁷

³²⁶ Leading Age Services Australia submission, p. 34.

8.28 Despite these issues, there were indications that My Aged Care was beginning to fulfil the goal of supporting access. AMR found that:

Satisfaction with the aged care system overall was clearly correlated with My Aged Care experience. Those who had contacted the gateway in some capacity were consistently more satisfied with aged care provision than those who were carers or recipients with no experience of the new system.

Those who had accessed care via My Aged Care were more satisfied with the ease of doing so than those who were carers or recipients not using the gateway, across most measures.³²⁸

8.29 Among consumers, there was a strong positive experience of the telephone contact centre, and of face-to-face services.³²⁹ Health professionals, however, were particularly critical of the access experience:

No more than 40% of health professionals indicated that any of the prompted activities were easy to access for consumers, with as few as 17% – including only 9% of hospital-based professionals – suggesting that it was easy for consumers to ‘get the services they need’.³³⁰

8.30 Wave 2 of the AMR research³³¹ found that:

- Overall consumer satisfaction ratings were high, including satisfaction with screening outcome (consumers:³³² 83 per cent, carers: 82 per cent), face-to-face assessment (consumers: 92 per cent, carers: 92 per cent), and referral to services (consumers: 86 per cent, carers: 79 per cent).
- Satisfaction with the information obtained from the My Aged Care contact centre has risen since wave 1 among several audiences, most notably carers (wave 1: 65 per cent, wave 2: 77 per cent), RAS assessors (wave 1: 43 per cent, wave 2: 56 per cent), and service providers (wave 1: 40 per cent, wave 2: 58 per cent).
- Carers’ experience of many parts of the My Aged Care process has improved to match that of consumers, especially their experience of the contact centre (77 per cent satisfied), face-to-face assessment (92 per cent satisfied), and arranging services (79 per cent satisfied).
- Both service providers and RAS assessors recorded significantly increased satisfaction since wave 1 on a number of measures of how My Aged Care supports them to carry out their professional roles. However, several of these ratings remain below 40 per cent.
- Health professionals’ views have not generally changed significantly since wave 1. General practitioners are often reasonably satisfied with aspects of the My Aged Care process, while hospital referrers continue to give satisfaction ratings below 30 per cent for most measures.
- ACAT assessors’ satisfaction was generally low across their My Aged Care experience, with no more than 30 per cent satisfied with measures related to their ability to carry out tasks under My Aged Care.
- RAS assessors’ satisfaction increased significantly with regard to how My Aged Care equips them to carry out their role, particularly their ability to engage with consumers (79 per cent) and establish basic demographic information via the assessor portal (64 per cent). However, lower satisfaction was recorded for how they were able to access consumer information (31 per cent), while satisfaction with the ability to forecast number of assessments was below 30 per cent.

³²⁷ AMR, 2016, *My Aged Care stage two wave 1 research: summary of findings*, p. 6, https://agedcare.health.gov.au/sites/g/files/net1426/f/documents/10_2016/amr_my_aged_care_evaluation_summary_of_findings.pdf

³²⁸ AMR, 2016, *My Aged Care stage two wave 1 research: summary of findings*, pp. 6–7.

³²⁹ AMR, 2016, *My Aged Care stage two wave 1 research: summary of findings*, pp. 10, 16–17.

³³⁰ AMR, 2016, *My Aged Care stage two wave 1 research: summary of findings*, p. 7.

³³¹ AMR, 2017, *My Aged Care stage two wave 2 research: summary of findings*, (unpublished report).

³³² AMR refer to consumers of aged care as ‘care recipients’. For the purposes of this Review they are referred to as ‘consumers’.

- Consumers from culturally and linguistically diverse (CALD) and Aboriginal and Torres Strait Islander backgrounds recorded lower levels of satisfaction than the rest of the population at some specific points in the My Aged Care process, especially when navigating the referral to services and when rating aspects of the aged care services received.

- 8.31 In their submission, National Seniors Australia also provided feedback on the My Aged Care experience. Of almost 5,000 members surveyed, nearly one-fifth of members indicated that they had used My Aged Care (62 per cent had used the website, 15 per cent the contact centre and 23 per cent had used both) with 54 per cent being satisfied or very satisfied with the information they received.³³³ I note these findings are different to those of AMR, and these differences may relate to the differences in My Aged Care channels used by survey participants.
- 8.32 Overall, it appears that consumer and carer satisfaction is relatively good, and has improved, but that results for other stakeholders are uneven, and at times poor. In the next section, the Review evaluates access to services through My Aged Care under three themes: entry, information and assessment.

ENTRY

A centralised gateway

- 8.33 A single entry point for information and access to aged care services was welcomed by the sector. Council on the Ageing (COTA) noted that:

*Its [My Aged Care] introduction... has enabled the development of greater consumer choice and direction in aged care that simply wasn't available prior to the reforms.*³³⁴

- 8.34 A few stakeholders, however, questioned the effectiveness of a centralised intake system for all consumers seeking entry to aged care services. In particular, they questioned the ability for a single entry point to meet the needs of those who require support and active face-to-face engagement to navigate the system:

*VHA members report that, based on previous experience with central intake systems and their impact on vulnerable cohorts, they anticipate a proportion of their community will choose to opt out of the new system and instead rely on family and other supports until they reach crisis point.*³³⁵

*...the realities of a single entry strategy not meeting the complex and particular needs of populations that require support and active face to face engagement to navigate the service system.*³³⁶

- 8.35 The issue of how to ensure everyone can access and navigate aged care effectively is returned to later in the chapter.

Interactions between My Aged Care and other government agencies

- 8.36 Submissions highlighted that the interaction between different government agencies involved in the aged care system could be confusing for consumers. They also noted the need to improve interoperability between My Aged Care and other organisations and systems. For example, Leading Age Services Australia stated:

*Varying systems do not 'talk to each other', including DHS, DVA and the electronic health record.*³³⁷

- 8.37 The National Presbyterian Aged Care Network asked the Review to examine:

³³³ National Seniors Australia submission, p. 15.

³³⁴ Council on the Ageing submission, p. 26.

³³⁵ Victoria Healthcare Association submission, p. 12.

³³⁶ Municipal Association of Victoria submission, p. 6.

³³⁷ Leading Age Services Australia submission, p. 34.

- 8.38 A consumer submission described the impact of this disconnection between government agencies as an extremely disempowering and distressing experience.³³⁹
- 8.39 Quality aged care requires links among sectors including health and community services to maximise use and effectiveness.
- 8.40 My Aged Care systems should share information with the IT systems used by other government agencies, health professionals, service providers and assessors. This would improve efficiency and speed of referral, and would see providers and health professionals accessing relevant information from their own systems. It would reduce the cost of administration and improve accuracy for service providers, health professionals and assessors. For example, assessors and service providers could update information directly from their IT systems into My Aged Care and remove the current need for double keying to update both their own systems and My Aged Care.
- 8.41 Greater connectivity would support development of stronger direct relationships where multiple healthcare/aged care providers deliver a range of services to an individual consumer. It would facilitate a more holistic picture of the consumer's health, their aged care needs and the services in place supporting these needs.

Interactions within My Aged Care

- 8.42 Some stakeholders raised issues with the way referrals are currently managed in My Aged Care. Based on the pathway identified at screening, an electronic referral is sent to either the RAS or ACAT to trigger an assessment. If the consumer is recommended for services (such as the CHSP) following the assessment, the assessor can send an electronic referral to the consumer's preferred service provider(s). Alternatively, the consumer can choose to search for and access services themselves, by presenting a referral code (generated by the assessor) to their chosen provider.
- 8.43 Some of the issues raised included that referrals can be lost, a feedback loop to the originating referrer can be lacking (so they are unable to confirm whether the referral has been actioned), and information in referrals can be incorrect. Submissions described the process as detailed, multi-faceted, onerous and cumbersome. One organisation stated it was:
- ...concerned that access to aged care services has become more difficult with the implementation of My Aged Care. Specific issues include long delays in clients accessing dietetic services; referrals being lost and unable to be tracked by the referral source; unnecessary reassessments; inadequate screening and assessment by My Aged Care contact centre staff, Regional Assessment Services and ACATs...aware that the Department of Health is undertaking work to address these issues.*³⁴⁰
- 8.44 It was also noted that My Aged Care was not providing readily understandable information about referrals, particularly among health professionals, older people and their carers and families. Poor referral management was reported to be resulting in delays for consumers to enter services.
- 8.45 The majority of these issues were also raised with the department during its co-design consultation process. Two key focus areas were around referrals to My Aged Care (by either the electronic webform or by fax), and supporting consumers with diverse needs. Issues included:
- the availability of information about a referral after it has been submitted to My Aged Care
 - the ability for third parties to represent people through the My Aged Care journey.

³³⁸ National Presbyterian Aged Care Network submission, p. 7.

³³⁹ Anonymous 13 submission, p. 7.

³⁴⁰ Dietitians Association of Australia submission, pp. 5–6.

- 8.46 Solutions to these problems were developed during the co-design process in late 2016, including:
- expanding consent to enable health professionals to access additional information about the referral status when they call the contact centre
 - ensuring capacity for co-workers of the original person submitting a referral to My Aged Care to have access to relevant referral information
 - providing support for consumers with diverse needs to use representatives to speak on their behalf and amending current pathways to support consumers who otherwise would not be able to engage with the contact centre.
- 8.47 These solutions are being progressively implemented from July 2017.

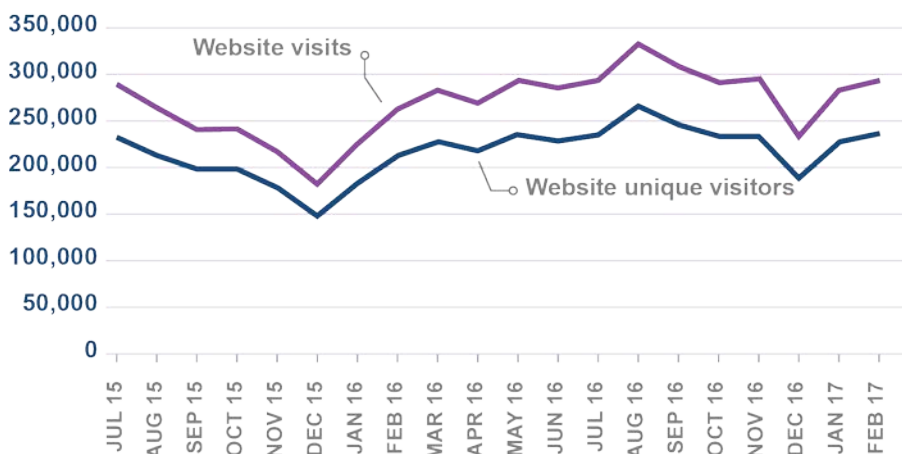
Recommendation 22

That the government improve the functionality and performance of the My Aged Care ICT platform with particular emphasis on improving information-sharing between My Aged Care and other government agency and provider ICT systems.

The My Aged Care website

- 8.48 Online information is accessed by a large number of consumers and their support networks. Figure 8.2 indicates the total number of website visits from July 2015 to February 2017. There appears to be seasonal variation with decreased visits over the Christmas period, but overall the numbers averaged around 290,000 visits per month in 2016.

Figure 8.2 Total number of visits and visitors to the My Aged Care website per month, July 2015–February 2017³⁴¹



- 8.49 Some stakeholders expressed concern that the inaccessibility of the website can be a barrier to accessing aged care services. This is because the ability of a consumer or their support network to access the website is dependent on their computer literacy and proficiency, whether they can physically access a computer and the internet, and the accessibility of the website content.

The aged care system has become heavily IT reliant, particularly since the changes to My Aged Care there were introduced in July 2015. This has made it difficult for consumer to access information about aged care services.

....many older people, particularly those from CALD backgrounds, would struggle to use the system without assistance. Even clients and their carers with higher levels of computer literacy have found it difficult to find information needed to access services.³⁴²

- 8.50 These barriers may be particularly prevalent for some population groups, such as people who are homeless, the vision impaired or people with dementia. Barriers are also a greater concern in rural and remote areas. These concerns are

³⁴¹ Department of Health, unpublished data.

³⁴² Occupational Therapy Australia submission, p. 8.

valid and need to be addressed. However, there is also a common misconception that access to My Aged Care by consumers must be via the website. The department and providers should do more to reinforce the role of the contact centre and promote this channel for older people who do not have access to technology.

The contact centre

- 8.51 Stakeholders who responded to the Review held a poor opinion of the contact centre. They felt the information provided was unreliable, unhelpful and that contact centre staff were unqualified, lacked specialist knowledge, consistently made errors in consumer details and that consumers were required to call several times to resolve their issue.

*My Aged Care is abysmal and staff on phones are unqualified and do not seem to have any idea of the real world of aged care. I also work as a case manager in community aged care and it is a daily complaint I hear.*³⁴³

*...better support and training for contact centre staff to enable them to respond to the information needs of people with dementia, carers and families.*³⁴⁴

- 8.52 This feedback is significantly different to the consumer satisfaction results reported in the AMR research.

- 8.53 Other feedback indicated inappropriate and culturally insensitive responses for vulnerable groups such as Aboriginal and Torres Strait Islanders, those from CALD communities, and those with special needs:

*It needs to be recognised that when some older people who lack English proficiency can be fearful when answering the phone.*³⁴⁵

*Access by phone is often more challenging when a person has cultural and language needs. Calls to clients who have limited access or comfort using government services require advocates to assist. Service providers/advocates have difficulty when calling for clients due to privacy issues.*³⁴⁶

*...difficulty of phone contact on My Aged Care for CALD clients whose first language is not English, leading to inability to complete an assessment and receive services. Basic assistance is available, including access to interpreters and translated information, however, more needs to be done to improvement consumer confidence and satisfaction with the service.*³⁴⁷

- 8.54 My Aged Care is making improvements to current privacy and consent arrangements to better support vulnerable consumers and improve health professionals' access to information.

- 8.55 There were certainly initial operational challenges at the contact centre. The volume of calls and correspondence to the contact centre far exceeded projections which resulted in long call wait times, missed calls and delays in actioning webform and fax referrals.

- 8.56 The department responded to these initial performance problems with a contact centre enhancement project in March 2016. Measures were put in place to:

- improve the contact centre's call handling efficiency
- improve the quality of call handling by contact centre staff
- minimise the number of avoidable follow up contacts.

- 8.57 These measures allowed the contact centre to:

- clear the backlog of referrals
- improve the quality of information provided

³⁴³ Anonymous 3 submission, p. 5.

³⁴⁴ Alzheimer's Australia submission, p. 11.

³⁴⁵ Multicultural Access Project Officers Network submission, p. 7.

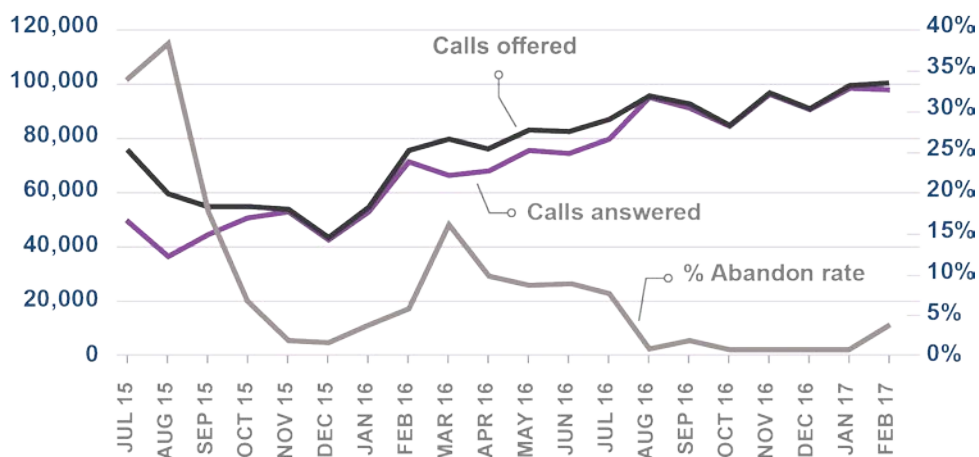
³⁴⁶ Caulfield Aged Care Assessment Service submission, p. 4.

³⁴⁷ UnitingCare Australia submission, p. 11.

- increase the accuracy of data gathered from callers
- improve call handling and response rates.

8.58 Departmental data shows the improvement at the My Aged Care contact centre in responding to calls (Figure 8.3). During July 2015, more than 30 per cent of calls were abandoned. In comparison, less than 5 per cent of calls in February 2017 were abandoned.

Figure 8.3 Calls received and answered by month, July 2015 to February 2017³⁴⁸



8.59 There continue to be reduced call wait times and faster responses to referrals.

8.60 I asked the department about whether performance had been benchmarked against other agencies or similar services. Healthdirect Australia conducted initial scoping work on the value of undertaking a market test to ascertain industry benchmarks for comparable contact centre services. This activity revealed that a full benchmarking exercise would potentially yield minimal information from contact centres with comparable business models and clients. As a result, the department has not proceeded with a benchmarking review.

8.61 While levels of satisfaction of those consumers who successfully connect with the contact centre appear high, that does not mean that access is effective for some population groups. There remains some uncertainty about how many people are not successfully connecting with the system, and what the barriers are for those people, as they cannot be captured in customer satisfaction surveys.

8.62 A common recommendation from stakeholders was to provide a face-to-face presence in the community for people who require extra support to access My Aged Care and the aged care system generally. COTA, for example, indicated that it:

...strongly supports the National Aged Care Alliance's call for a Consumer Support Platform to help support consumers not only to access but to navigate aged care services once they are within the system. Two types of supports, independent from aged care providers, are needed to ensure access:

- *an 'outreach' service to reach into populations known not to actively engage the aged care system or at risk of 'falling through the cracks'. The current outreach model only delivers services to those who are homeless or at risk of homelessness through the Assistance with Care and Housing for the Aged program. This could be expanded for a range of populations including those with mental health concerns.*
- *a system navigation service to assist vulnerable populations to navigate aged care once they are connected to the system. The 'systems wrangler/navigator' is a 'trusted, independent friend' who walks alongside the person while they are navigating aged care, providing one-on-one support to formulate and achieve goals and identify suitable providers.*³⁴⁹

³⁴⁸ Department of Health, unpublished data.

³⁴⁹ COTA submission, p. 27.

- 8.63 The National Aged Care Alliance (the Alliance) provided the Review with a draft discussion paper on integrated consumer supports. It puts forward a framework for aged care consumer supports including outreach services, system navigators, peer support activities, systemic advocacy, and expert advice.
- 8.64 In general, My Aged Care should be able to meet the needs of most consumers. However, My Aged Care needs to be improved and enhanced to better serve the needs of consumers in accessing the system. I am also of the view that some consumers will require a greater degree of assistance than might be possible through My Aged Care.
- 8.65 In this context I support further work being undertaken on the outreach and system navigation roles. The Alliance describes outreach as:

Outreach refers to the activity of actively 'seeking out' and engaging with clients in their own environment, rather than waiting for the person to request a service or waiting for another agency to make a referral. The provision of outreach recognises the most vulnerable and socially isolated people are those who often struggle the most to have their rights realised, including their ability to access the services they need. It is not enough to wait until those people reach out for help because often they do not have a voice to articulate what they need or want. Outreach ensures that the most hidden can be contacted and supported.³⁵⁰

- 8.66 The system navigator:

...has proved exceptionally successful in programs like the Younger Onset Dementia Key Worker Program and a wider model of this more intensive support could be provided through existing or new funded outreach or advocacy services.

Key issues to be considered in taking outreach and systems wrangler/system navigator supports forward include:

- Identifying the target groups for outreach and systems wrangler/system navigation;*
- Developing a definition of outreach and different outreach models tailored for different aged care consumers;*
- Clarifying where these roles sit in the system, including the interface with Regional Assessment Services and Aged Care Assessment Teams; and*
- How these supports can be neutral and comprehensive (for the target groups), as well as building on existing services and funding.*

- 8.67 I recognise that some limited activities of these kinds are intended to be provided by RASs. The RASs are contracted to provide "linking support":

Where an older person's complex circumstances may impede their access to aged care services, linking support will assist in linking the client to various services they require in order to live in the community with dignity, safety and independence. Linking support activities are aimed at working with the client to address areas of vulnerability that are preventing access to receiving mainstream aged care support, to the extent that the client is willing or able to access aged care services. Issues leading to vulnerability include homelessness, mental health concerns, drug and alcohol issues, elder ... abuse, neglect, financial disadvantage and cognitive decline.³⁵¹

- 8.68 Some stakeholders have expressed disappointment with the current RAS linking services for vulnerable consumers. RASs undertaking linking services were reported to be either inconsistently available or non-existent:

There is room for improvement with the current linking service at the Regional Assessment Service as it is not available uniformly, not well or not at all to effectively support all of the vulnerable people who require it.³⁵²

While the initial request for tender documentation for RASs included a 'Linking Service' as part of their service delivery it would seem the service has not been implemented. This type of service may have assisted consumers with the journey through the aged care system but there has been no discussion about why this has not occurred nor any indication from government for alternative arrangements. The Alliance notes its previous discussions under equity of access relating to

³⁵⁰ National Aged Care Alliance, May 2017, *Integrated consumer supports*, discussion paper, endorsement draft, p. 17.

³⁵¹ Department of Social Services, June 2015, *My Aged Care Regional Assessment Service guidelines*, p. 36.

³⁵² Aged & Community Services Australia submission, p. 17.

*'outreach' and 'system navigation' services that should be provided as part of a consumer support platform. The Alliance notes this may be an alternative to the original 'linking service' identified.*³⁵³

- 8.69 Given that stakeholders did not identify the RAS linking support as a service that meets these needs, it appears there are outreach and system navigator needs that remain to be addressed.
- 8.70 Introducing an aged care system navigator service would provide the small but significant group of consumers and families/carers who have difficulty engaging through the existing channels with assistance to understand, choose and access appropriate aged care services. The role would involve talking to consumers about their situation and needs, bringing them into contact with My Aged Care and, where appropriate, helping them to navigate the aged care system and complete paperwork.
- I agree that such a service would be worthwhile. It should be funded by government but be delivered by bodies independent of both government and providers such as non-government services or existing community organisations.

Recommendation 23

That the government introduce aged care system navigator and outreach services to assist consumers who have difficulty engaging through the existing channels to effectively engage with My Aged Care. The services should be funded by the government and not be delivered by the government or aged care providers.

INFORMATION

- 8.71 Stakeholders noted that key issues relating to information were the lack of broad public knowledge about My Aged Care and the quality of information currently available. Each of these issues is outlined further below.

Knowing how to access information

- 8.72 The stakeholders who responded to the Review consistently provided feedback that My Aged Care was still largely unknown to the broader population.
- 8.73 There was an overwhelming call for the department to undertake a comprehensive, ongoing advertising and marketing campaign for My Aged Care.

*Broader promotion of My Aged Care and easy access information would help raise community awareness and usability.*³⁵⁴

*...top priority to enable equal access for the CALD population is to raise public awareness and confidence in My Aged Care through extensive promotion and to address language barrier through bilingual workers.*³⁵⁵

- 8.74 This feedback supported government action to increase awareness and understanding around how to access aged care services. Such a campaign would promote My Aged Care's role in aged care and the overall process for accessing government-funded aged care services. Greater awareness could also result in less delay if the consumer understands how to enter the aged care system through My Aged Care at the beginning of their journey. In some cases, this request was emphasised for a particular population group, for example CALD communities, or those living with a disability. The Victorian Aboriginal Community Controlled Health Organisation drew attention to:

...lack of awareness and understanding amongst older Aboriginal people in relation to:

- The aged care system and current aged care reforms
- Their rights and entitlements in relation to aged care services/resources allocated to them and how to exercise them
- Lack of empowerment in discussing their support needs with assessors and service providers³⁵⁶

³⁵³ National Aged Care Alliance submission, p. 21.

³⁵⁴ City of Victor Harbor submission, p. 5.

³⁵⁵ Chinese Australian Services Society Ltd submission, p. 6.

- 8.75 A more informed population would help to set consumer expectations about the process to receive government-funded aged care services, including the concepts of eligibility, costs, the assessment process, and the types of services and support available.
- 8.76 It is pleasing to note that such a campaign was launched in June 2017 while the Review was underway. The department advised that the campaign aimed to:
- raise awareness of My Aged Care among older people and their families who are not yet in the aged care system
 - increase older people's intentions to
 - talk about aged care
 - plan ahead before a crisis occurs
 - visit the My Aged Care website or
 - call the contact centre.
- 8.77 The campaign featured in selected newspapers, magazines, radio, digital and social media. It also includes public relations activities aimed at Aboriginal and Torres Strait Islander and CALD audiences. This includes the dissemination of translated materials such as brochures, editorial content and key messages for CALD and Aboriginal and Torres Strait Islander media channels.
- 8.78 I note, however, that the campaign is a 'one-off'. To maintain awareness of My Aged Care in the broader community, it needs to be repeated on a regular basis.

Recommendation 24

That the government invest in regular advertising and awareness activities for My Aged Care, to explain the process for accessing government-funded aged care services.

Stakeholders' evaluation of information

- 8.79 Stakeholders generally noted that the website needed additional information and functionality to provide simpler, more comprehensive and useful information. Some stakeholders requested improvements to the service finder and better functionality to compare services side-by-side. Many stakeholders considered that current information is sparse and complex and sought additional information, including on such topics as:
- quality
 - types of services available
 - transparency of fees/additional costs of care
 - income and asset tests.
- 8.80 Some service providers reported that consumers are confused or dissatisfied with the current information. They said that service providers have to work with consumers to fill the information gaps, involving additional work, resources and costs.
- Much time is spent by providers supplying basic information to people ringing for advice. While we are happy to assist people this is a time consuming exercise for people who at this stage are not even prospective clients, they are just looking for information. This is a cost that has to be absorbed by the service provider.*³⁵⁷
- The general public is confused about the changes, and don't know where to obtain information. We spend an inordinate amount of time trying to guide people through the requirements of the system.*³⁵⁸
- 8.81 Some service providers indicated they were going further and delivering education information workshops, organising community booths and writing information resources with the aim of promoting My Aged Care and assisting older people

³⁵⁶ Victorian Aboriginal Community Controlled Health Organisation submission, p. 6.

³⁵⁷ Golden Glow Corporation NT Pty Ltd submission, pp. 6–7.

³⁵⁸ Sunnyside Lutheran Retirement Village submission, p. 6.

to make better informed choices. These providers are in addition to providers that are specifically funded to provide the service.

...Multicultural Access Programs in NSW deliver educational information workshops to CALD communities on the MAC [My Aged Care] system and call centre. The MAP programs are also in the process of organising MAC booths to be located in medical centres in regional and high CALD demographic areas and LGA's [Local Government Area]. This strategy was developed to try to combat the lack of knowledge of MAC in CALD communities.³⁵⁹

At present a number of advocacy organisations are working together to develop a uniform package of information resources that older people can access so that they can make more informed decisions about their aged care services.³⁶⁰

- 8.82 Several stakeholders sought website content improvements, such as information on dementia support services, services for people with a disability, and services for lesbian, gay, bisexual, transgender and intersex (LGBTI) people. There were also concerns that some information may not accurately reflect how aged care operated:

The LGBTI page on the My Aged Care website is somewhat misleading and/or aspirational. It states "... should be able to access care that is responsive..." This might lead LGBTI elders to think that the service continuum — from the portal through to screening, then assessment and then service delivery — with a range of potential players and organisations, is going to be LGBTI inclusive.³⁶¹

- 8.83 Concerns were raised about the accessibility and readability of information on My Aged Care:

Myagedcare has been very ineffective as a portal for information for potential residents. Many are just not aware of the site, don't access the internet, or find it very confusing. Whilst there are some useful documents (fact sheets) for providers to use, as a public portal it is not always that helpful as everyone's circumstances are different and the system itself is complex and highly administrative.³⁶²

...support improvements to the My Aged Care website to enable consumers to understand what services are available on a comparable basis including types and quality, including provision for consumer feedback.³⁶³

There is also a need to enhance the accessibility and useability of the My Aged Care website. ...One issue of concern is the difficulty for consumers to access important information and support sources, such as those provided by Alzheimer's Australia, through the My Aged Care website.³⁶⁴

The MAC [My Aged Care] site is not user friendly and does not meet the needs of the customer for clear, concise, comparable information provided in real time. Customers are often confused by the content and different areas and are contacting Providers directly for access to information. As a Provider the ability to make changes to the MAC site in respect of pricing and update room changes is arduous, with most changes needing to be made through the MAC help desk.³⁶⁵

- 8.84 The department has recently been improving the website. A predictive search function has been added to help people find content. Drop-down menus have been added to the home page and the tabs have been updated to reflect the most important topics as identified in market research with consumers (such as 'getting sorted', 'costs' and 'quality and

³⁵⁹ Ethnic Communities' Council of NSW submission, p. 9.

³⁶⁰ ACT Disability, Aged and Carer Advocacy Service submission, p. 7.

³⁶¹ National LGBTI Health Alliance submission, p. 9.

³⁶² Mercy Aged and Community Care Limited submission, p. 7.

³⁶³ Vision Australia submission, p. 9.

³⁶⁴ Alzheimer's Australia submission, p. 11.

³⁶⁵ Australian Unity submission, p. 6.

complaints'). All content on the site is being updated to be simpler and easier to scan, using the style recommended by the Digital Transformation Agency. Approximately three-quarters of pages have been updated so far.

- 8.85 There have been some recent additions to the information available on the website, particularly in relation to the February 2017 home care reforms that gave consumers greater choice of provider, and an ability to change their provider once they enter care. In February 2017, the department updated the My Aged Care website to provide a greater level of detail on individual providers. These changes included allowing providers to outline areas of specialisation, for example in providing care to people with dementia or cognitive impairment, specific cultural and language groups, LGBTI, Aboriginal and Torres Strait Islander services and other specialised areas.³⁶⁶ Home care providers can now also include their fees or a link to their website for pricing information. However, the display of this information on the website is dependent on providers uploading it via their My Aged Care portal.
- 8.86 The improvements in content and accessibility to date have been steps forward.
- 8.87 However, submissions to the Review indicate that there is more to do in this area. There is a difficult balance to be struck between providing comprehensive and accurate information, and ensuring the information is accessible and comprehensible to consumers, most of whom will have no familiarity with the aged care system.
- 8.88 Information and correspondence should continue to be updated and to be presented in more accessible, plain-English formats. This would ensure that consumers, clients, carers and their families are better informed about My Aged Care and the aged care system. Information in accessible formats may also encourage engagement from a broader range of stakeholders, including those from diverse backgrounds.
- 8.89 The department should consider a co-design process including consumers and expert stakeholders to review the website and correspondence to improve usability and strike the balance between simplicity and comprehensiveness of information. The goals should also include improving the accuracy and usefulness of the service finder, enhancing the ability to compare services, and including clearer information on fees and quality.

Recommendation 25

That the government continues to improve the My Aged Care website for consumers and providers by making the design and layout easier to use and providing information in more accessible, plain-English formats.

ASSESSMENT

- 8.90 Assessment allows My Aged Care to determine consumers' needs and help direct them to appropriate services. If a consumer is seeking access to aged care services, contact staff register them with My Aged Care and in doing so, establish a client record. The client record holds the results of assessments and services provided, and is updated over time. Once registered, consumers and representatives can view their information on the My Aged Care Client Portal through MyGov (the government online services login).
- 8.91 Consumers seeking information only do not need to register with My Aged Care.

Screening

- 8.92 Screening is the first stage of assessment and occurs at the My Aged Care contact centre. The purpose of screening is to understand a consumer's needs to determine an appropriate pathway for them. Screening occurs after registration, and uses a series of questions to determine a consumer's functional ability, including indicators to determine whether the consumer has more complex needs. After screening, consumers can be:
- provided with information, or given contact details of other services (such as non-government-funded aged care services) that may assist them
 - referred to an assessment organisation (either a RAS or an ACAT) for a face-to-face assessment of their needs
 - referred directly to a CHSP service provider for temporary or interim service prior to assessment if the consumer has a need for urgent services.

³⁶⁶ This functionality has its own issues, which are addressed in chapter 9 on equity of access.

8.93 For some, the registration and screening process was onerous, time consuming or duplicative, cohealth noted that:

Overall, consumers report finding the process confusing, burdensome and frustrating. They report:

- inability to differentiate between stages of the process;
- repetition in providing their details to multiple strangers;³⁶⁷

8.94 Consumers seeking access to a single service (e.g. community transport) have expressed their frustration with having to undergo an assessment prior to accessing the service, cohealth also commented that there is:

*...poor understanding about why they cannot simply book an appointment with somebody at the front counter of the service they have always attended*³⁶⁸

8.95 The department has already streamlined the screening process for consumers. However, there may be opportunities to simplify this further if it is not necessary for the contact centre to collect information to enable triage to the most appropriate assessment workforce.

A simplified screening pathway

8.96 Throughout consultation, I received reports of the need for a simplified screening pathway, where consumers are able to self-identify that they need a specific or targeted support service. This process could mean that consumers either bypass or delay the standardised holistic assessment process, in favour of a simplified targeted assessment option.

8.97 The Alliance stated:

*The Alliance notes that for small number of specific services there is an emerging question whether the newly designed regional assessment services are providing over-assessment by requiring a regional assessment for such services as community transport. The Alliance supports the principle of assessment of need for all entrants of the aged care system, but would welcome the reviews consideration of whether there are targeted exceptions that should be considered in the future of any redesigned system.*³⁶⁹

8.98 Submissions proposed this simple pathway for:

- community transport
- social support
- meals
- home maintenance.

8.99 Some stakeholders suggested that these services could be accessed on an ongoing basis, others suggested for a three-month period at which time they could enter My Aged Care and be formally assessed.

*It is the view of the members of this forum that community support programs such as Meals on Wheels, Community Transport, Home Maintenance and Social Support services, can be accessed without the requirement of a home comprehensive assessment via MAC [My Aged Care] and the RAS. We believe that MAC and the RAS is a disincentive to people accessing 'entry level' aged care. We recommend that older people have direct access to these services.*³⁷⁰

8.100 The department should consider a trial where an individual CHSP service such as community transport, social support, meals or home maintenance is accessed prior to holistic assessment, for a limited introductory period of time such as six to twelve weeks. If the consumer seeks longer-term or ongoing services, they would then require an assessment.

8.101 The goal would be to allow rigorous but not complex assessment, ensuring that consumers are not over-assessed for a simple need or service, and that they are able to receive necessary services in a timely manner. Consumers would still

³⁶⁷ cohealth submission, p. 9.

³⁶⁸ cohealth submission, p. 9.

³⁶⁹ National Aged Care Alliance submission, p. 22.

³⁷⁰ Riverina Murray Food Services Forum submission, pp. 5–6.

be registered and screened by My Aged Care, so their details would be available if/when they required additional support later that required holistic assessment.

Recommendation 26

That the government trial a simplified My Aged Care assessment process for consumers seeking a short-term single, simple service.

Quality of assessment—RAS and ACAT

- 8.102 I identified the requirement for a robust system for assessing eligibility for government-funded aged care services in chapter 3 on moving towards a consumer demand-driven system. This is one of four essential requirements that must be addressed before government can consider removing supply controls, a crucial step in moving towards a consumer demand-driven model.
- 8.103 From a service provision perspective, a robust assessment process ensures that a consumer's needs for care and services are accurately identified and matched to an appropriate type and level of care, and that this is done consistently across jurisdictions. It also ensures that consumers are assessed in a timely manner, that they receive reliable information through the referral process, and that their journey through assessment is seamless with limited duplication.
- 8.104 From a policy and planning perspective, a robust assessment process provides data through My Aged Care, the national prioritisation queue in home care, and ACAT data that accurately reflect demand for aged care services. This is essential for government as it attempts to implement changes that better match the supply of aged care places with demand for care.

Timeliness of assessment

- 8.105 The RASs assess consumers for the CHSP. High priority consumers should have an assessment finished within 10 days from referral. Medium and low priority cases should be completed within 14 and 21 days, respectively. From 1 July 2016 to 31 December 2016, the RAS completed approximately 105,000 assessments. Analysis indicates that nationally across all priorities, RASs are completing assessments in a median time of 12 days. This is a very positive result, indicating that consumers are being assessed in a timely manner.³⁷¹
- 8.106 The ACATs assess consumers for multiple services, including home care packages, residential care, residential respite care, transition care and short-term restorative care. Concerns regarding the timeliness of ACAT assessments were raised many times by consumers, service providers and aged care workers, with particular concern about wait times in regional and rural areas. At the workshop in Hobart, for example, consumers reported having to wait up to 12 months for an ACAT assessment. Similar reports were also given at the workshop in Bundaberg.
- 8.107 This issue was also raised in submissions. UnitingCare Australia noted that there is:
- ...excessive waiting times for assessments (which may put clients at risk as their needs increase).³⁷²*
- 8.108 The ACATs are administered by state and territory governments, under an agreement with the Australian Government. Under that agreement, high priority consumers should have the first clinical contact within 48 hours of a referral. Medium and low priority consumers should be contacted within 14 and 36 days, respectively.
- 8.109 From 1 July 2016 to 31 December 2016, ACATs completed approximately 80,000 comprehensive assessments. Analysis indicates that nationally, across all priorities, ACATs are completing assessments in a median timeframe of 11 days. However, the department has advised that it has identified variable waiting times for ACAT assessments among regions. This information confirms the feedback gathered during consultation.
- 8.110 The current key performance indicator for ACATs focuses on the time to the first clinical intervention, rather than the completion of the assessment. The department should undertake further work to identify measures that best capture the

³⁷¹ Department of Health, unpublished data.

³⁷² UnitingCare Australia submission, p. 14.

journey for consumers, including a review of the existing key performance indicators for ACATs, and whether they are adequately being met.

Duplication and coordination of assessment

8.111 The sector has reported that there is duplication and inefficiency within the current assessment process, with consumers required to undergo multiple assessments. Consumers and/or their carers and representatives recounted experiences where they had completed an assessment by the contact centre for screening, followed by an assessment by one, or both, of the assessment workforces (RAS and ACAT) and then were assessed again by a service provider.

8.112 Consumers reported frustration at having to repeat their story and answer questions many times over, particularly when their client record should have included this information from previous assessments. Consumers said they found the distinct assessments confusing and that the unnecessary duplication was a disincentive to access services.

I recently accessed My Aged Care for a RAS as I need community transport (I am 87 and have just stopped driving). I found the number of questions and the fact that I virtually had three interviews (initial MAC phone, followed by phone with RAS and then a home visit by RAS) a little overdone as I just needed one thing³⁷³

8.113 Some submissions proposed streamlining the system so that the RAS and ACAT functions are combined into one assessment agency.

8.114 A single assessment workforce would result in less duplication, greater efficiency, and above all, provide a better service to consumers, who would experience less confusion and need only to 'tell their story' once.

8.115 I consider that to create a seamless aged care system that is responsive to consumer needs and enable the government to fully understand demand, it should be a priority to combine the RAS and ACAT assessment workforces and systems into an integrated assessment workforce. It may be preferable to implement this using a staged approach, considering opportunities to trial the integration in some locations, for example in particular rural and remote regions or in jurisdictions that have not yet fully transitioned to the national system.

Recommendation 27

That the government integrate the RAS and ACAT assessment workforces.

8.116 I note, however, that even with an integrated workforce, a screening and triage process is still required to ensure that those with low needs are not over-assessed, and that older people with complex needs have access to expert assessment.

Assessment for funding allocation in residential care

8.117 Currently a residential care service provider uses the Aged Care Funding Instrument (ACFI)³⁷⁴ to assess and classify a resident's care needs, which in turn determines the level of subsidy the government pays. The government announced in the 2016–17 Budget that it would be exploring longer-term options to change how residential care is funded. This includes consideration of moving from the current funding arrangements to a new assessment tool that is independent of providers.

8.118 In my view, assessment for funding should be independent of service providers, as it would reduce the risk of conflict of interest.

8.119 If aged care funding assessment is moved from providers to an external service, then ideally, there should be a single assessment workforce that assesses a consumer's aged care needs, and for residential care, determines the funding required to meet these needs. This would reduce duplication in the existing needs assessment process. It could provide consumers with consistent assessments of care needs and a transparent process for the government to forecast expenditure that would be linked to eligibility and assessment of care needs.

³⁷³ Anonymous 30 submission, p. 6.

³⁷⁴ ACFI is a resource allocation instrument for residential aged care. Approved providers are required to complete an ACFI Answer Appraisal Pack for care recipients after they first enter care. It assesses the relative care needs of care recipients as the basis for allocating funding to approved providers.

- 8.120 This should occur after the RAS and ACAT assessment workforces have been combined (Recommendation 27), since a change from the existing arrangements of ACFI would take a significant amount of time to develop and is linked closely to the current (but separate) review of ACFI.

Recommendation 28

That, following review of ACFI, the government integrate residential aged care funding assessment with the combined RAS and ACAT functions, independent of aged care providers.

Outcomes of assessment

- 8.121 I have received feedback from both the sector and the department regarding variation in accuracy and consistency of RAS and ACAT assessments.
- 8.122 Assessment that accurately approves consumers for services that match their needs is an essential requirement for government. It ensures that consumers are approved for services that appropriately match their needs and that government can accurately gauge the demand for aged care services by service type and level, and plan accordingly.
- 8.123 Feedback ranged from consumers who were impressed with their experience of the assessment process and the assessors, to some providers who were frustrated at consumers receiving approval to access a service that was not appropriate for their needs. For example, some comments, mostly from service providers and aged care workers, noted their concerns that assessors often provide conflicting or misleading information.

ACATS also are at different levels and will often provide conflicting information and generally do not have a great understanding of the implications for the consumer, leaving much to the providers.³⁷⁵

- 8.124 There were examples where consumers reported being deemed ineligible when they were eligible, or where they were referred to an inappropriate service for their needs. It was also mentioned that assessors, particularly RAS assessors, should not override clinical recommendations by a health professional as this can present an unacceptable risk to a consumer's health and safety.
- 8.125 Submissions also questioned whether consumers were appropriately directed to the CHSP or the lower levels of home care packages. It is important that consumers be referred to services that appropriately meet their needs through screening and assessment. Further, it is important that there be consistency in outcomes of assessment among regions.
- 8.126 The CHSP is positioned as providing entry-level support such as relatively small amounts of a single service or a few services on an ongoing basis, or higher intensity episodic services where improvement in function can be made. Currently, an assessor must determine the suitability of recommending CHSP services on an interim basis (to meet a short-term need or as part of a restorative care intervention) or on an ongoing basis.
- 8.127 Where a consumer requires more than a few simple services and/or when there is a need for ongoing case management, the RAS assessor or CHSP provider should recommend a shift to a home care package. It appears that there needs to be better guidance on the differentiation between the CHSP and home care package level 1, and greater emphasis on moving consumers to a home care package when their service needs increase. The government also needs to ensure that fee structures are not inappropriately influencing these decisions, an issue I addressed in chapter 5 on means testing. Aged & Community Services Australia highlighted this issue, saying that there are:

Inconsistent outcomes from the assessment process – examples include RAS assessors referring a client for several CHSP services (resulting in support at higher than Home Care Package level 1 or 2 care) and the service may be provided through multiple services with little if any co-ordination³⁷⁶

- 8.128 The issue of consistency in assessment in terms of matching consumers' needs to the appropriate level of package, is particularly important in home care. I note this because the department has advised me that there has been a significant shift in the number of approvals by package level since implementation of the LLLB reforms, which has seen a significant

³⁷⁵ Community Vision submission, p. 7.

³⁷⁶ Aged & Community Services Australia submission, p. 17.

reduction in the number of approvals for low level home care packages, and a significant increase in the number of approvals for high level home care packages.

- 8.129 This shift in ACAT approvals could be due to a number of factors, such as ACATs potentially factoring in the perceived wait times for a package and consumers' future needs into their assessment decisions, the broad-banding³⁷⁷ of approvals, introduction of individualised budgets, and more robust income testing, which were introduced with the implementation of the Home Care Package Programme, and changes to supply. However, I consider that the shift in approvals deserves further exploration by government, to ensure it is satisfied that assessment is accurately approving services that match consumer need.
- 8.130 To address the sector's concerns about quality of assessment, stakeholders have called for greater training for both ACAT and RAS assessors to ensure that they are able to effectively communicate with consumers, focus on wellness and reablement, and ensure that their referrals are appropriate.
- 8.131 I am aware that work is currently underway. For example, the department is currently working with its contracted registered training organisation, CIT Solutions, to enhance training for My Aged Care staff.
- 8.132 The department undertook an evaluation of the progress of the RAS programme, which included:
- understanding the efficiency and effectiveness of the programme to date
 - developing a quality framework to enable RAS organisations to continuously improve outcomes
 - recommending how long-term outcomes should be evaluated.
- 8.133 As the department is currently reviewing the outcomes of the evaluation, I have not made a recommendation. However, I consider that work needs to continue on the required functions for the assessment workforce, how these functions interact, and how they will be measured and implemented.
- 8.134 In terms of ACAT assessments, the implementation of the Increasing Choice in Home Care reforms in February 2017 has seen the introduction of the ACAT Guidance Framework for Home Care Package Level, including a user guide that provides greater clarity for assessors on matching consumer need with the appropriate level of package. This framework aims to enhance the assessment system by providing assessors with a tool to assist in matching consumer needs with the appropriate package level.
- 8.135 Further, AMR research points to an increase in consumer and carer satisfaction with the referral to services from assessment, with consumer satisfaction increasing 13 percentage points (from 73 per cent to 86 per cent) and carer satisfaction increasing 12 percentage points (from 67 per cent to 79 per cent) between early 2016 and early 2017.³⁷⁸ However, there were lower satisfaction levels for other users of My Aged Care (including service providers and health professionals).
- 8.136 In my view, for government to continue to move towards a consumer demand-driven system, it needs to be assured that demand, as determined by eligibility, is a true reflection of consumer need at the time of assessment. Therefore, it is essential that government continue to review the performance of the assessment workforces, including the quality and consistency of assessments, and to seek feedback on assessment from consumers, providers, and the assessment workforce itself.

Assessment for reablement

- 8.137 Through a variety of consultation processes, including this Review, the sector has called for more support for reablement and wellness, including leadership, training and practical support to embed reablement and wellness within current practice. This theme has arisen in submissions to the Review, as well as in the My Aged Care codesign process.
- 8.138 Changes are needed to support a service delivery system that is more focused on understanding consumer strengths and goals and supporting informal carers. The current inconsistent application of reablement and wellness in both assessment and service delivery results in some consumers missing out on the opportunity to regain

³⁷⁷ Prior to the February 2017 changes to home care, consumers were assessed as eligible for a level 1–2 home care package or a level 3–4 home care package, this is referred to as 'broad-banding'. The changes to home care in February 2017 saw a consumer assessed as eligible for a level 1, or level 2, or level 3 or level 4 package.

³⁷⁸ AMR, 2017, *My Aged Care stage two wave 2 research: summary of findings*, (unpublished report).

skills, and maximise their confidence and long-term independence. Others experience over-servicing and the offer of more services than they necessarily need. Speech Pathology Australia indicated that the late stage at which speech pathologists are receiving referrals:

*means that a window of opportunity for preventative intervention (e.g. wellness and reablement services) is being missed that could prevent costly hospital admissions and enable people to remain living at home longer.*³⁷⁹

8.139 Vision Australia noted:

*Early intervention is a vital aspect of service provision, with evidence suggesting that early expert assessment and support planning to mitigate the functional impact of diagnosed conditions can allow people with vision impairment to retain their independence.*³⁸⁰

- 8.140 Using a reablement and wellness approach can reduce the cost of services for each consumer, through eliminating or reducing the need for ongoing and more complex services. This would enable more consumers to access required services. It may also assist in re-setting service provider and consumer expectations about the time period for which they need aged care services.
- 8.141 Embedding a reablement and wellness approach within assessment practice would increase consistency in assessment, assist assessors to provide appropriate information and recommendations for consumers on suitable pathways and also help assessors to better understand likely outcomes for particular consumer groups. From a consumer perspective, it supports greater choice and control through accessing services that are focused on their strengths and goals to either regain or maintain independence. This needs to be supported by the CHSP changes to ensure services are not delivered unnecessarily or without review.
- 8.142 There is also a need to review the reablement role within current CHSP-funded allied health and therapy services to redirect the role more towards shortterm restorative and reablement interventions.
- 8.143 The training for assessors could focus on integrating wellness, reablement and restorative care into assessment practice and also determining suitable strategies and interventions that do not involve funded supports, such as strategies to maintain informal care and/or access to mainstream community supports. Consideration could be given to expand training to service providers in the future. There could also be targeted information available for the contact centre.
- 8.144 Embedding wellness and reablement approaches into current practice should also take into account the outcomes of the national review of wellness and reablement approaches within the home care sector currently being undertaken by Nous Group on behalf of the department.
- 8.145 In addition, the department should ensure that the new funding conditions for RASs from July 2018 ensure a greater focus on activities that support independence and wellness and provide more choice to consumers.

³⁷⁹ Speech Pathology Australia submission, p. 9.

³⁸⁰ Vision Australia submission, p. 7.

Recommendation 29

That the government and providers work to improve access to wellness and reablement activities to provide greater choice and better support for consumers to live independently, including by:

- increasing access to short-term reablement supports and/or episodic care, rather than the provision of ongoing care, including an increased focus on the use of assistive technology
- enabling better integration with other available support systems such as the health care system and community-based support
- supporting staff and consumers to better understand and access information about wellness, reablement and restorative care
- providing aged care assessors with training on wellness, reablement and restorative care.

National Screening and Assessment Form

8.146 The NSAF supports the collection of information for the screening and assessment processes conducted under My Aged Care. The department developed it based on existing best-practice assessment processes from around Australia, and through significant consultation with stakeholders.

8.147 A minority of submissions noted that while the NSAF was holistic, it did contain gaps. These included identifying communication and swallowing difficulties, disability, and blindness or vision impairment. Vision 2020 Australia, for example, observed that:

...the National Screening and Assessment Form (NSAF) is limited in its capacity to respond to needs of older people who are blind or vision impaired and people with disability more broadly. While disability is identified as a health condition that may prompt referral to an allied health professional there is no trigger to refer an individual to specialised support services such as providers in blindness and vision impairment. In relation to blindness and vision impairment, NSAF instructs assessors to refer the person to an optometrist if the person has had changes to their vision in the last three months and does not seek any information on underlying vision impairment or consider the need for specialised blindness and vision impairment services.³⁸¹

8.148 It was argued that issues with the NSAF led to inappropriate referrals or the assessor missing key signs. The NSAF was also criticised for not always appropriately leading to

referral to some services. The National Rural Health Alliance noted that while progress has been made, barriers in the assessment process remain, such as:

- Inadequate training or skills within assessment staff and providers to identify the most appropriate services for consumers.
- Gaps in the assessment tool (e.g. NSAF does not adequately screen to capture responses that should trigger referral for early intervention, restorative care and reablement services).

The result is inappropriate referrals to providers or for example, assessors missing key signs that should trigger early referral to a service in order to retard functional decline.³⁸²

8.149 The department advised that issues around the NSAF were also raised within the My Aged Care co-design process. This included feedback from:

- My Aged Care assessors on the repetitiveness and length of the NSAF, and its inability to effectively reflect a consumer's needs and preferences, and to communicate their story
- service providers, who thought that the NSAF was lengthy, often incomplete and difficult to navigate. They are not using the assessment to its fullest potential in order to develop a consumer's care plan.

³⁸¹ Vision 2020 Australia submission, p. 13.

³⁸² National Rural Health Alliance submission, p. 9.

- 8.150 Through other feedback mechanisms, consumers have also highlighted the repetitiveness of questions across assessment levels as well as the length of the assessment process.
- 8.151 The department has agreed that it is timely to review the NSAF. Its preferred option is for the NSAF review to occur by the end of 2017 and changes to be implemented in the first half of 2018. In chapter 9 on equity of access, I have made a recommendation about using the screening and assessment process as a vehicle to help with identification and meeting of special needs (Recommendation 35). Beyond that specific issue, I agree that a review of the NSAF would assist in dealing with the issues that have been identified.

Recommendation 30

That the government immediately review the National Screening and Assessment Form.

- 8.152 I note that an integrated assessment workforce, particularly if it handles needs assessment for residential aged care (as per Recommendation 27 and 28) will need access to additional specialised assessment tools. These will need to be developed in the work to integrate RASs and ACATs.

CONCLUSION

- 8.153 The changes to how consumers access aged care and how they are assessed have been among the most significant of the LLLB reforms. The introduction of My Aged Care was both a large ICT project and a transformation of how consumers navigate the aged care system. There were significant implementation issues, but many of them have been resolved. There remain some ongoing challenges; nevertheless, the implementation of My Aged Care represents an important step towards consumer-centred and accessible aged care. To ensure ongoing improvements to My Aged Care, I have made several recommendations focused on improving its functionality and the consumer experience.
- 8.154 Robust assessment is an important feature of a sustainable aged care system. It is also essential if the government wishes to consider uncapping supply in the future. There have been changes to assessment processes over the last five years. Several further reforms, including integrating the assessment workforce and strengthening the quality and reliability of assessment, will help lay the groundwork for more robust assessment as the system grows and evolves.

CHAPTER 9

EQUITY OF ACCESS

INTRODUCTION

- 9.1 This chapter responds to matter (f) in the Review terms of reference: the effectiveness of arrangements for protecting equity of access to aged care services for different population groups.
- 9.2 Equity of access is important for many reasons. No population group should find it more difficult to access aged care than other groups. Equity of access recognises the value in ensuring that all services are welcoming and responsive to people regardless of their needs and that people are not discriminated against. Policies that support equity of access recognise that additional assistance for some groups of people will improve their ability to access care.
- 9.3 The goals for the Living Longer Living Better (LLLBB) reforms included steps to improve equity by taking account of people's means and needs.
- 9.4 Several important features of the aged care system help deliver equity of access:
- Consumer contributions in home care packages and residential care are set according to means.
 - Providers are offered an incentive to ensure that people with limited income and assets receive care.
 - Standards put in place by aged care law require providers to attend to the needs and preferences of each person in their care.
 - Aged care legislation, and processes for the allocation of places, recognise population groups with specific needs.
 - Government funding models provide additional funds when people with special needs require additional support.
 - Dedicated programs exist to support access and care for some population groups.
- 9.5 The first feature is that government funding is varied according to people's economic means. Home care packages and residential care are means tested; government funding is highest for those with the lowest means, ensuring that those who are less able to contribute to their cost of care are supported and those who can contribute to the cost of their care, do so. This is important for the sustainability of the aged care system, and is also critical for equity of access.
- 9.6 Second, residential aged care is an expensive service, and would be unaffordable to people relying on the aged pension who are not likely to be able to afford significant refundable accommodation deposits. To address the impact this has on providers, in addition to funding being targeted according to economic means of individual consumers, residential aged care providers are given additional funding if at least 40 per cent of their residents have limited means.³⁸³
- 9.7 Third, aged care law requires providers to meet consumer needs and preserve their rights. The accreditation standards in residential care state that consumers must retain their personal, civic, legal and consumer rights, and be assisted to achieve active control of their own lives within the residential care home and in the community. This includes a consumer's cultural and spiritual life choices.³⁸⁴ The home care common standards state that consumers must have appropriate access and service delivery when receiving a home care package.³⁸⁵
- 9.8 Fourth, the *Aged Care Act 1997* (the Act) recognises nine population groups as having special needs. These are groups of people who may find access to aged care services difficult due to their diverse characteristics and life experiences. These are:
- people from Aboriginal and/or Torres Strait Islander communities
 - people from culturally and linguistically diverse (CALD) backgrounds

³⁸³ In this context, 'limited means' refers to what aged care law describes as fully or partly supported residents.

³⁸⁴ See Standard 3, care recipient lifestyle of the accreditation standards.

³⁸⁵ See Standard 2 of the home care common standards.

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

9.9 When applying for residential aged care places (and previously home care packages) in the Aged Care Approvals Round (ACAR), providers are able to specify if they intend to prioritise care to any of these groups. This supports the creation of aged care services for people with particular care needs.

9.10 Fifth, there are several other ways in which the government provides funding to meet special needs requiring additional support. These include supplements in residential care and home care in the more remote parts of Australia, and for some people with specific needs such as homeless people and those at risk of homelessness, Aboriginal and Torres Strait Islander people with complex care needs, veterans, and people with dementia (in home care only). Furthermore, in residential care, the Aged Care Funding Instrument (ACFI)—the main vehicle for delivering funding for consumer care—includes a number of items that mean particular needs trigger higher levels of provider funding, for example if a resident has specific behavioural care needs relating to mental illness or dementia. This helps ensure that consumers are cared for according to their care needs. Additionally, the Department of Health (the department) provides capital grants for the construction or upgrade of residential care buildings when an organisation is unable to afford the proposed capital works without funding from the government.

9.11 Sixth, there is a range of dedicated programs designed to facilitate access to care by particular groups. These include, for example, Multi-Purpose Services (MPS) serving rural and remote communities, and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP).

9.12 While these measures are implemented by the government to support equity of access, aged care providers also contribute to ensuring equity of access across the community, independent of the government's subsidies and policies. Some service providers choose to focus on meeting particular community needs, to ensure that access is available to diverse groups. Examples include services that specialise in dementia care, homelessness, individual CALD communities, or being LGBTI-friendly. In addition, there are some initiatives, such as the Rainbow Tick standard, that are not aged care-specific but are used by some aged care providers to support the provision of quality care to some groups in the community.

REVIEWING EQUITY OF ACCESS

9.13 Consistent with the importance of equity in aged care policy generally, and to the government's objectives for the LLLB reforms in particular, the terms of reference for this Review require consideration of the effectiveness of arrangements for protecting equity of access to aged care services for different population groups.³⁸⁶

9.14 There are two definitional questions raised by the term of reference: what constitutes "equity of access"; and what population groups should be considered?

9.15 Equity of access can mean different things, in part because different population groups face different challenges in accessing aged care. For some, the cost of a service is the main barrier to accessing it, because they have low means. For others, there may be problems in finding care or navigating the system, even though cost is not inherently an issue. There are some population groups for whom the main barrier is the organisational culture of aged care providers, or limits to providers' expertise or understanding. Finally, the boundaries between care systems and the lack of supports for moving between them, create problems that prevent effective care for some population groups.

9.16 Inequitable access can therefore have complex causes. In general, I took equity of access to mean that members of a particular population group were just as likely to be able to find or receive care as the broader aged care population. It also means that there are not inappropriate aspects to care that might cause people to be discouraged from accessing the service or continuing to receive it.

³⁸⁶ Aged Care (Living Longer Living Better) Act 2013, s. 4(2)(f).

9.17 As noted in the introduction to this chapter, there are nine population groups identified in the Act as having special needs. These formed the starting point for the population groups considered in this Review. However, this list has some omissions. This was why the National Aged Care Alliance (the Alliance) recommended:

*That the review expand its consideration of the effectiveness of arrangements for equity of access beyond those populations listed in the Act.*³⁸⁷

9.18 National Presbyterian Aged Care Network, for example, stated:

*NPAC [National Presbyterian Aged Care Network] strongly supports equitable access for all older Australians to aged care services. We also note that the list of different population groups excludes people with mental health conditions, which in our experience are a group with particular needs. It also excludes people with dementia, who are of course already major users of aged care.*³⁸⁸

9.19 It was also clear from engagement with stakeholders that there are important considerations in relation to people with a disability. This is particularly important as the National Disability Insurance Scheme (NDIS) does not provide coverage to people who acquire a disability when aged 65 and over.

9.20 Accordingly, I considered the outcomes of the LLLB reforms as they impact on the following groups:

- people from Aboriginal and/or Torres Strait Islander communities
 - The aged care target population includes the Aboriginal and Torres Strait Islander population aged 50 years or older, compared with 65 years or older for non-Indigenous Australians. This is in recognition that health conditions associated with ageing often affect Aboriginal and Torres Strait Islander people at an earlier age.
- people from CALD backgrounds
 - An estimated 22 per cent of people aged 65 years and over were born overseas in countries where English is not the main language spoken.³⁸⁹
- people who live in rural or remote areas
 - Consumers and providers of aged care services in rural and remote areas may face particular challenges relating to geographical isolation.
- people who are financially or socially disadvantaged
 - In 2013–14, around 4 million people lived in low-income households; 30 per cent of these people were aged 65 and over.³⁹⁰
- veterans, including the spouse, widow or widower of a veteran
- people who are homeless, or at risk of becoming homeless
- people who are care leavers (including Forgotten Australians, Former Child Migrants and Stolen Generations)
 - From 1 December 2009, people who are care leavers were included under legislation as a special needs group. A care leaver is a person who, as a child, spent time in institutional care or out-of-home care. It is estimated that there are more than 500,000 care leavers in Australia.³⁹¹
- parents separated from their children by forced adoption or removal

³⁸⁷ National Aged Care Alliance submission, p. 3.

³⁸⁸ National Presbyterian Aged Care Network submission, p. 5.

³⁸⁹ Department of Health, 2016, *2015–16 Report on the operation of the Aged Care Act 1997*, p. 65.

³⁹⁰ Australian Bureau of Statistics, *Household income and wealth*, cat. no. 6523.0, 2013–14, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/6523.02013-14?OpenDocument> The number is expected to grow.

³⁹¹ Department of Social Services, Care leavers, <https://www.dss.gov.au/our-responsibilities/families-and-children/programs-services/apology-to-the-forgotten-australians-and-former-child-migrants/questions-and-answers/care-leavers>

- From 1 August 2013, this group were included under legislation as a special needs group, in acknowledgement of the traumatic experiences, health issues and socio-economic disadvantage that they may have.
- people from LGBTI communities
 - From 1 July 2012, LGBTI people were included within legislation as a special needs group. Up to 11 per cent of the population are LGBTI.³⁹²
- people with dementia
 - 10 per cent of people aged 65 or over in Australia have dementia, rising to 30 per cent of people 85 years and over. In 2016 there were an estimated 353,800 Australians with dementia, nearly half of whom were aged 85 years or over.³⁹³
- people with a disability
- people with a mental illness.

THE PRODUCTIVITY COMMISSION'S ANALYSIS AND THE LIVING LONGER LIVING BETTER REFORMS

- 9.21 The Productivity Commission's (the Commission) 2011 report, *Caring for older Australians*, made a range of recommendations that related to people from different population groups, including:
- ensuring that the accreditation standards be sufficient and robust enough to deliver services that cater to the needs and rights of people from different population groups
 - that a proposed Australian Seniors Gateway Agency cater for diversity by ensuring access by all, regardless of their cultural background and English proficiency, and that assessment tools be culturally appropriate for all people
 - ensuring that rural and remote and Indigenous services be supported to maintain buildings, staff development and applying funding models that support the development of service capabilities
 - that services be partially or fully block funded where there is a demonstrated need to do so. Examples could include aged care for homeless older Australians or Indigenous-specific, flexible services.³⁹⁴
- 9.22 As part of the LLLB reforms, the government implemented several initiatives aimed at improving access to aged care for key population groups:
- additional funding through the Aged Care Service Improvement and Healthy Ageing Grants (ACSIHAG) Fund to improve skills and knowledge of providers to meet the care needs of diverse populations. ACSIHAG was replaced with the Dementia and Aged Care Services (DACS) Fund on 1 July 2015
 - expansion of the NATSIFACP
 - expansion of the Assistance with Care and Housing for the Aged (ACHA) Program, which links older people with suitable accommodation and care services. ACHA was integrated with the Commonwealth Home Support Programme (CHSP) from 1 July 2015
 - introduction of a veteran's supplement in residential and home care
 - development of a National Ageing and Aged Care Strategy for People from CALD Backgrounds
 - development of a National LGBTI Ageing and Aged Care Strategy.
- 9.23 While these changes were specific to particular population groups, the LLLB reforms made major changes across the whole aged care system. One of the main reasons that this Review is considering equity of access is to check whether any of those broader changes have impacted negatively on equity of access. Some aspects of this are covered in chapters 5 and 6, regarding means testing and accommodation payments. While access is primarily defined as entry to care, it may also be the case that once a person is in care they may not receive appropriate and non-discriminatory care they need and are entitled to by law.

³⁹² Department of Health and Ageing, 2012, *National lesbian, gay, bisexual, transgender and intersex (LGBTI) ageing and aged care strategy*

³⁹³ Department of Health, 2016, *2015–16 report on the operation of the Aged Care Act 1997*, p. 7.

³⁹⁴ Productivity Commission, 2011, *Caring for older Australians*, vol. 1, pp. lxvii, lxix.

EVALUATION

- 9.24** Most of the discussion below regarding equity of access looks at individual population groups, and the measures needed to support them. However, the ACAR is one area of the aged care system that potentially impacts on all nine groups listed in the Act. This section examines ACAR data, to give a picture of how the reforms are affecting equity of access.
- 9.25** The ACAR is a competitive aged care places allocation process. Providers submit proposals for the provision of additional aged care places, and these proposals are evaluated by government, with the strongest bids being approved. The process can be intensely competitive. Resulting from the approvals process, new aged care places may have conditions of allocation attached to them. This is intended to ensure priority access is given to particular population groups. When submitting an ACAR application a provider may specify that they intend to prioritise care for one (or more) of the special needs groups. If approved this may be reflected as a 'condition of allocation'. While the government does not monitor them closely, the provider is expected to offer priority to someone belonging to that special needs group. However, where the place cannot be filled by a person from the specific special needs group, it can be offered to any eligible person. Many people with special needs face particular barriers in engaging with and trusting services to provide appropriate inclusive care.
- 9.26** As part of the February 2017 Increasing Choice in Home Care reforms, funding for home care packages is now allocated to the consumer instead of the provider. This saw the discontinuation of the ACAR for home care places, replacing it with a national prioritisation process. This is a national system for prioritising home care packages that is managed by My Aged Care. Consumers are prioritised based on their needs and circumstances and also how long they have been waiting for a package.
- 9.27** Table 9.1 shows the number of places applied for, and subsequently allocated, with a focus on one or more of the special needs groups in recent ACARs. The evidence suggests that providers have become more aware of special needs groups and the need to ensure specialised care is being considered as part of their service delivery model. Following the reforms there was an increase in the number of places applied for, and allocated, with a focus on one or more of the special needs groups since the 2011 ACAR. The effect was stronger for home care.

Table 9.1 Prioritised special needs groups in home care and residential care ACAR approvals³⁹⁵

GROUPS	2011		2012–13		2014		2015		2016–17***
	Home care	Residential care	Home care	Residential care	Home care	Residential care	Home care	Residential care	Residential care
ATSI*	75	42	180	94	266	48	231	32	66
CALD*	292	716	884	927	1,189	482	931	898	670
R & R*	43	266	140	246	374	190	303	201	214
FSD*	106	225	510	719	930	763	871	753	626
Veterans	170	189	302	299	238	279	187	240	148
Homeless	38	64	60	44	200	16	166	83	51
Care leavers	23	12	0	7	33	1	41	0	6
PSC*	0	0	0	0	0	0	0	0	0
LGBTI*	0	0	94	10	169	7	187	151	95
Multiple special needs groups focus**	43	399	20	170	83	2	233	318	246
Total special needs priorities	790	1,853	2,190	2,516	3,482	1,788	3,150	2,676	2,122
Total places allocated	1,724	7,933	5,835	7,775	6,653	11,196	6,445	10,940	9,911

³⁹⁵ Department of Health, unpublished data.

Notes: * ATSI: Aboriginal and Torres Strait Islander, CALD: culturally and linguistically diverse, R & R: rural and remote, FSD: financially and socially disadvantaged, PSC: parents separated from their children by forced adoption or removal, LGBTI: lesbian, gay, bisexual, transgender and intersex communities

** 'Multiple special needs groups focus' refers to where a provider has applied for and received an allocation of places with a focus on one or more of the special needs groups (for example, a service could apply for CALD and LGBTI)

*** The 2016–17 ACAR is only for residential care places

- 9.28 There was an appreciable increase in the number of places allocated with a focus on one or more of the special needs groups after the reforms. Rates of growth were greatest for CALD places, people who are financially or socially disadvantaged, and LGBTI places. Growth was more modest for Aboriginal and Torres Strait Islander places, people experiencing homelessness, veterans and people who live in rural and remote areas, however all four of these population groups have specific programs or funding tools that also assist them and that would not be reflected in these data. The two population groups for which the ACARs appear to have produced little or no result are care leavers and parents separated from their children by forced adoption or removal, a result to which I return later in the chapter.
- 9.29 In chapter 4 on demand and supply I have recommended that ACAR be discontinued for residential care, to further shift choice to consumers. These changes should give providers more incentive to be responsive to their needs and empower consumers with special needs to access appropriate care.
- 9.30 To ensure that these changes do not adversely impact on the population groups listed in the Act, a consumer demand-driven aged care system needs to do two things:
- There needs to be a system for consumers to signal their care preferences and needs, and for it to be possible for them to seek out and give preference to providers who will meet those needs.
 - The government needs a mechanism to maintain visibility of how care is being provided to different population groups.
- 9.31 I return to this issue at the end of this chapter.

ABORIGINAL AND TORRES STRAIT ISLANDER OLDER PEOPLE

- 9.32 Many Aboriginal and Torres Strait Islander aged people face a combination of challenges in accessing aged care. They are often economically disadvantaged, and there are additional logistical challenges (as for all people) when they live in remote communities. Care for Aboriginal and Torres Strait Islander people must also be culturally appropriate to ensure their continued participation.
- 9.33 Recognising the challenges faced by older Aboriginal and Torres Strait Islander people, the government has increased funding for several targeted programs. There were two initiatives specific to the LLLB reforms that assist access to services for Aboriginal and Torres Strait Islander people:
- additional funding through the ACSIHAG Fund to improve the skills and knowledge of providers to meet the care needs of diverse populations. The new DACS Fund has a focus on funding projects that support Aboriginal and Torres Strait Islander people
 - expansion of the NATSIFACP.
- 9.34 In addition, funding of the viability supplement was expanded in 2012 to provide additional support to Aboriginal and Torres Strait Islander people with complex care needs. The viability supplement is most often paid to providers in rural and remote areas in recognition of the higher costs associated with providing quality care to consumers.
- 9.35 Aboriginal and Torres Strait Islander people are under-represented in aged care relative to the aged care target population. In Figure 9.1, this is shown as an index, for which a result above zero indicates Aboriginal and Torres Strait Islander people have higher representation in these services, while below zero indicates proportionally lower representation.³⁹⁶

³⁹⁶ These data examine recipients of mainstream residential aged care and home care packages only and exclude the CHSP, the Multi-Purpose Service Program and the NATSIFACP. Therefore, the numbers of Aboriginal and Torres Strait Islander people receiving care may be slightly under-estimated.

Figure 9.1 Index of equity of access for residential care and home care services for older people from Aboriginal and Torres Strait Islander backgrounds, 2015–16³⁹⁷



- 9.36** Like much of the data available in this area, the information needs to be treated with some care. In some areas representation of Aboriginal and Torres Strait Islander people in the wider population is quite low. This can mean that sizeable changes in the indices could be due to a relatively small change in aged care client numbers. Despite this, the three significant findings from this data are that Aboriginal and Torres Strait Islander people:
- are less likely than the general population to be accessing aged care
 - are more likely to access home care than residential care
 - have significantly different access patterns from one jurisdiction to another.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

- 9.37** NATSIFACP providers are funded to deliver a mix of residential and home care services in accordance with the needs of the community. NATSIFACP aims to provide quality aged care services that meet the needs of Aboriginal and Torres Strait Islander people in a culturally appropriate setting, close to home and community.³⁹⁸ While NATSIFACP providers should develop care plans and provide care that is consumer directed, they are not required to provide individualised budgets.
- 9.38** As part of the LLLB reforms, the government expanded the NATSIFACP to provide an additional 200 aged care places (on top of the 675 places already funded through the program) to allow more Aboriginal and Torres Strait Islander people with complex high care needs to stay close to their home and receive culturally appropriate care.³⁹⁹
- 9.39** Places under the NATSIFACP are allocated to approved providers through specific grant funding rounds. The number of operational places as at 30 June each year since 2012 are presented in Table 9.2. The department has advised that there is approximately \$2.5 million remaining under the expansion of the program which will be allocated following a funding round in 2017.

Table 9.2 Operational National Aboriginal and Torres Strait Islander Flexible Aged Care Program places*, 30 June 2012 to 30 June 2016⁴⁰⁰

STATE/TERRITORY	30 JUNE 2012	30 JUNE 2013	30 JUNE 2014	30 JUNE 2015	30 JUNE 2016
NSW	27	27	27	27	27
Vic	124	124	124	124	124
Qld	87	59	59	59	59
WA	16	48	48	48	48

³⁹⁷ Department of Health, 2016, *2015-16 report on the operation of the Aged Care Act 1997*, p. 65.

³⁹⁸ Department of Health, 2016, *National Aboriginal and Torres Strait Islander Flexible Aged Care Program Guidelines*, p. 6.

³⁹⁹ NATSIFACP providers operate outside the Act and are required to enter into a funding agreement with the government.

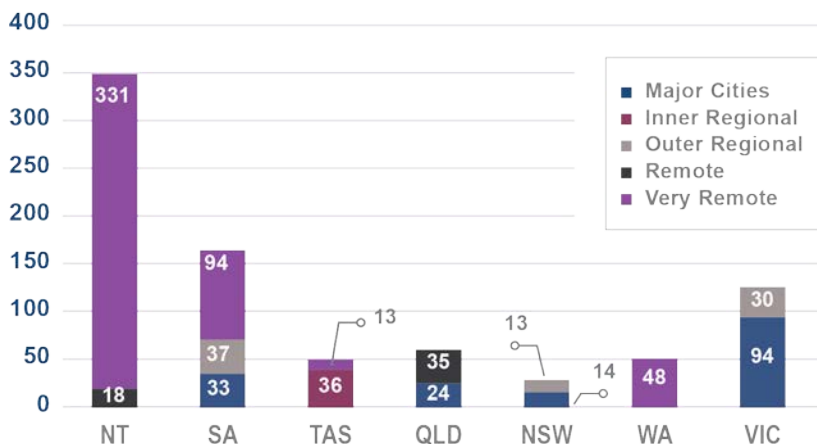
⁴⁰⁰ Department of Health, *Stocktake of Australian Government Subsidised Aged Care Places*, 2012, 2013, 2014, 2015 and 2016, <https://agedcare.health.gov.au/news-and-resources/publications/research-and-statistics/links-to-the-30-june-2016-stocktake-of-australian-government-subsidised-aged-care-places>

STATE/TERRITORY	30 JUNE 2012	30 JUNE 2013	30 JUNE 2014	30 JUNE 2015	30 JUNE 2016
SA	164	164	164	164	164
Tas	49	49	49	49	49
ACT	0	0	0	0	0
NT	208	208	268	331	349
Australia	675	679	739	802	820

Note: * Places include residential and home care places. Residential places include low care and high care places.

9.40 The places provided in the NATSIFACP are across all regions, as shown in Figure 9.2.

Figure 9.2 Allocation of flexible program places by state/territory and location⁴⁰¹



9.41 The reforms have gone some way to addressing the aged care needs of Aboriginal and Torres Strait Islander older people. The expansion of the NATSIFACP appeared to be well received by stakeholders. During stakeholder consultations in the Northern Territory, it was noted that there remained a need to expand and use the NATSIFACP further in rural and remote locations.

9.42 It was also raised with me during this Review that NATSIFACP should be expanded in metropolitan locations with a high Aboriginal and Torres Strait Islander population. I have considered whether this would be useful to ensure that Aboriginal and Torres Strait Islander people have access to the culturally sensitive aged care.

9.43 Concern was also expressed during consultation that changes to home care, including the introduction of Consumer Directed Care (CDC) and individualised budgets, does not meet the needs of Aboriginal and Torres Strait Islander people.

9.44 This year the Australian National Audit Office (ANAO) assessed the effectiveness of government-funded aged care services for Indigenous Australians.⁴⁰² The ANAO concluded that the services are largely delivered effectively, but noted that the department can strengthen its administration by implementing a coordinated approach across the agency to share relevant information.

9.45 The ANAO found that Aboriginal and Torres Strait Islander people were most likely to access aged care services through the CHSP or the Home Care Packages Programme, at rates consistent with their share of the aged care population. Fewer than 1 per cent of residential aged care places were taken up by Aboriginal and Torres Strait Islander people.⁴⁰³

9.46 Further, the report found that NATSIFACP has been effective in increasing the access to culturally appropriate aged care services for elderly Indigenous Australians. The ANAO concluded that the NATSIFACP is a more cost-effective and

⁴⁰¹ ANAO, 2017, *Indigenous aged care*, p. 25.

⁴⁰² ANAO, 2017, *Indigenous aged care*.

⁴⁰³ ANAO, 2017, *Indigenous aged care*, p. 9.

viable model for specialised aged care delivery to Indigenous Australians when services are located in remote and very remote communities.⁴⁰⁴

- 9.47 The ANAO noted, however, that the direct selection and recurrent funding approach of the program provides few opportunities for new service providers to enter the market. The report suggests that the department provide opportunities for both existing and new service providers to apply for funding. The department should also apply a consistent assessment process to ensure that places allocated through the program align with service provider capacity and are targeted to those service providers who will generate the greatest community benefit.⁴⁰⁵
- 9.48 Considering available departmental data, the ANAO audit and consultations with the sector, it appears Aboriginal and Torres Strait Islander people's access to services has been moderately improved by the reforms. Further improvement is possible. The NATSIFACP appears to be successful in supporting delivery of the care needs of Aboriginal and Torres Strait Islander people. The government should consider options for expanding the NATSIFACP.

Recommendation 31

That the government expand the NATSIFACP to better support Aboriginal and Torres Strait Islander people.

CULTURALLY AND LINGUISTICALLY DIVERSE POPULATIONS

- 9.49 Australia is one of the most culturally diverse nations in the world. It is estimated that 22 per cent of people aged 65 years and over were born overseas in countries where English is not the main language spoken.⁴⁰⁶ This number is expected to grow over the coming years.
- 9.50 Funding is provided to organisations under the ACSIHAG Fund (now replaced), to provide time-limited, innovative measures to assist in the care and support of older people in CALD communities.
- 9.51 Complementing the additional funding through the ACSIHAG Fund to improve skills and knowledge of providers to meet the care needs of diverse populations, the government introduced the National Ageing and Aged Care Strategy for People from CALD Backgrounds. This strategy included 35 specific action areas to be addressed across six broader goals. To assist with implementation and general advice on CALD issues, a CALD working group of relevant stakeholders was created in 2015.
- 9.52 The Partners in Culturally Appropriate Care (PICAC) Program supports CALD communities. The PICAC Program was established in 1997 and under current agreements receives approximately \$2 million per year. A PICAC organisation in each state and territory is funded to support aged care providers in delivering culturally appropriate care to older people from CALD communities. PICAC organisations also help older CALD people and their families make informed decisions about their aged care needs. PICAC organisations conduct a range of activities including training, information sessions, workshops and resource development.
- 9.53 In the 2016–17 ACAR, \$11.2 million in capital grants were allocated to five residential aged care services focusing on the provision of care for people from CALD backgrounds, with 120 residential aged care places allocated to those services with a condition of priority of access for people from CALD backgrounds.
- 9.54 As at 30 June 2016 there were nearly 50,000 people from a CALD background in receipt of aged care (residential or home care). This compares to around 245,000 people receiving residential or home care in total. Since 2012 the proportion of people from CALD backgrounds receiving aged care services has slowly risen (Table 9.3).

⁴⁰⁴ ANAO, 2017, *Indigenous aged care*, p. 9.

⁴⁰⁵ ANAO, 2017, *Indigenous aged care*, p. 35.

⁴⁰⁶ Department of Health, 2016, *2015–16 report on the operation of the Aged Care Act 1997*, p. 65.

Table 9.3 Representation of people from CALD backgrounds in residential care and home care (%)⁴⁰⁷

STATE/ TERRITORY	30 JUNE 2012	30 JUNE 2013	30 JUNE 2014	30 JUNE 2015	30 JUNE 2016
Residential care	17.0	17.5	17.9	18.3	19.0
Home care levels 1–2	23.0	23.2	23.6	25.5	27.0
Home care levels 3–4	24.9	24.7	24.8	25.8	26.9

- 9.55 Compared to the general population accessing aged care, people from CALD backgrounds have proportionally higher representation in home care services and proportionally lower representation in residential care services.
- 9.56 There are many possible explanations for this pattern of access, and this Review was not able to examine this in more detail. Lower representation in residential care could be linked to a stronger cultural preference for care in the home. It could result from a lack of culturally appropriate residential care. It may also be linked to stronger informal support networks which can reduce the need for formal aged care services, or for particular service types.⁴⁰⁸
- 9.57 As with Aboriginal and Torres Strait Islander populations, I considered representation of CALD people in aged care relative to their representation in the aged care target population, broken down by jurisdiction. This is expressed as an index, for which a result above zero indicates CALD people have higher representation in these services, while below zero indicates proportionally lower representation (Figure 9.3).⁴⁰⁹

Figure 9.3 Index of equity of access for residential care and home care packages for older people from CALD backgrounds, 2015–2016⁴¹⁰



- 9.58 The representation of people from CALD backgrounds varies less between states and territories than for Aboriginal and Torres Strait Islander people. It is also the case that in some areas representation of people from CALD backgrounds in the wider population is quite low. This can mean that sizeable changes in the indices could be due to a relatively small change in aged care client numbers.
- 9.59 There appears to be steady improvement for people from CALD backgrounds in accessing aged care services. The time series in Table 9.3 indicates that the reforms have not harmed CALD access to home or residential care, and that, while the pattern of access is different from the general population, overall access is high and growing.
- 9.60 Given the relatively good access of CALD groups to home care to date, it will be important to monitor the impact of home care reforms on these groups.

⁴⁰⁷ Productivity Commission, 2015, 2016, 2017, *Report on government services* and Department of Health (unpublished) ageing and aged care data warehouse.

⁴⁰⁸ Productivity Commission, 2017, *Report on government services*, table 14.1.

⁴⁰⁹ These data examine recipients of mainstream residential care and home care packages only, they exclude care provided under the CHSP and therefore may slightly under-estimate the numbers of CALD people receiving care.

⁴¹⁰ Department of Health, 2016, *2015-16 report on the operation of the Aged Care Act 1997*, p. 66.

PEOPLE WHO LIVE IN RURAL AND REMOTE AREAS

9.61 Consumers and providers of aged care services located in rural and remote areas face particular challenges in access to services and service provision. These challenges can include issues related to the operation of small services that may be remote from professional assistance and support and have limited internet availability. There may also be higher infrastructure and supply costs. Aged and Community Services Australia, for example, commented:

*Rural and remote providers face additional costs in providing aged care including for example cost of food, travel costs and staff remuneration and training costs. These additional costs are not adequately factored into government funding which results in an inequitable system as consumers in these communities receive less care compared to consumers with similar aged care needs living in metropolitan communities. A different funding model is required.*⁴¹¹

9.62 Geographical isolation can mean higher cost pressures for those who provide services outside of metropolitan areas and regional centres, and these are passed on to consumers. Geography also impacts workforce costs and access to allied health professionals.⁴¹² If these factors cause providers to be less viable, this could present a risk to access for consumers:

*The higher cost of operating in rural areas ultimately has an impact on service provision for consumers.*⁴¹³

9.63 The Aged Care Financing Authority (ACFA) was tasked by government to undertake a study into the factors influencing the financial performance of rural and remote aged care providers. In January 2016, the ACFA released its report *Financial issues affecting rural and remote aged care providers*.

9.64 ACFA's analysis showed that in most cases aged care providers in regional areas had lower financial results than city-based providers, but this was not the case for every regional provider. Some were performing financially on par with or above their city counterparts.

9.65 Reflecting the high costs of care provided to people in rural or remote areas, the government provides a viability supplement to some aged care services to increase their capacity to offer care. The viability supplement is available in residential care and home care, as well as in MPS and the NATSIFACP.

9.66 In the 2016–17 Budget, changes were announced to improve the viability supplement by using a more accurate method for classifying providers in regional, rural and remote areas.⁴¹⁴ As a result, the viability supplement increased for most remote home, residential care services and MPS. This change came into effect from 1 January 2017.

9.67 Government spending on the viability supplement has increased from 2011–12 to 2015–16 in both home care and residential care (Table 9.4).

Table 9.4 Viability supplement claims for home care and residential care, 2011–12 to 2015–16⁴¹⁵

STATE/TERRITORY	2011–12	2012–13	2013–14	2014–15	2015–16
Home care	\$6.12m	\$6.33m	\$6.21m	\$7.10m	\$7.70m
Residential care	\$28.64m	\$28.75m	\$29.51m	\$35.07m	\$35.64m
Total	\$34.76m	\$35.08m	\$35.72m	\$42.17m	\$43.34m

9.68 Given the various measures intended to ensure geographical equity of access, it is worthwhile examining the availability of care across Australia. Table 9.5 shows the ratio of aged care places per 1,000 people over the age of 70 and Aboriginal and Torres Strait Islander people aged 50–69, living at different levels of geographical remoteness.

⁴¹¹ Aged & Community Services Australia submission, p. 18.

⁴¹² See chapter 10 for more detail on this issue.

⁴¹³ Aged & Community Services Australia submission, p. 12.

⁴¹⁴ This change, to a system known as the Modified Monash Model, was recommended by ACFA in its 2016 report.

⁴¹⁵ Department of Health, unpublished data.

Table 9.5 Residential and community aged care places per 1,000 population aged 70 years or over and Aboriginal and Torres Strait Islander people aged 50-69 years, by remoteness, 30 June 2014–2016, Australian total⁴¹⁶

REMOTENESS CLASSIFICATION	30 JUNE 2014		30 JUNE 2015		30 JUNE 2016	
	Residential care	Home care	Residential care	Home care	Residential care	Home care
Major cities of Australia	83.8	30.9	82.2	31.2	80.8	34.3
Inner regional and outer regional	73.3	25.8	72.2	25.6	70.9	28.4
Remote and very remote	50.6	33.4	49.0	31.9	46.5	30.9

Note: Count includes places delivered under the MPS Program, NATSIFACP and Innovative Care Programs.

- 9.69** The figures in Table 9.5 should be interpreted with caution. The absolute numbers of consumers served in the remote and very remote areas is low, so small fluctuations can affect the result significantly.
- 9.70** Table 9.5 indicates that residential care is less available in remote areas but that home care packages are available across all geographical regions.

Regional Assessment Service evaluation

- 9.71** The department is currently evaluating the Regional Assessment Services (RAS). As part of the evaluation, the department will examine the issues and options related to accessing aged care services in rural and remote areas, particularly the workforce practices in remote areas. Further information on the evaluation is in chapter 8 on access to services.

Multi-Purpose Services Program

- 9.72** The MPS Program is a flexible care program that is a joint initiative between the Australian Government and state and territory governments. MPS provide integrated health and aged care services for small communities, allowing services to exist in regions that could not viably support stand-alone hospitals or aged care services.
- 9.73** Nationally, the MPS Program provides over 3,000 flexible places delivered as residential or home care. Over the last five years there has been a small increase in the number of flexible aged care places provided through the MPS Program (Table 9.6).

⁴¹⁶ Productivity Commission, *Report on Government Services*, 2015, table 13A.21, 2016, table 13A.21, and 2017, table 14A.16.

Table 9.6 Operational Multi-Purpose Service Program flexible places*, 30 June 2012 to 30 June 2016⁴¹⁷

STATE/ TERRITORY	30 JUNE 2012	30 JUNE 2013	30 JUNE 2014	30 JUNE 2015	30 JUNE 2016
NSW	1,006	1,060	1,089	1,109	1,149
Vic	375	375	375	375	378
Qld	463	539	552	552	556
WA	778	794	794	794	794
SA	607	607	607	607	607
Tas	102	102	102	102	102
ACT	0	0	0	0	0
NT	6	6	6	6	6
Australia	3,337	3,483	3,525	3,545	3,592

Note: * Flexible places include residential and home care places.

- 9.74** During ACFA's consultations, MPS were supported by some stakeholders as a key mechanism for service delivery outside metropolitan areas. The Victorian Healthcare Association said:

*The MPS model is an excellent mechanism to provide access to aged care services in rural areas. MPS are able to gain some scale by amalgamating health, disability and aged care services and their service flexibility means they are able to be highly responsive to community need.*⁴¹⁸

- 9.75** In those areas where MPS operate alongside other services, ACFA noted there was a range of views about how MPS should operate. During its consultations, ACFA indicated that views of mainstream providers were divided:

*Some mainstream providers consider that they struggle to compete in some cases with MPS which they consider are better resourced and benefit from being part of a broader health or hospital network. Some mainstream providers also consider MPSs benefit from not being subject to the same regulatory requirements (though they would have to comply with state requirements). On the other hand, some mainstream providers reported having the hospital and the attached MPS in the area resulted in better access to clinicians for their consumers, and that a good relationship with an MPS can be beneficial.*⁴¹⁹

- 9.76** While the original intent of the MPS Program remains a valid and viable option to deliver aged care services in rural and remote locations, the department suggested that there are aspects of the program which now appear to be out of step with contemporary aged care policy, particularly in relation to the MPS funding model, the service delivery model in some locations, fees and payments, and approved provider responsibilities.
- 9.77** MPS providers and state governments report that, similar to their mainstream counterparts, care recipients enter care later and with more complex care needs and that retaining a low care rate of subsidy may no longer be appropriate.
- 9.78** The implementation of aged care reforms since the program's introduction, including ageing in place and Increasing Choice in Home Care, may have resulted in a departure from the original MPS delivery model in some communities.
- 9.79** Feedback from some providers suggested that MPS and mainstream residential and home care services in the same location have become competitive rather than complementary.⁴²⁰ Approximately 23 per cent of MPS are located in a

⁴¹⁷ Department of Health, *Stocktake of Australian Government Subsidised Aged Care Places*, 2012, 2013, 2014, 2015 and 2016, <https://agedcare.health.gov.au/news-and-resources/publications/research-and-statistics/links-to-the-30-june-2016-stocktake-of-australian-government-subsidised-aged-care-places>

⁴¹⁸ Victorian Healthcare Association submission, p. 29.

⁴¹⁹ ACFA, 2016, *Issues affecting the financial performance of rural and remote providers, both residential and home care providers*, p. 26.

⁴²⁰ ACFA, 2016, *Issues affecting the financial performance of rural and remote providers, both residential and home care providers*, p. 175.

town where a residential aged care service operates. Prior to 2014, it was common for MPS to deliver “high care” nursing services, while the residential aged care service delivered “low care” hostel services as a complementary arrangement. The removal of the low/high distinction, as well as changes to government policy in relation to accommodation payments, means there may now be some unfair competition in some locations. This is largely due to variations in accommodation fees and payments.

- 9.80 MPS are not required to deliver home care services on a CDC basis and clients do not have an individualised budget. In some locations, there are consumers receiving home care services through the Home Care Packages Programme on a CDC basis and others receiving home care services under the MPS Program who are not.
- 9.81 The lack of consistency in the operating environments of MPS across a range of areas, including fees and charges, assessment and approval and quality standards, compared to residential aged care services or the Home Care Packages Programme, contributes to inequity for aged care providers and aged care consumers.
- 9.82 At the same time, there was support from stakeholders with experience in regional and rural areas for the expansion of the MPS Program. The National Rural Health Alliance said:
- Multi-Purpose Services (MPS) offer a viable business model to enable a range of health services together with aged care support to be provided in rural and remote locations. Increasing the number of MPS within rural and remote based settings is needed to bridge the gap of delivery and access to services to the ageing rural.*⁴²¹
- 9.83 The decision to establish a new MPS is contingent on agreement by the relevant state or territory government, which is responsible for the capital and infrastructure costs.
- 9.84 While I support the MPS Program and believe that it should be explored as a way to improve access to services in remote areas, I consider that the service delivery model should be reviewed, as should the location of services.

Recommendation 32

That the government engage with state and territory governments and service providers to review the MPS Program to better align its service delivery model with mainstream aged care programs, where appropriate, to ensure greater consistency of services for aged care consumers and providers, and to consider the location of services to ensure that MPS funding is properly targeted.

PEOPLE WHO ARE FINANCIALLY OR SOCIALLY DISADVANTAGED

- 9.85 A number of submissions and stakeholder workshops pointed out that people who are financially disadvantaged have less choice in accessing residential aged care. For example, Sir Charles Gairdner Hospital Aged Care Assessment Team said:

*Financially supported clients appear to have difficulty in accessing residential care in terms of choice.*⁴²²

Accommodation supplement and the supported resident ratio

- 9.86 The two main mechanisms by which financial means are considered are the supported resident ratio and means testing. Both are areas in which the work of the ACFA has been invaluable to assist this Review.
- 9.87 As outlined in detail in chapter 6 on accommodation payments, people who are unable to pay the full amount or part of their accommodation costs are referred to as supported residents. The government pays an accommodation supplement to the residential care provider for these people to ensure they are not disadvantaged. For a provider to claim the maximum accommodation supplement payable for a supported resident, more than 40 per cent of all residents must be in that category; this is referred to as the supported resident ratio. If a service does not meet the 40 per cent ratio, the amount of accommodation supplement paid will be reduced for all residents by 25 per cent.

⁴²¹ National Rural Health Alliance submission, p. 8.

⁴²² Sir Charles Gairdner Hospital Aged Care Assessment Team submission, p. 3.

9.88 The accommodation supplement is a significant source of funding in residential aged care; in 2015–16 the government's expenditure on it was \$845.7 million. In January 2017, ACFA released a report on the operation of the supported resident ratio. The report concluded:

ACFA is of the view that the 40 per cent rule provides an important incentive to providers to accept supported residents...ACFA considers it essential that the 40 per cent rule remain and considers it is providing an appropriate financial incentive to providers and supporting access to care for supported residents. A 40 per cent target ratio remains appropriate noting that supported residents make up around 47 per cent of all residents nationally.

The net impact of the 1 July 2014 reforms does not appear to have adversely affected access to services for supported residents with the overall proportion of supported residents increasing from 44.4 per cent at 30 June 2014 to 46.8 per cent at 30 June 2016. Some anecdotal information was provided to ACFA that some providers were showing a preference for non-supported residents but this does not appear to have led to significant shifts in access.⁴²³

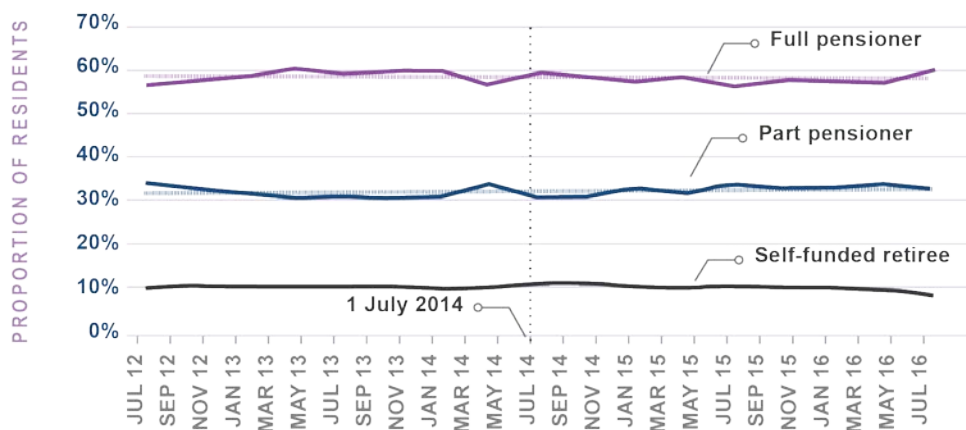
9.89 The evidence I received was consistent with ACFA's conclusions.

9.90 Data about the pension status of people being admitted into care can give insight into whether access to care by people on limited incomes was affected by the reforms. Relevant data and analysis was provided in ACFA's *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*.

9.91 Age pensioners are by far the largest group accessing home care. At 30 June 2016, 82.1 per cent of all post-LLLB reform home care package consumers were full pensioners, 15.2 per cent were part-pensioners and 2.7 per cent were self-funded retirees.⁴²⁴

9.92 Pensioners also predominate in residential care. Figure 9.4 shows new admissions to permanent residential care by pension status.

Figure 9.4 New permanent admissions to residential care by pension status, 2012–13 to 2015–16⁴²⁵



9.93 The pension status of new admissions has not changed significantly from before to after the implementation of the reforms (dotted line in Figure 9.4). This indicates that the reforms, including the changes to means-testing arrangements, did not reduce access to government-funded residential care by low-means residents.

9.94 These figures make it clear that not only have the reforms not negatively impacted on access by people of limited means, but that lower income retirees were and are accessing subsidised care at least as much as the broader population. This is a positive outcome.

⁴²³ ACFA, 2017, *Report on access to care for supported residents*, p. 2.

⁴²⁴ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*. Full pensioners were defined as those consumers assessed as not being able to pay an income-tested care fee. Part-pensioners were defined as those who paid an income-tested care fee up to the first cap (explained in chapter 5). Self-funded retirees were defined as consumers who paid an income-tested care fee up to the second cap.

⁴²⁵ ACFA, 2017, *Report to inform the 2016–17 review of amendments to the Aged Care Act 1997*.

VETERANS

9.95 Veterans can receive aged care services in one or both of two systems, one administered by the Department of Health and the other by the Department of Veterans Affairs (DVA). The DVA provides a suite of aged care programs to assist veterans with support in the home, and a veteran can access a DVA program as well as an aged care program as long as the services that are being provided are not the same.

9.96 Services provided by the DVA include:

- Veterans' Home Care (VHC) Program—gold and white card-holders with low care needs can receive these services once they have been assessed by the VHC Assessment Agency. VHC provides a range of services to ensure veterans' health, wellbeing and independence are maintained. VHC also offers respite care.
- Attendant care and household services—for veterans with incapacitating medical conditions.
- Community nursing—providing clinical nursing and/or personal care services by registered and enrolled nurses.
- Rehabilitation Appliances Program—giving veterans access to mobility aids or appliances to assist them to maintain their independence at home.

9.97 The Department of Health monitors the number of gold or white card-holders in residential care (Table 9.7). Similar data is not collected for veterans accessing support in the home.

Table 9.7 Number of gold or white treatment card-holders in residential care, by state and territory⁴²⁶

STATE/TERRITORY	30 JUNE 2012	30 JUNE 2013	30 JUNE 2014	30 JUNE 2015	30 JUNE 2016
NSW	9,706	9,677	8,636	7,437	6,781
Vic	6,793	6,648	6,063	5,159	4,701
Qld	5,462	5,283	4,951	4,115	3,830
WA	2,014	1,997	1,832	1,549	1,404
SA	2,373	2,364	2,142	1,850	1,682
Tas	799	801	722	635	608
ACT	315	341	312	247	256
NT	26	21	20	12	19
Australia	27,488	27,132	24,678	21,004	19,281

9.98 Table 9.7 appears to indicate that the proportion of veterans in residential care is stable, as there is a declining number of veterans in the broader community.⁴²⁷

9.99 It is difficult to quantify the extent of veterans' access to aged care given the limited data collected by the Department of Health. However, during this Review I did not receive evidence to suggest that their access to care was deficient or had been negatively affected by the reforms.

PEOPLE WHO ARE HOMELESS OR AT RISK OF BECOMING HOMELESS

9.100 The government provides additional funding and support for people experiencing homelessness or at risk of homelessness once they are in receipt of an aged care service, but their circumstances make it difficult for them to access care in the first instance. There are several government mechanisms aimed at ensuring that these people receive care. These include a linking service and funding supports for care and for capital works. In 2015, ACAR grants totalling \$12.4 million were provided to two residential aged care services specialising in caring for people who have a history of

⁴²⁶ Department of Health, *Report on the operation of the Aged Care Act 1997*, 2011-12, table 40, 2012-13, table 44, 2013-14, table 38, 2014-15, table 35, and 2015-16, table 21.

⁴²⁷ An approximate indicator of whether there has been a change over time can be gained by determining the proportion of all DVA service pensioners who are in residential care homes. In 2012, it was around 17 per cent, and in 2016 around 16 per cent. Department of Veterans Affairs, March 2017, *Pensioner summary statistics*, <https://www.dva.gov.au/about-dva/statistics-about-veteran-population#summary>

homelessness or disadvantage, and 56 residential care places were allocated to those services with condition of priority access for people that are homeless or at risk of homelessness.⁴²⁸

- 9.101 Currently, there are approximately 700 residential aged care places delivered by around 16 services that are dedicated to providing care to homeless people across Australia.⁴²⁹ This is in addition to mainstream aged care providers offering care and services to homeless people.
- 9.102 One of the mechanisms supporting access to care for the homeless is the ACHA Program. The ACHA Program addressed access to aged care by linking older people who were homeless or at risk of homelessness with suitable accommodation and care services so they could continue to remain in the community rather than prematurely entering residential care.
- 9.103 Under the LLLB reforms, the government expanded the ACHA Program by \$7.3 million over five years. It was subsequently integrated into the CHSP from 1 July 2015. Consumers in receipt of services under the ACHA Program continued to receive these services through grandfathering arrangements. The department has advised that no consumer was disadvantaged through the integration of the ACHA Program to CHSP. In 2014–15, the ACHA Program received around \$6.7 million; with the move to CHSP, these funds have received real growth and annual indexation.⁴³⁰
- 9.104 In some respects, the LLLB reforms appear to have had a positive impact on access for this group. There is significant financial support for homeless people once they are in residential care. Services that specialise in caring for people who are homeless or at risk of becoming homeless can apply for a homeless supplement. To receive the supplement, the aged care home must have more than 50 per cent of residents meeting criteria set out in the *Viability expansion component and homeless supplement assessment*. Expenditure on the supplement has increased over the past three years from \$4.5 million in 2013–14 to \$7.6 million in 2015–16.
- 9.105 Services supporting homeless people are also eligible for the viability supplement. Previously used only to support rural and remote services, it was expanded in 2012 to provide additional support to others, including the homeless or those at risk of becoming homeless, to meet the higher costs for providers to respond to these consumers' complex needs.
- 9.106 Notwithstanding this additional financial support, some providers expressed concern that the level of support is not keeping pace with cost increases and that it does not adequately cover additional costs incurred by providers. In the absence of family members providers are meeting costs such as arranging attendance at medical appointments, and purchasing toiletries and clothing. It is difficult to assess the extent of this problem. However, it does point to the need to closely monitor the costs being borne by providers and if necessary consider whether the homeless supplement should be increased.
- 9.107 A second issue raised was the impact of the CDC model of home care on homeless people.
- 9.108 During the Review, I met with a provider specialising in the care of homeless consumers who indicated that one result of the individualised budgets and administrative requirements for consumers' packages was that it was more difficult for providers to offer flexibility in the care and services they provide to people who are homeless
- or at risk of homelessness. It can also be difficult for providers to have meaningful discussions with homeless consumers about choice in their package and in ensuring they understand their care options and financial circumstances.
- 9.109 Previously, a provider could use their home care funds to provide outreach services to older people who were homeless and advise them that they could be receiving aged care services. With the introduction of individualised budgets this now cannot occur.
- 9.110 Some aspects of the reforms have benefited homeless people, particularly through more funding in residential care, however, others may have made access to aged care more challenging for homeless people and those at risk of being homeless.
- 9.111 I was advised by the same provider that a block funding model, providing funds directly to providers, may help to solve the difficulties, and that alternative care options should be considered. However, homeless people equally deserve the benefits of CDC and individualised budgets, even if their choice is then to leave it to the provider to manage their care on

⁴²⁸ Department of Health, 2016, *2015-16 report on the operation of the Aged Care Act 1997*, p. 68.

⁴²⁹ Advice provided by The Salvation Army.

⁴³⁰ As advised by the department.

their behalf. I do not think there is sufficient evidence that block funding is the right solution for homeless people. I do, however, agree that this group needs outreach services and that there appears to be inadequate services available.

Recommendation 33

That the government review whether further ways of assisting in the delivery of improved services to homeless people are needed in the context of reform to home care and residential care.

CARE LEAVERS AND PEOPLE SEPARATED FROM CHILDREN BY FORCED ADOPTION OR REMOVAL

- 9.112 Care leavers and people separated from children by forced adoption or removal face a particularly significant barrier to entering residential care. The very idea of entering residential care can cause care leavers extreme anxiety as it brings back painful memories of being institutionalised as a child.
- 9.113 The University of New South Wales recently published a report entitled *No child should grow up like this: identifying long-term outcomes of Forgotten Australians, Child Migrants and the Stolen Generations*.⁴³¹ This report highlights the issues these groups are faced with when entering aged care, in particular residential care. According to the report, a large number of respondents stated that they would rather kill themselves than enter into another institutionalised care facility.⁴³²
- 9.114 The report included a wide range of recommendations, some of which related to aged care:
- Forgotten Australians, Former Child Migrants and Stolen Generations be recognised as a vulnerable group with special needs and that the collection of data on people who have been in care be included on forms seeking client information. This would include aged care.
 - Aged care providers and assessors (My Aged Care call centre staff, Aged Care Assessment Teams and RASs) undertake mandatory training in working with care leavers.
 - Non-institutional forms of aged care be looked at to support care leavers who may require aged care services as they get older.
- 9.115 Some of the recommendations I have made in this report will support achieving the outcomes proposed in the University of New South Wales study, including:
- Recommendation 35—that the government give consumers the opportunity to identify as belonging to a population group with special needs, as part of their client record.
 - Recommendation 7—introduction of a Level 5 home care package, which would allow for a higher level of care to be provided outside of residential care.
- 9.116 It is difficult to quantify the extent of care leavers' access to aged care given the limited data collected by the department.
- 9.117 The government has developed the *Caring for Forgotten Australians, Former Child Migrants and Stolen Generations information package*, which aims to ensure that this group of people are cared for with the dignity and respect they deserve as they age. The information package includes an information booklet, a training facilitator guide, a PowerPoint presentation and a video to assist aged care providers in responding to the needs of care leavers in an aged care setting.
- 9.118 Information is also limited in relation to the experience of aged parents separated from their children by forced adoption or removal. It is unknown how many such parents are accessing aged care, meaning it is not possible to draw a conclusion on whether their equity of access is challenged. This is the only group for which there has been no specific focus by providers through the ACAR (Table 9.1). The issue has not been raised as part of the Review.

⁴³¹ UNSW, *Forgotten Australians, long-term outcomes of Forgotten Australians study*, <http://www.forgottenaustralians.unsw.edu.au/>

⁴³² Fernandez, Elizabeth, et al., 2016, *No child should grow up like this: identifying long term outcomes of Forgotten Australians, Child Migrants and the Stolen Generations*, UNSW, p. 211.

- 9.119 Together, these two groups represent a significant number of people. There are around half a million care leavers and, while there are no estimates of the number of parents affected by *forced* adoption, there were around 150,000 adoptions in the period prior to 1975.⁴³³ However, care leavers and people separated from their children by forced adoption or removal are not well represented in the approved places as part of the ACAR. This could suggest providers are not finding ways to identify and offer tailored care to these populations.
- 9.120 The lack of information and evidence in relation to aged care for these people is concerning. Giving people the opportunity to identify as coming from a group with a special need such as these, and having that recorded in the client record, is one step toward understanding the population and responding to them, but more needs to be done in terms of the provision of care, and of training the assessment workforce.

PEOPLE FROM LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX COMMUNITIES

- 9.121 Older Australians who identify as LGBTI may face significant barriers to aged care. Similar to the Commission's 2011 inquiry, this Review has received submissions that continue to raise the importance of aged care workers needing to understand the needs of the LGBTI community to ensure that sexuality, gender or intersex status does not act as a barrier to receiving quality care.
- 9.122 The majority of older LGBTI people may be fearful of declaring they are LGBTI, for fear of discrimination and victimisation. There is:
- Still a reluctance by LGBTI community to access aged care services and to feel safe about disclosing their sexuality or gender identity.*⁴³⁴
- 9.123 It is difficult to quantify the extent of access by LGBTI people to aged care given the limited data collected by the department. Evidence I received suggested that:
- LGBTI elders face a risk of vulnerability by having to disclose their sexuality, relationships, bodies or genders. Historic and current experiences have shown many that 'coming out' is dangerous. It is therefore unlikely that an LGBTI elder will disclose and this can impact on their access to, and the delivery of, services.*⁴³⁵
- 9.124 The government has provided some resources to support quality care in this area. For example, in May 2017, a 24-minute educational video on LGBTI inclusiveness in aged care was broadcast on the Aged Care Channel. The video was designed to improve aged care providers' understanding of LGBTI aged care consumer issues and highlights initiatives providers can implement to make their services more LGBTI inclusive. The video is available on the department's YouTube channel.
- 9.125 An LGBTI strategy was introduced in 2012 and informed the way the government responded to the needs of older people who identify as LGBTI. The strategy supported the aged care sector to develop care that was sensitive and appropriate. It included 36 specific action areas to be addressed across six broader goals. To assist with implementation and general advice on LGBTI issues, an LGBTI Working Group of relevant stakeholders was created in 2015. The 2012 LGBTI strategy will conclude in 2017. The sector is currently developing a new Diversity Framework, and I expect that the framework will continue to build on improving inclusive aged care service deliver for LGBTI people and carers.

PEOPLE WITH DEMENTIA

- 9.126 Dementia is a common condition in older Australians. The Australian Institute of Health and Welfare anticipates that the number of people with dementia will grow to nearly 900,000 by 2050.⁴³⁶ People with dementia require specific consideration around access for a number of reasons. Dementia may inhibit understanding of the aged care system and how to access it. For some people, the symptoms of dementia may restrict the range of providers willing to accept

⁴³³ Senate Community Affairs Committee, 2012, *Former forced adoption policies and practices*, p. 8.

⁴³⁴ Advocare submission, p. 5.

⁴³⁵ National LGBTI Health Alliance submission, p. 5.

⁴³⁶ Australian Institute of Health and Welfare, 2012, *Dementia in Australia*, p. ix.

them into care. Dementia care can be more expensive to provide than general aged care, which can affect service supply.

- 9.127 As part of the LLLB reforms, the government committed \$268.4 million over five years from 2012–13 to implement reforms to address dementia across the health system. These included:
- expansion of the Dementia Behaviour Management Advisory Service (DBMAS) into acute and primary care
 - additional funding for providers caring for people with severe behavioural and psychological symptoms of dementia (BPSD) in residential aged care
 - a new supplement for people living with dementia receiving home care
 - expansion of the National Dementia Support Program to improve access to better coordinated care services for people with younger onset dementia
 - support for primary health care providers to undertake more timely dementia diagnosis through additional training and education programs for GPs and practice nurses
 - improving acute care services for people living with dementia.
- 9.128 The expansion of the DBMAS was intended to ensure that professional and family carers had 24-hour access to support from multidisciplinary teams of behaviour consultants, no matter which care setting they are in.
- 9.129 A Dementia and Severe Behaviours Supplement in residential aged care was introduced on 1 August 2013 as further support for people with severe BPSD.
- 9.130 Based on research evidence and consultation with dementia experts, it was expected that 2,000 people per year would attract the supplement and it was projected to cost \$11.7 million in its first year.⁴³⁷ However, when it ceased in 2014, 33,000 residents were attracting the supplement, and government expenditure for 2013–14 was \$135 million.⁴³⁸
- 9.131 The government decided to cease the Dementia and Severe Behaviours Supplement on 31 July 2014.⁴³⁹
- 9.132 Some stakeholders criticised the government for having underestimated the number of people who would be eligible for the supplement and for being silent on what would replace it. Other stakeholders acknowledged that termination of the supplement was inevitable. The department advised that some providers may have had as many as 60 per cent of their resident group on the supplement.
- 9.133 In late 2015, in response to stakeholder suggestions, the government established Severe Behaviour Response Teams (SBRTs). Funding of \$52 million that had been previously been allocated for the Dementia and Severe Behaviours Supplement was redirected to this program.
- 9.134 SBRTs operate closely with the DBMAS as a second, more intensive tier of behaviour management support. A survey of SBRT clients conducted by the SBRT provider reported a 91 per cent staff and carer satisfaction rate in its first year of operation, and 85 per cent agreed that the SBRT strategies assisted in managing the behavioural symptoms.
- 9.135 Following a 2015 analysis of dementia programs,⁴⁴⁰ in October 2016, the eight separate state- and territory-based DBMAS providers were replaced with a single national DBMAS. Similarly, the 10 separate dementia training organisations funded by the government were replaced with a single national provider from October 2016.

⁴³⁷ Senator the Hon Mitch Fifield, 26 June 2014, media release, 'Cessation of the Dementia and Severe Behaviours Supplement', <http://www.formerministers.dss.gov.au/15592/cessation-of-the-dementia-and-severe-behaviours-supplement/>

⁴³⁸ Senator the Hon Mitch Fifield, 4 February 2015, media release, 'More support for people with severe symptoms of dementia in aged care', <http://www.mitchfifield.com/Media/MediaReleases/tabid/70/articleType/ArticleView/articleId/864/MEDIA-RELEASE--More-support-for-people-with-severe-symptoms-of-dementia-in-aged-care.aspx>

⁴³⁹ Senator the Hon Mitch Fifield, 26 June 2014, media release, 'Cessation of the Dementia and Severe Behaviours Supplement', <http://www.formerministers.dss.gov.au/15592/cessation-of-the-dementia-and-severe-behaviours-supplement/>

⁴⁴⁰ Department of Health, Analysis of Dementia Programmes funded by the Department of Social Services - Final report, <https://agedcare.health.gov.au/older-people-their-families-and-carers/dementia/analysis-of-dementia-programmes-funded-by-the-department-of-social-services-final-report>

- 9.136 The Dementia and Cognition Supplement in home care, which was introduced on 1 August 2013, provides an additional 10 per cent on top of base funding for the home care package. Table 9.8 shows the numbers of recipients in home care that are receiving the supplement.

Table 9.8 Number of dementia supplement recipients in home care, 2013–14 to 2015–16⁴⁴¹

	2013–14	2014–15	2015–16
Australia-wide	9,756	10,239	11,147

- 9.137 The department advised that in 2016 they reviewed communication materials on the supplement and identified that there was a gap in information available to the sector that may have been contributing to barriers to access. The department has since enhanced communication materials, including making the tools more accessible to download and clarifying the requirements of the Department of Human Services claiming process. I would encourage providers to take note of this information and, if appropriate, apply to receive this supplement.
- 9.138 There are no data available on the number of people with dementia who find it difficult to access aged care because of the behavioural symptoms associated with their dementia. Alzheimer's Australia has raised with me that this is an ongoing issue for people with dementia.
- 9.139 The Aged Care Sector Committee's *Aged care roadmap* proposes that dementia be treated as 'core business'⁴⁴² as an important step toward ensuring equitable access. However, this will only provide part of the solution for people with dementia. Alzheimer's Australia stated:

*...although dementia is a core part of aged care, it is not enough to rely on the provision of mainstream services to adequately provide for the needs of people with dementia.*⁴⁴³

- 9.140 Alzheimer's Australia indicated that one of the elements of ensuring access to appropriate care is more access to home care, and respite care to complement it:

*...the delivery of services at a consumer's home or through the community should be increased in order to reduce the rate of admission to permanent residential care. Alzheimer's Australia understands that carer burden is cited as the reason for most admissions into permanent care. If there are more supports available for carers within the community, there may be potential to delay admission to costly permanent care.*⁴⁴⁴

- 9.141 Recommendations I have made in chapter 4 on demand and supply, relating to the availability of home care packages and respite care, should help to address this issue.
- 9.142 Once people enter the system, appropriate and sensitive care is required to ensure they remain in the system. This highlights the importance of ensuring staff are adequately resourced and trained in dealing with dementia. This issue is addressed in chapter 10 on workforce.

National Framework for Action on Dementia

- 9.143 Underpinning government activity in this field is the National Framework for Action on Dementia (the Framework), which includes priorities across primary, acute and aged care.
- 9.144 The timeliness of dementia diagnosis is an important step in providing access to appropriate services. The Framework will see the primary health care workforce receive ongoing dementia training.
- 9.145 The Review found no significant evidence that access to aged care for older people with dementia has been impacted adversely as a result of the LLLB reforms. There is scope for improvement, some of which is being addressed through the new Framework, while greater access to home and respite care will also help ensure that access to aged care for people with dementia care is maintained.

⁴⁴¹ Department of Health, unpublished data.

⁴⁴² Aged Care Sector Committee, *Aged care roadmap*.

⁴⁴³ Alzheimer's Australia submission, p. 2.

⁴⁴⁴ Alzheimer's Australia submission, p. 18.

PEOPLE WITH A DISABILITY

- 9.146 Many older Australians have a disability. Those whose disability was acquired before they were aged 65 and who meet the eligibility requirements will receive support through the NDIS. In addition, there is a transition arrangement, the Commonwealth Continuity of Support Programme, for older people who were receiving specialist disability services managed by states and territories but are not eligible for the NDIS (because they were over the age of 65 when the NDIS rolled out in their area).
- 9.147 There are two other groups of people with disability for whom the aged care system must provide. The first is people whose disability is not severe enough to trigger eligibility for the NDIS and are now over the age of 65. The second is people who acquire a disability when over the age of 65.
- 9.148 In both cases, it is intended that the aged care system will provide the services they require. This could be through the CHSP, home care packages or in residential care.

However, these services are not intended to support people with a disability on the same basis as the NDIS; the aims of the two systems are different.

- 9.149 One of the key issues for some groups of older people with a disability is timely and affordable access to aids and equipment, which may mean the difference between remaining independent or requiring ongoing aged care services. This issue affects a range of disabilities, such as vision impairment and people with motor neurone disease:

*The need for rapid access to...a range of aids and equipment to maintain independence and quality of life are poorly understood...*⁴⁴⁵

- 9.150 The government's position is that people should continue to access aids and equipment through their state or territory government:

*The CHSP is not designed to replace the existing state managed schemes which provide medical aids and equipment (e.g. Medical Aids Subsidy Scheme). CHSP service providers are encouraged to access these state and territory aids and equipment programs where appropriate.*⁴⁴⁶

- 9.151 There are a number of issues in this area. First, the state and territory schemes do not provide access to all consumers. Service is limited through prioritisation systems, eligibility restrictions, and budget limitations. People in higher level home care packages or residential care homes are sometimes ineligible.⁴⁴⁷ In South Australia recipients of any package are excluded; it is not clear whether elsewhere, in practice, people in lower level packages have effective access.⁴⁴⁸

- 9.152 Second, while CHSP is able to provide some aids and equipment, the value is generally limited to \$500, far less than needed for aids in some cases.⁴⁴⁹

- 9.153 Third, the delineation of responsibilities between different schemes appears to be leading to reduced access for consumers with disabilities. The Alliance reported:

The different roles and responsibility for medical, ageing and disability related aids and equipment continues to confuse consumers, whose eligibility, access and out-of-pocket costs will differ depending on where they live, their age and which service system they are able to access.

The potential for people to be referred from service system to service system is also great, given the determination of Commonwealth and State and Territory programs to avoid taking on each other's responsibilities. In an environment of

⁴⁴⁵ Motor Neurone Disease Australia Inc. submission, p. 5.

⁴⁴⁶ CHSP Manual 2017.

⁴⁴⁷ See for example *Medical Aids Subsidy Scheme (MASS)—general guidelines*, June 2016 (Queensland); Department of Human Services (Victoria), 2010, *Victorian Aids and Equipment Program guidelines*; EnableNSW, 2011, *Assistive technology for communication, mobility, respiratory function and self-care*, p. 4. The NSW guidelines indicate that they were reviewed in 2016, but replacement guidelines have not been released.

⁴⁴⁸ National Aged Care Alliance, 2016, *Improving the interface between the aged care and disability sectors*.

⁴⁴⁹ The CHSP Manual 2017 states: "In general it is expected that clients who are unable to purchase the item/s independently will be able to access up to \$500 in total support per financial year under this service type. Where a provider assesses it to be necessary, however, the provider has the discretion to increase the cap to \$1,000 per client per financial year".

*on-going reform across the ageing and disability sectors there is an increasing risk that people who acquire a disability over the age of 65 years will fail to access aids, equipment and assistive technology. Waiting lists associated with assessments by occupational therapists for aids and equipment are also of a concern to Alliance members.*⁴⁵⁰

9.154 Organisations representing people with disabilities have been raising these issues for many years,⁴⁵¹ yet it is not clear whether either broad reforms or individual programs have resolved them. If the aged care system is to have a reablement focus, it is important that people who need a specific aid and/or equipment can receive it, as it is likely to support independence and mean they would not need ongoing care and services.

9.155 It appears that this is an area in which reform remains necessary, and which will need close monitoring as the NDIS is rolled out and the disability services environment evolves as a result. Supporting longer independent living by older people with a disability is clearly the preferred outcome. The Alliance suggested:

*The Alliance recognises a nationally consistent scheme may take some time to implement. As an interim solution for the urgent needs of older people with disability who are ineligible for the NDIS, the Commonwealth Government should specifically fund aids and equipment for this group.*⁴⁵²

Recommendation 34

That the Australian, state and territory governments work together to resolve current issues with the provision of aids and equipment for older people.

PEOPLE WITH A MENTAL ILLNESS

9.156 Some stakeholders suggested that there should be more explicit recognition of mental illness in aged care policy. People with mental illness were one of several groups that UnitingCare Australia, for example, considered need “strategies and targeted investment measures to improve access for, and services provided”.⁴⁵³

9.157 According to the New South Wales Mental Health Commission, there are issues around the alignment of mental health and aged care services:

*There is a paradoxical divide between mental health care and aged care which makes each the other's lowest priority. Services that should be seamless across settings are commonly perceived to be someone else's problem. Priorities don't align, opportunities for co-ordination are lost and bad care often follows.*⁴⁵⁴

9.158 One of the suggestions was that the special needs groups be extended to include mental illness, and that these special needs categories could influence prioritisation in queues for accessing services (such as this national queue currently operating in home care).⁴⁵⁵

9.159 Mental illness does not afford an older person specialised consideration like other conditions such as dementia. Like the management of any other chronic health condition, providers have a responsibility to ensure that a person with mental illness can access specialised services and treatment. This could include transport to appointments, medication management and assistance with supplementary activities such as diversional therapy or behaviour training.

9.160 ACFI recognises mental illness as a factor influencing the costs of residential care. If a consumer has a diagnosed mental illness that is affecting their behavioural care needs, their provider can receive a higher level of funding. However,

⁴⁵⁰ National Aged Care Alliance, 2016, *Improving the interface between the aged care and disability sectors*, p. 28.

⁴⁵¹ See for example Senate Community Affairs Committee, *Report on Aged Care (Living Longer Living Better) Bill 2013 [Provisions] and related bills*, Chapter 6.

⁴⁵² National Aged Care Alliance, 2016, *Improving the interface between the aged care and disability sectors*, p. 29.

⁴⁵³ UnitingCare submission, p. 16.

⁴⁵⁴ New South Wales Mental Health Commission, *Mental health and older people*, <https://nswmentalhealthcommission.com.au/mental-health-and/older-people>

⁴⁵⁵ Brotherhood of St Lawrence submission, p. 13.

this is not for clinical mental health treatment but support and supervision to reduce the incidence of complicated behaviours.

- 9.161 Like other people with a mental health condition, older people who are receiving home care can access mental health services under the government's Better Access initiative.⁴⁵⁶ Medicare rebates are available for up to 10 individual and 10 group allied mental health services each year following assessment of a mental health condition. This is not available in residential care. The department has advised me that it is currently exploring the issues associated with accessibility to psychological therapy services for consumers in residential care, for future consideration by government.
- 9.162 I examined the ACFI data that provide some limited information about mental illness in residential care overall. The data suggest that the prevalence of mental illness in residential care is relatively high. This may relate to the experiences of sadness, grief or depression that can come with functional decline, change of life circumstances and the approach of end of life. The move into residential care is often associated with the loss of a life partner, and/or leaving the long-term family home, and/or a loss of quality of life or freedom that is distressing. The high prevalence of mental illness may also be related to increasing frailty, or the ACFI data may overestimate the true prevalence due to issues with the robustness of assessment under the ACFI, which is currently under review.
- 9.163 Understanding the causes of the apparently high prevalence of mental illness in residential care is beyond the scope of this Review. Certainly, one reason may be that mental illness combined with frailty means people need the care that residential services can offer. The data on mental illness in residential care suggest that mental health care must be regarded as a core part of aged care, but sufficient access to appropriate services is also necessary.
- 9.164 While there is no evidence available to assess the effect of the LLLB reforms on people in aged care with a mental illness, the data does not suggest that people experiencing mental illness are experiencing difficulty accessing residential aged care.

WHOLE-OF-AGED-CARE APPROACHES TO ENSURING EQUITY OF ACCESS

- 9.165 It is important that the aged care system be designed to ensure that population groups with special needs are able to obtain care. There are cases where this is best achieved through a policy or program that is targeted to that one group. In other cases, it is about ensuring services and staff have appropriate information and training.
- 9.166 Targeted measures should be complemented by whole-of-system strategies designed to ensure that the diversity of consumers receive appropriate care.

An Aged Care Diversity Framework

- 9.167 Prior to 2017 there have been two strategies designed to support whole-of-system care for particular populations: the National Ageing and Aged Care Strategy for People from CALD Backgrounds; and the National LGBTI Ageing and Aged Care Strategy. Both were introduced in December 2012 to inform the way government responds to the needs of older people and carers from these two groups. Both strategies were developed in partnership with advocacy and support groups, and aimed to support the aged care sector to develop care that is sensitive and appropriate.
- 9.168 The two strategies are currently being reviewed. This process has included an online survey, a request for submissions from stakeholders, focus groups and feedback from the department's CALD and LGBTI stakeholder working groups.
- 9.169 The Aged Care Sector Committee is currently developing the Aged Care Diversity Framework (the Diversity Framework), expected to be completed later this year. The Diversity Framework will bring together diversity issues raised under other strategies, including the CALD and LGBTI strategies.
- 9.170 The Diversity Framework is intended to comprise a set of overarching shared principles with action plans to drive change across the sector to improve outcomes for older people from diverse backgrounds. Providers and peak organisations will be encouraged to use it to inform their own policies and procedures in the design and delivery of aged care services. The Diversity Framework will include principles:
- to underpin a system that is responsive to older persons' diverse needs to ensure equity and access
 - that ensure diversity is considered in current implementation and future reforms
 - that consider the intersections between services, the aged care system and other broader service considerations.

⁴⁵⁶ The Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule Initiative.

- 9.171 Under the Diversity Framework, three initial action plans will be developed for:
- Aboriginal and Torres Strait Islander peoples and communities
 - people from CALD communities
 - LGBTI elders.
- 9.172 The Diversity Framework is envisaged to be a living document and action plans may be adjusted as the need arises over time. It is expected to be completed by December 2017 and action plans by May 2018.
- 9.173 I expect the Diversity Framework will have increasing importance in the future, as a way of ensuring equitable access to aged care and also appropriate provision of aged care for people from diverse backgrounds.

Using information to improve service access in a diverse community

- 9.174 In this chapter, I have pointed to the lack of data for a number of groups for assessing whether, and to what extent, their backgrounds or circumstances prevent them from being able or willing to access aged care. In many cases, it has therefore been difficult to assess to what extent the LLLB reforms have impacted access to aged care.
- 9.175 Gathering the right information will have two purposes. The first is to facilitate access to appropriate care. Some people may feel greater confidence that their needs will be addressed if they are able to submit information on their needs early in the process and, similarly, if they are able to search for providers who identify as being able to address those needs.
- 9.176 Review consultations indicated that, if consumers are given an opportunity at the point of assessment to indicate that they belong to a population with particular needs, assessors could better connect the older person to an appropriate service provider.
- 9.177 The second purpose of improved data collection is to support effective decision-making and resource allocation. The National LGBTI Health Alliance indicated:

*Identification of Special Needs Groups must be collected at the point of registration for all groups. Currently this only occurs for Aboriginal and Torres Strait Islander elders and CALD elders. This should be expanded to include identification of LGBTI elders.*⁴⁵⁷

- 9.178 The Diversity Sub-group of the Aged Care Sector Committee explained this further in correspondence to the Review:

*Without the inclusion of data in reporting mechanisms it will be challenging to determine the effectiveness of aged care reforms for these groups. Further, without data collection allocation of future resources and initiatives addressing the needs and experiences of these groups will be hindered. If we are to have an accurate reflection of diversity groups experiences in aged care, both access and outcomes, then we need to have the data to do this.*⁴⁵⁸

- 9.179 Implementation of the following recommendations would allow consumers and assessors to search for services matching their needs, while also allowing for better data collection on different population groups accessing the aged care system. They will also form the foundation for government to develop an understanding of who

is accessing care and, by comparing this data with what is known about the general population, determine whether there are barriers to care that are impeding access. Information that consumers offer about their special needs should also be linked with data about when they enter the system, what services they access and where. Government should then use this information to shape policy and supports targeted to ensure equity in aged care for diverse populations.

Recommendation 35

That the government give consumers the opportunity to identify as belonging to a population group with special needs as part of their client record.

- 9.180 This recommendation would be implemented by assessors advising clients about special needs groups and providing opportunities for clients to identify as a person from one of these groups. The decision to provide this

⁴⁵⁷ National LGBTI Health Alliance submission, p. 7.

⁴⁵⁸ Aged Care Sector Committee Diversity sub-group correspondence, May 2017.

information would be voluntary but would allow the assessor to better assist clients and provide information about the care available to them. Clients should have an opportunity to decide to whom this information is disclosed.

- 9.181 For assessors to know which providers would be most appropriate for a person who has identified as having special needs, providers need to be able to nominate as specialising in appropriate care for particular groups. This information should be visible and, importantly, searchable on My Aged Care, to allow assessors and consumers to conduct their own searches.

Recommendation 36

That the government enhance the capacity of My Aged Care to provide information that meets consumers' special needs by:

- a) allowing 'pre-qualified' providers to indicate that they have expertise in delivering services to particular population groups
- b) adding a search function on My Aged Care to allow consumers to search providers by population group.

- 9.182 This recommendation proposes that there be threshold requirements that providers must meet before indicating on My Aged Care that they provide care to a specific special needs group. It is not sufficient to leave it to providers to self-identify, with no guidance or criteria, whether they have expertise in delivering services to particular population groups. The recommendation refers to this as 'pre-qualification'. It is recognised that the nature of pre-qualification may vary depending on the specific group and would need further consultation.

CONCLUSION

- 9.183 While this chapter provides some information about how effective the LLLB reforms were in providing and maintaining access to aged care to the varied population groups that need it, it has been difficult to quantify the extent to which people have equitable access to care services. Data do not exist for all population groups examined, and, as one stakeholder highlighted:

*There is no true evidence to indicate that current arrangements for protecting equity of access for different population groups are effective.*⁴⁵⁹

- 9.184 For these reasons, and as set out earlier in this chapter, it is important that the government gather better data on population groups, and also analyse and act on it.
- 9.185 In most cases where information was available, it appears that access has been maintained. There are, of course, ways access can be improved, outlined in recommendations in this chapter and throughout this report.

⁴⁵⁹ Leading Age Services Australia submission, p. 23.

CHAPTER 10

THE AGED CARE WORKFORCE

INTRODUCTION

- 10.1 This chapter responds to matter (g) in the Review terms of reference: the effectiveness of workforce strategies in aged care services, including strategies for the education, recruitment, retention and funding of aged care workers, and looks at opportunities to address these challenges into the future.
- 10.2 There is a keen interest in workforce matters from many parties: consumers, providers, workers, unions, peak employer and consumer organisations, as well as health professionals, universities and other education providers and researchers. Of the 145 Review’s submissions, 112 mentioned workforce issues.⁴⁶⁰ The topic of workforce featured consistently in the workshops with consumers, workers and providers.
- 10.3 On 15 December 2015, the Senate referred the matter of the future of Australia’s aged care sector workforce to a Senate Community Affairs References Committee for inquiry.⁴⁶¹ The terms of reference for the Senate workforce inquiry were broad,⁴⁶² and considered in greater depth many of the themes and issues covered in this Review. The final report was tabled on 20 June 2017 and is publicly available.
- 10.4 As the Senate Committee examined a broad range of workforce issues in great depth, this Review is focused more specifically on the Living Longer, Living Better (LLLb) reforms and the aged care workforce, key workforce issues raised during consultation, and on the development of an aged care workforce strategy.

A PICTURE OF THE WORKFORCE

- 10.5 The aged care sector workforce is employed by a diverse range of providers and services—large multi-jurisdictional businesses, specialist providers, stand-alone services, not-for-profit and mission-based providers and a significant number of organisations that are small businesses. Provider capacity and financial performance is variable.⁴⁶³
- 10.6 The aged care workforce is significantly different from the Australian workforce as a whole. It is overwhelmingly female (87 per cent for residential care and 89 per cent for home care), while the national workforce has a slight majority of male workers.

Most aged care workers work on a permanent part-time basis (78 per cent in residential care and 75 per cent in home care), whereas most workers in the general workforce are full-time employees. The aged care workforce also has lower wages than other sectors.⁴⁶⁴

⁴⁶⁰ 34 per cent from aged care providers, 22 per cent from individuals, and the remaining 44 per cent from a mix of advocacy groups, health and other professional associations, unions and government organisations.

⁴⁶¹ Referred to as the Senate workforce inquiry for the remainder of this chapter.

⁴⁶² For the full terms of reference see:
http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/AgedCareWorkforce45/Terms_of_Reference

⁴⁶³ Stewart Brown, June 2016, *Aged care financial performance survey – home care report* and Stewart Brown, June 2016, *Residential care report*, <http://www.stewartbrown.com.au/news/june-2016-aged-care-financial-performance-survey-reports-released>

⁴⁶⁴ NACWCS, 2016, *The aged care workforce 2016*, pp. xvi–xvii.

- 10.7 The 2016 National Aged Care Workforce Census and Survey (NACWCS) reported that the aged care sector employs around 366,000 workers,⁴⁶⁵ making up approximately 3 per cent of Australia's total workforce;⁴⁶⁶ 236,000 are employed in residential care homes, and 130,000 are employed in home care and home support services.⁴⁶⁷
- 10.8 Approximately two-thirds of the workforce works in direct care roles, meaning they provide care directly to care recipients as a core component of their work.⁴⁶⁸
- 10.9 The largest portion of the residential care workforce is personal care attendants, while community care workers represent around four out of every five direct care employees in home support and home care. These two groups are referred to here as personal care workers.
- 10.10 Informal carers and personal care workers provide most care services, together representing nearly 90 per cent of people providing care for the aged.⁴⁶⁹ The remaining workforce comprises allied health workers, nursing staff (enrolled, registered and practitioner) and managers.
- 10.11 Much of the following data is reported from the NACWCS, which contains information about the size and composition of the workforce, including training and education, characteristics of aged care workers and the organisations in which they work, experiences of working in the sector, and factors impacting staff recruitment and retention.

Box 10.1 2016 statistical snapshot of the direct care workforce

Residential aged care workforce

70 per cent are personal care attendants⁴⁷⁰

87 per cent are female

The workforce is getting younger, with a median age of 46 years

32 per cent were born overseas

78 per cent are employed on a permanent part-time basis

10 per cent are casual or contract employees (down from 19 per cent in 2012)⁴⁷¹

Home care and home support workforces

84 per cent are community care workers⁴⁷²

89 per cent are female

The workforce is getting older, with a median age of 52 years

23 per cent were born overseas

75 per cent are employed on a permanent part-time basis

14 per cent are casual or contract employees (down from 27 per cent in 2012)⁴⁷³

⁴⁶⁵ This is a point-in-time figure from the NACWCS, 2016, *The aged care workforce 2016*, p. xv.

⁴⁶⁶ Based on Australian Bureau of Statistics total workforce figure of 12,059,000, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/6202.0>

⁴⁶⁷ This is a point-in-time figure from the NACWCS, 2016, *The aged care workforce 2016*, p. xv.

⁴⁶⁸ NACWCS, 2016, *The aged care workforce 2016*, pp. xiv–xvi.

⁴⁶⁹ Comprising approximately 420,000 carers, 108,000 personal care attendants and 72,000 community care workers. Calculated using Australian Bureau of Statistics, Disability, Ageing and Carers, Australia: Summary of Findings, cat. no. 4430.0, 2015, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>; NACWCS, 2016, *The aged care workforce 2016*, tables 3.2, 5.2.

⁴⁷⁰ Note for the rest of the chapter, where there is reference to personal care attendants and community care workers combined, they are referred to as personal care workers.

⁴⁷¹ NACWCS, 2016, *The aged care workforce 2016*, p. xvi.

⁴⁷² Note for the rest of the chapter, where there is reference to personal care attendants and community care workers combined, they are referred to as personal care workers.

⁴⁷³ NACWCS, 2016, *The aged care workforce 2016*, pp. xvi–xvii.

- 10.12** Personal care workers are by far the largest occupational group of all direct care workers. In residential care, they make up 70 per cent of the direct care workforce, and in home care and home support, they make up 84 per cent. Although personal care workers are the dominant workforce, with the percentage increasing in both systems, the trend in absolute numbers is complex.
- 10.13** In 2016, across residential care, home care and home support, registered nurses (RNs) comprise approximately 13.5 per cent of the workforce, while enrolled nurses (ENs) comprise 7.2 per cent. The NACWCS indicates that overall the number of full-time equivalent nurses as a proportion of the workforce is declining slightly (Table 10.1).

Table 10.1 RNs and ENs as a proportion of the direct care workforce, 2012 and 2016⁴⁷⁴

	2012	2016
Residential care RNs full-time equivalent	13,939	14,564
Home care RNs full-time equivalent	6,544	4,651
Total RNs	20,483	19,215
Proportion RNs	13.7%	13.5%
Residential care ENs full-time equivalent	10,999	9,126
Home care ENs full-time equivalent	2,345	1,143
Total ENs	13,344	10,269
Proportion ENs	8.9%	7.2%

- 10.14** Allied health professionals and allied health assistants comprise just over 1 per cent and nearly 3 per cent respectively of all residential direct care workers.⁴⁷⁵ For home care and home support, allied health professionals and allied health assistants comprise 6.3 per cent and 1.7 per cent, respectively, of direct care workers.⁴⁷⁶ Allied health services include physiotherapy, speech pathology, occupational therapy, dietetics, podiatry, and music therapy.
- 10.15** In terms of the workforce's qualifications and training, in 2016:⁴⁷⁷
- The direct care workforce as a whole included a high number of people with post-school education and training.
 - 80 per cent of direct care workers in residential care had engaged in work-related training in the previous 12 months and 58 per cent undertook continuing and professional development.
 - 75 per cent of direct care workers in home care and home support had engaged in work-related training in the previous 12 months and 48 per cent undertook continuing and professional development.
 - These levels of work-related training were lower than in 2012.
- 10.16** In relation to retention and job satisfaction:⁴⁷⁸
- The direct care workforce is relatively stable overall, with only a small minority indicating an intention to leave the sector within 12 months.
 - Job satisfaction is high across all work aspects, except for pay.
 - Community care workers in home care report greater job satisfaction in terms of time available to care for clients, having freedom in their work, and less stress and pressure than their residential care counterparts.
 - On average, the existing workforce would like to work more hours than currently, but a minority want fewer hours.

⁴⁷⁴ Calculated based on NACWCS, 2016, *The aged care workforce 2016*, tables 3.3, 5.3.

⁴⁷⁵ NACWCS, 2016, *The aged care workforce 2016*, p. 13.

⁴⁷⁶ NACWCS, 2016, *The aged care workforce 2016*, p. 70.

⁴⁷⁷ NACWCS, 2016, *The aged care workforce 2016*, pp. 21–23 and pp. 79–83.

⁴⁷⁸ NACWCS, 2016, *The aged care workforce 2016*, pp. 36–38 and pp. 96–97.

- Workers reported that the most stressful aspect of their jobs was unanticipated changes in work patterns, including working longer than scheduled and variations being made to hours or location of work at short notice.

- 10.17 Since 2012 there has been a considerable shift away from casual or contract employment arrangements towards permanent employment in both residential and home care.
- 10.18 The NACWCS reports a drop in the total number of workers in home care and home support, from approximately 150,000 in 2012 to approximately 130,000 in 2016.⁴⁷⁹ This decline appears even stronger when measured in terms of full-time equivalent (FTE) staff, with “a 19 per cent fall in the home care and home support FTE carer workforce” (by 10,450 workers, from 54,537 in 2012 to 44,087 in 2016).⁴⁸⁰ This reported decline does not appear consistent with the growth in the number of home care packages and in the Commonwealth Home Support Programme over the period, nor was it reported as the experience of providers or consumers during consultations.
- 10.19 Aged care is a part of the healthcare and social assistance sector, predicted to be the strongest growing industry in the Australian workforce over the next four years.⁴⁸¹ Three of the expected top five growth occupations relate to the aged care workforce: RNs, aged and disabled carers⁴⁸² and nursing support, and personal care workers.
- 10.20 The Productivity Commission (the Commission), in its 2011 report, estimated that by 2050, the aged care workforce will need to have grown to around 980,000 workers.⁴⁸³ The increased number is necessary partly because of the ageing of the population and the consequent growth in the number of people needing care, and partly because of an expected decline in ‘informal’ carers. Between 2012 and 2016, the workforce grew by around 4 per cent. To meet the Commission’s estimate, the workforce will need to grow at around three times its current growth rate.

The ‘informal workforce’: carers

- 10.21 Many submissions to the Review, including many by individual carers and consumers, referred to the contribution made by ‘informal’ carers. Of the estimated 2.7 million carers in Australia, 420,700 primary carers are caring for people aged 65 years and over.⁴⁸⁴ This is more than the entire formal aged care workforce.
- 10.22 The Commission and the *Aged care roadmap* refer to these carers as ‘the informal workforce’. Informal carers are instrumental in:
- supporting people to make choices and to access the right services
 - navigating both the health and aged care systems
 - providing essential direct care assistance and easing the demand for government-subsidised services
 - informed and productive relationships with providers and their workforces
 - consumers’ experiences of aged care.
- 10.23 In recognising the essential role that informal carers perform in aged care and the economic value of carers, the Commission recommended that government provide greater assistance for carers. This recommendation was reflected in the LLLB reforms, discussed later in this chapter. While I have not made a recommendation on informal care in this chapter, a number of other recommendations in this report would increase the level of support for this valuable part of the overall system of care for elderly Australians.

⁴⁷⁹ NACWCS, 2016, *The aged care workforce 2016*, p. 69.

⁴⁸⁰ NACWCS, 2016, *The aged care workforce 2016*, p. 70.

⁴⁸¹ The Department of Employment produces employment projections by industry, occupation and region for five-year blocks, the latest being the five years to November 2020. These use detailed data from the Australian Bureau of Statistics (ABS) Labour Force Survey. From: Department of Employment and ABS, Labour Force Australia, Detailed, Quarterly, cat. no. 6291.0.55.003. National employment data trend, August 2016. See: <http://lmip.gov.au/default.aspx?LMIP/GainInsights/EmploymentProjections>

⁴⁸² As identified in: ABS, Australian and New Zealand standard classification of occupations, 2013, <http://www.abs.gov.au/AUSSTATS/abs@.nsf/DetailsPage/1220.02013,%20Version%201.2?OpenDocument>

⁴⁸³ Productivity Commission, 2011, *Caring for older Australians*, vol. 2, p. 367.

⁴⁸⁴ Australian Bureau of Statistics, Disability, Ageing and Carers, Australia: Summary of Findings, cat/no. 4430.0, 2015, <http://www.abs.gov.au/ausstats/abs@.nsf/mf/4430.0>. Primary carers are those who provide the most substantial amount of support.

HISTORY OF WORKFORCE POLICY IN AGED CARE

- 10.24 Workforce considerations have been a continuing feature as the aged care system has changed. Since 2002, successive governments have funded different types of workforce programs, and made significant adjustments as the sector has evolved. A workforce strategy for residential aged care was co-developed by the sector and government and was implemented from 2005 to 2010.
- 10.25 Workforce issues featured in major reform packages, including changes based on the 2004 *Review of pricing arrangements in residential aged care* (the Hogan review); and the 2010 National Health and Hospitals Network reform package.
- 10.26 Further, the Commission's 2011 report made several recommendations about workforce requirements, including:
- consideration of the need to pay fair and competitive wages to nursing and other care staff delivering approved aged care services, and the appropriate mix of skills and staffing levels for the delivery of those services
 - promotion of skills development through the expansion of accredited courses to provide aged care workers at all levels with the skills they need
 - joint funding between government, universities and providers to expand the teaching of aged care services to promote the sector and provide appropriate training for health professionals
 - the need to undertake an independent and comprehensive review of aged care- related vocational education and training (VET) courses and their delivery by registered training organisations.⁴⁸⁵
- 10.27 The government's response to the report acknowledged that "an appropriately skilled and well qualified workforce is fundamental to the delivery of quality aged care"⁴⁸⁶ and addressed some of these in the LLLB reforms.

The Living Longer Living Better reforms

- 10.28 The LLLB reform package included two main workforce initiatives, one targeted at the formal workforce, and one at informal carers.

Workforce compact and supplement

- 10.29 The most significant workforce measure in the LLLB reform package was a Workforce Compact (the Compact). The Compact comprised \$1.2 billion allocated over four years to improve recruitment, retention and overall geographical distribution of aged care workers. As part of the Compact, in March 2012, the government announced the introduction of a Workforce Supplement (the Supplement).
- 10.30 The main objective of the Supplement was to increase wages in the sector, by distributing funding to aged care providers on condition that the funding contributed to wage increases negotiated with their employees. There were also other requirements that related to education and training and career development. The arrangements were complex, but contained three key drivers for increased wages. The first two were that employers had to:
- provide annual increases in base wages of 2.75 per cent per annum...in each financial year that the Workforce Supplement is payable from 2013–14 to 2016–17... and*
- ...further increase base wages by at least 1 per cent per annum each financial year that the Workforce Supplement is payable from 2013–14 to 2015–16, and by at least 0.5 per cent increase in 2016–17...*⁴⁸⁷
- 10.31 The third requirement was that "wages must exceed the relevant Award rates for all staff by at least" a certain percentage in each year. These percentages varied according to the type of employee, ranging from 3 per cent for personal care workers, up to 12.6 per cent for RNs.⁴⁸⁸

⁴⁸⁵ Productivity Commission, 2011, *Caring for older Australians*, vol. 2, p. 347.

⁴⁸⁶ Living Longer Living Better, April 2012, <http://www.flexiliving.org.au/wp-content/uploads/2012/07/D0769-Living-Longer-Living-Better-SCREEN-070512.pdf>

⁴⁸⁷ Department of Health and Ageing, 2013, *Aged care workforce supplement guidelines*, p. 12.

- 10.32 The Supplement was made available from 1 July 2013. However, take up by providers was low. Employers opposed the arrangement for three broad reasons.
- 10.33 First, in order to receive the Supplement, employers had to negotiate industrial agreements that paid wage increases of greater value than the Supplement they would receive. They argued that they would be left 'out of pocket'.⁴⁸⁹
- 10.34 Second, employers did not want their ability to access the Supplement to depend on what kind of employment arrangements they had. They argued that this created inequity between providers. As Catholic Health Australia (CHA) put it at the time:
- CHA had always argued that the funding for the Workforce Compact should be spread evenly across the aged care sector so that all providers, regardless of their size or the nature of the employment contracts they had with their staff, could use the money to improve care outcomes for older people.*⁴⁹⁰
- 10.35 Third, employers more generally objected to government involvement in what they saw as their internal industrial arrangements. CHA commented that "governments should have no role in setting wages for workers".⁴⁹¹
- 10.36 Following the change of government in September 2013, the Supplement ceased and the remaining funding was re-directed, resulting in:
- residential care, home care and flexible care providers receiving an increase in funding of 2.4 per cent of their basic subsidy from 1 July 2014
 - eligible grant programs, such as the Commonwealth Home and Community Care Program,⁴⁹² also receiving a 2.4 per cent increase in their funding
 - the Viability Supplement being increased by 20 per cent to assist aged care services in rural and remote areas with the extra cost of delivering services in those areas
 - a government commitment to undertake a stocktake of workforce initiatives to inform future education and training priorities.
- 10.37 Employers were supportive of these changes. However, the consumer peak body Council on the Ageing (COTA) observed that "giving aged care providers back the \$1.5 billion Aged Care Workforce Supplement over five years will do nothing for development of the aged care workforce."⁴⁹³
- 10.38 Since the Supplement's re-direction, comparative wages remain as issue. For instance, prior to the Supplement, there was a difference of around 10 per cent between nurse wages in the acute sector and in aged care.⁴⁹⁴ That difference remains.

⁴⁸⁸ Department of Health and Ageing, 2013, *Aged care workforce supplement guidelines*, pp. 12–13.

⁴⁸⁹ Employee organisations argued though that this is always the case with wage increases, with or without a supplement, so the argument made by employers was not valid.

⁴⁹⁰ Australian Ageing Agenda, 2014, *Budget: stakeholders react*, 14 May 2014, <http://www.australianageingagenda.com.au/2014/05/14/budget-stakeholders-react/>

⁴⁹¹ Australian Ageing Agenda, 2014, *Budget: stakeholders react*, 14 May 2014, <http://www.australianageingagenda.com.au/2014/05/14/budget-stakeholders-react/>

⁴⁹² Now the Commonwealth Home Support Programme.

⁴⁹³ Australian Ageing Agenda, 2014, *Budget: stakeholders react*, 14 May 2014, <http://www.australianageingagenda.com.au/2014/05/14/budget-stakeholders-react/>

⁴⁹⁴ Evidence around the wage differential is set out in the section on pay in this chapter.

10.39 Since the cessation of the Supplement, government has not directly engaged in pay and conditions in the aged care sector. Pay and conditions, however, remain one of the key issues for the aged care workforce, and is returned to later in the chapter.

'Informal' carers measure

- 10.40 The second part of the LLLB reforms relevant to the workforce focused on informal carers. As part of the reform package, the government committed up to \$54.8 million under the Supporting Carers measure, providing for:
- additional funding for the National Respite for Carers Program of \$2 million per year, distributed to 54 Commonwealth Respite and Carelink Centres to expand the provision of short-term and emergency respite for carers, in 2012–13 and 2013–14
 - consolidating respite initiatives into a single program, finalised from 1 July 2015 when the National Respite for Carers Program was incorporated into the Commonwealth Home Support Programme (CHSP)
 - early steps to establish a regional network of carer support centres, with funding for research and stakeholder consultation to develop a draft model for delivery. This was completed in July 2013.
- 10.41 In addition, in 2012–13 and 2013–14, \$1 million per year in extra funding was provided to Carers Australia to deliver more carer counselling services under the National Carer Counselling Program.

Other significant workforce-related developments

- 10.42 There have been several other policy developments since the LLLB reforms that affect the context for considering aged care workforce policy. From the 2012–13 financial year, the government committed \$2.8 billion over nine years to cover its share of wage increases for workers in the Commonwealth Home and Community Care Programme and the National Respite for Carers Programme (now the CHSP), who were affected by an Equal Remuneration Order issued by Fair Work Australia.⁴⁹⁵
- 10.43 In December 2015, the findings of the stocktake and analysis of government-funded aged care workforce activities were released.⁴⁹⁶
- 10.44 Changes were made during 2015 to the discretionary Aged Care Workforce Fund; funding was reduced, and the aged care and health workforce funding was combined into a single Health Workforce Fund.

KEY WORKFORCE ISSUES

- 10.45 This section focuses on the key issues raised during this Review, namely pay and conditions, education and training, rural and remote workforce issues, quality of care, as impacted by the workforce, and the development of a sector-wide workforce strategy. I give particular attention to this last issue, including the form that such a strategy should take, where responsibility for the strategy lies, and the elements it should encompass.

Pay

- 10.46 Wages and conditions for workers were raised frequently in submissions to the Review and during consultations. Attention was drawn to the continuing wages gap between workers in the aged care sector and those in the acute care sectors. During consultations, one aged care sector worker summarised that the solution to workforce issues is pay and conditions and presented it as one of the key drivers for improving the attractiveness or image of the sector to attract workers.
- 10.47 The NACWCS provides information about pay in the sector. As the two most recent surveys were conducted in 2012 and 2016, they provide an opportunity for comparison before and after the LLLB reforms. In addition, the Australian Bureau of Statistics (ABS) undertakes a twice-yearly survey on average weekly earnings, including a sector breakdown for the

⁴⁹⁵ Now the Fair Work Commission. The order was issued in February 2012. Government supplementation was made available for defined in-scope programs.

⁴⁹⁶ Department of Social Services, 2015, Stocktake of analysis of Commonwealth funded aged care workforce activities.

health care and social assistance sector (which includes aged care and comparator sub-sectors such as acute health and disability care).

10.48 Understanding pay value and trends in pay increases is complex in aged care because part-time work is more common than full-time. This means that relying solely on conventional indexes of full-time earnings may not reflect the circumstances of employees in the sector. One of the advantages of the NACWCS is that it looks at pay for different numbers of hours worked.

10.49 Tables 10.2 and 10.3 show the gross median earnings in 2016 of the major employee categories in residential and home care across all hours.

Table 10.2 Median weekly earnings of the residential direct care workforce, all hours worked, \$ per week⁴⁹⁷

OCCUPATION	ALL HOURS*, \$ PER WEEK
Nurse practitioner	1,000
Registered nurse	1,352
Enrolled nurse	946
Personal care attendant	750
Allied health professional	820
Allied health assistant	750
All occupations	800

*The “all hours” measure is used here, rather than full-time earnings, recognising that most of the aged care workforce does not work full-time.

Table 10.3 Median weekly earnings of the home care and home support direct care workforce, all hours worked, \$ per week⁴⁹⁸

OCCUPATION	ALL HOURS*, \$ PER WEEK
Nurse practitioner	750
Registered nurse	1,200
Enrolled nurse	874
Community care worker	650
Allied health professional	1,153
Allied health assistant	660
All occupations	693

*The “all hours” measure is used here, rather than full-time earnings, recognising that most of the aged care workforce does not work full-time.

10.50 These figures show the range of pay received by workers in aged care, with the lowest weekly earnings being for personal care workers, especially those in the community (Tables 10.2, 10.3). While nurses earn significantly more than other workers, their wages are appreciably lower than their counterparts in the acute sector, which are the major competing employment sector.

10.51 An analysis of two examples—a level 1 RN, and a year 5 EN—demonstrates the differential (Table 10.4).

⁴⁹⁷ NACWCS, 2016, *The aged care workforce 2016*, table 3.20.

⁴⁹⁸ NACWCS, 2016, *The aged care workforce 2016*, table 5.20.

Table 10.4 Comparison of wages, 2016⁴⁹⁹

	ACUTE CARE AVERAGE WEEKLY WAGE \$	AGED CARE AVERAGE WEEKLY WAGE \$	DIFFERENCE, \$	DIFFERENCE, %
Registered nurse, level 1	1,552.83	1,393.18	-159.65	-10.3
Enrolled nurse, year 5	1,120.93	1,017.57	-103.35	-9.2

Notes: Wages are collected from a sample of up to 75 collective agreements that apply to 57 Australian Government-funded approved providers of aged care services. The NSW acute care wage is sourced from an award. The state/territory aged care wages are weighted averages of rates derived from a total of 59 nursing collective agreements. The weighting factor is derived from the ratio of aged care places allocated to each approved provider as a proxy for size of workforce. The national totals are population-weighted averages of the state/territory wages. The national total uses population-weighted averages of the state/territory wages—in the case of aged care, using estimated aged care workforce distribution data derived from *The aged care workforce 2016* (distribution of residential direct care workforce) and for acute care using public sector hospital RN and EN workforce distribution data from Australian Institute for Health and Welfare, *Nursing and Midwifery Labour Force 2012*.

- 10.52 Given this differential, I looked at changes in pay in the aged care sector, to see whether pay rises nevertheless were raising sector remuneration substantively. This was undertaken by calculating average annual growth using the gross earnings reported by workers in the 2012 and 2016 NACWCS, for each occupational group.
- 10.53 The results indicated variable wage outcomes across the sector. I have focused on personal care workers, as they represent around three-quarters of the direct care workforce. In residential care, their reported annualised rate of pay increase—3.5 per cent—matched that of all other occupations in residential services (3.4 per cent overall). In home care, the reported annual pay increases were lower in general (2.9 per cent for home care), but particularly low for the already poorly-paid community care workers (2.0 per cent).⁵⁰⁰
- 10.54 Over the same period covered by the NACWCS, the ABS measure of full-time ordinary time earnings in the broader health care and social assistance sector indicated annual increases of 4.1 per cent.⁵⁰¹ While the data sets are only partially comparable (as the NACWCS data measures neither *only* “full-time”, nor *only* “ordinary time” earnings), they nevertheless suggest that aged care pay is not keeping pace with the broader health sector. Wage increases for aged care workers have been particularly low in the home care sector and, in absolute terms, they are the lowest paid of all sector workers.
- 10.55 The modest wage growth in the aged care sector is consistent with my observation that recent policy on wages in the sector has not narrowed the wages gap between aged care and other sectors.
- 10.56 It is not surprising that when the NACWCS asked employees in the sector in 2016 to rate their job satisfaction, the survey found that:
- ...total pay stands out as being the area with which residential aged care workers are least satisfied (5.6), with PCAs [personal care attendants] (5.4) reporting more dissatisfaction with their pay compared to the other occupations. This was also the case in 2012. Apart from pay, residential direct care workers appear to be reasonably satisfied with all other aspects of their work...*⁵⁰²
- 10.57 The gap between pay and other issues was small for community care workers in home care, but pay still stood out as the point of least satisfaction.

⁴⁹⁹ Analysis published by the Australian Nursing and Midwifery Federation places the pay disparity higher, at 15 per cent: see comparison with public sector pay rates, *Nurses' Paycheck*, March–May 2017, vol. 16, issue 2, p. 36.

⁵⁰⁰ Calculated from NACWCS, 2012, *The aged care workforce 2012*, tables 3:19, 3:21, 5:19, 5:21; *The aged care workforce 2016*, tables 3:18, 3:20, 5:18, 5:20.

⁵⁰¹ ABS 6302.0 - Average weekly earnings, Australia, May 2012–May 2016.

⁵⁰² NACWSC, 2016, *The aged care workforce 2016*, p. 38.

10.58 Changes in the broader social services environment also make adequate remuneration important. There is concern, for example, that competition with the disability sector workforce for a limited carer labour pool may place further pressure on recruitment and retention. For example, Leading Age Services Australia (LASA) noted that:

*It is anticipated that the increasing demand for nursing and allied health professionals in the age services industry will be further exacerbated by increased competition for staff with the staged introduction and upscaling of the National Disability Insurance Scheme.*⁵⁰³

10.59 Provider peak bodies and employers expressed uncertainty as to how additional wage increases would be funded. LASA reported employer comments that “funding cuts negatively impact the amount of wages that can be paid”.⁵⁰⁴ The Aged Care Industry Association wrote:

*Aged care providers’ ability to invest in their workforce is directly related to their revenue levels – in an environment where aged care funding is targeted for cuts, and where funding formulae change at short notice, providers’ scope to fund workforce development programs and to pay competitive wages are severely constrained.*⁵⁰⁵

10.60 Other peak organisations did not comment directly on the wages issue, focusing instead on the need to develop a workforce strategy, but not commenting on how wages would be addressed in that context.

10.61 While I recognise the concerns of providers, the fact that policy change, including additional funding, like the roll in of the Supplement, have not closed pay differences between aged care workers and those in other sectors, indicates that funding is not the only issue. Addressing the problem of comparatively low wages—and hence, low attractiveness of aged care as a job choice or career path—is clearly a complex one, and one that cannot be addressed only through government funding or changes to awards. It will need to be addressed in a workforce strategy, to be led by the sector, discussed in the last section of this chapter.

Education and training

10.62 Education and training are fundamental to providing a workforce able to meet the care needs of older people. A large number of submissions to the Review raised this, and education, in particular, was a focus throughout the workshops. Issues raised included the adequacy of entry-level qualifications, the role of ongoing education and training in maintaining skills and providing career pathways, and the performance of training providers.

10.63 Education and training are significant in funding terms: the 2015 stocktake and analysis of government-funded aged care workforce activities found that “the greatest proportion of Commonwealth funded workforce activity has been directed towards workforce training, education and upskilling.”⁵⁰⁶

Entry-level training and qualifications

10.64 A key concern in relation to entry-level training and qualifications was ensuring that workers have the basic clinical understanding necessary to provide safe care. While diploma-level qualifications in the VET system cover such areas as leisure and health, as well as mental health, alcohol and drugs, there appears to be no diploma-level qualification for ageing and aged care or individual support.⁵⁰⁷

10.65 At a number of workshops, workers and providers identified topics for entry-level training where more effort is needed, including:

⁵⁰³ LASA submission, p. 27.

⁵⁰⁴ LASA submission, p. 29.

⁵⁰⁵ Aged Care Industry Association submission, p. 7.

⁵⁰⁶ Department of Social Services, 2015, *Stocktake and analysis of Commonwealth funded aged care workforce activities*, p. 6.

⁵⁰⁷ In 2017, the University of Newcastle started an Associate Diploma in Integrated Care in Ageing which is described as a bridge between vocational education and university.

- basic care matters such as hydration, speech and swallowing, nutrition, wound management, working with people who experience depression, working with people who experience drug and alcohol addiction, and continence management⁵⁰⁸
- personal skills, such as communication, critical thinking, person-centred care and client relationships and negotiation
- financial and accounting literacy skills
- care coordination competencies and skills
- specialised training on dementia and palliative care.

Ongoing education and career pathways

10.66 The NACWCS showed that less work-related training took place in 2016 than in 2012, raising concerns about skills development in aged care.⁵⁰⁹ Some of the priority areas for future training identified by the NACWCS included dementia, palliative care and mental health.⁵¹⁰

10.67 Based on submissions to the Review and feedback from workshops, areas for action in relation to postentry education and training have been identified as including:

- well-supervised on-the-job training
- support by providers for leadership cadres, particularly first-time leaders
- building geriatric and age care specialisations, specifically for dementia and palliative care.

10.68 While workforce-wide issues were raised, the most prominent concern was with post-entry training related to nursing specialisation and career pathways.⁵¹¹ HammondCare's submission to the Review sums up what is required in considering advanced nursing education and training:

*...nurses should be given the opportunity to develop expertise in areas of practice that are relevant to aged care, including dementia and mental health nursing. Once they have graduated, registered nurses should be able to be recognised as specialised aged care nurses who provide clinical leadership and consultation as part of multidisciplinary teams working within innovative models.*⁵¹²

10.69 Support for ENs to add to their skills and gain additional accreditation to enable them to extend their scope of practice is also an important area for further development.

10.70 While submissions were more likely to raise training and development issues for nurses, the NACWCS indicates that priority may need to be given to the training environment for personal care workers. They are a large and growing proportion of the workforce, but their training lags behind other occupations. Less than half of personal care attendants in residential aged care undertook continuing professional development, and nearly a quarter reported receiving no training in the last 12 months. Compared to 2012, both figures trend in the wrong direction: continuing professional development was down, while the proportion reporting no training was up.⁵¹³ The figures and trends in home care are similar.⁵¹⁴

10.71 On the positive side though, many providers have adopted a range of approaches to improving retention by focusing on opportunities for training and career progressions, including:

- upskilling existing workers

⁵⁰⁸ The 2015–16 annual report of the Aged Care Complaints Commissioner (p. 18) shows the top complaints considered by the Commission in residential aged care related to clinical care, the administration of medication, continence management and the choice and dignity of the person receiving care.

⁵⁰⁹ NACWCS, 2016, *The aged care workforce 2016*, p. xvii.

⁵¹⁰ NACWCS, 2016, *The aged care workforce 2016*, p. xvii.

⁵¹¹ The role of nurses in aged care, their standing in the nursing profession and the need for nursing career paths were referred to in 24 submissions.

⁵¹² HammondCare submission, p. 9.

⁵¹³ NACWCS, 2016, *The aged care workforce 2016*, p. 30.

⁵¹⁴ NACWCS, 2016, *The aged care workforce 2016*, p. 89.

- creating supportive working environments, particularly given that the work is physically and emotionally demanding
- using complaints as a means of assessing areas for improvement
- attending to the equipment needs of employees, including use of technology
- mentoring for first-time leaders
- accessing the government-funded supports available for providers and their workforces for specialised training, such as on dementia or palliative care.

10.72 Initiatives such as these should be encouraged more broadly across the sector, with peak organisations taking on a greater leadership role.

Training providers and methods

10.73 The Review received feedback that delivery of nationally agreed qualifications by registered training organisations (RTOs) is inconsistent. Quality ranges from highly responsive to patchy, and in some cases, there is simply a lack of delivery of what is required. COTA submitted:

*COTA Australia also recognises that the aged care sector has been significantly impacted by the lack of sector-ready graduates due to recent poor quality delivery by some VET training providers. This has caused various providers to deliver greater on the job training to get graduates job ready for the role they have been employed in. We note that in 2015 as part of the revised qualification a 120 hour work experience requirement has been included and believe this will help improve the quality of training across the board.*⁵¹⁵

10.74 Providers made clear in a number of workshops that they are selective in their interactions with RTOs, and will not support poor local performers. Some providers indicated that they have worked closely with RTOs to improve training, and thus the quality of the pool of workers available for recruitment. It is important that providers identify the lead performers and encourage poorly performing RTOs to improve their quality.

10.75 In addition to issues with RTOs, evidence to the Review suggested other methods for improving workforce training. Examples include best-practice use of online methods for evidence-informed self-paced training, such as Massive Open Online courses (known as MOOCs). There is also an opportunity to explore innovative ways of linking providers with education and training systems.⁵¹⁶

How should education and training issues be addressed?

10.76 Views varied on who is responsible for addressing the known education and training issues in the sector. For example, at the Melbourne workshops with workers and providers, some suggested that the government should increase its support through training subsidies and play a more active role in setting minimum training standards. Others considered that in a market-driven environment, providers should facilitate access to training.

10.77 Many submissions also discussed the quality of education and training, again with varying emphasis on who should be responsible for addressing the issues. For example, Anonymous 19 stated:

*Lift the standard of qualification, regulate and control the education process so that better standards are met by working with the Nursing sector.*⁵¹⁷

10.78 According to Shepparton Retirement Villages:

⁵¹⁵ COTA Australia submission, p. 23.

⁵¹⁶ For example, a WA provider, Juniper, created the Juniper Simulation Centre in partnership with Curtin University and using seed funding from the government. The Centre recreates an older person's living spaces, where activities of daily living and care can be enacted and analysed in adjacent training rooms, in real time. Juniper, Innovative Juniper Simulation Centre is best in the State, <http://www.juniper.org.au/news-publications/news/innovative-juniper-simulation-centre-is-best-in-the-state>

⁵¹⁷ Anonymous 19 submission, p. 6.

*Educational institutions, government, and providers all need to do more in this space to attract and retain staff. SRV [Shepparton Retirement Villages] believe that educational institutions and providers need to work together to develop and implement...training/ apprenticeship type programs that are funded either directly or indirectly by government. Without proper funding and the implementation of student wages the industry will always be under-skilled and under-resourced.*⁵¹⁸

- 10.79 Further, some noted that these issues should be addressed in a workforce strategy, including HammondCare and the National Presbyterian Aged Care Network. The latter had concerns about:

*...the variability in quality of aged care training courses from the Vocational Education & Training sector. Improving course quality has to be a feature of any workforce strategy.*⁵¹⁹

- 10.80 There were also indications that there is capacity to use existing education and training mechanisms better. For example, student placements in aged care settings could be used more effectively, including work experience, vocational student workplace placements, undergraduate nurse placements and allied health practicums. Workplace experience and well-managed placements can introduce students to the sector, enable them and prospective employers to test their suitability and aptitude, and support development of their job readiness. In evidence before the Senate workforce inquiry, a number of provider examples showed the value of investing in positive placement experiences to spot talent, assess aptitudes for the work, and influence workers to stay.
- 10.81 Providers can and should take a lead in developing and sharing successful and practical strategies like these. Provider peak organisations also have a leadership role to play in improving education and training in the sector.

Conclusions

- 10.82 Significant growth is needed in the aged care workforce to meet the demands of the ageing population, a greater proportion of whom will continue to live at home and receive care there. The gaps and deficiencies in current education and training regimes have been well identified in this Review and numerous other inquiries and reviews. While individual providers may have differing education and training needs, the sector needs to develop a view on priorities, and be prepared to take steps to address these priorities and assess progress.
- 10.83 This is an area where I believe that the sector itself, rather than government, should take the lead. The sector should consider how to build and extend the skill sets, competencies and knowledge needed in the aged care workforce, including:
- setting out what is needed for post-entry on-the-job training, specialised training and continuing professional development
 - developing options and partnerships to deliver what is required
 - advocating for, and assisting in, the development of ageing and aged care as a specialisation in post-secondary education
 - making more effective use of allied health workers.
- 10.84 Through peak organisations, sector employers need to work collectively to:
- revisit and test the base-level core subjects that should be covered in vocational education and training, including dementia and palliative care, while taking into account differences between residential care, home care and home support
 - establish how best to secure national aged care diploma-level qualifications in the VET system
 - identify and spread good practice in managing student placements.

⁵¹⁸ Shepparton Retirement Villages submission, p. 6.

⁵¹⁹ National Presbyterian Aged Care Network submission, p. 6.

Recommendation 37

That the aged care sector, in collaboration with the vocational education and training, and tertiary education sectors, should act to ensure education and training is responsive to the sector's needs including:

- identifying the scope of training required for on-the-job training, continuing professional development, and specialised training
- exploring a range of options to deliver what is required, e.g. partnerships, cooperative models or arrangements with existing non-aged-care training providers
- promoting and encouraging ageing and aged care as a specialisation in nursing education
- making effective use of allied health workers.

Rural and remote workforce issues

10.85 Providers and stakeholder representative bodies report significant challenges in recruiting and retaining workforce in rural and remote areas. In its submission to the Review, the National Rural Health Alliance stated:

*The Alliance believes that significant work needs to be done to develop the appropriately qualified workforce of the future in rural and remote locations. At present, there are significant difficulties in recruiting and retaining qualified staff...*⁵²⁰

10.86 The Aged Care Financing Authority (ACFA), in examining the financial performance of rural and remote aged care providers, agreed with provider reports that rural and remote providers face high workforce 'churn' and challenges in recruiting and retaining both skilled and unskilled staff.⁵²¹ These can lead to difficulties and delays in filling positions and, in some cases, the need to pay higher wages or offer other additional support. Support might be in relation to accommodation, paying relocation and travel expenses, or agreeing to provide longer and more certain hours to staff.

10.87 ACFA found that geographical isolation can lead to higher costs in engaging and retaining staff, less access to RNs and allied health professionals, and smaller-scale facilities and services due to limited catchment areas. In addition, accommodation contributions from consumers are lower or not available.⁵²²

10.88 The challenges facing rural and remote providers are not unique to the aged care sector; similar challenges are also experienced in other sectors that deliver services in rural, remote and very remote locations, such as health, the National Disability Insurance Scheme (NDIS) and carer support.

10.89 There are no easy solutions to rural and remote workforce issues. In developing the aged care sector workforce strategy, specific attention should be given to the challenges faced in rural and remote areas, particularly in regards to recruitment and retention.

Workforce role in quality of care

10.90 Quality of care issues were not directly included in the terms of reference for this Review. There are also several other processes underway to address quality in aged care. The government has commissioned a separate independent review of the aged care quality regulatory process. On 13 June 2017, the Senate required that the Senate Community Affairs References Committee inquire on the effectiveness of the aged care quality assessment and accreditation framework for protecting residents from abuse and poor practices, and ensuring proper clinical and medical care standards are maintained and practised. In addition, the department is currently working with the sector on developing a Single Aged

⁵²⁰ National Rural Health Alliance submission, p. 8.

⁵²¹ ACFA, 2016, *Financial issues affecting rural and remote aged care providers part 1*, <https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority/issues-affecting-the-financial-performance-of-rural-and-remote-providers-both-residential-and-home-care-providers>

⁵²² ACFA, 2016, *Financial issues affecting rural and remote aged care providers part 1*, <https://agedcare.health.gov.au/aged-care-reform/aged-care-financing-authority/issues-affecting-the-financial-performance-of-rural-and-remote-providers-both-residential-and-home-care-providers>

Care Quality Framework. However, as quality was raised many times throughout the consultation process with a link to workforce capacity, I consider this issue in the context of the workforce.

10.91 Many factors combine to drive the quality of aged care. These include:

- legislated and other regulatory requirements
- the quality framework which includes aged care quality standards, quality assessment and monitoring processes undertaken by the Australian Aged Care Quality Agency
- compliance action by the Department of Health, where providers are not meeting their legislative obligations
- access to complaints mechanisms (such as the Aged Care Complaints Commissioner)
- transparent information for consumers (via My Aged Care and provider information)
- provider governance, leadership and systems
- the day-to-day delivery of care and services and quality of interactions between consumers and workforces.

10.92 Submissions and workshops consistently commented on the connection between quality and staffing levels and skills mix. These concerns were expressed by a variety of stakeholders, but stakeholders differed in their views on how concerns should be addressed. National Seniors Australia, in its submission to the Senate workforce inquiry said:

*National Seniors is concerned that not enough is being done to increase the number of workers being employed in direct care roles within the aged care sector. Over time this will have a dramatic impact on the quality of care for residents and clients.*⁵²³

10.93 National Seniors Australia also observed that nurse-to-resident ratios are an important issue for some of their members. Its submission also noted:

*The ability of nursing staff to respond to residents' needs in a timely fashion is related to registered nurse to resident ratios. The more residents each registered nurse has to care for, the poorer the level of resident safety was and the more frequently medication errors occur. One study of the relationship between patient outcomes, work environment, nursing skills mix and workloads in New South Wales hospitals has found that skills mix is more critical to patient outcomes than total hours of nursing provided. It found that a higher proportion of registered nurses produced decreased rates of negative patient outcomes.*⁵²⁴

10.94 However, National Seniors Australia did not endorse particular approaches to resolving the issue because of the complexity of the situation:

*National Seniors believes that further research is needed to better understand the appropriate skills mix required to maintain acceptable standards of care in the aged care sector. We recognise the challenge for service providers in balancing staff workloads to meet peak demand periods, while maintaining adequate staff in times when demand for assistance is lower as well as ensuring staff are available to respond to emergencies.*⁵²⁵

10.95 COTA did not raise the issue of ratios or round-the-clock presence of nurses in residential care, focusing instead on turnover and training and how they impact on quality of care.

10.96 Alzheimer's Australia, however, did argue for specific policy changes on staff levels, saying:

*Two issues – ratios of staff to residents, and levels of qualified nursing staff – are the two most important workforce issues that impact on quality of care, and they need to be addressed urgently...Mandated minimum ratios of staff to residents, and mandated minimum levels of qualified nursing staff, are required; including a requirement for all stand-alone residential aged care facilities to have a Registered Nurse on site at all times.*⁵²⁶

⁵²³ National Seniors Australia, Senate Inquiry submission pp. 6–7.

⁵²⁴ National Seniors Australia, Senate Inquiry submission pp. 6–7.

⁵²⁵ National Seniors Australia, Senate Inquiry submission pp. 6–7.

⁵²⁶ Alzheimer's Australia submission, pp. 15–16.

- 10.97 The Australian Nursing and Midwifery Federation (ANMF) supported similar changes to those advocated by Alzheimer's Australia:
- That the legislation reflects mandated minimum staffing levels and skills mix requirements for registered nurses, enrolled nurses and assistants in nursing/personal care workers (however titled) in the residential and community aged care sectors.*
- That the legislation mandates the requirement for 24 hour registered nurse cover for all high care residents in aged care facilities, inclusive of those low care facilities with residents assessed with high care needs.*⁵²⁷
- 10.98 The ANMF also conducted a phone-in survey of just under 2,500 people in 2016, in which the issue of staffing levels elicited the highest level of concern from both consumers and aged care workers.⁵²⁸
- 10.99 Providers, however, have not expressed support for any type of mandated staffing requirements. At the workshops, providers strongly opposed any mandated staff-to-resident ratio including the introduction of a mandated 24-hour RN. The main objections were that:
- it limits providers' flexibility to match staffing levels to the specific care needs of residents, which are constantly changing
 - it results in increased costs, which for many providers could not be borne long term, resulting in closure of a service
 - there is an overall lack of evidence linking these requirements to improved quality of care
 - providers operating in rural and remote areas, would, in many situations, be unable to meet these requirements due to challenges faced in recruiting and retaining staff.
- 10.100 It was noted at numerous workshops, however, that many providers already have an RN on site at all times.
- 10.101 Currently, government legislation requires residential care homes to have an adequate number of appropriately skilled and qualified staff to ensure residents receive quality care to meet their needs.⁵²⁹ It does not prescribe the qualifications required by staff, or what hours should be covered by staff with particular kinds of qualification. However, regulation does set standards to ensure quality of care. These include some instances where an RN is required for recipients of residential aged care. For example, a nurse practitioner or RN must carry out care recipients' initial assessment and care planning, and a nurse practitioner, RN, or EN acting within their scope of practice must carry out ongoing management and evaluation.⁵³⁰
- 10.102 In addition, state and territory legislation governs certain nursing roles in residential aged care, such as the administration of some medications.
- 10.103 It is important that aged care providers have the right staff to deliver quality care that meets consumer needs. What is less clear is what this translates to in practice. The numbers and proportion of the aged care workforce drawn from nursing professions overall appears to be continuing to decline, with the exception of a small increase in the number of RNs in residential care, as shown in the last workforce census.⁵³¹ On the other hand, there is also evidence from the residential care sector that the number of hours worked per consumer (across all workers) has been rising,⁵³² so decline in numbers of one particular type of worker does not necessarily translate to a decline in care for consumers.
- 10.104 What is important is not the number of workers of a particular type at any particular point in time, but the quality of care outcomes for consumers. There is no evidence to suggest that there has been a decline in the quality of care since the LLLB reforms.

⁵²⁷ ANMF submission, p. 6.

⁵²⁸ ANMF, July 2016, *National aged care survey, final report*, p. 12.

⁵²⁹ *Aged Care Act 1997*, s. 54-1 (b)

⁵³⁰ *Quality of Care Principles 2014*, Schedule 1, Part 3 - Care and services for residential care services.

⁵³¹ NACWCS, 2016, *The aged care workforce 2016*, tables 3.3 and 5.3.

⁵³² Stewart Brown, December 2016, *Aged care financial performance survey, residential care report*, p. 20.

- 10.105 Providers and individual residential care homes are responsible for determining the type of staff they require to ensure consumers receive quality care. In my view, this is appropriate, and ensuring the right staffing mix to deliver quality in residential care homes is not best achieved through mandated staffing ratios.
- 10.106 There are diverse staffing models across residential care services with different approaches to care, all of them capable of delivering quality care outcomes. Diversity is to be expected given the considerable variation across the sector, including in the nature of the care recipients' needs, the service's size and design, the way work is organised and the extent to which some services are delivered in-house or outsourced. Requirements will also change over time within individual residential care homes, as changes occur in the needs and acuity of care recipients.
- 10.107 Mandated staffing ratios or attendance requirements risk increasing costs of care, because they will operate regardless of the care needs of the particular consumers that a provider is catering for. Increasing costs of care in turn means the viability of smaller residential care services, or those in areas where it is difficult to attract nurses, would be threatened. This is disproportionately likely to affect rural and regional sites.
- 10.108 The government is currently supporting the sector to maintain quality in a number of ways. For instance, the government provides a national complaints system through the Aged Care Complaints Commissioner, and it seeks to maintain a baseline of quality and safety through accreditation, undertaken and monitored by the Australian Aged Care Quality Agency and compliance activities by the department. In addition, the
- department is working with the sector to develop a single set of aged care quality standards focused on the consumer and the outcomes they experience, including in relation to staff skills and the way staff perform their roles.
- 10.109 It is my view that in developing the aged care workforce strategy the focus on improving education and training will also go some way to addressing concerns consumers may have about quality of care.

AN AGED CARE WORKFORCE STRATEGY

- 10.110 The specific term of reference for this Review to which this chapter relates, refers to “the effectiveness of workforce strategies in aged care services”. This idea was also contained in the stocktake and analysis of government-funded aged care workforce activities in 2015:

*Consideration should be given to the development of a nationally coordinated workforce development strategy and capability framework taking into account how aged care could better plan, collaborate and combine effort with health and disability services.*⁵³³

- 10.111 The need for an aged care sector workforce strategy was covered in 36 submissions. Similarly, during the workshops, peak organisations, providers and advocacy groups called for the development and implementation of a workforce strategy to address systemic issues in the aged care workforce. This is to be led by the sector and supported by the government.

- 10.112 The same calls were flagged during the Senate workforce inquiry. COTA, for example, said:

*COTA Australia seeks to be part of the design and development of a cross sector workforce strategy that creates an environment in which care workers will have rewarding career paths, be adequately resourced and remunerated, and be empowered to work with service users to meet their support and care needs.*⁵³⁴

- 10.113 A national strategy can identify priorities for action and support sequencing of steps along the way. Taking the time to develop a strategy will be a significant investment for the sector.

Provider-led

- 10.114 The development of an aged care workforce strategy led by the sector has provider support. This was clear from evidence put to both the Senate workforce inquiry and to this Review. The government has also expressed the view that

⁵³³ Department of Social Services, 2015, *Stocktake and analysis of Commonwealth funded aged care workforce activities*, p. 6.

⁵³⁴ COTA Australia, Senate inquiry submission 283.

aged care providers are best able to determine their workforce needs and the development of a workforce strategy is best led by the sector.⁵³⁵ I agree with this view.

10.115 A number of sector leaders have already initiated work on a developing a strategy. In November 2016, five aged care organisations jointly provided a proposed framework, for consideration by government, to develop a sector-led aged care workforce strategy. The organisations are Aged & Community Services Australia, the Aged Care Guild, Leading Age Services Australia, Catholic Health Australia and UnitingCare Australia. Together they represent a significant proportion of the sector, offering a mixture of residential and home-based care expertise and a combination of not-for-profit and for-profit perspectives.

10.116 In the 2017 Budget, the government announced it would provide funding to support the establishment of an industry-led taskforce responsible for the development of an aged care workforce strategy that would:

*...explore short, medium and longer term options to boost supply, address demand and improve productivity for the aged care workforce... The taskforce will consult widely within the sector, and engage with other sectors, including disability, education and employment.*⁵³⁶

10.117 I agree that developing an effective national workforce strategy requires cross-sectoral engagement with the education and employment sectors, health professionals, their colleges and representative organisations, and universities and other research institutions.

10.118 The workforce strategy also needs to involve consumers and their families and informal carers. The development of the workforce strategy will therefore need equal engagement by providers, consumers, workers and professionals.

10.119 From the evidence provided to this Review, I believe there are at least five areas that the sector needs to address in its workforce strategy.

Addressing pay

10.120 Low pay is consistently identified as a concern by all stakeholders. Worker satisfaction with pay is low, and the rates of increase in the sector do not appear to be addressing the problem. I note ACFA's work that indicates provider viability and financial performance have improved.⁵³⁷ The sector now needs to develop a workforce strategy that translates some of this positive capability into improved wages and conditions for its employees.

Training and education

10.121 Training and education will need to be a major focus of the strategy. Areas for attention include:

- entry-level qualifications that provide sufficient guidance for clinical safety and quality of care
- sufficient training and development opportunities, particularly for personal care workers
- resolution of quality issues with the offerings of RTOs
- ensuring sufficient investment in training by the sector, including collaborative investments in new or innovative ways of delivering education and training to the sector.

10.122 For the strategy to be effective, it will need to be developed in partnership with the VET sector.

⁵³⁵ See speech by former Minister for Health, Minister for Aged Care and Minister for Sport, 21 February 2016, <http://sussanley.com/leading-age-services-australia-tri-state-conference-sunday-21-february/>

⁵³⁶ Health Budget 2017–18, *Strengthening aged care – developing an aged care workforce strategy*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2017-factsheet56.htm>

⁵³⁷ ACFA, 2016, *Fourth report on the funding and financing of the aged care sector*, p. 58.

Developing recruitment, retention and workforce growth

10.123 A workforce strategy should address methods for widening the recruitment pool, and for embedding improved recruitment and retention strategies systematically across the sector, with specific consideration given to addressing challenges in rural and remote areas. Some providers have already implemented new strategies to tap underutilised labour sources by targeting different parts of the labour market and accessing new cohorts as sources of employees, including:

- students undertaking schools-based apprenticeships, including work placements⁵³⁸
- school leavers
- parents returning to work once their children have reached school age
- women returning to work or taking up work after home caring responsibilities ceased⁵³⁹
- older workers looking for rewarding work
- informal carers seeking to translate their experience and skills into paid work
- job seekers on income benefit who have the right attributes.⁵⁴⁰

Improving the sector's image

10.124 Submissions to this Review and to the Senate workforce inquiry have raised the question of how to improve the image and standing of the sector.⁵⁴¹ The NACWCS recently observed:

*Negative perceptions of aged care work as an occupation of low pay and status remain. Given the need for the expansion of the aged care workforce, this issue must be addressed.*⁵⁴²

10.125 Part of the image problem is clearly pay. The sector also needs to consider whether it wants to engage with the tertiary education and VET sectors to target potential recruitment pools with a view to changing perceptions around aged care work.

Consideration of cross-sectoral workforce issues: health, disability and community services

10.126 Care for older people often involves workers beyond the aged care sector. Primary health care workers, multidisciplinary teams and specialists, pathology and pharmacy, disability services, mental health services, palliative care and community services all play a part in caring for older Australians.

10.127 A number of matters relating to the aged care workforce call for a 'whole-of-health' approach. Examples include consumer health and aged care literacy, workforce modelling, education and training for Indigenous workers, training in palliative care and dementia care approaches, and nursing reform.

10.128 Some of the key occupations in the aged care sector are also represented in other sectors, so changes in policy settings relating to these occupations may have a flow-on effect into the aged care system and provider workforce strategies. For example:

- The NDIS is significantly expanding demand for personal care workers, but is also shaping conditions of employment, affecting the supply of workers and expectations in the aged care sector.

⁵³⁸ For example, the IRT Group, Wollongong, has developed a schools-based apprenticeship trainee program which has 15 students working towards Certificate III in Individual Support.

⁵³⁹ The Department of the Prime Minister and Cabinet and the Department of Employment partnered with UnitingCare on a project designed to develop models that address recruitment and retention issues in the community and aged care sector and support women back into the workforce.

⁵⁴⁰ Suitable screening and selection tools must be used to help employers and employment service providers identify key attributes and skills required for employees in the community and aged care sectors.

⁵⁴¹ This issue of raising the sector's profile and image was also covered in the 2005 workforce strategy for residential aged care.

⁵⁴² NACWCS, 2016, *The aged care workforce 2016*, pp. xviii, 132.

- With aged care nurses comprising 14.6 per cent of the total nursing workforce⁵⁴³ and community-based nursing supporting older people to remain healthy and functioning at home, reforms in nursing will be pertinent to the aged care system.

- 10.129 Providers in both the aged care and disability sectors have a stake in accessing the same pool of potential workers for care work. Many of the skills involved are shared and a number are portable across the sectors.
- 10.130 The NACWCS sought to identify potential workforce competition with the disability sector. The report concluded that there appeared to be very little interaction between the aged care and disability care workforces. However, the significant reforms in the disability sector in recent years may see a different scenario in the future. The NACWCS report suggested that the full NDIS roll-out over the next two to three years could have a substantial impact on the aged care workforce.⁵⁴⁴
- 10.131 Aged care and NDIS providers and services are geographically distributed across the country. This offers opportunities for sharing workforce skills and knowledge, opening career paths, and local collaboration, particularly in rural, remote and very remote areas. The 2017 Budget recognised opportunities for aged care and disability workforce-related joint effort, with a focus on outer suburban and regional collaboration, better use of data and accessing wider potential recruitment pools.⁵⁴⁵
- 10.132 I expect that the workforce strategy will consider the challenges and possible opportunities of the intersections and interactions between the aged care workforce and other workforces, particularly health and the NDIS.

Recommendation 38

That the aged care sector, in developing a workforce strategy, ensure that the strategy:

- reflects that primary responsibility for workforce rests with providers, with government providing support
- draws on engagement with relevant sector and interest groups to ensure that all workforce groups are included
- results in actions that can be sustained by the sector, including particular focus on the areas of pay, education and training, developing retention, recruitment and workforce growth, improving the sector's image, and considering cross-sectoral workforce linkages.

CONCLUSION

- 10.133 The role of government is to focus on the overall policy settings, integrity, consumer safeguards and funding of the aged care system. This sets the context within which providers need to play their part in developing strategies for the workforces providing care and service to older Australians. Workforce planning is an area in which employers (the providers) should take a lead role on major issues such as pay and conditions, training and education, recruitment and retention, and in fostering a positive image of the sector.
- 10.134 In my view, peak provider organisations, individually and collectively, also need to strengthen their role in supporting their members on workforce matters. This may involve strengthening or undertaking new functions, such as giving members workplace advice, online tools and resources, business services, and workforce development and assistance.
- 10.135 The immediate task for the sector is to develop a workforce strategy that addresses the challenges outlined in this chapter. This will make the sector a more attractive place to work, which will lay the groundwork for the larger workforce needed for the future, and will ensure it will be ready to meet the increasingly complex needs of consumers.

⁵⁴³ Data provided to the Senate inquiry, Commonwealth submission 293, p. 43. See: http://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Community_Affairs/Aged_Care_Workforce/Submissions

⁵⁴⁴ NACWCS, 2016, *The aged care workforce 2016*, p. xviii.

⁵⁴⁵ Health Budget 2017–18, *Strengthening aged care – developing an aged care workforce strategy*, <http://www.health.gov.au/internet/budget/publishing.nsf/Content/budget2017-factsheet56.htm>

APPENDIX A

ACRONYMS

AAAC	Australian Aged Care Commission
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
ACER	Aged Care Entry Record
ACFA	Aged Care Financing Authority
ACFI	Aged Care Funding Instrument
ACHA	Assistance with Care and Housing for the Aged
ACPC	Aged Care Pricing Commissioner
ACSA	Aged and Community Services Australia
ACSC	Aged Care Sector Committee
ACSIHAG	Aged Care Service Improvement and Healthy Ageing Grants
ADA	Aged and Disability Advocacy Australia
AIHW	Australian Institute of Health and Welfare
AMA	Australian Medical Association
ANAO	Australian National Audit Office
ANMF	Australian Nursing and Midwifery Federation
BDF	Basic daily fee
BPSD	Behavioural and psychological symptoms of dementia
CACP	Community Aged Care Package
CALD	Culturally and linguistically diverse
CCF	Client Contribution Framework
CDC	Consumer Directed Care
CHA	Catholic Health Australia
CHSP	Commonwealth Home Support Programme
COTA	Council on the Ageing
DAC	Daily Accommodation Contribution
DACS	Dementia and Aged Care Services [fund]
DAP	Daily Accommodation Payment
DBMAS	Dementia Behaviour Management Advisory Service
DHS	Department of Human Services
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH-D	Extended Aged Care at Home – Dementia
EN	Enrolled nurse
EY	Ernst & Young

FTE	Full-time equivalent
GDP	Gross Domestic Product
HACC	Home and Community Care
ICT	Information and communication technology
IGR	Intergenerational report
LASA	Leading Age Services Australia
LGA	Local Government Area
LGBTI	Lesbian, gay, bisexual, transexual and intersex
LLLB	Living Longer Living Better
MPIR	Maximum Permissible Interest Rate
MPS	Multi-purpose service
NACWCS	National Aged Care Workforce Census and Survey
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NDIS	National Disability Insurance Scheme
NHHR	National Health and Hospitals Reform
NPAC	National Presbyterian Aged Care Network
NSAF	National Screening and Assessment Form
PHN	Primary Health Networks
PICAC	Partners in Culturally Appropriate Care [Program]
RAC	Refundable Accommodation Contribution
RAD	Refundable Accommodation Deposit
RAS	Regional Assessment Service
RN	Registered nurse
RTO	Registered training organisation
SBRT	Severe Behaviour Response Team
SDAC	Survey of Disability, Ageing and Carers
SRV	Shepparton Retirement Village
TIS	Translating and Interpreting Service
VET	Vocational and educational training
VHA	Victorian Healthcare Association
VHC	Veterans' Home Care

APPENDIX B

LIST OF SUBMISSIONS RECEIVED

As part of the consultation for the Review a call for submissions opened on 14 October 2016 and closed on 4 December 2016. A total of 145 submissions were received from a range of stakeholders, including consumers, carers, workers, providers and peak bodies.

108 submissions agreed to be made public; they are on the Department of Health's website.

They were from:

- ACT Disability, Aged and Carer Advocacy Service
- Advocare Incorporated
- Aged & Community Services Australia
- Aged and Disability Advocacy Australia & Aboriginal and Torres Strait Islander Disability Network of Queensland
- Aged Care Crisis Inc.
- Aged Care Guild
- Aged Care Industry Association
- Aged Care Matters
- Alzheimer's Australia
- Anglicare SA
- Anonymous 2
- Anonymous 3
- Anonymous 4
- Anonymous 5
- Anonymous 11
- Anonymous 13
- Anonymous 14
- Anonymous 15
- Anonymous 16
- Anonymous 17
- Anonymous 18
- Anonymous 19
- Anonymous 20
- Anonymous 21
- Anonymous 22
- Anonymous 23
- Anonymous 25
- Anonymous 28
- Anonymous 29
- Anonymous 30
- Association of Age Service Professionals Inc.
- Australian Association of Gerontology
- Australian Blindness Forum

- Australian College of Nursing
- Australian Meals on Wheels Association
- Australian Medical Association
- Australian Nursing & Midwifery Federation
- Australian Projections Pty Ltd
- Australian Unity
- Baptist Care Australia
- Better Caring Pty Limited
- Brotherhood of St Laurence
- Carers Australia
- Catholic Health Australia
- Caulfield Aged Care Assessment Service
- Charles Penheiro (two submissions)
- Chinese Australian Services Society Ltd
- City of Victor Harbour
- cohealth
- Combined Pensioners & Superannuants Association of NSW Inc.
- Committee for the Aged, Catholic Diocese of Wollongong
- Community Vision
- Council on the Ageing
- Council on the Ageing ACT
- Dalby Meals on Wheels Inc.
- Deaf Services Queensland
- Dietitians Association of Australia
- Ethnic Communities' Council of NSW
- Ethnic Community Services Co-operative
- Federation of Ethnic Communities' Councils of Australia Inc.
- Gilgai Aboriginal Centre Inc.
- Golden Glow Corporation NT Pty Ltd
- Greek Welfare Centre NSW Community Services
- HammondCare
- Health Care Consumers' Association
- IRT Group
- La Trobe Financial
- Leading Age Services Australia
- Macarthur Diversity Services Initiative
- Mercy Aged and Community Care Limited
- Merri Health
- Motor Neurone Disease Australia Inc.
- Multicultural Access Project Officers Network
- Municipal Association of Victoria
- National Aged Care Alliance
- National Association of People Living with HIV Australia
- National LGBTI Health Alliance

- National Presbyterian Aged Care Network
- National Rural Health Alliance
- National Seniors
- NSW Ministry of Health
- Occupational Therapy Australia
- Office of the Public Guardian (QLD)
- Painaustralia
- Palliative Care Australia
- Provider Assist
- Public Trustee of QLD
- Queensland Nurses' Union
- Returned & Services League of Australia
- Riverina Murray Food Services Forum
- Ryman Aged Care (Australia) Pty Limited
- Shepparton Retirement Villages
- Sir Charles Gairdner Hospital Aged Care Assessment Team
- Speech Pathology Australia
- STAR Community Services
- Suncare Community Service Ltd
- Sunnyside Lutheran Retirement Village
- United Voice
- UnitingCare Australia
- University of South Australia, University of Adelaide, and Torrens University Australia
- Victorian Aboriginal Community Controlled Health Organisation
- Victorian CHSP Carer Programs Network
- Victorian Healthcare Association
- Vision Australia
- Vision 2020 Australia
- Volunteer Task Force
- 3Bridges Community Ltd

37 submissions did not wish their submission to be made public.

APPENDIX C

LIST OF WORKSHOPS

During February and March 2017, I held a number of workshops with the following groups of stakeholders:

- consumers, carers and representatives of consumers
- aged care workers
- aged care providers.

Separate workshops were held with each of these stakeholder groups in all capital cities as well as three regional centres: Bendigo, Bundaberg and Port Augusta. The locations and dates of each workshop are listed below:

- Canberra, 3 February 2017
- Bendigo, 7 February 2017
- Melbourne, 8 February 2017
- Hobart, 9 February 2017
- Bundaberg, 13 February 2017
- Brisbane, 14 February 2017
- Sydney, 21 February 2017
- Port Augusta, 27 February 2017
- Adelaide, 28 February 2017
- Darwin, 7 March 2017
- Perth, 21 March 2017