Australian Government

Department of Health and Ageing

SECRETARY

Dr Ian Holland
Secretary
Standing Committee on Community Affairs
Legislation Committee

Dear Dr Holland

Aged care package of bills inquiry

Thank you for your letter of 7 May 2013 seeking further information from the Department of Health and Ageing (the Department) in relation to the package of Bills currently being considered before the Legislation Committee of the Standing Committee on Community Affairs (the Committee).

I understand from your letter that the Committee is concerned that the delegated legislation, to be implemented over the next two years, has not been provided at the same time as the primary legislation. The Department welcomes the opportunity to continue to provide as much detail on the proposed changes to legislation to support these important reforms as is possible. I have provided further details regarding the availability of this information at **Attachment 1**.

The questions asked by the Committee in your letter and during the hearing cut across a number of key themes detailed in the Bills and in the aged care reform package. The Department has responded to these questions with a number of attachments, which address the questions posed by the Committee and provide context and information on the underpinning policies.

To assist the Committee in working through these questions, a matrix has been prepared at **Attachment 2**. In addition, each question has been highlighted in the attachments.

The *Living Longer Living Better* aged care reform package has been developed in close consultation with the aged care industry and consumers and builds on the detailed work of the National Aged Care Alliance Blue Print on Ageing and the Productivity Commission. Information on the consultations undertaken, including key steps the Department has undertaken to engage with stakeholders, is detailed at **Attachment 3**.

The Department, at the request of the Committee, has examined the submissions of the Aged Care Guild (#46), UnitingCare (#69), Aged Care Gurus (#86) and ANZ Bank (#94) with regard to some of the assumptions and modelling. To assist the Committee in understanding these matters raised, the Department has sought, at **Attachment 4**, to respond to matters

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relating to accommodation payments and, at **Attachment 5**, to respond to matters relating to aged care means testing.
The Committee asked the Department to provide further detail in relation to a recent mail out of material on the aged care workforce supplement, which is at **Attachment 6**, along with other material on the supplement and broader workforce matters.

The Department noted from the hearings that a number of witnesses and submissions to the Inquiry outlined their concerns in relation to changes to the Aged Care Funding Instrument (ACFI). I have included at **Attachment 7** further ACFI details to assist the Committee in working through these issues.

Responses to questions regarding homelessness, rural and remote services and elimination of faith-based discrimination on the basis of sexual orientation, gender identity or intersex status can be found in the Special Needs Group information at **Attachment 8.** Responses regarding the new Dementia Supplement and Mental Health can be found at **Attachment 9** and those relating to the Productivity Commission Inquiry Recommendations can be found at **Attachment 10.**

The Department is concerned by a number of statements being made by organisations in submissions which do not reflect the intent or the announced policies that make up the reform package. I would like to take the opportunity to correct some of the issues identified in the submissions.

- With regard to the removal of retention amounts, the removal of retention amounts was a recommendation of the Productivity Commission which takes into account consumer interests and sits alongside decision to extend the option of lump sum accommodation payments to high care. The impacts of this policy need to be considered in the context of the whole reform package, not in isolation. Under the reforms providers will be able to receive additional revenue flows from the removal of the high/low distinction, a measure which has long been championed by industry, and for new or significantly refurbished facilities from 1 July 2014 the government accommodation supplement increases to $52 per day. The new accommodation payment system provides flexibility. For example, providers and residents can agree to payments involving a combination of lump sum and periodic payments to provide revenue flow. This effectively provides a voluntary retention amount, but ensures consumers have choice.

- A number of submissions referenced items 222/223 stating that these provisions would give union officials the right of entry into a residential aged care facility. This is not the case. These amendments relate to the powers of authorised officers. Authorised officers are officers of the Department appointed by the Secretary to exercise monitoring powers under the *Aged Care Act 1997* (see section 90-3 of the Act). Individuals who are not officers of the Department cannot be appointed as authorised officers. The amendment extends the existing powers of authorised officers so they can continue their role under the new arrangements. The Department advises providers that, at all times, an authorised officer must be able to produce an identity card verifying their authority.

Finally, during the Department's attendance at the Committee Hearing on 2 May 2013, Senator Fierravanti-Wells asked the Department about correspondence received from Mr Patrick Reid, CEO Leading Age Services Australia, dated 5 April 2013. I have included for your information, at **Attachment 11**, the Department's response to this correspondence.

The Department welcomes any further questions the Committee may have which can assist in the finalisation of the Committee's findings.

Yours sincerely

Jane Halton PSM
Secretary

14 May 2013

Attachments

1. Availability of delegated legislation
2. Responses to Questions posed by Committee - Matrix
3. Consultation on the Aged Care Reform Package
4. Accommodation Payments
5. Aged Care Means Testing
6. Aged Care Workforce Supplement
7. Aged Care Funding Instrument (ACFI)
8. Special Needs Groups
9. Dementia and Mental Health
10. Productivity Commission Inquiry
11. Department's response to LASA correspondence, 5 April 2013

Availability of Delegated Legislation

Introduction

Significant amendments to the *Aged Care Act 1997* (the Act) and consequential amendments to other legislation are required to give effect to the *Living Longer Living Better* aged care reform package.

The changes to the Act can broadly be grouped into four categories:

1. Changes relating to home care, including the transition from community care, EACH and EACHD to home care and the way that Government subsidies and care recipient fees are calculated.
2. Changes relating to residential care, such as changes to the way that Government subsidies and resident fees are calculated, and the options available to care recipients to pay for their accommodation.
3. Changes relating to governance and administration, such as the establishment of the new Aged Care Pricing Commissioner and the new Australian Aged Care Quality Agency.
4. Changes that are minor, administrative or consequential, for example changes that improve the operation of the Act or address anomalies in the legislation.

Consistent with the principles of good regulation, the Government's approach has been to:

1. describe the broad legal and policy framework in the Act;
2. ensure that important safeguards are expressly included in the Act; and
3. enable the Principles and Determinations to deal with matters of detail that are likely to change over time and where flexibility is needed.

Required amendments

Currently there are 22 sets of Principles under the *Aged Care Act 1997* that contribute to the operation of aged care programs. For those Principles where the changes are consequential or machinery in nature, the reflected changes incorporated into the primary legislation and the outcome of consultations undertaken as part of the *Living Longer Living Better* reforms.

The proposed amendments to the relevant Principles are being drafted as consultation processes are completed and in line with the commencement dates in the *Living Longer Living Better* Bills:

- 1 July 2013;
- 1 January 2014; and
- 1 July 2014.

Timetable for release of draft amendments

<u>1 July 2013 start date — public release week of 20 May 2013</u>

Nineteen Principles will be amended for effect from **1 July 2013**. Many of the changes are consequential to the changes in the bills (e.g. replacing the term community care with the term home care) or machinery in nature (e.g. updating out-dated references to documents and repealing redundant provisions).

Drafts of the proposed amending Principles will be released on the *Living Longer Living Better* website in the week of 20 May 2013. This release will be accompanied by an overview of the proposed changes to subordinate legislation.

Substantive changes are being made to enable three new supplements to be paid (workforce, dementia and veterans'), to implement new home care arrangements and to strengthen powers of the Aged Care Commissioner. Consultations have been undertaken with the appropriate working groups under the National Aged Care Alliance (NACA) and with the Aged Care Commissioner on the proposed changes.

There are several papers currently out for public consultation including the Home Care Packages Program Guidelines, Dementia and Veterans' Supplements in Aged Care Discussion Paper and the draft Aged Care Workforce Supplement Guidelines. Comments and feedback from stakeholders on these papers will inform the final guidelines and the relevant Principles.

- Drafting of the Principles cannot be finalised until these processes are completed.
- The consultation period for these elements concludes on 30 May 2013.

<u>1 January 2014 start date — public release by end of October 2013</u>
The changes due to take effect from **1 January 2014** relate to the new Quality Agency and the introduction of the Aged Care Pricing Commissioner. These changes will utilise targeted consultation processes. Drafts of the proposed amended Principles will be released on the *Living Longer Living Better* website by the end of October 2013.

In relation to the Aged Care Pricing Commissioner, amendments are required to establish requirements for self-assessing accommodation payments and advertising accommodation payments. Consultations have already been undertaken regarding the proposed Accommodation Pricing Guidelines and the comments received will inform further amendments to the User Rights Principles.

The existing arrangements and procedures set out in the Accreditation Grant Principles will be the basis of the new Quality Agency Principles and the Quality Agency Reporting Principles. Consultation will be undertaken with the Aged Care Standards and Accreditation Agency Ltd and industry to inform the content of these new Principles.

<u>1 July 2014 start date – staggered public release from March 2014</u>
There will be significant changes required to the Principles as a result of the proposed changes to the Act planned to come into effect from **1 July 2014**.

The Department intends to undertake discussions and consultations with the relevant groups under NACA and provide discussion papers and/or draft guidelines for broader public consultation.

As these Principles are drafted, it is anticipated that they will be progressively released (from March 2014) on the *Living Longer Living Better* website. Those with substantive amendments will be subject to consultation processes.

Specific questions from the Committee

There were no specific questions from the Committee on this issue; however, it is an important area of industry interest.

As outlined above, the Department proposes to release draft legislative instruments for comment where the proposed changes are significant. Where the changes are minor, they will be published for information on the *Living Longer Living Better* website, in line with reform implementation timeframes.

Attachment 2

Themes (Committee Letter)	Attachment 3	Attachment 4	Attachment 5	Attachment 6	Attachment 7	Attachment 8	Attachment 9	Attachment 10
Home Care user co-payments			Questions 1-8					
Residential Care pricing arrangements		Questions 9 & 10						
Residential Care pricing arrangements - 28 day period / Bond v DAP		Question 11	Question 12					
Rural and Remote services						Questions 13-17		
Homelessness supplement						Questions 18 & 19		
Dementia Supplement - diagnosis							Questions 20-22	
Amendments to the Aged Care (Bond Security) Levy Amendment Act		Questions 23 - 25						
Pricing Authority		Question 26						
Elimination of faith -based sex discrimination						Question 27		
Productivity Commission approach as an alternative								Questions 28 & 29
Consultation	Question 30							

Consultation Undertaken by the Department of Health and Ageing on *Living Longer Living Better* Reforms

Introduction

Following the release of the Productivity Commission report, *Caring for Older Australians*, Minister Butler and the Department worked with the National Aged Care Alliance (NACA) in establishing several key working groups to examine the following issues:

- **Quality of care** – quality and regulatory matters, innovation, consumer choice/control over care and the establishment of an Australian Seniors Gateway Agency.
- **Workforce** – wages, scope of practice, training and career pathways.
- **Wellness approach** – healthy ageing considerations focusing on health promotion, linkages with primary health care both in residential and community care, the role of e-health and dementia/psychogeriatric issues.
- **Financing, care and accommodation** – the implementation of financing reform considered in further detail the assumptions made in the Productivity Commission Report to be further explored, for example the stop-loss proposal.
- **Assessment, choice and consumer-oriented care** – exploration of latent demand for aged care services, choice and supply, when and how individuals enter the aged care system and the fiscal impact of different options for assessment and care delivery.
- **Palliative Care** – exploring how palliative care is administered across Australia with variable funding and differences in support, access to medications and the exploration of business models to enable access to palliative care.

The output from these groups formed part of the thinking for the *Living Longer Living Better* reform package.

This attachment addresses the following question asked by the Committee: 30
30. During evidence in Perth, the CEO of Baptistcare made the following statement:
But specifically from us in Baptistcare I think the consultation process on the reform package and on the draft legislation has not listened to feedback from providers outside of the National Aged Care Alliance and certainly comments from the WA providers and our peak body, which has had occasionally different views to NACA, the minister and the department, have
been, in my personal experience, quite rudely dismissed and not been taken into consideration. Our advice has been that this current package is untenable.
Could the Department respond?

Ongoing Consultation

Since the *Living Longer Living Better* aged care reforms were announced, the Department has consulted through a range of mediums with the aged care sector:

- stakeholder advisory groups, those set up by the Department and those auspiced by NACA;
- sector /industry briefings;
- *Living Longer Living Better* website communications; and
- through seeking submissions and/or comments on papers and proposed legislation changes.

In addition, the Department attends NACA meetings every three months to have a two way conversation on progress, updates and areas of concern. In these meetings NACA member organisations have the opportunity to seek clarification, raise issues and provide comments of components of the reforms.

The Department has attended four of these meetings since July 2012 with the next one planned for late May 2013. On 23 April 2013 the Department provided a special briefing to this group on the proposed legislative changes.

Summary of NACA advisory groups

Currently 12 advisory groups (including 6 sub-groups) auspiced by NACA, have been established, each with a focus on different parts of the reforms. Their membership is comprised of representatives from NACA organisations and other non-NACA organisations such as National Seniors Australia. Departmental officers also attend these meetings.

Since July 2012 there have been 42 meetings of these groups. These groups are the:

- **Ageing Expert Advisory Group**
- **Home Care Packages Working Group**
- **Gateway Advisory Group**
- **Commonwealth Home Support Program Advisory Group** which has the following subgroups:
    - HACC service Group 2 Sub-group;
    - Respite Sub-Group;
    - Home maintenance and Modifications Sub-Group;
    - Meals Review Sub-Group; and
    - Community Transport Review Sub-Group.
- **Quality Indicators Advisory Group**
- **Specified Care and Services Reference Group** which has the following sub-group:
    - Combined Clinical Care Sub-Group and Additional Services Sub-group

Summary of Non NACA advisory groups

In addition to the NACA groups the Minister and the Department have also established or refocused a number of advisory groups.

These groups have met 49 times since July 2012. There are currently 12 of these groups, which include:

- **Aged Care Reform Implementation Council** – an independent body established to monitor, evaluate and report to the Minister on the progress of the reforms.
- **Aged Care Financing Authority** – provides the Minister with independent advice on aged care pricing and financing and helps ensure care recipients receive value for money. Since being established on 1 August 2012, ACFA has consulted extensively with industry and consumers, and made recommendations to the Minister in relation to accommodation payments, and the definition of significant refurbishment. Documents circulated for consultation by the ACFA are:
    - Interim Operating Framework for the Authority;
    - Consultation on the meaning of ‘significant refurbishment’;
    - Accommodation payments discussion paper; and
    - Draft recommendations on Accommodation Payments. The Department also released draft Accommodation Payment Pricing Guidelines for consultation.

Note, during the finalisation of some aspects of the legislation relating to accommodation payments, consultation was conducted by the Minister with industry peak bodies (including the Aged and Community Services Australia, the Australian Nursing Federation, Alzheimer's Australia, BUPA Care, COTA, Catholic Health Australia, National Seniors, UnitingCare Australia, and Leading Aged Services Australia) followed by the publication of final decisions.

- **Strategic Workforce Advisory Group -** assisted in developing the requirements for the Workforce supplement to improve the capacity of the aged care sector to attract and retain staff.
- **Minister's Dementia Advisory Group** – provides advice to the Minister and to the Department on issues relating to the implementation and monitoring of programs, and dementia-related issues.
- **Aged Care Funding Instrument Monitoring Group** – monitors the impact of the recent Aged Care Funding Instrument changes.
- **Aged Care Funding Instrument Technical Reference Group** – reports to the Aged Care Funding Instrument Monitoring Group on technical issues.
- **Dementia and Veterans' Supplement Working Group** – provides advice to the Department on eligibility criteria for new supplements for the care of people with dementia and other behavioral conditions and veterans with specified mental health conditions.
- **Aged and Community Care Officials** – provides a forum for the Commonwealth to engage with state and territory aged care officials to progress multilateral discussions on the existing aged care programs, including transition arrangements in line with the reforms. Cross-jurisdictional issues around aged care reform are addressed predominantly through Aged and Community Care Officials.
- **Gateway Consultation Forum** – provides a vehicle for the Commonwealth to consult with state/territory government representatives and other key parties on implementation arrangements for the Aged Care Gateway. The Group links with Aged and Community Care Officials and the National Aged Care Alliance Gateway Advisory Group, and reports directly to the Department.
- **National Aboriginal and Torres Strait Islander Aged Care Reference Group** – provides advice to the Department on matters relating to the reforms that affect Aboriginal and Torres Strait Islander people.
- **Lesbian, Gay, Bisexual, Transgender, and Intersex Advisory Group** – provides advice and guidance on the development of a Strategy to help inform the way Government responds to the needs of older lesbian, gay, bisexual, transgender and intersex (LGBTI) Australians and better supports the aged care sector to deliver care that is sensitive to their needs.
- **Culturally and Linguistically Diverse Advisory Group** – provides advice and guidance on the development of a Strategy to help inform the way Government responds to the needs of older people from culturally and linguistically diverse (CALD) backgrounds and better supports the aged care sector to deliver care that is sensitive to their care needs.

Legislative Changes - Consultation

Aged Care Commissioner

In the development of the amendments to the Complaints Principles 2011, to support strengthened powers for the Aged Care Commissioner, the Department has undertaken consultation with the Commissioner and the National Aged Care Alliance (NACA)

complaints subgroup. This subgroup is the Complaints Scheme's key advisory consultative group on matters related to aged care complaints.

New Prudential Requirements

The majority of new prudential requirements for accommodation bonds commenced on 1 October 2011. The Department is monitoring the effect of the regulatory changes and is continuing to engage with the aged care sector about issues arising during implementation. Further detail on the prudential requirement is provided in **Attachment 4**.

Further consultation on the proposed legislative changes

On 21 November 2012, the Department released a paper providing an overview of the proposed legislation changes.

This paper was publicly released on the *Living Longer Living Better* website. A video presentation detailing the proposed legislative changes and providing an executive summary of the overview document was also made available through the *Living Longer Living Better* website, to assist with public access to information on, and understanding of, the proposed changes. The video was produced as an additional medium to assist those with reading difficulties or unable to attend the briefing sessions in person.

- During November and December 2012, some 8,648 hits were made to the legislation section of the *Living Longer Living Better* website.

From late November to early December 2012, the Department also held briefing sessions in Melbourne, Sydney and Canberra on the proposed changes. Sessions were also offered in Brisbane and Perth however industry did not accept the invitations.

Stakeholders were able to provide written comments on the proposed changes during a four week period (21 November 2012 – 21 December 2012) with comments made publicly available on the *Living Longer Living Better* website, unless the author requested otherwise. The Department received 54 submissions from members of the public, peak bodies and approved providers in response to the published overview of legislative amendments. These submissions were used to inform drafting of the Bills and will also inform the development of delegated legislation and program arrangements.

In regard to bond insurance, for example, the Government subsequently decided not to pursue private insurance arrangements for accommodation bonds/payments. Instead the Bills seek to extend the current Government-backed bond guarantee scheme to cover the new types of lump-sum deposits for accommodation being introduced through the reforms. Changes were also made to the Bills to give greater clarity of the scope for the five year review and who would be consulted as part of the process.

Release of Program Guidelines

A range of Program Guidelines have recently been released for public consultation to assist stakeholders in understanding upcoming changes, and to provide an opportunity for stakeholders to provide feedback on the proposed implementation arrangements. These include:

- Draft Accommodation Pricing Guidelines (9 April – 1 May 2013);
- Home Care Packages Program Guidelines - Consultation Draft (29 April – 17 May 2013);
- Dementia and Veterans' Supplement in Aged Care Consultation Paper (1 May – 22 May 2013); and

- Draft Aged Care Workforce Supplement Guidelines (2 May – 30 May 2013).

Aged Care Bills - Industry Briefings – Autumn 2013

In late February 2013, the Department announced that it would be holding briefing sessions across Australia to provide information and explain, in detail, the proposed legislative changes that have been introduced into Parliament. These industry briefings have been in:

- Canberra 19 March 2013
- Sydney 20 March (two sessions) and 18 April 2013
- Brisbane 27 March 2013
- Hobart 3 April 2013
- Melbourne 8 and 9 April 2013
- Adelaide 10 April 2013
- Perth 12 April 2013
- Darwin and Alice Springs 23 April 2013

For those who were unable to attend the briefings a copy of the presentation, supporting handouts, a detailed Questions and Answers document and an information video have been made available on the *Living Longer Living Better* website.

- Since 19 March 2013, over 6,557 hits have been made to the legislation section of the website.

FaxStream

The Department also utilises a faxstream distribution system that contains over **10,000** email address of providers, peaks and organisations in the aged care sector. The faxstream has been used to inform those on it about the legislation briefings, consultations taking place and updates on the reforms.

Ongoing Consultation

In addition, updates on reform implementation have been provided through electronic newsletters. Seven editions have been disseminated since June 2012 to 1,464 subscribers. Electronic dissemination of draft reform guidelines also occurs through emails to stakeholders and providers as well as on the website.

The Attachment provides further detail including the consultation calendar which shows when groups have met and when meetings are planned, and the relationship of these groups including the organisations represented.

Specific Questions from the Committee

30. During evidence in Perth, the CEO of Baptistcare made the following statement:
'But specifically from us in Baptistcare I think the consultation process on the reform package and on the draft legislation has not listened to feedback from providers outside of the National Aged Care Alliance and certainly comments from the WA providers and our peak body, which has had occasionally different views to NACA, the minister and the department, have been, in my personal experience, quite rudely dismissed and not been taken into consideration. Our advice has been that this current package is untenable'.
Could the Department respond?

As outlined above, the consultation process has been comprehensive over the past 18 months with a particular emphasis on providing information and opportunities for feedback through a multitude of avenues such as face to face briefings, working group collaborations, public submissions, email, web blogs and more formal written correspondence. Further, there are numerous groups outside of NACA which have been consulted during the reform process. Membership of these groups includes representation from Western Australia such as Care Options WA; Catholic Homes Incorporated; Western Australia Department of Health; and Curtin University.

Over 1600 people attended the most recent industry briefings and feedback has overall been extremely positive with participants conveying their thanks to the presenters and support staff at all sessions. There has been a call for similar ongoing communications related activities, while acknowledging the key role that industry representative groups need to play in disseminating such information to their members.

On 21 November 2012, there was a public call for comments on the proposed legislative amendments. Baptistcare did not submit any comments to the Department on the proposed legislative changes. Representatives attended the industry briefing in Perth and asked a question of the presenter. Their question could not be answered at that time as it related to a matter that was under active consideration by the Government. Staff made a commitment to post a reply to the question on the *Living Longer Living Better* website. This will be completed in the coming week.

Accommodation Payments

Introduction

From 1 July 2014 there will be a number of reforms to the accommodation payments system in residential aged care. These reforms are designed to:

- Improve transparency and disclosure around accommodation pricing;
- Ensure accommodation pricing appropriately reflects value;
- Provide greater choice and control to residents and their families over how they pay for accommodation;
- Harmonise the accommodation payment arrangements across high care and low care, and in the process remove a number of current restrictions on how providers can charge for accommodation;
- Ensure appropriate safeguards for consumers, both through enhanced disclosure and choice and through specific measures such as the establishment of the Aged Care Pricing Commissioner to approve prices above a certain level; and
- Provide additional support to providers supporting residents with low means, and encourage investment in residential aged care facilities, by increasing the Government accommodation supplement paid for new or significantly refurbished services.

In developing this attachment the Department has considered the evidence provided in submissions and at the hearings including by the Aged Care Guild, Australian Unity, LASA, UnitingCare Australia, Aged Care Gurus and the ANZ.

This attachment specifically addresses the following questions asked by the Committee: 9-11 and 23-26.

9. In an environment that is supporting increased user choice, is there a reason why a retention payment could not remain as an option for consumers, along with the Refundable Accommodation Payments (RAD) and Daily Accommodation Payments (DAP)?

10. During the hearing, there was discussion about modeling being done in relation to payment options and sensitivity testing. Can the Department describe exactly what modeling has been, or is being, undertaken of the price and other economic effects of the LLLB package? What modeling has been completed, and what were the aims, methods and results of that modeling? What modeling is still underway, and what are the aims and methods of that modeling, and when is it scheduled to be completed? Will the result of that modeling be released to stakeholders in the sector?

11. Most aged care providers have raised concerns about the 28 day period for deciding payment, and have asked that if a consumer is ready to make a decision on the day they move in, that this should be allowed. Does the government oppose this? Why?

23. This bill does not make any significant amendments to the existing Act apart from terminology. However, it would provide an opportunity to amend a levy that the committee has heard unfairly penalises competent providers for the actions of a few providers who mis-manage their Bond or RAD holdings. Could the scrutiny of new approved providers and the existing prudential arrangements be strengthened to prevent these situations occurring, rather than having to deal with them after the event?

24. Could there be a limit on how long these liabilities should stand with providers?

25. Should providers not be responsible for managing their own risks, rather than the risks of others?

26. Why is this agency not independent from your Department?

Impact on providers of residents being able to choose their payment method

Under the reforms, residents will decide if they wish to pay for their accommodation by lump sum (a 'refundable accommodation deposit' or RAD) or periodic payment (a 'daily accommodation payment' or DAP) or by a combination of RAD and DAP. Residents will have up to 28 days after entering care to make that choice to ensure they have time to properly consider their decision.

Choice of payment is an important reform as it allows the resident to make a choice that suits their particular individual objectives and circumstances. In conjunction with reforms to improve transparency and disclosure, this change provides greater flexibility and control for consumers.

A number of submissions have raised concerns over the potential financial impact on providers of the new choice of payment rules. These concerns have largely reflected a view that there may be a significant shift from residents paying lump sums to periodic payments and this may affect the funding arrangements for some providers.

These submissions have generally not taken a balanced view. In particular, in considering the drivers of why a resident may choose a lump sum or periodic payment they have tended to not take into account all the factors that will influence an individual's decision.

These submissions have also tended to look at the issue of choice of payment in isolation from other aspects of the reform package, and so have failed to take into account the effect of significant increases in the pool of residents who may pay a lump sum (by removing the current restriction on the payment of lump sum accommodation payments in high care) and other aspects of the reform package which could increase revenue flows to providers.

Factors that may affect a resident's choice of payment method

A number of factors can be expected to impact on a resident's choice of payment method. These include both factors that may encourage payment of a RAD and factors that may encourage payment of a DAP. These factors include both financial and non-financial considerations. Some of these factors include:

- Simplicity of arrangements – for example, where a choice is being made over whether to sell a home, some residents and their families may prefer to sell the home and pay a RAD rather than prepare the home for rental, manage the rental and manage the daily payment requirements.
- Estate planning considerations. This could include simplifying financial affairs.
- Financial factors:
    - Where the rental from a property after maintenance and other costs is insufficient to cover daily payments, there may be a preference to pay by RAD.
    - Means testing considerations – this could include both factors which may encourage payment of a RAD, such as the exemption of a RAD from age pension means testing, and factors that may encourage the opposite, such as the inclusion of the RAD in aged care means testing arrangements.
- Other non-financial considerations – the wishes and personal circumstances of the resident and family members are also likely to influence a decision.

The Department has heard both views suggesting there could be a shift towards DAPs and views suggesting there may be little change in consumer behavior (which in the context of the approximate doubling of the number of consumers eligible to pay by lump sum suggests the number of lump sum payments will grow).

The Aged Care Financing Authority has also been examining this issue and has commissioned modelling on the potential impacts of the LLLB reforms on the amounts of RADs and DAPs. This modelling is expected to be publicly available before the end of May.

Impact of other parts of the LLLB package

Other parts of the LLLB package significantly increase the potential pool of lump sum payments and also potentially increase revenue flows to providers.

Under the reforms RADs would be able to be paid by residents entering what is currently high care, whereas previously only periodic payments could be paid in high care unless those place were extra service places. This reform has long been championed by industry but many submissions do not appear to have considered this, or have dismissed its impact.

- The pool of potential refundable deposits will increase significantly. RADs (currently referred to as bonds) can now only be charged in low care where there are approximately 94,000 operational low care places.
- There will now be an additional approximately 94,000 operational high care places where RADs will be able to paid.

Some submissions suggest that residents who are requiring high care are unlikely to pay a RAD due to expectations of a short time spent in care. While stays are on average shorter in high care, the difference is not anywhere as stark as many submissions imply and many high care residents have long stays (e.g. residents with dementia). Data shows that the average length of stay in high care is actually 2.7 years (compared to 3.5 years in low care), with 55 per cent of stays being greater than one year (70 per cent for low care) and 40 per cent of stays being greater than two years (55 per cent for low care). Furthermore, when high care residents are eligible to pay an accommodation bond, (i.e.in an extra service place) approximately 93 per cent pay a bond or combination payment.

Not only does removing the high and low care distinction allow bonds in high care, it also provides potentially increased revenue in the form of accommodation payments for high care places. For non-supported residents (around 60% of residents) providers will be able to charge an accommodation price based on the value and amenity of the facility, rather than be restricted to the maximum daily accommodation charge ($32.58 March 2012 prices).

The total additional revenue to industry from this change will depend on the accommodation payment prices. If the average daily accommodation payment paid by a non-supported resident in high care is $50 per day the additional revenue would be approximately $331 million per annum[1] across the industry, when fully implemented2. This is a conservative estimate noting while there will be an obligation on providers to charge prices commensurate with the amenity of the facility at all levels, providers will only need to seek approval from the Aged Care Pricing Commissioner for prices above $85 per day.

[1] "Based on 93,579 high care places (30 June 2012) with occupancy of 92.8% and 60% non-supported residents.
[2] This includes the DAP equivalent of any RADs.

Providers can also gain revenue from the Government through the increase in the accommodation supplement paid for residents with low means (supported residents). The supplement is being increased by more than 50% from approximately $32 to approximately $50 per day (2012 prices) for new or significantly refurbished premises.

In considering the impact of the reforms all these changes need to be taken into account.

Time for making choice of payment

The Bill provides that the resident has up to 28 days but can make their choice before the end of that period, including on the day of entry. Requiring individuals to enter a home before being able to make a choice gives the resident security of tenure and enables them true choice in how they make their payment.

The price of accommodation is agreed before the resident enters care and providers will still receive that agreed price from the time that residents enter care, in the form of a daily payment.

Retention amounts

Under the current aged care legislation, providers are able to deduct up to $3,876 per year from an accommodation bond for up to five years. This does not require the agreement of the resident.

The reforms will mean that deductions from refundable deposits can only be made with the resident's agreement. The Productivity Commission recommended removal of retention amounts to improve the transparency of pricing arrangements.

A number of submissions have expressed concern over the possible impact of the removal of providers' ability to compulsorily deduct retention amounts from a RAD (bond).

However, it is important to appreciate, and it is not clear this has been understood in a number of submissions to the inquiry, that the removal of retentions does not prevent an aged care home from receiving the equivalent revenue flow from accommodation payments as they do currently, nor does it mean that a resident will have to pay more for their accommodation than they would under the current arrangements. Some providers are starting to understand this element of the arrangements. The UnitingCare Australia network, which includes 8% of total allocated aged care places nationally, had initially suggested in its submission that a retention amount should remain as an option for consumers. UnitingCare subsequently advised the Committee:

> "The retention on bonds is in theory compensated by the fact that there are changing arrangements for the way that you can charge accommodation charges."
>
> "The way that the legislation has been structured it is not as significant an issue as it might have been. It will be more difficult than the current arrangements for providers to enable people to access care, but it can be done. In the scheme of things that is not as significant as we thought it would be. I think it is better that that is put on the table. There have been changes in the way that you can charge for accommodation payments which overcome most of the issues around retention."[3]

[3] Senate Community Affairs Legislation Committee Inquiry, 30 April 2013, Hansard page 67

As long as an accommodation price is set in accordance with the proposed accommodation payments guidelines a provider could charge an accommodation payment that provides an equivalent revenue flow to the amount that they are charging now with retentions. The difference is that a resident can choose whether they pay that amount by daily payment, lump sum, or a combination of both, including the ability to drawdown the daily payment from the lump sum.

Take for example a provider currently charging a lump sum of $100,000 and keeping the full retention amount of $323 per month. The provider could calculate an accommodation price for these amounts in both daily and lump sum terms, which provides an equivalent cash flow, and the resident could choose how they pay.

- If paid entirely as a daily payment, the amount for this scenario would be $31.58 (using MPIR as at Dec 2012).
- If paid entirely as a refundable accommodation deposit, it would be $150,866 (fully refundable).
- The resident can also choose to pay a combination of a refundable deposit and a daily payment. One possible combination would be a $100,000 lump sum (subject to being left with the minimum permissible assets level as is currently the case) and daily payments of $10.65, approximately $323 per month.

Providers will continue to be able to keep deducting retention amounts from accommodation bonds or entry contributions for residents who entered care prior to 1 July 2014 under the grandparenting arrangements.

Method for converting a DAP into a RAD using the maximum permissible interest rate (MPIR)

Under the reforms providers are required to offer residents a choice of payment between a DAP or RAD and the Minister may determine the methodology for converting a DAP amount to a RAD. The Minister has announced a formula that uses the MPIR.

Some submissions have raised concerns that the MPIR will rise when interest rates rise, causing RADs to fall in value (for a given value of DAP) when the cost of borrowing is also rising. Concerns have been expressed that movements in RAD values as interest rates move will provide less certainty to providers over RAD flows.

Changes in RAD values would not affect residents already in care as they have agreed a price with the provider based on the MPIR at the time they entered care.

Some submissions have suggested a different rate be used such as some measure of the industry's weighted average cost of capital (WACC).

Impact of movements in the MPIR on RAD values

Submissions on this issue have tended to focus on the impact of rising interest rates on RAD values. However, the submissions have generally not provided a balanced analysis of all relevant issues and have not considered this issue in the context of the broader package of aged care reforms. The submissions have generally not considered:

- That the MPIR is likely to move in both directions over the longer term, resulting in RAD values that will also rise when interest rates fall.

- That there is significant flexibility under the announced methodology to moderate the impact of changes in the MPIR by adjusting the DAP in response to interest rate changes. This allows the provider to maintain a desired RAD value, or mitigate movements.
    - For example, on 1 July 2014 a provider may publish a DAP of $50 with an equivalent RAD of $238,845 (based on the December 2012 MPIR of 7.62%). On 1 October 2014, the MPIR may rise to 8%. If the provider chooses to keep their DAP at $50, the equivalent RAD becomes $227,500.
    - However, under the current methodology, the provider is also able to retain their RAD at $238,845 by adjusting their DAP to $52.49.
- The potentially significant increase in the potential RAD pool resulting from the removal of restrictions on lump sums in high care which may offset the impact of any changes in the value of RADs in current low care places.
- Greater flexibility in payment arrangements for residents, including the ability to make the agreed accommodation payment by drawing down a DAP from a RAD.

The concerns on this issue are also partly a subset of concerns noted earlier on the broader choice of payment issue, that is, that providers will no longer be able to require a particular value of lump sum payment as the resident will be provided with choice.

Use of the MPIR

The methodology and use of the MPIR was recommended by the Aged Care Financing Authority (the Authority) after consultation with industry.

The use of a market-based interest rate such as the MPIR creates a relationship between accommodation payments and the financial market.

- The situation where the RAD decreases (for a given value of DAP) due to increasing interest rates reflects the position that as interest rates rise, the amount of lump sum needed to generate a specified level of return on investment (equal to the DAP amount) falls.
- Similarly, the RAD will increase (for a given value of DAP) when interest rates fall as a higher amount of RAD is then required to provide the same level of return.

The Authority advised that the continued use of the MPIR as the rate for determining equivalence of lump sum and periodic payments was appropriate, as it broadly reflects the treatment of a lump sum payment as unsecured finance.

The Authority considered but did not recommend using the Weighted Average Cost of Capital (WACC) to calculate equivalence for a number of reasons, including that the WACC varies significantly between businesses, dependent on how they are structured. The WACC is not a fixed rate across industry. This is because the equity component of the WACC incorporates company specific premiums, and companies and their investments face different costs of debt finance which are sensitive to broader market circumstances.

References to ‘capping’ of accommodation payments

Some submissions have suggested that there is a cap on the size of accommodation payments, implying that prices above a certain level cannot be charged.

There is no ‘cap’ on accommodation payments.

Prices of up to $85 per day can be charged on a self-assessment basis, in accordance with the accommodation payment pricing guidelines. Providers wishing to charge in excess of $85 per day can charge that price if approved by the Aged Care Pricing Commissioner. The criteria for assessing applications have been set out in the draft accommodation payment pricing guidelines. Consultation on the draft accommodation payments guidelines closed on 1 May 2013. Feedback was received from industry groups, consumer groups, advisory bodies and both not for profit and for profit providers. The Government is now considering comments received.

Aged Care Pricing Commissioner

Some submissions have raised concerns over the Aged Care Pricing Commissioner's (ACPC) operation.

The ACPC is an independent statutory officer and all decisions will be made under the ACPC's authority.

While section 95B-11 of the Bill allows the ACPC to delegate all or any of his/her functions to an APS employee in the Department, it is expected that the ACPC will make all decisions.

Some submissions also have noted that the ACPC has the power to delegate functions to officers of the Department and that this could lead to a conflict of interest for such officers. However Departmental officers assigned to work for the ACPC will not have other Departmental functions.

These arrangements are the same as those which apply to the Aged Care Commissioner and which have worked appropriately.

All ACPC decisions will be reviewable – the legislation includes mechanisms for the ACPC to reconsider his or her own decisions, and for the Administrative Appeals Tribunal to review the ACPC's decisions.

Accommodation bond protections

UnitingCare suggested possible changes to the arrangements for the bond security levy that were introduced in 2006 on the basis that they have the potential to unfairly penalise competent providers for the failure of others.

The Accommodation Bond Guarantee Scheme (Guarantee Scheme), which included levy arrangements, was supported by industry when introduced in 2006. The arrangements benefit all approved providers by maintaining the public confidence in the aged care sector and the security of more than $13 billion in residents' savings which is essential to maintaining this source of funding.

The Government did propose in the original reform package to require aged care providers to privately insure bonds (and refundable deposits) from 1 July 2014. However, after further consideration of the matter, including industry and consumer feedback, the Government decided that neither the sector nor the insurance market were ready for an insurance-based solution at this time. Instead the existing Guarantee Scheme is being continued and expanded to ensure that the lump sums paid by consumers now and in the future continue to be protected, providing certainty for providers and consumers.

The legislation currently provides that the Minister may decide to levy the industry to recover costs incurred by the Commonwealth in refunding accommodation bonds to consumers in the event of a provider default. To date, while the Guarantee Scheme has been triggered on five occasions and the Commonwealth has paid out approximately $24 million, the levy arrangements have not been used.

The decision on whether to levy approved providers to recoup the costs of the Guarantee Scheme is a decision for the Minister. It is important to note that a liability is only created if a levy is imposed.

It would not be appropriate to impose a time limit as this may constrain the Department's capacity to pursue defaulting providers to recover costs of the Guarantee Scheme. It is essential to seek to take action against these approved providers as this reduces the moral hazard impact of the Guarantee Scheme and holds them accountable for their failure to refund bonds. However, this can take time. A time limit would also increase the risk of there being a shortfall which might then be met by the imposition of a levy. Should a Minister decide to levy the industry in the future, the legislation provides for flexibility in how and to what extent the levy would be applied.

The issue of bond (and refundable deposit) protections is included in the list of issues to be considered under the review of the reforms provided for in the Bill (clause 4).

Prudential standards

Reforms to the accommodation bond regime in October 2011 provided clearer and stronger arrangements to protect accommodation bonds. The arrangements clarify the intended purpose of bonds by restricting approved providers to certain permitted uses of bonds. The permitted uses are mainly built around acquisition and significant development of capital assets; investments to generate income for the approved provider; and repayments of bonds.

Providers are required to adhere under these arrangements to a new governance standard which requires them to have in place clearly articulated governance arrangements for the management and use of bonds. There is also greater transparency and accountability for bonds through strengthened reporting to the Commonwealth and additional powers by which the Commonwealth can require providers to provide information.

The Minister for Mental Health and Ageing, the Hon Mark Butler MP, recently provided policy approval to expand the permitted uses for accommodation bonds. Minister Butler has approved expanding permitted uses to:

- allow for loans of bonds for repayment of debt incurred for the purposes of aged care capital expenditure and for the repayment of bonds (i.e. the uses defined by section 57-17A(d) and (e) of the *Aged Care Act 1997* (the Act); and
- allow for bonds to be placed directly with Religious Charitable Development Funds. This will be subject to the implementation of an Investment Management Strategy, as is currently the case for investment of bonds in financial products other than investments into a deposit-taking facility made available by an authorised deposit-taking institution in the course of its banking business.

The arrangements also put in place criminal penalties in relation to use of bonds outside the permitted uses. These penalties may apply where bonds have been used incorrectly and the

Commonwealth's Guarantee Scheme is triggered within two years. The penalties may apply to the approved provider, or individually to key personnel of the approved provider who were able to influence the use of bonds.

The changes will be brought about through amendments to the *User Rights Principles 1997* (the Principles), as provided for by section 57-17A of the Act. While these changes are not part of *Living Longer Living Better* reforms, it is anticipated that the amendments will be made in association with the amendments to the Principles through that process.
It is intended that the changes will be in place before the end of the transition period for accommodation bond use that expires on 1 October 2013.

The industry was supportive of the reforms, with stakeholders acknowledging the balance that the changes strike between giving providers access to capital and protecting the life savings of care recipients. Moreover, it strengthened protection while managing the additional regulatory burden imposed on approved providers. Prudential regulation reinforces the role of approved providers in managing the risks of defaulting on accommodation bond refunds. However, it is not possible for regulation to completely remove the risk of failure and the Guarantee Scheme provides a safety net for these cases.

Aged Care Means Testing

Introduction

To ensure the ongoing sustainability of the aged care system there will be new arrangements for ensuring that those care recipients who are in a position to do so contribute appropriately to the cost of their care. These changes will apply from 1 July 2014.

There is considerable agreement that people who can afford to contribute to their care should do so. This view was strongly supported in submissions to the Productivity Commission and was reflected in their findings.

Similarly the NACA blueprint stated the required reforms will "Increase Australia's ability to pay for aged care services through a combination of Government funding and co-contributions from older people according to their financial capacity". This view is also reflected in a number of submissions to the Inquiry.

The reforms improve the equity of the means testing arrangements.

- Income tested fees will be applied consistently in home care, in contrast to the current system where different care recipients with the same incomes and receiving the same care are charged different fees.
- In residential care, both assets and income will be tested, improving the equity of the arrangements. Currently, asset rich and income poor residents may pay for all of their accommodation but little for their care, while income rich and asset poor residents pay for their care but do not contribute to their accommodation.

While these changes will help provide a more sustainable system, the Government will continue to provide significant and growing subsidies, and be the main contributor to the cost of care for aged care recipients.

In developing this attachment the Department has considered the evidence provided in submissions and at the hearings, including by UnitingCare and Kalyna Care.

This attachment specifically addresses the following questions asked by the Committee: 1-8, and 12.

1. As discussed during the hearing, could the Department outline the reasoning on user co-payments for Home Care services on low to moderate incomes (part pensioners), where a person on $35,000 per annum will potentially be paying 23% of their income in fees but a person on $43,186 will only be paying 19% of their income. Did the Department consider the fairness of this approach?
2. The care contributions don't seem to address the cost of living for part-pensioners, particularly single part-pensioners. Have you modelled the impact of spending 25% of total income on a pensioner – particularly a part pensioner who is not in possession of their own home?
3. Can the Department provide any modelling on alternative tapering rates?
4. Some submitters have raised concerns about older people self-selecting out of the home care that they need, to minimise costs in the face of what they perceive as high fees – particularly while other programs like HACC are being phased out, the price difference between HACC and these packages can be significant. Has any research been done on the potential responses of older people to the increased charges for Home Care?

5. Some of our submitters raised concerns about self-rationing in the context of the service providers duty of care to ensure that the older person who is reducing their service due to concern about fees isn't left vulnerable through lack of appropriate services. How do you propose service providers address this situation and ensure that those people who need care receive it, even if they don't want to, or are not in a position to, pay?
6. We also heard from Community Care providers that there is already a difficulty in collecting the basic fee from older people using these services. Do you think service providers should bear the costs of care when people refuse to pay, and to effectively become "debt collectors" for unpaid Home Care co-payments?
7. Have you provided any advice to service providers about how they can manage the period in which they are unable to collect fees for service – are you recommending that they reduce services where clients fail to pay?
Note: the committee understands that while there are hardship provisions in the act, these processes take some time and providers will need to bear the costs in the interim particularly in individualised packages where there is no opportunity to smooth costs as there is with block funding.
8. Kincare indicated that they had been experimenting with price signals to encourage clients to contract services in the 'off-peak' time in order to smooth the workflow, which also allows staff to have more hours of work per day. Is their scope for providers of home care to use price signals when negotiating with consumers about the delivery of the home care packages? Why/Why not?
12. Concerns have been raised about whether Human Services will be able to conduct the means testing within the 28 day period, particularly for regional clients. Do you have a response to those concerns? Why is there no time frame for assessment set out in the legislation?

Fees in residential care

Some submissions raised concerns over the fees and charges payable in residential care.

As noted the new arrangements address the current inequitable treatment of residents dependent on their asset and income mix.

There are important safeguards in the new arrangements:

- The Government will support those on low means by paying the full accommodation supplement and care costs (basic daily subsidy and primary supplements) for a care recipient with income less than the income free threshold and assets lower than the asset free threshold.
- An annual cap of $25,000 on means tested care fees applies to other residents.
- A lifetime cap of $60,000 applies to all care recipients covering both income tested care fees in home care and means tested care fees in residential care.
- Hardship provisions apply where a care recipient can apply to the Secretary of the Department for a hardship supplement.

Income testing in Home Care

The expansion of home care is an important feature of the reforms. The number of home care places available will increase by almost 40,000 to nearly 100,000 over the forward estimates (2013-14 to 2016-17). The additional places will cost $877.2 million over the forward estimates (2013-14 to 2016-17).

In addition, the introduction of four levels of home care will enable care recipients to receive a seamless continuum of care at home. Over the ten years from 2013-14, the number of places will expand by almost 90,000 places to just under 150,000 places.

Outline of proposed arrangements and safeguards

Income testing is not a new principle in home care. There is an existing income test in home care which already allows providers to charge care recipients up to 50 per cent of their income above the basic rate of age pension.

However, under existing arrangements the Government does not reduce its contribution towards a person's care costs even where the provider charges an income tested care fee. This has implications for the long term sustainability of the aged care system, especially in the context that many older Australians wish to stay at home for as long as possible – a desire which is supported under the direction of the reforms through the significant expansion of home care places.

The proposed home care income testing arrangements save $268 million over the forward estimates (2013-14 to 2016-17). The amount grows significantly over time as grandfathering phases out and the increase in places is realised.

Important safeguards are built into the proposed income testing arrangements:

- There will be no income tested care fee for full pensioners and other individuals with incomes less than the maximum amount for a full pensioner.
- An annual cap will apply so that part pensioners, or those on equivalent incomes, will not contribute more than $5,000 a year in income tested care fees (or $13.74 per day).
- Self-funded retirees cannot be asked to contribute more than $10,000 per year in income tested care fees ($27.47 per day).
- A lifetime cap of $60,000 will also apply and cap the entire amount an individual contributes as income or means tested care fees across their lifetime (i.e. in both home care and residential care).
- Hardship provisions will be introduced in home care so that a care recipient having difficulty paying the basic daily fee, their income tested care fee or both can apply to the Secretary of the Department for a hardship supplement.

In contrast to the recommendations made by the Productivity Commission, assets, including the family home, have not been included in the income test in home care.

The new income test applies so that for every dollar of income a person earns above the income free area, the Government reduces its contribution by 50 cents. The provider can recoup this amount from the care recipient as an income tested care fee. Under the design of the test, a care recipient's disposable income still increases for every additional dollar he or she earns after fees have been paid.

It is estimated that 84 per cent of home care recipients will be in receipt of a full or part pension and will therefore either pay no income tested care fee at all or not more than $5,000 per annum in income tested care fees.

Taper rate for income testing – UnitingCare submission

In its submission, UnitingCare support the concept that care recipients who can contribute to the cost of their care should do so. However, they propose a softening of the impact on part-pensioners. The UnitingCare submission suggested an alternative approach with a lower taper rate so that for every dollar of income above the income free area, the Government would reduce its contribution by 25 cents (rather than by 50 cents). This would lower the

care recipient's contribution to their care but would also accordingly come with a substantial cost to the Government. This additional cost (or reduction in savings) is estimated to be $116 million over the forward estimates.

The UnitingCare submission focuses on fees as a proportion of total income. The concerns raised by UnitingCare, such as cost of living pressures, are better considered by focusing on remaining income after fees have been paid. The income testing arrangements are designed such that for each additional dollar of income a care recipient earns, the care recipient has more remaining income after fees have been paid, than had they not earned that extra dollar.

The table below is based on the table in the UnitingCare submission with two differences.

- A row has been added at the bottom of the table to demonstrate remaining income after fees have been paid.
- The maximum potential basic fee ($3,163) has been replaced with the average basic fee currently charged ($1,800). The arrangements in relation to the basic fee are not changing therefore there is no reason to assume that how providers approach fee charging of the basic fee will change.

A full pensioner with total income of $23,543 p.a. has $21,743 remaining after paying home care fees. The contribution the full pensioner is making is the basic daily fee which is, on average, $1,800 but can be up to 17.5 per cent of the basic single age pension as a daily payment (this is not income tested).

A part-pensioner with total income of $32,864 p.a. has $26,403 remaining after paying fees, approximately $5,000 more in remaining income when compared to a full pensioner (at the top of the income free area).

UnitingCare table from their submission adjusted to include remaining income after fees paid

Annual total income	$23,543	$32,864	$35,000	$43,186	$50,000	$55,952	$81,952
Basic fee	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800	$1,800
Care fee	$0	$4,661	$5,000	$5,000	$8,407	$10,000	$10,000
Total fee	$1,800	$6,461	$6,800	$6,800	$10,207	$11,800	$11,800
% income	8%	20%	19%	16%	20%	21%	14%
Remaining income	$21,743	$26,403	$28,200	$36,386	$39,793	$44152	$70,152

Differences between Home Care and Residential Care

The proposed means testing arrangements in home care and residential care differ. In home care, it is only a care recipient's income which would determine their contribution to care. In residential care it would be the care recipient's assets and income which determine their contribution to care as well as eligibility for an accommodation supplement.

Some submissions raised concerns over the different tests in residential care and home care. Assets are not considered when determining a care recipient's contribution to home care based on two factors. First in many cases the assets held by a care recipient are not liquid and

cannot be easily sold or generate an income – for example the home the recipient is living in, their car or their furniture. Secondly, attempting to distinguish between types of assets based on their liquidity would add another level of complexity to the arrangements.

Kalyna Care Submission

During the Department's appearance before the Committee it was requested that we respond to issues raised in the submission from Kalyna Care.

Kalyna Care included a worked example in their submission looking at fees for a Mrs Jones in home care and a Mrs Smith in residential care. There are some errors in the example. The Department's worked calculations are at **Appendix 5a**. The key issues to note are:

- That the difference in fees between Mrs Jones and Mrs Smith as a result of the respective income and means testing arrangements is $6,020 not $18,755 as indicated in the Kalyna Care submission. Mrs Smith's higher amount of fees reflects the inclusion of assets in the residential care arrangements.
- It would appear that Kalyna Care has included the basic daily fee (or standard resident contribution) in its calculation. These amounts (a maximum of 17.5 per cent of the basic single pension in home care and 85 per cent in residential care) are not income/means tested fees and have not changed from the current arrangements. The lower rate of these fees that apply in home care reflects that people in their home have additional costs to meet that those in residential care do not. Including these basic fees as care costs when trying to demonstrate a difference based on means has inflated the difference for reasons unrelated to means by $12,201.44 per annum.

We have also responded directly to Kalyna Care's letter to Peter Shergold, Chair of the Aged Care Reform Implementation Council. A copy of our response is at **Appendix 5b**. Please note, for simplicity we have used the figures included in Kalyna Care's Submission to the Committee.

Treatment of the home in residential care means testing

A number of submissions raised issues relating to the proposed capping of the value of the former home at $144,500 (March 2012 prices) for aged care means testing and the treatment of the former home (or its proceeds if sold) under the aged care means test and age pension means test.

A summary of the current and proposed arrangements for aged care means testing, including its interaction with the pension, has been provided for the Committee's information at **Appendix 5c**.

Home occupied by a protected person

The former home is currently exempt from any means testing if occupied by a protected person (such as a spouse). The Productivity Commission recommended removing this special treatment and to include the full value of the home in the means test.

The Government did not agree with this suggestion on the basis that removal of the 'protected person' arrangements would cause unnecessary hardship for spouses and close relatives of care recipients. A home occupied by a protected person thus remains exempt from the means testing arrangements for aged care and the age pension.

Home not occupied by a protected person – Aged Care Means Testing1

Under the reforms, the home is included in the residential aged care means test when not occupied by a protected person (as is the case under current asset testing arrangements) but its value is capped. The cap of $144,500 is designed to broadly maintain the current arrangements.

Currently the full value of the principal residence is included in the assets test that is used to determine whether the Government will pay an Accommodation Supplement on behalf of a particular resident. However, the Accommodation Supplement cuts out when a person's assets exceed about $108,266. This effectively means that the value of the person's former residence is 'capped' at $108,266. For most home-owners, it is the fact that they own a home at all that makes them ineligible for the Accommodation Supplement.

Under the proposed new arrangements, the threshold at which Government will no longer pay an Accommodation Supplement (for someone with income below the income free threshold) will be $144,500. This amount has been increased in line with the increase to the maximum value of the Accommodation Supplement (i.e. from $32 per day to $50 per day). In assessing someone's assets for the aged care means test, the value of the principal residence will be capped at $144,500. So, it is still the case that for most home-owners it is the fact that they own a home at all that makes them ineligible for the Accommodation Supplement.

For the purposes of the aged care income test, no income will be deemed to be derived from the home while it remains vacant. This is consistent with existing arrangements.

Home not occupied by a protected person - Age Pension Means Testing

Under the reforms there is no proposal to change the treatment of the home under the age pension means testing arrangements.

Where unoccupied, the value of the home will be exempt from the age pension asset test for two years. After this period the full value will be included. No income will be deemed to be derived from the home while it remains vacant.

Home rented out

Consistent with current arrangements, under the reforms if the home is rented out its value is not included as an asset and the rental income is not included in the age pension means test if the person is paying a DAP.

Under the aged care means test, the value of the home will be included in the asset test up to the cap ($144,500). Rental income from the home will not be included in the income test under the aged care means test where the person is paying a DAP.

Proceeds from sale of home

Once sold, the proceeds of the home are treated as any other cash asset under both the age pension means test and aged care means test. The full amount is included as an asset and any related income (e.g. deemed income) is included in the income test.

[1] The amounts given are in March 2012 prices.

If the amount is paid as a RAD then the amount will be exempt from the age pension means test, as is currently the case for accommodation bonds. However, the amount of the RAD will be included as an asset for the purposes of the aged care asset test. Interest earned on the RAD goes to the approved provider and hence is not included as income under the aged care means test.

Annual and lifetime caps

Annual versus Daily Caps

Some submissions argued that a daily cap should be applied to means tested care fees in residential care. These submissions also included incorrect figures which implied that a majority of care recipients would pay up to $200 per day without a daily cap.

The legislation does apply the annual caps differently in home and residential care. In home care the caps are effectively applied on a daily basis. This is because care recipients in home care would reach the annual cap quickly. This was considered to make it difficult to budget across the year. Whereas, in residential care very few care recipients are expected to reach the annual cap.

The suggestion that care recipients will pay a large care fee in residential care is incorrect. A care recipient would only be liable to pay $200 per day in care fees where they had high care needs and substantial wealth. That is, either income over $200,000 per annum or approximately $4 million in assets. The majority of care recipients entering residential care are not expected to possess these income and asset levels.

An annual cap in residential care was considered preferable to a daily cap as it gave care recipients greater ability to budget and anticipate their costs. It also meant that where a care recipient's wealth enabled them to make a greater contribution to their care (limited by their actual costs of their care) they could be asked to do so.

Administration of caps

Some submissions asked for additional clarity around the operation of the proposed annual and lifetime caps, including the indexation arrangements.

The caps apply to means tested or income tested care fees paid on or after 1 July 2014 by care recipients who do not meet the definition of a continuing care recipients[2]. Payments made towards accommodation costs, the basic daily fee (home care) or standard resident contribution (residential care) do not count towards the caps.

The Department of Human Services will keep a tally of the amount by which the basic subsidy and primary supplements paid by the Government subsidy are reduced for each care recipient as a result of the income and means testing arrangements. Once the sum has reached one of the caps the Government will cease reducing its contribution and pay the full cost of a care recipient's care costs (i.e. basic subsidy and primary supplements).

[2] A continuing care recipient is a care recipient who was in care before 1 July 2014 and has not left care (other than on approved leave) for longer than 28 days or moved to a new facility and elected to move to the new arrangements.

The caps will be set in determinations and will be subject to indexation. The expectation is that the caps will be indexed annually in line with the indexation of the basic subsidy, primary and other supplements. Consistent with the broader practice of the Department, the indexation parameters are not published. There is also no single rate of indexation that applies to all Australian Government expenditure on aged care. Subsidies and supplements are indexed differently according to the underlying cost drivers of each payment type (e.g. the proportion of wage and non-wage costs within the total cost). The formula for calculating the relevant indexes are based on the minimum wage decisions of Fair Work Australia and movements in the Consumer Price Index as a measure of increases in non-labour costs.

Supporting the new arrangements

Timeliness of DHS assessments

Some submissions raised a concern as to the timeliness of income and asset assessments.

As is currently the case the Department of Human Services (DHS) will be responsible for determining income and asset assessments, except where the care recipient is a Department of Veterans' Affairs' (DVA) customer. In those cases, income and assets will be determined by DVA. Where the care recipient is already in receipt of an age pension or Veterans' pension their income assessment will be known. It will just be a matter of having an asset assessment completed.

Formal arrangements already exist between the Department of Health and Ageing and both DHS and DVA in relation to asset testing which requires that these agencies complete the majority of assessments within 14 days. The 14 day period commences from date of receipt of the form if all relevant questions have been answered. There are occasions where the person's situation is complex and therefore the assessment can take longer than 14 days. DHS has completed 97 per cent of asset assessments within the agreed time frames in the financial year to date. This is consistent with their performance since they began testing on 1 July 2005. The most common causes of delay are the form not being completed correctly or in full, or the necessary supporting evidence not being attached. When the form has not been completed correctly DHS or DVA have to write to the applicant to obtain the necessary information.

Where the care recipient is not an existing customer of either DHS or DVA the care recipient will need to complete a form seeking both an income and asset assessment. There is no reason that determining the means tested amount in these circumstances would take any longer provided that the person's circumstances are not complicated, the application form has been completed in full and accurately, and the necessary supporting evidence has been included with the application.

The Department is working with DHS and DVA to ensure an efficient administration system.

Ensuring consumers understand the means testing arrangements

Some submissions considered additional information needed to be made available to explain the means testing changes.

Following passage of the legislation the Department intends to work with relevant stakeholder groups, particularly consumer groups and financial planners, to ensure comprehensive information is available to support consumer understanding of the new

arrangements. The timing has to be carefully managed to avoid confusing consumers who are entering under the current arrangements and for whom the new arrangements will not apply as they will be grandparented. Initial discussions on this issue have been held with the Ageing Expert Advisory Group.

The My Aged Care website will provide information on aged care for consumers, including explanatory information on the current and planned means testing arrangements for residential care. This information will be supported by a “Fees Estimator” which will enable prospective care recipients and their families to enter asset and income information and obtain an estimate of the care fees they could be asked to pay, their eligibility for an Accommodation Supplement and if they could be asked to pay an Accommodation Payment.

The national contact centre being established as part of the Aged Care Gateway will help consumers to understand and use the information on the My Aged Care website, and refer for more specialised advice.

Worked calculations based on Kalyna Care's Submission to the Committee

Mrs. Smith - Calculation of means tested care fee for residential care (March 2012 prices)

Assume:

The total assessable income free area is $22,701
The asset free area is $40,500
The first asset threshold is $144,500
The second asset threshold is $353,500
The maximum Accommodation Supplement is $50 per day

As per the details included in Kalyna Care's submission, Mrs Smith has sold her home and opted to pay a refundable accommodation deposit of $350,000

Assessable Assets
Proceeds from sale of home: $350,000
Investments: $200,000
Total: $550,000

Income
Part-Pension: $17,593
Income earned from investments: $ 8,000 (The actual income earned would be different as investment income is calculated at a deemed rate based on DHS published deeming rates)
Total: $25,593

Care Fee Calculation
Step 1: Calculate the income tested amount and asset tested amount
Step 2: Calculate the means tested amount
Step 3: Calculate the care subsidy reduction
Step 4: Calculate the means tested care fee

Income Tested Amount
Total assessable income = $25,593
$25,593 - $22,701 = $ 2,892
Annual (50% of excess) = $ 1,446
Daily (divided by 364) = $ 3.97[1] (rounded to 2 decimal places) (a)

Asset Tested Amount
Sum
1% of difference between first asset threshold & second asset threshold $ 2,090
17.5% of difference between asset free area and first asset threshold $ 18,200
2% of difference between 2nd asset threshold and total asset value $ 3,930
Annual amount $ 24,220

Daily (divide by 364) = $ 66.54[1] (rounded to 2 decimal places) (b)

Means Tested Amount = asset tested amount + income tested amount = $ 70.51 (a) + (b)

[1] These figures have been rounded for ease of use. Note that the Department of Human Services' payment system will not round, so actual numbers may be slightly different.

Care subsidy reduction (the amount by which the Government basic subsidy and primary supplements are reduced)
= means tested amount less the maximum accommodation supplement
= $70.51 - $50
= $20.51

Means tested care fee is $ 20.51 per day

Standard resident contribution paid by every care recipient irrespective of means is $ 42.21 per day

Total daily care fee (standard resident contribution plus means tested care fee) is $ 62.72 per day

Total annual care fees: $22,830.08 ($62.72 x 364 = $22,830.08)

Mrs Jones – Calculation of income tested care fee for home care (2012 prices)

Assume:

The total assessable income free area is $22,701
The income threshold for a single is $43,186
The first cap is $13.74 per day (ie $5,000 annually)
The second cap is $27.24 per day (ie $10,000 annually)

Income
Part-Pension: $17,593
Income earned from investments: $ 8,000 (The actual income earned would be different as investment income is calculated at a deemed rate based on DHS published deeming rates)
Total: $25,593

Income Tested Care Fee Calculation
Total assessable income = $25,593
$25,593 - $22,701 = $ 2,892
Annual (50% of excess) = $ 1,446
Daily (divided by 364) = $ 3.97[1] (rounded to 2 decimal places)

Income tested care fee is $3.97 per day

Basic daily care fee paid by all care recipients irrespective of means is $ 8.69 per day

Total daily care fee (basic daily fee and income tested care fee) is $ 12.66 per day

Total annual care fees: $ 4,608.24 ($12.66 x 364 = $4608.24)

[1] These figures have been rounded for ease of use. Note that the Department of Human Services' payment system will not round, so actual numbers may be slightly different.

Attachment 5b

Australian Government

Department of Health and Ageing

Mark Sheldon-Stemm
General Manager
Kalyna Care
344 Taylors Road
Delahey VIC 3023

Dear Mr Sheldon-Stemm

Means Testing Arrangements under the *Living Longer Living Better* Reforms

Thank you for your letter to Peter Shergold, Chair of the Aged Care Reform Implementation Council on the 18 April 2013. He has asked me to reply on his behalf.

As you are aware, new means testing arrangements will be introduced for care recipients entering into residential care on or after 1 July 2014. The new means test will combine an asset and income test to determine a means tested amount.

The impact of the means tested amount is best described in the attached diagram which is explained as follows.

Where a resident's means tested amount is zero (a fully supported resident), the Government will pay the full accommodation supplement applicable to that facility and the full amount of subsidy and supplements on the individual's behalf. The individual cannot be asked to pay a means tested care fee or an accommodation payment. This would be the case where the care recipient had income and assets below the asset and income free thresholds.

Where a resident has a means tested amount greater than zero but less than the annual maximum accommodation supplement (a partially supported resident), the individual will be eligible for only some accommodation supplement from the Government and can be asked to make a contribution towards their accommodation. The contribution can be no greater than the difference between the maximum accommodation supplement applicable to that facility and the accommodation supplement payable by the Government for the particular individual. The individual cannot be asked to pay a means tested care fee.

Where a resident has a means tested amount greater than the annual maximum accommodation supplement (a non-supported resident) the individual will negotiate their accommodation payment directly with the approved provider. No accommodation supplement will be payable by the Government. The individual may have to pay a means tested care fee. In this case the means tested amount will affect the amount of means tested care fee but will not affect the amount of accommodation payment.

In applying these rules, the means tested amount will first exhaust a person's eligibility for an accommodation supplement before determining the amount of means tested care fees payable.

I have provided specific responses to your questions in the attached.

In relation to the submission you made to the Senate Inquiry into the Living Longer Living Better Bills, the proposed means testing arrangements in home care and residential care do differ. In home care, it is only a care recipient's income which would determine their contribution to the cost of their care. In residential care it would be the care recipient's assets and income which determine their contribution to their care (if any) as well as eligibility for an accommodation supplement.

Assets are not considered when determining a care recipient's contribution to home care based on two factors. First in many cases the assets held by a care recipient are not liquid and cannot be easily sold or generate an income – for example the home the recipient is living in, their car or their furniture. Secondly, attempting to distinguish between types of assets based on their liquidity would add another level of complexity to the arrangements.

In relation to the asserted difference in means tested care fee payable by people with comparable wealth, we calculate a difference in means tested care fee and income tested care fee of $6,021 per annum between Mrs Smith and Mrs Jones, not $18,755.

Further information on the reforms and worked examples of the means testing arrangements can be found on the *Living Longer Living Better* website and in the Explanatory Memorandum to the Bill.

I hope this has been of assistance to you.

Yours sincerely

Rachel Balmanno
Assistant Secretary
Aged Care Reform Transition Branch
13 may 2013


Residential Care - Single person, March 2012 prices
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
Assessable assets
17.5% between 40,500 and 144,500, 1% between 144,500 and 353,500
2% for amounts over 353,500
$144,500 (asset level where accommodation supplement is zero, if income < $22,701)
Partially supported residents
Basic daily fee +
Accommodation Contribution
(some Accommodation Supplement)
No Means Tested Care Fee
Non-supported residents
Basic daily fee +
Accommodation Payment (no supplement) +
Means Tested Care Fee
$40,500 (Asset Free Area)
Fully supported
Pays basic daily fee only
Full Accommodation Supplement
No Means Tested Care Fee
$22,701 (Income Free Area)
Accommodation supplement is zero, if assets <$40,500 and income $59,101
$0
$10,000
$20,000
$30,000
$40,000
$50,000
$60,000
$70,000
Assessable Income
50% of income over Income Free Area

1. If Mrs Smith Decides to pay $350,000 as a RAD will this satisfy the threshold of the $144,500 and the provider can show that the full cost of accommodation has been paid (or deemed to have been paid)?

There is no threshold at which a person's accommodation is deemed to have been paid. At entry, Mrs Smith has assets greater or equal to the first asset threshold. As such she is not eligible for a Government Accommodation Supplement, instead she can be asked to pay an accommodation payment.

2&3. Therefore, if this is accepted to satisfy the full cost of accommodation then the only amount that would be calculated towards the cost of her care would be the $2,500 from her income and $2,000 from her assets above the $144,500. This would leave a deduction of $4,500 per annum from the Aged Care Provider's ACFI payment towards her care and she would be charged this by the aged care provider, as is the current case of the income tested care fee? Can you please confirm the above?

This is not correct. There is no threshold at which a person's accommodation has been met. Secondly, the legislation before Parliament provides that an amount paid as a RAD is treated as an asset and included when determining a care recipient's asset tested amount. It will therefore contribute to the amount of means tested care fee payable.

Based on March 2012 prices, Mrs Smith could be asked to pay a means tested care fee of $20.51 per day or $7,465.64 per year.

I have set out my calculations below and using the figures you provided in your submission to the Senate Inquiry.

Assume
The total assessable income free area is $22,701
The asset free area is $40,500
The first asset threshold is $144,500
The second asset threshold is $353,500
The maximum Accommodation Supplement is $50 per day

Assets

RAD:	$ 350,000
Investments:	$ 200,000
Total:	$ 550,000

Income

Part-Pension:	$ 17,593
Income on investments:	$ 8,000 (As per the amount given in the Kalyna submission)
Total:	$ 25,593

Means Tested Care Fee Calculation

1. Income Tested Amount

   Total assessable income = $ 25,593
   $25,593 - $22,701 = $ 2,892
   Annual (50% of excess) = $ 1,446
   Daily (divided by 364) = **$ 3.97**[1] (rounded to 2 decimal places) (a)

2. Asset Tested Amount

   Assessable Assets = $550,000
   Sum:
   2% of difference between second asset threshold and assets = $ 3,930

   1% of difference between first asset threshold & second asset threshold = $ 2,090

   17.5% of difference between asset free area and first asset threshold = $18,200

   Annual asset tested amount = $ 24,220

   Daily (divide by 364) **$ 66.54**[1] (rounded to 2 decimal places)(b)

Means Tested Amount	**$ 70.51** (a) + (b)
Care subsidy reduction ($70.51- $50)	$ 20.51
Means tested care fee	**$ 20.51**
Total annual means tested care fees $7465.64)	**$ 7,465.64 ($20.51 x 364 =**

4&5. In the case where Mrs Smith wants to pay an accommodation payment and is charged $50 per day, will this be taken to satisfy the requirement of full cost of accommodation (which is equal to the $18,200 as stated above) and the only amount that would be calculated towards her cost of care would be $4,500 per annum? Can you please confirm the above?

For this example, I assume that Mrs Smith has not sold her house, and instead has rented it to meet daily payments. In this circumstance the value of the house will be capped at $144,500 for the purposes of the asset test and the rental income will be exempt from the income test.

In this circumstance, Mrs Smith's means tested care fee would be $3,443.44 per annum. The difference may be based on the different amount we used as Mrs Smith's income. We determined Mrs Smith's income based on the amount of part pension she would receive given her assets and the $8,000 amount of income on her $200,000 cash asset (as per the Kalyna submission).

[1] These figures have been rounded for ease of use. Note that the Department of Human Services' payment system will not round, so actual numbers may be slightly different.

I have set out the calculations:
Assume:
The total assessable income free area is $22,701
The asset free area is $40,500
The value of the family home is capped at $144,500
The first asset threshold is $144,500
The second asset threshold is $353,500
The maximum Accommodation Supplement is $50 per day

Assets

Family home:	$ 144,500
Investments:	$ 200,000
Total:	$ 344,500

Income

Part-Pension:	$ 17,593
Income on investments:	$ 8,000
Total:	$ 25,593

Care Fee Calculation

Income Tested Amount
Total assessable income = $ 25,593
$25,593 - $22,701 = $ 2,892
Annual (50% of excess) = $ 1,446
Daily (divided by 364) = **$ 3.97**[1] (rounded to 2 decimal places) (a)

Asset Tested Amount
Total assessable assets = $ 344,500

Sum:
1% of difference between first asset threshold and total assessable assets = $ 2,000
17.5% of difference between asset free area and first asset threshold = $ 18,200

Annual asset tested amount $ 20,200

Daily (divide by 364) $ **55.49**[1] (rounded to 2 decimal places) (b)

Means Tested Amount **$ 59.46** (a) + (b)

Care subsidy reduction
($59.46 - $50) $ 9.46

Means tested care fee **$ 9.46**

Total annual means tested care fees **$3,443.44**

[1] These figures have been rounded for ease of use. Note that the Department of Human Services' payment system will not round, so actual numbers may be slightly different.

6. Will the $350,000 held by the aged care provider be exempt for Mrs Smith in regard to her Centrelink Pension Payments?

Yes, as is currently the case the amount paid as RAD will be exempt from the age pension means tests.

7. What if Mrs Smith sells the house for $350,000 and decides to pay the accommodation payment of $50 per day. Will this asset ($350,000 less the amount she is paying monthly for her accommodation payment) affect her pension and also be reviewed in terms of her payment under the aged care means test? Considering that she has turned a $144,500 asset into a $350,000?

Yes, the amount will impact the amount of means tested care fee Mrs Smith can be asked to make as well as her age pension.

The means tested care fee would be higher than the amount calculated in response to questions 2 and 3 above. This is because if Mrs Smith holds the asset as a cash asset income will be deemed to be earned on the amount, so Mrs Smith's income tested amount will be greater.

8 & 9. What would happen if Mrs Smith decided to pay (and the aged care provider agreed) only $40 per day towards her accommodation payment? Therefore leaving $10 per day under the limit set by the formula. Would this $10 per day or $3,650 per year then be deducted from her cost of care, which would be added to the $4,500 per annum amount above as a cost of her care? Can you please clarify this?

No, as Mrs Smith is a non-supported resident she will negotiate the amount of accommodation payment directly with her provider. The amount of Accommodation Payment Mrs Smith pays will not change the amount of means tested care fee payable.

Mrs Smith could still be asked to pay $3,443.44 per year in means tested care fees (assuming she has retained the house and rented it out as per questions 4 and 5).

10. There are now a series of questions that follow on from these in terms of a mixture of payments where Mrs Smith may pay an amount (say $200,000) as a refundable deposit and an amount as an accommodation payment (say $30 per day). There is any number of combinations that will occur under the above scenario, as each person's circumstances change.

As per the response to questions 8 and 9, the method by which the resident elects to pay their accommodation payment will not impact on the means tested care fee a person is required to pay.

Comparison of current and proposed means testing arrangements (March 2012 rates)

	Current Arrangements	Proposed Arrangements
Home Care Basic Fee	Providers may charge a Basic Fee (not income tested) of up to 17.5% of basic single age pension. Government does not reduce the level of subsidy paid by this amount.	Providers may charge a Basic Fee (not income tested) of up to 17.5% of basic single age pension. Government does not reduce the level of subsidy paid by this amount.
Home Care Income Tested Fee	Providers may charge an Income Tested Fee of 50% of income above $19,643. Government does not reduce the level of subsidy paid by this amount.	Providers may charge an Income Tested Care Fee of 50% of income above maximum income of a full pensioner ($22,701, single). Government will reduce the level of subsidy paid by an amount equal to the amount of income tested fee that can be charged. • Full pensioners will not pay any income tested care fee. • Part pensioners will pay no more than $5,000 per annum in income tested care fees due to the annual cap. • Self-funded retirees will pay no more than $10,000 per annum due to the annual cap. • A lifetime cap of $60,000 applies to income tested and means tested fees across both home care and residential care.
Residential Care Basic Fee	Providers may charge a Basic Fee (not means tested) of up to 85% of basic single age pension.	Providers may charge a Basic Fee (not means tested) of up to 85% of basic single age pension.
Residential Care Means Tested Fee	Providers may charge an **income** tested fee of 5/12 of income above maximum income of a full pensioner ($22,701, single).	A **combined income and asset** test is applied in determining both the level of means tested care fee and the level of accommodation supplement. The arrangements are represented graphically in the attached graph. • The income test component is the same as the income test in Home Care with a taper rate of 50% of income above the maximum income of a full pensioner ($22,701, single). • The asset tested component includes a proportion of assets above $40,500.[1] The former principal residence is treated differently from other assets – see below. As a result: • residents with low to moderate means do not pay a means tested care fee; and • residents with higher wealth will be liable to pay a means tested care fee. (Note income/asset interaction on graph.) An annual cap of $25,000 applies to means tested care fees in residential care and a lifetime cap of $60,000 applies to income tested and means tested fees across both home care and residential care.

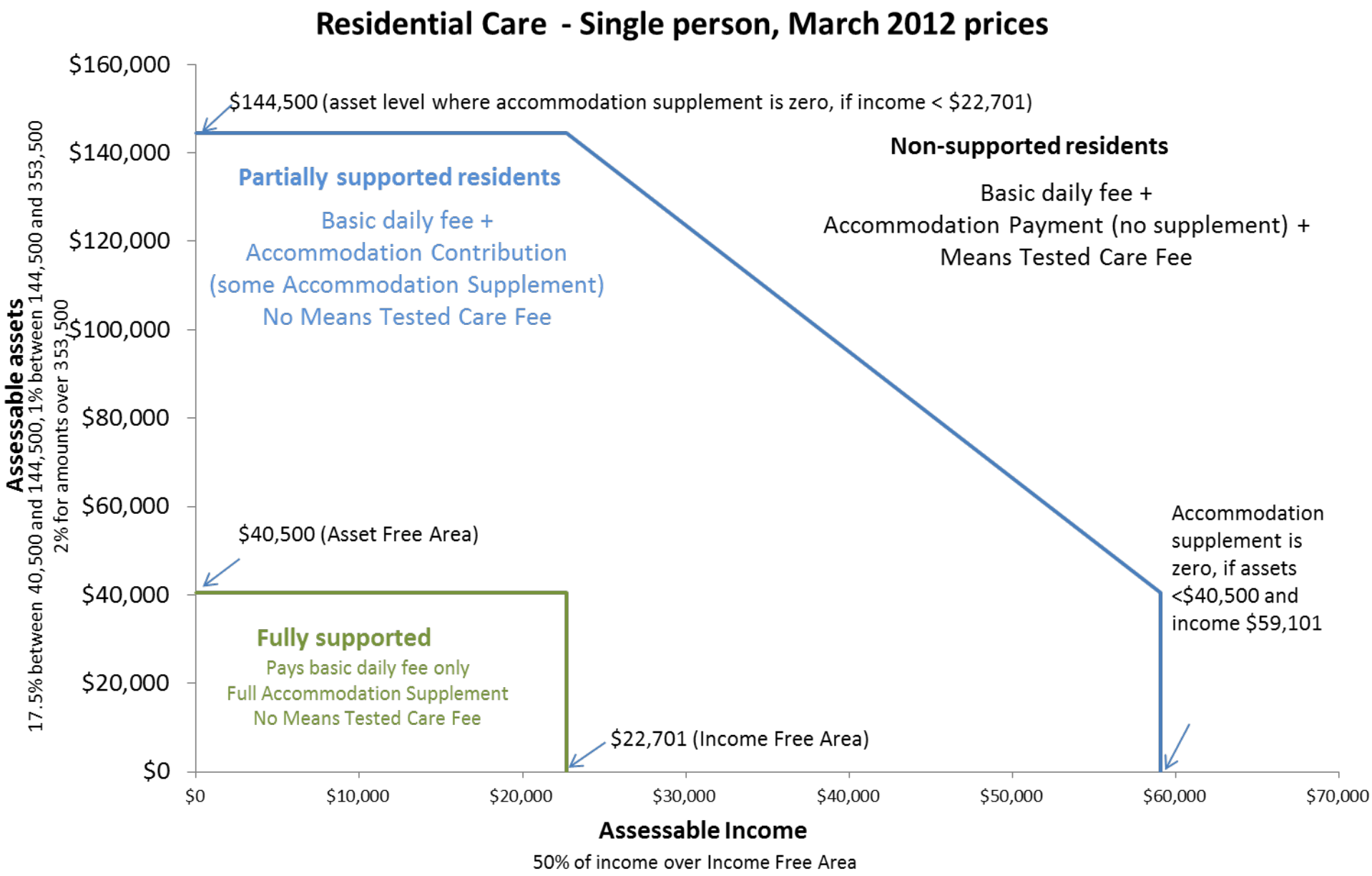
[1] 17.5% of the value of assets between $40,500 and $144,500, plus 1% of the value of assets between $144,500 and $353,500, plus 2% of the value of assets above $353,500

Accommodation costs	An assets test applies to determine the amount of Government accommodation supplement payable for those with low assets (assets below$108,266). The former principal residence is treated differently than other assets. This is explained further below.	As noted above, the combined income and asset test is also applied in determining the level of accommodation supplement (as well as the level of means tested care fee). • Residents with income below $22,701 (single) and assets below $40,500 will have their accommodation costs fully paid by Government through the accommodation supplement. • Residents with moderate means (note income/asset interaction on graph) will have their accommodation costs capped and are eligible for an accommodation supplement. • Residents with greater wealth will pay their own accommodation costs (note income/asset interaction on graph). The way the means test is designed means that it first determines whether a Government accommodation supplement is paid. If someone has higher means and is not eligible for any accommodation supplement, then the means test determines the means tested care fee.

Status of former principal residence	**Current Arrangements**	**Proposed Arrangements**
Occupied by a protected person	**Age Pension -** Not counted as an asset. Income from the asset not counted (nor deemed).	No change
	Aged Care – Not counted as an asset. Income from the asset not counted (nor deemed).	No change
Retained as an asset (but no protected person and not rented out)	**Age Pension** – Excluded for 2 years from asset test after the person has entered residential care. Not included in income test (ie: no deemed income)	No change
	Aged Care – Included in applying asset test on accommodation supplement which cuts out at asset level of $108,266. Not included in income test (ie: no deemed income) and hence does not affect income tested care fee.	Included in applying asset part of means test. Value capped at $144,500 (same level that accommodation supplement cuts out). Not included in income test (ie: no deemed income). Former principal residence on its own does not affect means tested care fee.
Rented out (to other than protected person)	**Age Pension** – Asset and rental income excluded while the person remains in residential care and is paying a bond by periodic payment or an accommodation charge. If not paying a bond by periodic payment or an accommodation charge, the rental income will be included in the income test, and after 2 years, the value of the asset will be included in the asset test.	No change
	Aged Care – Included in applying asset test on accommodation supplement which cuts out at asset level of $108,266. Rental income fully excluded if person is paying a bond by periodic payment or if paying an accommodation charge. Otherwise rental income included.	Included in applying asset part of means test. Value capped at $144,500 (same level that accommodation supplement cuts out). Rental income fully excluded if person is paying a full or part DAP. Otherwise rental income included. Former principal residence on its

		own does not affect means tested care fee.

Accommodation Bond/Refundable Accommodation Deposit	**Age Pension** – Value of bond excluded. No deemed income on bond.	No change
	Aged Care – Value of bond is not specifically excluded from definition of assessable assets in legislation, though means tested only on entry to care at which point bond generally has not been paid.	Value of RAD is included in definition of assessable assets in legislation, so where means are re-tested after entering care value of Refundable Accommodation Deposit would be counted.
Proceeds from sale of principal residence	**Age Pension** - If used to pay a bond as above. Included in tests if converted into any other form of asset and income will be deemed to be earned on the asset.	No change.
	Aged Care - Assets are assessed only once, generally at entry. If the residence has been sold prior to this, the proceeds would be included in the asset test to determine whether an accommodation supplement is paid. If the proceeds are held (not paid as a bond) then an income test will apply and the income deemed to be earned from the proceeds will impact the income tested care fee. If used to pay a bond, no income will be deemed to be earned from the amount.	Proceeds will be treated as an asset in the means test. If not used to pay a RAD, income will be earned at the deeming rate. If proceeds used to pay a RAD, the value of the RAD will be included as an asset, but no income will be deemed. The asset test can be applied more than once.


Residential Care - Single person, March 2012 prices
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
Assessable assets
17.5% between 40,500 and 144,500, 1% between 144,500 and 353,500
2% for amounts over 353,500
$144,500 (asset level where accommodation supplement is zero, if income < $22,701)
Partially supported residents
Basic daily fee +
Accommodation Contribution
(some Accommodation Supplement)
No Means Tested Care Fee
Non-supported residents
Basic daily fee +
Accommodation Payment (no supplement) +
Means Tested Care Fee
$40,500 (Asset Free Area)
Fully supported
Pays basic daily fee only
Full Accommodation Supplement
No Means Tested Care Fee
$22,701 (Income Free Area)
Accommodation supplement is zero, if assets <$40,500 and income $59,101
$0
$10,000
$20,000
$30,000
$40,000
$50,000
$60,000
$70,000
Assessable Income
50% of income over Income Free Area

Aged Care Workforce Supplement

Introduction

A skilled, stable and adequately qualified workforce is essential to deliver quality aged care for the growing number of older Australians, many of whom have complex health needs. The Australian Government supports a range of workforce initiatives designed to provide additional training opportunities for staff and to create better career paths. These initiatives assist providers to meet their responsibilities under the *Aged Care Act 1997*.

The Aged Care Workforce Supplement complements the range of training and education initiatives funded by the Government by improving the aged care sector's capacity to attract and retain a skilled and productive workforce. The Workforce Supplement assists the sector in delivering fair and competitive wages in the short-term, while longer term options for meeting the challenges of the sector are considered by the Aged Care Financing Authority.

This attachment summarises aged care workforce support, in particular the role played by the Workforce Supplement, and provides information on those issues where the Committee, during the hearing, requested additional information.

Aged Care Workforce Supplement

As part of the Addressing Workforce Pressures measure in the *Living Longer Living Better* aged care reform package, aged care workers employed by providers who meet the eligibility criteria for the Aged Care Workforce Supplement will receive better pay and conditions. The Australian Government will make a contribution to increased wages through the Workforce Supplement.

Through the Workforce Supplement, people working in aged care and their employers will benefit through improved wages, enhanced training and education opportunities, and improved career structures, career development and workforce planning. There will also be more data and information available through participation in the Aged Care Workforce Census and Survey.

In order to be eligible for the Workforce Supplement, employers must undertake to provide employees with annual wage increases that meet the following requirements:

a) annual increases in wages of a minimum of 2.75 per cent per annum, or the Fair Work Commission annual minimum wage increase, whichever is higher;
b) wages exceed the relevant Award rates for all staff by at least the percentage margin shown in Table 1 below;
c) subject to the Department's determination that the Aged Care Workforce Supplement is payable, the approved provider will further increase wages by a minimum of 1 per cent each financial year that the supplement is payable to 2015-16 and by 0.5 per cent increase in 2016-17.

Table 1 Percentage margin over the relevant award rate

Aged Care Worker	2013-14	2014-15	2015-16	2016-17
Personal and community care workers and other aged care staff	1.50%	3.00%	3.00%	3.00%
Enrolled nurses	2.50%	5.50%	8.50%	8.50%
Registered nurses	4.00%	8.00%	12.60%	12.60%

Wage increases can be expected to start from 1 July 2013.

In addition to the wages requirements, there are other minimum commitments for aged care providers to meet in order to access the Workforce Supplement, which are intended to improve the capacity of the aged care sector to attract and retain employees. These are:

- enhancing training and education opportunities, including access to training and education, professional development, and representation leave; and
- improved career structures, improved career development and workforce planning, including through review of part-time hours, conversion of casual employees to permanent employees, workload management, workplace health and safety, and disciplinary matters.

In order to access the Workforce Supplement, aged care providers must also take part in the Department of Health and Ageing's regular Aged Care Workforce Census and Survey.

Details about the Workforce Supplement, including the eligible programs, eligibility criteria, minimum wage increases, payment arrangements, and compliance arrangements, are detailed in the Aged Care Workforce Supplement Guidelines currently available on the Department's website. Comments on the draft Guidelines are being sought as part of a consultation period through to the end of May 2013.

A copy of these guidelines has been included at **Appendix 6a**.

Aged Care Workforce Development Plan

The second element of the Addressing Workforce Pressures initiative is the establishment of an Aged Care Workforce Development Plan. The Plan will articulate the aims and objectives of the Australian Government's aged care workforce initiatives and set the framework for future priorities for improved career structures and pathways, better training and education, career development opportunities, better work practices, including less workplace injuries, and better workforce planning. The Plan will be developed in 2013 with representatives of care providers, consumer groups, and workforce representative bodies including unions and professional associations. Input will also be sought from other government agencies that fund aged care workforce training initiatives.

Aged Care Workforce Fund

The Aged Care Workforce Fund was established in 2011 to improve the quality of aged care by developing the skills of the aged care workforce. The Fund supports activities that target: knowledge transfer through education and training activities; the capacity of aged care workers and the ability of approved providers to effectively utilise them; innovation and reform to promote new and more effective ways of structuring working arrangements; and incentive payments for eligible aged care workers which encourage workers to undertake approved aged care certificates or nursing qualifications.

The Fund will deliver funding of more than $400 million over the next five years to support priorities identified in the Aged Care Workforce Development Plan.

Training support for Aboriginal and Torres Strait Islander people and people in rural and remote areas

One of the primary objectives of the Aged Care Workforce Fund is to support targeted workforce training and development strategies for priority target groups, specifically services in rural and remote areas and culturally diverse care workers including Aboriginal and Torres Strait Islander people.

Support is provided through a number of training and employment initiatives that enable access to skill development, experience and work readiness that will provide ongoing employment opportunities. Funding supports a range of culturally appropriate models of accredited training to Aboriginal and Torres Strait Islander aged care workers on-site within eligible remote communities. Support also includes funding for business and management traineeships to Aboriginal and Torres Strait Islander people in remote areas. Trainees are provided with a range of training from certificate level to advanced diploma courses. Support also includes the creation of permanent part-time positions, including funding for award wages and gaining access to superannuation and leave entitlements, and support in some instances to assist providers temporarily backfill positions so that staff can undertake development opportunities.

Specific questions from the Committee

What are the requirements regarding enterprise agreements and eligibility for the Workforce Supplement?

For those aged care providers that have an enterprise agreement in place, in order to access the Workforce Supplement, aged care providers must ensure that their enterprise agreement is consistent with the eligibility criteria. Information available to the Department indicates that 75 per cent of residential care employees and 60 per cent of employees in the community are already covered by enterprise agreements.

For those aged care providers that do not have an enterprise agreement in place:

- in order to access the Workforce Supplement, residential aged care providers with 50 or more operational places must put in place an enterprise agreement consistent with the eligibility criteria;
- residential aged care providers with fewer than 50 operational places and home care providers will need to certify that they meet the eligibility criteria, including that they have written to all employees advising that they have applied for the Workforce Supplement;
- providers of the Commonwealth Home and Community Care program, the National Respite for Carers program, and the Day Therapy Centre program will need to certify that they meet the eligibility criteria, including that they have written to all employees advising that they have applied for the Workforce Supplement; and
- providers of the Veterans' Home Care and Community Nursing programs will need to satisfy the Department of Veterans' Affairs that they meet the eligibility criteria.

What scope is there to create more generous and flexible eligibility criteria for other supplements such as the workforce supplement, for these [rural and remote] providers?

Supplements are purpose driven to deliver a specific outcome. Existing supplements, such as the Viability Supplement and the Oxygen and Enteral Supplement, all go to meet specific funding needs within the aged care sector.

The new Workforce Supplement aims to improve the aged care sector's capacity to attract and retain a skilled and productive workforce which is a key issue, in particular for regional and remote service providers. It aims to do so by providing funding to assist the sector in delivering fair and competitive wages in the short-term while longer term options for meeting the challenges of the sector are considered by the Aged Care Financing Authority.

The eligibility criteria have already been adjusted to take account of the needs of smaller residential aged care facilities, including in rural and remote areas. As outlined above, residential facilities with less than 50 operational places will be able to attract the workforce supplement through certifying that they meet the eligibility criteria, and that they have written to all employees advising that they have applied for the Workforce Supplement.

Under its Operating Framework, the Aged Care Financing Authority is giving particular consideration to special needs groups including rural and remote services, the homeless, Indigenous Australians and people from culturally and linguistically diverse backgrounds.

Regarding the information sent by the Department in April 2013, who was the information sent to?

In April 2013, the Department sent a package of information about the Workforce Supplement to aged care providers for them to provide to their staff. The materials provided were hard copies of existing public documents which were produced to support aged care workers in their understanding of the measure.

While these documents formed part of a package of communication materials designed to support peak bodies, employers and employees, as a result of an administrative error the documents were released prematurely and without the accompanying information which was to include draft guidelines on the Workforce Supplement for consultation and a covering letter to support providers.

The information was not sent to any individuals working in aged care.

The Department has apologised to aged care providers for sending out the information prematurely. A copy of the letter to industry peak bodies is at **Appendix 6b**.

The information in the package is currently available on the Department's website and is intended to support discussions between employees and employers about the Workforce Supplement.

Around the conversion from casual to part-time employments. As I understand it, the employee has the right to make a request within four weeks. The employer has the right to consent or refuse the risk. What are the grounds on which an employer can refuse such a request? Can you give us some examples?

On 2 May 2013, the Department of Health and Ageing released a draft of the Aged Care Workforce Supplement Guidelines for consultation to assist stakeholders in understanding the eligibility criteria for the new Workforce Supplement and to provide an opportunity to comment.

The guidelines set out that the employer may consent to or refuse the request, but shall not unreasonably withhold agreement to such a request.

While what can be considered to be reasonable may vary according to the individual circumstances surrounding each request, examples of where it would be reasonable to withhold such a request could generally include instances where the service's business requirements were quickly changing, or where an employee's request could not be accommodated within existing shift and rostering arrangements.

Australian Government
Department of Health and Ageing

AGED CARE WORKFORCE SUPPLEMENT

GUIDELINES

Consultation Draft

Version 2

Correct as at 9 May 2013

Comment and feedback to be provided to:

workforcesupplement@health.gov.au

by

30 May 2013

This version replaces the version released on 2 May 2013

CONTENTS

PART A — INTRODUCTION

Covered in this part:

- Aged care reforms
- Aged Care Workforce Pressures initiative
- Aged Care Workers and the Aged Care Workforce Supplement
- Purpose of this consultation draft

1 Aged care reforms

On 20 April 2012, the Australian Government released *Living Longer Living Better*, a comprehensive 10 year package to reshape aged care in Australia.

The *Living Longer Living Better* aged care reform package provides $3.7 billion over five years. It encompasses a 10 year reform program to create a flexible and seamless system that provides older Australians with more choice, control and easier access to a full range of services, where they want them and when they need them.

As part of these reforms, the Government announced up to $1.2 billion from 1 July 2013 for the Addressing Workforce Pressures initiative which will better support the people who work in aged care.

This initiative will be delivered in two parts, through:

- the Aged Care Workforce Supplement (the subject of these guidelines); and
- an Aged Care Workforce Development Plan.

2 Addressing Workforce Pressures initiative

An appropriately skilled and well qualified workforce is fundamental to the delivery of quality aged care, whether in residential aged care or in a person's home. The Aged Care Workforce Census and Survey, which is conducted every four years, has highlighted that aged care providers continue to have difficulties in attracting and retaining sufficient numbers of skilled and trained workers.

To enable the organisations providing aged care services to assist the growing number of older Australians, it is essential to build their capacity. This includes developing the workforce through better training, increased wages, changes to the workforce structure, better work practices and improved quality in the delivery of care.

The requirements included in these guidelines were developed in consultation with providers and unions during 2012-13 and contain a number of minimum commitments designed to build the capacity of the aged care sector.

From 1 July 2013, the Australian Government will provide additional funding through an Aged Care Workforce Supplement to aged care providers or organisations that meet the eligibility requirements. This additional funding will provide higher wages and better conditions for aged care workers.

The aim of the Aged Care Workforce Supplement is to:

- improve the aged care sector's capacity to attract and retain a skilled and productive workforce, and
- provide Australian Government funding to assist the sector in delivering fair and competitive wages in the short-term, while longer term options for meeting the challenges of the sector are considered by the Aged Care Financing Authority.

3 Aged care workers and the Aged Care Workforce Supplement

The Terms and Acronyms section of these guidelines provides important information about the staff members, employees or aged care workers that are to be considered in relation to the coverage of the Aged Care Workforce Supplement.

4 Purpose of this consultation draft

Comments and feedback from stakeholders on this consultation draft will inform the final guidelines for the Aged Care Workforce Supplement and relevant subordinate legislation.

These draft guidelines provide information for organisations on:

- proposed application and eligibility requirements for the Aged Care Workforce Supplement, and
- considerations in making the decision whether to apply for the Aged Care Workforce Supplement.

Question 1: After reviewing the guidelines, do they provide sufficient detail to assist your organisation in deciding whether to apply for the Aged Care Workforce Supplement?

If not, what additional information would assist?

PART B — PROVIDERS FUNDED AND REGULATED UNDER THE *AGED CARE ACT 1997*

Covered in this part:

- Eligible programs
- Application
- Eligibility criteria
- Compliance requirements
- Review of eligibility decisions
- Eligibility commencement date

1 Eligible programs

Residential aged care

An approved provider of residential care is eligible to receive the Aged Care Workforce Supplement in respect of a care recipient if subsidy is payable to the approved provider under Chapter 3 of the *Aged Care Act 1997* for the provision of residential care to the care recipient and the approved provider meets the eligibility requirements described at 3 below in these guidelines.

Home Care Packages

An approved provider of home care is eligible to receive the Aged Care Workforce Supplement in respect of a consumer if subsidy is payable under Chapter 3 of the *Aged Care Act 1997* for the provision of home care to the consumer and the approved provider meets the eligibility requirements described at 3 below in these guidelines.

2 Application

An approved provider must submit an application for the Aged Care Workforce Supplement in a form approved by the Department of Health and Ageing. The proposed draft form is attached to these guidelines.

3 Eligibility criteria

In order for the Department to determine that an approved provider is eligible to receive the Aged Care Workforce Supplement, the following criteria must be satisfied:

- The approved provider must have provided advice in writing to its staff of the provider's intention to apply for the Aged Care Workforce Supplement.

- If the approved provider is a provider of residential care with 50 or more operational residential care places, the advice to staff must include that the provider will negotiate an enterprise agreement with its employees that meets the minimum wage requirements described at 3.1 below, or negotiate a variation to an existing enterprise agreement so that it meets those requirements.
- If the approved provider is a provider of residential care with fewer than 50 operational residential care places, or is a provider of home care, the advice to staff must include that the provider will negotiate employment arrangements[1] that meet the minimum wage requirements at 3.1 below.
- The advice to staff must include information regarding how the approved provider intends to implement other workforce commitments as described at 3.2 below.
- The approved provider must give the Department an undertaking that it will participate in the Aged Care Workforce Census and Survey as described at 3.3 below and must comply with that undertaking.

3.1 Minimum wage requirements

The advice to employees referred to above must include an undertaking that:

(a) annual increases in wages (excluding the margin and the Workforce Supplement referred to in paragraphs (b) and (c) below) will be a minimum of 2.75 per cent per annum, or the Fair Work Commission annual minimum wage increase, whichever is higher[2];

(b) wages will exceed the relevant Award rates for all staff by at least the percentage margin shown in Table 1 below[3];

(c) subject to the Department's determination that the Aged Care Workforce Supplement is payable, the approved provider will further increase wages above the margin in paragraph (b) above by a minimum of 1 per cent each financial year that the supplement is payable to 2015-16 and by 0.5 per cent increase in 2016-17.

[1] A provider of residential care with fewer than 50 operational residential care places or a provider of home care may negotiate an enterprise agreement with its employees or negotiate a variation to an existing enterprise agreement to meet the wage requirements and other workforce commitments included in its advice to staff.

[2] If the Fair Work Commission determines a dollar amount, providers will be expected to convert the dollar amount into a percentage to achieve a minimum increase of 2.75 per cent or higher.

[3] The relevant Award rate includes but is not limited to modern awards. See Terms and Acronyms for information about modern awards.

On-costs are to be borne by providers or organisations, and cannot be offset against wage increases made using Aged Care Workforce Supplement funding. On-costs include superannuation (including the Superannuation Gurantee Charge) and provision for leave.

Table 1 Percentage margin over the relevant Award rates

Aged care occupations	2013-14	2014-15	2015-16	2016-17
Personal and community care workers and other aged care staff	1.50%	3.00%	3.00%	3.00%
Enrolled nurses	2.50%	5.50%	8.50%	8.50%
Registered nurses	4.00%	8.00%	12.60%	12.60%

Supporting information and examples of calculations relating to the minimum wage increase requirements can be found at Part D.

The method used by an approved provider to advise staff that the provider will be submitting an application for the Aged Care Workforce Supplement will depend on each provider's existing staff communication procedures. Providers will need to ensure that all staff are aware that the organisation has applied for the Aged Care Workforce Supplement. If a provider reasonably believes that all staff will be aware of information made available on the organisation's website, or via an email to all staff, or through some other means, then this condition will be met.

Staff engaged after the approved provider has applied for and is receiving the Aged Care Workforce Supplement must be advised that the approved provider is receiving the Aged Care Workforce Supplement.

3.2 Other workforce commitments

The advice to staff referred to above must include information regarding how the approved provider intends to implement other workforce improvements, as summarised in Table 2 below, in addition to the minimum wage increases summarised in 3.1 above in these guidelines.

Table 2 – Summary of minimum commitments to workforce improvements

Area	Workforce commitment
Enhancing training and education opportunities	• Access to training and education • Professional development • Representation leave
Improved career structures Improved career development and workforce planning	• Review of part-time hours • Conversion of casual employees to permanent employees • Workload management • Workplace health and safety • Disciplinary matters

Further detail on these commitments can be found at Part D.

3.3 Aged Care Workforce Census and Survey

In order be eligible to receive the Aged Care Workforce Supplement, an approved provider must participate in the Department of Health and Ageing's regular Aged Care Workforce Census and Survey.

This commitment refers to future census and survey activity. An approved provider is not prevented from applying for the Aged Care Workforce Supplement if it did not participate previously.

Approved providers of residential care are currently required to participate in the same census and survey to be eligible to receive the Conditional Adjustment Payment (CAP). Participation in the census and survey will continue to be an eligibility requirement for receipt of CAP payments.

4 Compliance arrangements

The Department of Health and Ageing is responsible for determining whether an organisation complies with the requirements of the Aged Care Workforce Supplement, and these guidelines, in relation to the programs administered by the Department of Health and Ageing.

The Application Form:

- asks applicants to specify the programs covered
- seeks details of the advice provided by providers to employees, and
- incorporates a Declaration by providers about the information provided on the Form.

The Department of Health and Ageing seeks to balance minimising the regulatory burden on providers and obtaining assurance from providers that the pay increases for aged care workers set out in these guidelines are achieved, and the minimum commitments are met.

In addition to the requirements set out in these guidelines and the Application Form, the Department is considering further steps relating to compliance.

The Department of Veterans' Affairs will be responsible for compliance arrangements in relation to VHC and Community Nursing programs.

Question 2 Are there additional assurance mechanisms that the Department should consider in relation to compliance with the requirements of the Aged Care Workforce Supplement?

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5 Review of decisions relating to eligibility

In respect of residential aged care and Home Care approved providers, if the Department decides that an approved provider is not eligible to receive the Aged Care Workforce Supplement, the approved provider may apply to the Department for reconsideration of the decision. A decision that has been reconsidered by the Department may be reviewed by the Administrative Appeals Tribunal.

6 Eligibility commencement date

An approved provider is eligible to receive the Aged Care Workforce Supplement from the relevant date specified below.

Approved providers who notify the Department prior to 1 July 2013 that they meet the eligibility criteria

- The Aged Care Workforce Supplement is payable to an approved provider from 1 July 2013 if, before that date, the approved provider gives the Department sufficient information to satisfy the Department that the approved provider meets the eligibility requirements specified in 3 above in these guidelines.

Applications received between 1 July 2013 and 31 December 2013

- If the Department receives an application in an approved form on or after 1 July 2013 and before 1 January 2014, and the Department is satisfied that the approved provider met the eligibility requirements specified in 3 above on 1 July 2013 or on a later date specified in the application, the Aged Care Workforce Supplement is payable from the date, on or after 1 July 2013 and before 1 January 2014, when the approved provider met the eligibility requirements.

Applications received on or after 1 January 2014

- If the Department receives an application in an approved form on or after 1 January 2014, and the Department is satisfied that at the time the application is received the approved provider meets the eligibility requirements specified in 3 above in these guidelines, the Aged Care Workforce Supplement is payable from the date the application is received by the Department.
- If the Department is satisfied that the application was not received within two days of the application being sent, the application will be taken to have been received two days after it was sent.
- In considering whether an application was sent more than two days before the application was received by the Department, the Department may have regard to any information, relevant to that question, that the approved provider gives to the Department.
- Applications received on or after 1 January 2014 that meet the eligibility requirements will be eligible to receive a level of the Supplement that applies at the time of application.

Question 3 Is the information provided sufficiently clear on the dates that are relevant to receiving the Supplement?

Note: The same question applies to Part C.

PART C — ORGANISATIONS FUNDED OTHER THAN UNDER THE *AGED CARE ACT 1997*

Covered in this part:

- Eligible programs
- Application
- Eligibility criteria
- Compliance arrangements
- Review of decisions relating to eligibility
- Eligibility commencement date

1 Eligible programs

Organisations delivering the Commonwealth HACC program, National Respite for Carers Program (NRCP) and Day Therapy Centre (DTC) programs

The Aged Care Workforce Supplement may be paid to an organisation funded through the Commonwealth HACC program, the National Respite for Carers Program (NRCP) and the Day Therapy Centre (DTC) program.

Home and Community Care (HACC) in Victoria and Western Australia

As at May 2013, the Commonwealth and state governments are discussing arrangements for HACC organisations in Victoria and Western Australia to access the Aged Care Workforce Supplement.

National Aboriginal and Torres Strait Islander Flexible Aged Care Program

The Aged Care Workforce Supplement may be paid to a provider funded through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

Department of Veterans' Affairs (DVA) programs

The Aged Care Workforce Supplement may be paid to an organisation funded through DVA to deliver services under:

- The Veterans' Home Care (VHC) Program which provides low level home care services to eligible veterans and war widows/widowers.
- The DVA Community Nursing (CN) Program which provides access to community nursing services to meet veterans' or war widows/widowers' assessed clinical and/or personal care needs in their own home.

2 Application

An organisation must submit an application for the Aged Care Workforce Supplement to the Department. The proposed draft form is attached to these guidelines.

3 Eligibility criteria

In order for the Department to determine that an organisation is eligible for the Aged Care Workforce Supplement, the following criteria must be satisfied:

- The organisation must have provided advice in writing to their staff of their intention to apply for the Aged Care Workforce Supplement.
- The advice to staff must include that the organisation will negotiate employment arrangements[4] that meet the minimum wage requirements at 3.1 below in these guidelines.
- The advice to staff must include information regarding how the provider intends to implement other workforce commitments as described at 3.2 below in these guidelines.
- The organisation must give the Department an undertaking that it will participate in the Aged Care Workforce Census and Survey as per the conditions described at 3.3 below in these guidelines.

3.1 Minimum wage requirements

The advice to staff referred to above must include an undertaking that:

(a) annual increases in wages (excluding the margin and the Workforce Supplement referred to in paragraphs (b) and (c) below) will be a minimum of 2.75 per cent per annum, or the Fair Work Commission annual minimum wage increase, whichever is higher[5];

(b) wages will exceed the relevant Award rates for all staff by at least the percentage margin shown in Table 1 below[6];

[4] An organisation may negotiate an enterprise agreement with its employees or negotiate a variation to an existing enterprise agreement to meet the wage requirements and other workforce commitments included in its advice to staff.

[5] If the Fair Work Commission determines a dollar amount, providers will be expected to convert the dollar amount into a percentage to achieve a minimum increase of 2.75 per cent or higher.

[6] The relevant Award rate includes but is not limited to modern awards.

(c) subject to the Department's determination that the Aged Care Workforce Supplement is payable, the provider will further increase wages above the margin in paragraph (b) above by a minimum of 1 per cent each financial year that the supplement is payable to 2015-16 and by 0.5 per cent increase in 2016-17.

On-costs are to be borne by providers or organisations, and cannot be offset against wage increases made using Aged Care Workforce Supplement funding. On-costs include superannuation (including the Superannuation Guarantee Charge) and provision for leave.

Table 1 Percentage margin over the relevant Award rates

Aged care occupations	2013-14	2014-15	2015-16	2016-17
Personal and community care workers and other aged care staff	1.50%	3.00%	3.00%	3.00%
Enrolled nurses	2.50%	5.50%	8.50%	8.50%
Registered nurses	4.00%	8.00%	12.60%	12.60%

Supporting information and examples of calculations relating to the minimum wage increase requirements can be found at Part D.

The method used by an organisation to advise staff that they will be submitting an application for the Aged Care Workforce Supplement will depend on each organisation's existing staff communication procedures. Organisations will need to ensure that all staff are aware that the organisation has applied for the Aged Care Workforce Supplement. If an organisation reasonably believes that all staff will be aware of information made available on the organisation's website, or via an email to all staff, or through some other means, then this condition will be met.

Staff engaged after the organisation has applied for and is receiving the Aged Care Workforce Supplement must be advised that the organisation is receiving the Aged Care Workforce Supplement.

3.2 Other workforce commitments

The advice to staff referred to above must include information regarding how the organisation intends to implement other workplace improvements, as summarised in Table 2 below, in addition to the minimum wage increases summarised in 3.1 above in these guidelines.

Table 2 – Summary of minimum commitments to workforce improvements

Area	Workforce commitment
Enhancing training and education opportunities	• Access to training and education • Professional development • Representation leave
Improved career structures	• Review of part-time hours
Improved career development and workforce planning	• Conversion of casual employees to permanent employees • Workload management • Workplace health and safety • Disciplinary matters

Further detail on these commitments can be found at Part D.

3.3 Aged Care Workforce Census and Survey

In order to be eligible to receive the Aged Care Workforce Supplement, an organisation must participate in the Department of Health and Ageing's regular Aged Care Workforce Census and Survey.

This commitment refers to future census and survey activity. An organisation is not prevented from applying for the Aged Care Workforce Supplement if it did not participate previously.

4 Compliance arrangements

The Department of Health and Ageing is responsible for determining whether an organisation complies with the requirements of the Aged Care Workforce Supplement, and these guidelines, in relation to the programs administered by the Department of Health and Ageing.

The Application Form:

- asks applicants to specify the programs covered
- seeks details of the advice provided by providers to employees, and
- incorporates a Declaration by providers about meeting the requirements of the Aged Care Workforce Supplement.

The Department of Health and Ageing seeks to balance minimising the regulatory burden on providers and obtaining assurance from providers that the pay increases for aged care workers set out in these guidelines are achieved, and the minimum commitments are met.

In addition to the requirements set out in these guidelines and the Application Form, the Department is considering further steps relating to compliance.

The Department of Veterans' Affairs will be responsible for compliance arrangements in relation to VHC and Community Nursing programs.

Question 4 Are there additional assurance mechansisms that the Department should consider in relation to compliance with the requirements of the Aged Care Workforce Supplement?

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5 Review of decisions relating to eligibility

Organisations may apply to the Department for reconsideration of a decision that they are not eligible to receive the Aged Care Workforce Supplement.

6 Eligibility commencement date

An organisation is eligible to receive the Aged Care Workforce Supplement from the relevant date specified below.

Applications received prior to 1 July 2013

- The Aged Care Workforce Supplement is payable to an organisation from 1 July 2013 if, before that date, the provider gives the Department sufficient information to satisfy the Department that the provider meets the eligibility requirements specified in 3 above in these guidelines.

Applications received between 1 July 2013 and 31 December 2013

If the Department receives an application in an approved form on or after 1 July 2013 and before 1 January 2014, and the Department is satisfied that the

organisation met the eligibility requirements in 3 above in these guidelines on 1 July 2013 or on a later date specified in the application, the Aged Care Workforce Supplement is payable from the date, on or after 1 July 2013 and before 1 January 2014, when the organisation met the eligibility requirements.

Applications received on or after 1 January 2014

- If the Department receives an application in an approved form on or after 1 January 2014, and the Department is satisfied that at the time the application is received the organisation meets the eligibility requirements specified in 3 above in these guidelines, the Aged Care Workforce Supplement is payable from the date the application is received by the Department.
- If the Department is satisfied that the application was not received within two days of the application being sent, the application will be taken to have been received two days after it was sent.
- In considering whether an application was sent more than two days before the application was received by the Department, the Department may have regard to any information, relevant to that question, that the approved provider gives to the Department.

Applications received on or after 1 January 2014 that meet the elgibility requirements will be eligible to receive a level of the Supplement that applies at the time of application.

PART D — MEETING THE COMMITMENTS OF THE AGED CARE WORKFORCE SUPPLEMENT

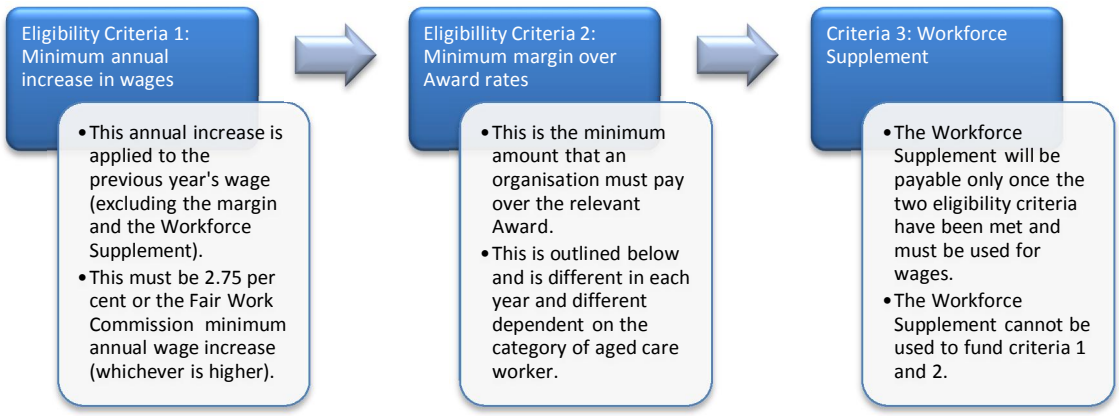
Covered in this part:

- Wage increases - minimum requirement
- Examples of minimum wage increases
- Workforce commitments
- Considerations for providers or organisations

1 Wage increases - minimum requirement

There are two minimum wage requirements that must be applied prior to passing on the Aged Care Workforce Supplement as a further increase. These two minimum requirements are referred to as eligibility criteria and are outlined below. The explanatory examples provided demonstrate the process for calculating the minimum wage increases and calculating the Workforce Supplement.

Figure Minimum Wage increases — Workforce Supplement Criteria



Eligibility Criteria 1. Minimum annual increase in wages

Firstly, ensure that the annual increase in wages is a minimum of 2.75 per cent per annum, or the Fair Work Commission (FWC) annual minimum wage increase, whichever is higher by following the steps below:

1. Calculate the annual increase in wages by determining the percentage difference between the previous year annual wage and current year annual wage

2. If the percentage difference is less than 2.75% or less than the FWC annual minimum wage increase, then the eligibility criteria has not been met and the Workforce Supplement is not payable

3. If the percentage difference is at least 2.75% (or the FWC annual minimum wage increase if this is higher than 2.75%), criteria 1 is met. Continue to eligibility criteria 2, Minimum margin over the relevant Award rates.

Eligibility Criteria 2. Minimum margin over the relevant Award rates

A minimum margin over the relevant Award rates as set out in Table 1 - Percentage margin over the relevant award rate, must be paid as wages for all staff and is determined by following the steps below:

1. Calculate the percentage difference between the current year annual wage and the relevant current year annualised Award rate

2. If the percentage difference calculated in step 1 is less than the margin set out at Table 1 - Percentage margin over the relevant award rate, for the relevant occupation, then the eligibility criteria has not been met and the Workforce Supplement is not payable

3. If the percentage difference of the current year annual wage and the relevant current year annualised Award rate is at least the margin set out at Table 1 - Percentage margin over the relevant award rate, for the relevant occupation, continue to criteria 3, Workforce Supplement.

Table 1 - Percentage margin over the relevant Award rates

Aged care occupations	2013-14	2014-15	2015-16	2016-17
Personal and community care workers and other aged care staff	1.50%	3.00%	3.00%	3.00%
Enrolled nurses	2.50%	5.50%	8.50%	8.50%
Registered nurses	4.00%	8.00%	12.60%	12.60%

Criteria 3. Aged Care Workforce Supplement amount

The Aged Care Workforce Supplement must be passed on to aged care staff as wage increases, delivering a **minimum** wage increase of 1 per cent for all aged care staff each year to 2015-16 and a 0.5 per cent increase in 2016-17. The Workforce Supplement cannot be used for any other purpose, including employee on-costs such as superannuation (including the Superannuation Guarantee Charge) or leave provisions.

The Workforce Supplement is not cumulative: rather, it is applied to each year's annual wage at a rate of 1.0 per cent up to 2015-16 and 0.5 per cent in 2016-17.

The aged care Workforce Supplement amount of 1% (or 0.5% in 2016-17) is applied to the current year annual wage determined after satisfying eligibility criteria 1 and 2. The supplemented wage is calculated as follows:

1. Determine the wage increase component due to the Workforce Supplement which is 1% (or 0.5% in 2016-17) of the current year annual wage (after satisfying eligibility criteria 1 and 2).
2. Add this wage increase component to the current year annual wage

2 Examples of minimum wage increases

The following examples are for illustrative purposes only. The examples are intended to assist providers and organisations to understand the process in calculating the Aged Care Workforce Supplement after applying the eligibility requirements.

Scenario 1 (for organisations without Enterprise Agreements):

For the purposes of the scenario, Malina is an entry level community care worker and her employer has applied for the Workforce Supplement. Malina's annual wage at 1 July 2012 is $34,413 per year and Malina's annual wage from 1 July 2013 is $35,359. The relevant Award that applies to Malina's occupation and level in 2013-14, is $30,175. The Fair Work Commission annual minimum wage increase in 2013-14, for this scenario, is 2.50 per cent.

Step 1: Meeting Criteria 1 - Minimum annual increase in wages

Firstly, ensure that annual increases in wages are a minimum of 2.75 per cent per annum, or the Fair Work Commission annual minimum wage increase, whichever is higher.

To meet step 1, even though the Fair Work Commission annual minimum wage increase in 2013-14 is, for this scenario, 2.50 per cent, Malina's wage must increase by at least 2.75 per cent each year. Malina's annual wage from 1 July 2013 is $35,359. This amount is 2.75 per cent above her 2012-13 wage. The first eligibility criteria has been met and the minimum margin over the relevant Award rate can now be considered in step 2.

Step 2: Meeting Criteria 2 - Minimum margin over the relevant Award rates

A minimum margin over the relevant Award rates for all staff must be paid as wages, by at least the percentage margin shown in the Table 1 Percentage margin over relevant Award rates.

Malina's actual wage for 2013-14 of $35,359must be at least 1.50 per cent higher than the relevant annualised Award wage of $30,175. Malina's wage is 1.50 per cent higher than the

relevant annualised Award rate and therefore the second eligibility criteria has been met and Malina's wage is eligible for the Aged Care Workforce Supplement wage increase.

Step 3: Aged Care Workforce Supplement

The Aged Care Workforce Supplement amount of 1% (or 0.5% in 2016-17) is applied to the current year annual wage determined after satisfying eligibility criteria 1 and 2. Malina's wage in 2013-14 is $35,359and satisfies the requirements of steps 1 and 2. Malina's employer passes on the Aged Care Workforce Supplement of $354 as a wage increase. This brings Malina's supplemented annual wage to $35,713 ($35,359 + $354).

From 2013-14 to 2016-17, Malina's wage will increase as shown below:

Table 2 - Changes in Malina's annual wage

	2013-14	2014-15	2015-16	2016-17
Wage	$35,359	$36,695	$38,081	$39,616
Annualised Award wage*	$30,175	$31,005	$31,780	$32,733
Fair Work Commission annual minimum wage increase*	2.50%	2.75%	2.50%	3.00%
Annual wage increase*+	2.75%	2.75%	2.75%	3.00%
Margin above award wage	1.50%	3.00%	3.00%	3.00%
Supplement	$354	$367	$381	$198
Supplemented Wage	$35,713	$37,062	$38,462	$39,814

** For illustrative purposes only +The annual wage increase provides indicative figures only. This figure is required to be a minimum of 2.75 per cent per annum, or the Fair Work Commission (FWC) annual minimum wage increase, whichever is higher.*

Scenario 2 (for organisations with enterprise agreements):

For the purposes of this scenario, Hayley is a registered nurse working in residential aged care and her employer has applied for the Workforce Supplement. Hayley's annual wage at 1 July 2012 is $71,500 and she receives a 4.0 per cent annual wage increase each year (as specified in her employer's enterprise agreement). If Hayley were to be on an Award rate rather than an enterprise agreed rate, her annualised wage would be $46,571. The FWC annual minimum wage increase in 2013-14, for this scenario, is 2.50 per cent.

Step 1: Minimum annual increase in wages

To meet step 1, Hayley's wage must increase by at least 2.75 per cent each year (or the FWC annual minimum wage increase, whichever is higher). In 2013-14 based on Hayley's enterprise agreement, her annual wage will increase by 4.0 per cent to $74,360.

The 4.0 per cent is greater than the minimum increase of 2.75 per cent per annum and the FWC annual minimum wage increase of 2.5 per cent. The first eligibility criteria has been met and the minimum margin over the relevant annualised Award rate can now be considered in step 2.

Step 2: Minimum margin over the relevant Award rates

Hayley's annual wage is $74,360 in 2013-14. In order to apply for the Workforce Supplement, Hayley's employer must provide her with a margin over the annualised Award rate of 4.0 per cent as determined in Table 1 - Percentage margin over the relevant Award rates. If Hayley was paid an Award rate rather than a rate agreed in her enterprise agreement, her annual wage would be $46,571. As Hayley receives more than 4.0 per cent over the annualised Award rate, the second eligibility criteria has been met and Hayley's wage is eligible for the Aged Care Workforce Supplement wage increase.

Step 3: Aged Care Workforce Supplement

Hayley's wage in 2013-14 is $74,360, which satisfies steps 1 and 2 above. Hayley's employer passes on the Aged Care Workforce Supplement of $744 as a wage increase. This brings Hayley's 2013-14 supplemented annual wage to $75,104 ($74,360 + $744).

From 2013-14 to 2016-17, Hayley's wage will increase as shown below:

Table 3 - Changes in Hayley's annual wage

	2013-14	2014-15	2015-16	2016-17
Wage	$74,360	$78,108	$82,045	$86,179
Annual Award wage*	$46,571	$47,852	$49,048	$50,519
Fair Work Commission annual minimum wage increase*	2.50%	2.75%	2.50%	3.00%
Annual wage increase*+	4.0%	4.0%	4.0%	4.0%
Margin above award wage	4.0%	8.0%	12.60%	12.60%
Supplement	$744	$781	$820	$431
Supplemented Wage	$75,104	$78,889	$82,865	$86,610

** For illustrative purposes only +The annual wage increase provides indicative figures only. This figure is required to be a minimum of 2.75 per cent per annum, or the Fair Work Commission (FWC) annual minimum wage increase, whichever is higher.*

Question 5 Will the examples of the kind provided in section 2 assist your organisation in considering how the the Aged Care Workforce Supplement will contribute to minimum wage increases?

3 Workforce commitments

The wording on the workforce commitments below is provided for guidance only and does not constitute model clauses for use in enterprise agreements or other workplace mechanisms or employment arrangements.

It is open to approved providers or organisations to improve upon these provisions, based on agreed operating requirements at the enterprise level, and in line with the objectives of their enterprise agreements or employment arrangements.

Providers or organisations are expected to commit to these workforce commitments in their written advice to employees.

Enhancing training and education opportunities

Access to training and education

- Aged care employees are to be given access to appropriate and targeted education, training and development opportunities that are necessary and relevant to their roles and responsibilities.
- Such training should be provided to employees during normal rostered hours of work.

Professional development

Employers commit to the professional development of employees. This commitment can be supported in a variety of ways at the enterprise level.

Representation leave

Employers recognise the importance of training for those who play a representative role in the workplace through consultative committees and dispute resolution. This can be recognised in different ways at the enterprise level.

Improved career structures, improved career development and workforce planning

Employers make a commitment to taking action in areas identified as contributing to supporting improved retention rates for aged care employees.

Review of part-time hours — work-life balance and flexible working arrangements

The inclusion of work-life balance and flexible working arrangements is an essential part of attracting and retaining employees.

Providers will need to commit to cover processes and arrangements for managing and systematically reviewing the working hours of part-time employees.

- Where an employee is regularly working more than their guaranteed minimum number of hours the employee may request to have their hours reviewed annually.
- The hours worked in the following circumstances will not be incorporated in any adjustment.
    - If the increase in hours is as a direct result of another employee being absent on leave, such as for example, annual leave, long service leave, maternity leave, workers compensation; and
    - If the increase in hours is due to a temporary increase in hours only due, for example, to the specific needs of a resident or client.
- If a review establishes that a consistent pattern of greater hours is being worked, the employer will offer the employee those additional hours as part of their guaranteed minimum number of hours.

Providers may set this provision, at the enterprise level, in the context that any adjusted guaranteed minimum number of hours resulting from a review is to reflect roster cycles and shift configurations.

Conversion of casual employees to permanent employees

Employers will use an agreed mechanism for converting casual employees who work regular and systematic hours, covering the following:

- A casual employee who has been rostered on a regular and systematic basis over a period of 26 weeks has the right to request conversion to permanent employment. An employee, who does not make a request within four weeks of the right to request falling due, is deemed not to have elected to convert.
- The new contract would generally be on the basis of the same number of hours as previously worked; however, the hours must be capable of fitting within the existing

shift and rostering arrangements. Other arrangements may be implemented by agreement between the employer and the employee.

- The employer may consent to or refuse the request, but shall not unreasonably withhold agreement to such a request.

Providers may set this provision, at the enterprise level, in the context that the hours must be capable of fitting within the existing shift and rostering arrangements.

Workload management

- Employees and management have a responsibility to maintain a balanced workload and recognise the adverse effects that excessive workloads may have on employee/s and the quality of resident/client care.

- Workload management should be dealt with as and when the need arises, as determined at enterprise level.

Workplace health and safety

In recognition that improved occupational health and safety is a priority for improving the working lives of employees and the overall productivity of the sector more broadly, the minimum expectation is as follows:

Employers should set up consultative structures to support positive change in the area of workplace health and safety, supported by a program of training for participants and managers, and staff more broadly.

Disciplinary matters

Employers should ensure that, in disciplinary procedures, provision is made to cover representation and procedural fairness.

4 Considerations for organisations

The Aged Care Workforce Supplement is a contribution by the Commonwealth to increased wages.

Each organisation will need to consider its individual circumstances to determine whether or not to apply for the Aged Care Workforce Supplement.

Considerations may include, but are not limited to:

- The requirement that an enterprise agreement must be in place for residential aged care providers with 50 or more operational places.

- The eligible programs or combinations of programs for which the provider is funded, taking into account that:

- the Aged Care Workforce Supplement only applies to the programs specified in these guidelines.

- The organisation's current business and employment arrangements, including workplace relations arrangements and current wage rates, noting that:
  - applying for the Aged Care Workforce Supplement provides an opportunity for those organisations with existing enterprise agreements, or proposing to negotiate an agreement, to consider increasing workplace flexibility and enhancing workforce capacity, and
  - the Aged Care Workforce Supplement provides increased funding for organisations to offer above-award wages and other employment conditions that can improve the attraction and retention rates for their aged care workers.

PART E — PAYMENT ARRANGEMENTS

Covered in this part:

- Payment arrangements for programs funded under the *Aged Care Act 1997*
- Payment arrangements for programs funded other than under the *Aged Care Act 1997*

1 Payment arrangements for programs funded under the *Aged Care Act 1997*

1.1 Residential aged care provider

An approved provider of residential care that meets the eligibility requirements for the Aged Care Workforce Supplement will receive additional funding equal to:

- 1% of the basic subsidy amount for residential care in 2013-14 calculated on a pro rata basis if the approved provider is not eligible for the Aged Care Workforce supplement for the whole of the financial year
- 2% in 2014-15
- 3% in 2015-16, and
- 3.5 % in 2016-17.

The Aged Care Workforce Supplement is calculated on the basic subsidy amount, being:

- daily ACFI subsidy rate, or
- daily RCS saved rate, or
- default rate for new residents for whom an Application for Classification has not been received by Department of Human Services, or
- daily residential respite care rate

less any reductions that have been applied for late receipt of appraisals or reappraisals.

The basic subsidy amount does not include any primary or other supplements.

1.2 Home Care Package approved providers

An approved provider of home care that meets the eligibility requirements for the Aged Care Workforce Supplement will receive additional funding equal to:

- 1% of the basic subsidy amount for Home Care in 2013-14 calculated on a pro rata basis if the approved provider is not eligible for the Aged Care Workforce supplement for the whole of the financial year
- 2% in 2014-15
- 3% in 2015-16, and
- 3.5 % in 2016-17.

The basic subsidy amount does not include any primary or other supplements.

2 Payment arrangements for programs funded other than under the *Aged Care Act 1997*

2.1 Commonwealth HACC program — All States and Territories (excluding Victoria and Western Australia)

Organisations that apply for and meet the eligibility requirements and commitments for the Aged Care Workforce Supplement will receive additional funding equal to:

- 1% of the total amount payable under the funding agreement in 2013-14, calculated on a pro rata basis if the organisation is not eligible for the Aged Care Workforce Supplement for the whole of the financial year
- 2% in 2014-15
- 3% in 2015-16, and
- 3.5 % in 2016-17.

Organisations will receive payment through the implementation of new schedules linked to their funding agreements. Organisations will not need to provide invoices as supplement payments will be linked to their milestone payments.

2.2 Joint Home and Community Care (HACC) Program in Victoria and Western Australia

As at publication of this Guide, the Commonwealth and States are discussing arrangements for organisations to access the Workforce Supplement in Victoria and Western Australia.

2.3 National Respite for Carers Program (NRCP)

Organisations that apply for and meet the eligibility requirements and commitments for the Aged Care Workforce Supplement will receive additional funding equal to:

- 1% of the total amount payable under the funding agreement in 2013-14, calculated on a pro rata basis if the organisation is not eligible for the Aged Care Workforce Supplement for the whole of the financial year
- 2% in 2014-15
- 3% in 2015-16, and
- 3.5 % in 2016-17.

Organisations will receive payment through the implementation of new schedules linked to their funding agreements. Organisations will not need to provide invoices as supplement payments will be linked to their milestone payments. Organisations receiving brokerage funding for respite services will not be eligible for the Aged Care Workforce Supplement for the brokerage component of their funding.

2.4 Day Therapy Centre (DTC) program

Organisations that apply for and meet the eligibility requirements and commitments for the Aged Care Workforce Supplement will receive additional funding equal to:

- 1% of the total amount payable under the funding agreement in 2013-14, calculated on a pro rata basis if the organisation is not eligible for the Aged Care Workforce supplement for the whole of the financial year
- 2% in 2014-15
- 3% in 2015-16, and
- 3.5 % in 2016-17.

Organisations will receive payment through the implementation of new schedules linked to their funding agreements. Organisations will not need to provide invoices as supplement payments will be linked to their milestone payments.

2.5 National Aboriginal and Torres Strait Islander Flexible Aged Care Program

Organisations that apply for and meet the eligibility requirements and commitments for the Aged Care Workforce Supplement will receive additional funding equal to:

- 1% of the total amount payable under the funding agreement in 2013-14, calculated on a pro rata basis if the organisation is not eligible for the Aged Care Workforce supplement for the whole of the financial year
- 2% in 2014-15
- 3% in 2015-16, and
- 3.5 % in 2016-17.

Organisations will receive payment through variations to their funding agreements.

2.6 Department of Veterans' Affairs (DVA) Programs – Veterans' Home Care and Community Nursing Programs

Organisations that apply for and meet the eligibility requirements and commitments for the Aged Care Workforce Supplement will receive additional funding equal to:

- 1% of the total amount payable under the funding agreement in 2013-14, calculated on a pro rata basis if the organisation is not eligible for the Aged Care Workforce Supplement for the whole of the financial year
- 2% in 2014-15
- 3% in 2015-16, and
- 3.5 % in 2016-17.

Organisations will receive payment through variations to their contractual arrangements with the Department of Veterans' Affairs. As DVA pays a fee for the provision of these services, this payment process will be based on the actual fees paid to VHC and Community Nursing providers.

PART F — SUPPORTING INFORMATION RELATING TO ENTERPRISE AGREEMENTS

Covered in this part:

- Enterprise agreements
- Resolution of workplace disputes

1 Enterprise agreements

1.1 Sources of information on enterprise bargaining

The Fair Work Commission (FWC) website provides information on:

- Agreement-making
- the agreement approval process,
- how to terminate an agreement, and
- how to vary an agreement.

In addition, organisations may wish to consider contacting their national or local aged care association.

1.2 Enterprise agreement-making

Awards cover a whole industry or occupation and only provide a safety net of minimum pay rates and employment conditions. Enterprise agreements can be tailored to meet the needs of particular enterprises.

Organisations that must have an enterprise agreement to be eligible for the Aged Care Workforce Supplement can negotiate amendments to an existing agreement, or choose to negotiate a new agreement to access the Aged Care Workforce Supplement.

1.3 Role of the Fair Work Commission

The Fair Work Commission is an independent body with the power to carry out a range of functions relating to the safety net of minimum wages and employment conditions, enterprise bargaining, industrial action, dispute resolution, termination of employment, and other workplace matters.

1.4 Enterprise agreements

The *Fair Work Act 2009* provides a framework that assists employers and employees to bargain in good faith to make an enterprise agreement. Employers, employees and their bargaining representatives are involved in the process of bargaining for a proposed enterprise agreement.

The Australian Government is seeking to encourage benefits of bargaining, including in smaller enterprises, to drive greater productivity at the workplace through a focus on improved flexibility and enhanced workforce capability.

For more information regarding enterprise bargaining, refer to:

www.fairwork.gov.au/resources/fact-sheets/workplace-rights/pages/enterprise-bargaining-fact-sheet.aspx

www.fairwork.gov.au/BestPracticeGuides/11-Improving-workplace-productivity-in-bargaining.pdf

Enterprise agreements are agreements made at an enterprise level between employers and employees about terms and conditions of employment.

Good faith enterprise bargaining is at the heart of Australia's workplace relations system which includes a framework that provides opportunities for all workers, including nurses and carers, to negotiate enterprise agreements that improve wages and conditions as well as workplace productivity and flexibility.

Types of enterprise agreements include:

- Single-enterprise agreements—involving a single employer or one or more employers (such as in a joint venture) co-operating in what is essentially a single enterprise (such employers are known as single interest employers).
- Multi-enterprise agreements—involving two or more employers that are not all single interest employers.

1.5 Union membership

It is not a requirement for employees of an organisation to be members of a union in order to negotiate an enterprise agreement.

Under the *Fair Work Act 2009*, all employers, employees and independent contractors are free to become, or not to become, members of an industrial association, such as a trade union or employer association.

For more information regarding 'General Protections' under the *Fair Work Act 2009* refer:

www.fairwork.gov.au/factsheets/FWO-Fact-sheet-General-Workplace-Protections.pdf

1.6 Approval of enterprise agreements by the Fair Work Commission

Once an enterprise agreement is made, a bargaining representative for the agreement must apply to the Fair Work Commission (the Commission) for approval of the agreement.

For further information on enterprise bargaining, including the approval process, please visit the Fair Work Commission's website at www.fwc.gov.au.

There is no lodgement fee when lodging an application for agreement approval.

An employer may incur other costs such as the cost of a workplace consultant/lawyer and the cost of conducting a vote. These costs may vary significantly depending on a range of factors including the size of the workplace, the complexity of the issues involved and the voting method selected.

2 Resolution of workplace disputes

2.1 Role of the Fair Work Commission in dispute resolution

Members of the Fair Work Commission are experienced in a wide range of alternative dispute resolution techniques including conciliation, mediation and arbitration.

They are skilled in helping employers and employees resolve workplace disputes and can suggest means of resolving differences that may not have been immediately apparent to those directly involved.

They are also impartial and have a sound knowledge and understanding of the relevant legal and industrial issues.

Depending on the circumstances, the Commission can exercise statutory powers that enable disputes to be resolved on a final basis.

Who can seek assistance from the Fair Work Commission?

In general, the Commission can assist in resolving disputes involving employers, employees and unions and employer associations who are covered by the national workplace relations system.

These include:

- any employer that is a constitutional corporation
- any employer in Victoria or the territories

- the Commonwealth (including any Commonwealth authority)
- any employee of one of the above types of employers, and
- a registered union or employer organisation.

2.2 Types of disputes that can be referred to the Fair Work Commission

The main types of disputes that can be referred to the Commission are:

- disputes under the terms of an award or a collective or enterprise agreement
- bargaining disputes, and
- disputes arising under the general protections provisions of the *Fair Work Act 2009*

For further information please visit the Fair Work Commission's website at www.fwc.gov.au.

Australian Government
Department of Health and Ageing

AGED CARE WORKFORCE SUPPLEMENT APPLICATION FORM

Draft – not for official use

Complete one form to apply for the Aged Care Workforce Supplement.

Approved providers or organisations must satisfy the Department of Health and Ageing that they are eligible to receive the Aged Care Workforce Supplement.

PART A – Applicant Details

Question 1:	**What is the Legal Entity name, postal address and ABN of the Applicant:**	

Question 2: **Which services /programs does your organisation deliver for which you wish to receive the Aged Care Workforce Supplement (you may select more than one):**

Services / Programs	**ID**
Residential Aged Care	NAPS ID:_____
Home Care Packages	NAPS ID:_____
Commonwealth HACC Program	Aged Care Portal SK Number:_____
National Respite for Carers Program (NRCP)	PIMS:_____
Day Therapy Centre Program (DTC)	PIMS:_____
National Aboriginal and Torres Strait Islander Flexible Aged Care Program	NAPS ID:_____
Department of Veterans' Affairs Veterans' Home Care Program (VHC)	DVA Provider Number or UIN:_____
Department of Veterans' Affairs Community Nursing Program (CN)	DVA Provider Number or UIN:_____

PART B – Terms and Conditions

Question 3: **Have you written to each of your aged care staff to notify them that you are applying for the Aged Care Workforce Supplement? Yes / No**
Please attach a copy of your advice to your staff (e.g. copy of letter, email, staff website update).

Question 4: **Does your written advice to your aged care staff comply with the requirements specified in Part B 3 and Part C 3 of the Aged Care Workforce Supplement Guidelines? Yes/No**

Question 5: **Does your organisation undertake to participate in the Aged Care Workforce Census and Survey? Yes/No**

Question 6: **What is the date that you have indicated you will meet the matters specified in Part B 3 and or Part C 3 of the Aged Care Workforce Supplement Guidelines, in your written advice to staff? (DD/MM/YYYY)_____**

To ensure payment is correct, please ensure you specify the start for wage increases. (DD/MM/YYYY) for wage increase_____

PART C - Declaration

I declare that:

1. I am the authorised person to certify against the information provided above; and
2. I declare that the details I have provided in this form are true and correct to the best of my knowledge; and
3. I understand that giving false or misleading information to the Australian Government is a serious offence.

Authorised Person			**Witness**	
Signature:			Signature:	
Name:			Name:	
Job/Title:			Job/Title:	
Date:			Date:	
Phone:			Phone:	

Please return by either:
Post: TBA

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Question 6 Is the proposed Form clear? Are there aspects that need to be improved?

Note: Information on completing the form will be provided, once the entries have been settled, following consultations about the guidelines.

TERMS AND ACRONYMS

These terms are defined for the purposes of the interpretation of this document. The interpretation of terms defined in legislation, including the *Aged Care Act 1997* and Principles made under that Act, will take priority to the extent of any inconsistency with these terms.

Aged Care Act 1997	The principal legislation that regulates the aged care program from 1 October 1997
Aged Care Principles	The Aged Care Principles are subordinate legislation made under the *Aged Care Act 1997*
Approved provider	A person or body approved by the Secretary of the Department of Health and Ageing to operate aged care services funded by the Australian Government under the *Aged Care Act 1997*
CALD	Culturally and Linguistically Diverse
CAP	Conditional Adjustment Payment
Commonwealth	Commonwealth of Australia
Community Nursing (CN)	Community Nursing Program administered by the Department of Veterans' Affairs
The Department	The Department of Health and Ageing
DTC	Day Therapy Centres provide a wide range of therapy and services to frail aged people living in the community and to some residents of Commonwealth funded residential aged care facilities
DVA	The Department of Veterans' Affairs
EA	Enterprise agreements relating to workplace relations matters that are made at an enterprise level between employers and employees and cover terms and conditions of employment.
Existing EA	An enterprise agreement that is in place as at 1 July 2013. It is possible that approved providers or organisations may have more than one existing EA in place as at 1 July 2013.
The Commonwealth HACC program	The Commonwealth HACC program provides services such as domestic assistance, personal care as well as goods and

	equipment, transport, meals, home modifications and maintenance, counselling, information and advocacy for people aged 65 years and over, or 50 years and over for Aboriginal and Torres Strait Islander people, in all states and territories except Victoria and Western Australia
Home Care Packages	Subject to the passage of amending legislation, from 1 July 2013, four levels of Home Care Packages will be established, providing a continuum of home care options covering basic home care support through to complex home care. The packages will be delivered by providers approved under the *Aged Care Act 1997* to provide home care: • Level 1 — a new package to support people with basic needs • Level 2 — a package to support people with low level care needs similar to the existing Community Aged Care Package • Level 3 — a new package to support people with intermediate care needs • Level 4 — a package to support people with high level care needs similar to the existing Extended Aged Care at Home (EACH) package Further information on the Home Care Packages Program is available on the *Living Longer Living Better* website.
Minister	The Commonwealth Minister responsible for the *Aged Care Act 1997*
Modern Awards	Modern Awards are legal documents made by Fair Work Commission, setting out certain minimum conditions; including pay rates workers receive in a particular industry or when doing a certain job. Each Modern Award also describes the types of work to which it applies
NRCP	The National Respite for Carers Program is designed to contribute to the support and maintenance of caring relationships between carers and their dependent family members
Residential aged care	Personal and/or nursing care that is provided to a person in an

	aged care home in which the person is also provided with accommodation that includes appropriate staffing, meals, cleaning services, as well as furnishings, furniture and equipment for the provision of that care and accommodation
Secretary	Secretary of the Commonwealth Department of Health and Ageing OR Secretary of the Commonwealth Department of Veterans' Affairs
Staff member, employee or aged care worker	Staff member, employee or aged care worker includes (but is not limited to): • a personal and community care worker; • an Enrolled Nurse; or • a Registered Nurse. It may also include other employees of the organisation. Further information about the types of aged care workers covered by the Aged Care Workforce Supplement, can be found in the following Modern Awards: • *Nurses' Award 2010* - applies to a range of nursing classifications including enrolled and registered nurses in the health and aged care industries. • *Aged Care Award 2010* - is the relevant award for residential aged care workers including personal care workers. • *Social, Community, Home Care and Disability Services Industry Award 2010* (modern SACS award) - is the relevant award for community care workers. • *Health Professionals and Support Services Award 2010* - applies to allied health workers. • *Aboriginal Community Controlled Health Services Award 2010* – applies to organisations delivering aged care services under the National Aboriginal and Torres Strait Islander Flexible Aged Care program. While it is not feasible to cover in the definition every possible workplace or employment arrangement, it is intended that **all** staff directly employed by the organisation will be included. The following staff **are not** covered by the Workforce Supplement:

	• state and territory government employees • staff hired by an organisation on a temporary basis through a labour hire agency • independent contractors sub-contracted by an organisation.
Veterans' Home Care (VHC)	The Veterans' Home Care Program administered by the Commonwealth Department of Veterans' Affairs

Australian Government

Department of Health and Ageing

Mr Patrick Reid
Chief Executive Officer
Leading Age Services Australia
Unit 4, 21 Torrens St
Braddon ACT 2612

Dear Patrick

Re: Addressing Workforce Pressures communication

I am writing in relation to your correspondence of 18 April 2013 and the distribution of materials relating to the Addressing Workforce Pressures initiative to aged care providers.

I apologise for any distress or confusion this has caused your members or their staff.

The materials provided are hard copies of existing public documents which were produced to support aged care workers in their understanding of this important measure.

While these documents form part of a package of communications material designed to support peak bodies, employers and employees, as a result of an administrative error, the documents were released prematurely and without the accompanying information which was to include draft guidelines on the Workforce Supplement for consultation and a covering letter to support providers. It was always our intention to consult with peak bodies before materials were circulated.

Once again, I apologise. The Department remains committed to working with the sector, including peak aged care bodies on this and related aged care reforms. I am keen to meet with LASA to work through the implementation details for the initiative.

Yours sincerely

Carolyn Smith
First Assistant Secretary
Ageing and Aged Care Division

19 April 2013

Australian Government

Department of Health and Ageing

Prof John Kelly
Chief Executive Officer
Aged and Community Services Association Australia
Level 1, 10 Thesinger Court
Deakin ACT 2600

Dear John

Re: Addressing Workforce Pressures communication

I am writing in relation to the recent distribution of materials relating to the Addressing Workforce Pressures initiative to aged care providers. I understand that this distribution has caused some confusion for your members.

I apologise for any inconvenience or distress this may have caused your members or their staff.

The materials provided are hard copies of existing public documents which were produced to support aged care workers in their understanding of this important measure.

While these documents form part of a package of communications material designed to support peak bodies, employers and employees, as a result of an administrative error, the documents were released prematurely and without the accompanying information which was to include draft guidelines on the Workforce Supplement for consultation and a covering letter to support providers. It was always our intention to consult with peak bodies before materials were circulated.

Once again, I apologise. The Department remains committed to working with the sector, including peak aged care bodies, consumers and unions on this and related aged care reforms.

Yours sincerely

Carolyn Smith
First Assistant Secretary
Ageing and Aged Care Division

19 April 2013

Australian Government

Department of Health and Ageing

Mr Gary Barnier
Managing Director
Domain Principal Group
Level 8/341 George Street
Sydney NSW 2000

Dear Gary

Re: Addressing Workforce Pressures communication

I am writing in relation to the recent distribution of materials relating to the Addressing Workforce Pressures initiative to aged care providers. I understand that this distribution has caused some confusion for Aged Care Guild members.

I apologise for any inconvenience or distress this may have caused your members or their staff.

The materials provided are hard copies of existing public documents which were produced to support aged care workers in their understanding of this important measure.

While these documents form part of a package of communications material designed to support peak bodies, employers and employees, as a result of an administrative error, the documents were released prematurely and without the accompanying information which was to include draft guidelines on the Workforce Supplement for consultation and a covering letter to support providers. It was always our intention to consult with peak bodies before materials were circulated.

Once again, I apologise. The Department remains committed to working with the sector, including peak aged care bodies, consumers and unions on this and related aged care reforms.

Yours sincerely

Carolyn Smith
First Assistant Secretary
Ageing and Aged Care Division

19 April 2013

Australian Government

Department of Health and Ageing

Mr Martin Laverty
Chief Executive Officer
Catholic Health Australia
PO Box 330
Deakin ACT 2600

Dear Martin

Re: Addressing Workforce Pressures communication

I am writing in relation to the recent distribution of materials relating to the Addressing Workforce Pressures initiative to aged care providers. I understand that this distribution has caused some confusion for your members.

I apologise for any inconvenience or distress this may have caused your members or their staff.

The materials provided are hard copies of existing public documents which were produced to support aged care workers in their understanding of this important measure.

While these documents form part of a package of communications material designed to support peak bodies, employers and employees, as a result of an administrative error, the documents were released prematurely and without the accompanying information which was to include draft guidelines on the Workforce Supplement for consultation and a covering letter to support providers. It was always our intention to consult with peak bodies before materials were circulated.

Once again, I apologise. The Department remains committed to working with the sector, including peak aged care bodies, consumers and unions on this and related aged care reforms.

Yours sincerely

Carolyn Smith
First Assistant Secretary
Ageing and Aged Care Division

19 April 2013

Australian Government

Department of Health and Ageing

Ms Lin Hatfield-Dodds
National Director
UnitingCare Australia
PO Box 518
Dickson ACT 2602

Dear Lin

Re: Addressing Workforce Pressures communication

I am writing in relation to the recent distribution of materials relating to the Addressing Workforce Pressures initiative to aged care providers. I understand that this distribution has caused some confusion for your members.

I apologise for any inconvenience or distress this may have caused your members or their staff.

The materials provided are hard copies of existing public documents which were produced to support aged care workers in their understanding of this important measure.

While these documents form part of a package of communications material designed to support peak bodies, employers and employees, as a result of an administrative error, the documents were released prematurely and without the accompanying information which was to include draft guidelines on the Workforce Supplement for consultation and a covering letter to support providers. It was always our intention to consult with peak bodies before materials were circulated.

Once again, I apologise. The Department remains committed to working with the sector, including peak aged care bodies, consumers and unions on this and related aged care reforms.

Yours sincerely

Carolyn Smith
First Assistant Secretary
Ageing and Aged Care Division

19 April 2013

Australian Government

Department of Health and Ageing

Mr Ian Yates
Chief Executive Officer
COTA Australia
GPO BOX 1583
Adelaide 5001

Dear Ian

Re: Addressing Workforce Pressures communication

I am writing in relation to the recent distribution of materials to aged care providers relating to the Addressing Workforce Pressures initiative. I understand that this distribution has caused some confusion for many aged care providers and other stakeholders.

I apologise for any inconvenience or confusion this may have caused.

The materials provided are hard copies of existing public documents which were produced to support aged care workers in their understanding of the workforce measure.

While these documents form part of a package of communications material designed to support peak bodies, employers and employees, as a result of an administrative error, the documents were released prematurely and without the accompanying information which was to include draft guidelines on the Workforce Supplement for consultation and a covering letter to support providers. It was always our intention to consult with peak bodies before materials were circulated.

Once again, I apologise. The Department remains committed to working with the sector, including peak aged care bodies, consumers and unions on this and related aged care reforms.

Yours sincerely

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Department of Health and Ageing

Ms Sue Lines
Assistant National Secretary
United Voice
303 Cleveland St
Redfern NSW 2016

Dear Sue

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Department of Health and Ageing

Mr Chris Brown
National President
Health Services Union
PO Box 635
North Hobart, Tasmania, 7002

Dear Chris

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Australian Government

Department of Health and Ageing

Ms Lee Thomas
Federal Secretary
Australian Nursing Federation
Unit 3, 28 Eyre Street
Kingston ACT 2604

Dear Lee

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First Assistant Secretary
Ageing and Aged Care Division

19 April 2013

Aged Care Funding Instrument (ACFI)

Introduction

Since the Aged Care Funding Instrument (ACFI) was introduced in March 2008, it has achieved its primary objective to better match funding to care. It was always anticipated that residential care expenditure would increase with the introduction of the instrument. Firstly, this is because the ACFI has more funding levels for high care than the previous scale, the RCS. Secondly, grandparenting of subsidies for existing residents ensured that funding would not reduce for any resident in care at the time of commencement. However, subsidies were expected to return to the long term trend of between 2 per cent and 3 per cent growth (excluding indexation) after the first few years of implementation.

During the ACFI Review in 2009-10, it was noted that subsidies were continuing to grow at a higher rate than expected. The Department continued to monitor this growth after the review was published. In late 2011, the Government increased its residential care estimates by $2.3 billion for the period from 2011-12 to 2014-15 to reflect continued higher than anticipated growth. Following the revision to estimates, the department consulted extensively with the sector on options to bring future growth back to trend. The ACFI Monitoring Group met four times in 2011-12 to discuss these options.

On 20 April 2012, the Government announced that it would make changes to the ACFI to bring future growth back to the long term-trend rate and to redirect funding to other parts of the announced aged care reforms. During subsequent discussions with peak bodies and individual providers, a consistent view was expressed that any changes that Government made to the tool should not be too tightly targeted at the high growth areas of the instrument as this increased the risk of negative impacts on some providers. Instead there was a view that a smoothing approach which had a smaller impact on a larger number of providers would be preferred.

Announced changes to ACFI

Following the above consultations, the Government announced changes to the ACFI on 21 June 2012 which addressed high growth questions. This first set of changes, included:

- changes to the scores for Activities of Daily Living for question 3 from 1 July 2012; and
- changes to the Complex Health Care domain from 1 July 2012.

In addition, a one-off price change took effect from 1 July 2012, which when taken with the indexation, resulted in all ACFI subsidy rates remaining at 2011-12 levels.

At the Minister's request, the Department convened a revamped ACFI Monitoring Group to monitor the impact of the changes to the ACFI on government expenditure growth, including the distribution of the financial impact across the aged care sector. The Group has met six times since July 2012 and considered claims through to January 2012. As providers have up to two months after a person enters care to submit a claim for funding, the Monitoring Group reviews claim data two months after the end of a particular month. For example, in April 2013, the Group considered the claims to the end of January 2013.

The second set of changes, implemented on 1 February 2013, enhanced the evidence requirements within the ACFI, and reinforced the original intent of the ACFI. In particular, providers are now required to keep a copy of the assessments conducted to support the claim as part of the claim pack.

A third set of changes to the ACFI, due to be implemented on 1 July 2013, will further enhance the evidence requirements within the ACFI, particularly in regards to pain management. These subsequent ACFI changes were supported by a Technical Reference Group and endorsed by the ACFI Monitoring Group.

Monitoring the impact of ACFI changes

It is important to note that the $2.3 billion in additional funding provided by Government in late 2011 remained in the aged care forward estimates when the aged care reforms were announced in April 2012. Further, residential aged care subsidies have not been reduced with the changes announced by Government. Funding for residential care has increased by $433 million to $9.2 billion in 2012-13. Under these changes, average care subsidies are projected to grow by 2.7% per annum (above indexation) between 2012-13 and 2016-17.

The Monitoring Group has been provided with actual monthly claim data at their meetings since the changes took effect. At its most recent meeting on 26 April 2013, the Group noted that the seven months of ACFI appraisal data from July 2012 to January 2013 was broadly in line with the Government's estimated impact prior to implementation. The Group expects that over the next several months, following the analysis of further data, this trend will be continued.

Average ACFI subsidies for July 2012 to January 2013 were $135.07, which is 4.39% higher than the average for the same period last year of $129.39. Excluding indexation, the growth rate is 2.75%, which is very close to the projected target growth rate to 2016-17 of 2.7% per annum.

The Department of Health and Ageing will continue to work closely with national peak bodies and aged care stakeholder groups, through the ACFI Monitoring Group, to ensure the changes are implemented as intended and to identify whether there are any unintended outcomes so that they can be addressed.

Impact on high and low care services

The table below compares the average daily subsidy paid per resident since the changes took effect with the average during 2011-12 for all providers ranked by their average subsidy. This method shows the effect of the changes on providers based on their mix of residents. It can be used to demonstrate whether the changes are impacting more heavily on providers that are providing low care, low mixed care, high mixed care or high care.

High vs Low care

2011-12 Average Subsidy	**2011- 2012**	**July 2012-January 2013**	**Change**
Under $103.24	$88.02	$93.80	6.57%
$103.24-$125.86	$116.74	$122.46	4.90%
$125.87-$146.43	$136.60	$140.04	2.52%
$146.44+	$159.20	$161.95	1.73%

It can be seen that growth in average subsidies continued for all categories of providers. The highest rate of growth is coming from providers that have the lowest average subsidy (ie, the greatest proportion of low care residents). This is an expected result as there is less capacity for a high care service to achieve growth as many of their residents are already receiving the maximum rate of payment or close to it.

Impact on providers by state, size and remoteness

Average subsidy growth by State/Territory

The following table illustrates the recorded growth in average subsidy by state and territory over the period July 2012 to January 2013.

State/Territory

State/Territory	**2011- 2012**	**July 2012 - January 2013**	**Change**
NSW	$129.74	$132.79	2.35%
ACT	$128.79	$129.81	0.80%
NT	$133.20	$134.61	1.06%
QLD	$128.84	$133.09	3.30%
SA	$138.54	$142.44	2.82%
TAS	$126.38	$134.80	6.67%
VIC	$131.79	$136.62	3.67%
WA	$128.23	$135.85	5.95%

A number of submissions to the inquiry have suggested that the changes to the ACFI have had a negative impact on providers in particular states, by size or by remoteness. This does not appear to be the case based on the actual claim data. Over the period, average subsidies grew in every state and territory.

Since the introduction of the changes, average subsidies in Western Australia have grown by nearly 6%. Financial benchmarking data from Stewart Brown over this time has shown growth in earnings (EBITDA) above the national average during the same period.

Average subsidy growth – by size of provider and remoteness

The following tables illustrate the recorded growth in average subsidy by remoteness and size over the period July 2012 to January 2013.

Remoteness

Remoteness	**2011- 2012**	**July 2012-January 2013**	**Change**
Major City	$133.62	$138.07	3.33%
Inner Regional	$125.06	$128.67	2.89%
Outer Regional	$123.45	$129.04	4.52%
Remote	$106.20	$110.28	3.84%
Very Remote	$124.02	$125.76	1.40%

Provider Size

Provider Size	2011- 2012	July 2012-January 2013	Change
0-41 residents	$111.10	$114.20	2.79%
42-69	$127.46	$130.16	2.12%
70-125 residents	$128.64	$133.48	3.77%
126-499 residents	$131.10	$135.24	3.16%
500-999 residents	$134.24	$139.19	3.69%
1000+ residents	$133.56	$137.67	3.08%

Other submissions have put the view that small, regional services have been impacted by the changes. However, the actual claim data shows growth in average subsidies has continued for smaller services – although not at the same rate as larger services – as well as for regional and remote services.

The ACFI Monitoring Group asked for specific information on the rate of growth for remote and very remote services. This analysis, which was provided at the March 2013 meeting, highlighted that the lower than average rate of growth in very remote services was a consequence of changes in the mix of residents rather than the changes to the ACFI. These results are also impacted by the very small number of claims in very remote services which increases the volatility of the results.

Average subsidy growth – specialist services

The following table illustrates recorded growth in average subsidies for services specialising in the care of people at risk of homelessness and services specialising in the delivery of care to people from Aboriginal and Torres Strait Islander communities.

Specialist Facilities

Type	2011- 2012	July 2012-January 2013	Change
Homelessness#	$96.32	$99.02	2.91%
Aboriginal and Torres Strait Islander Facilities*	$122.58	$127.48	4.00%

Identified as facilities specialising in homelessness for the purposes of viability supplement.
*Identified by DoHA staff.

Average subsidies have continued to grow for specialist services providing care for people at risk of homelessness or for Aboriginal and Torres Strait Islander peoples. The Department has committed to working with aged care services that specialise in care for people at risk of homelessness. These services have had two months of data showing greater than expected impacts due to the changes to the ACFI. However, the results are highly variable between services; ranging from no effect in some services to nearly 10% in others. A representative from the Prime Minister's Council on Homelessness is a member of the ACFI Monitoring Group and is assisting the Department in further analysing this early impact.

Special Needs Groups

Introduction

A key object of the *Aged Care Act 1997* is facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location. The proposed legislative amendments will continue to recognise the current range of special needs groups, and maintain the requirement for services for these communities to be a focus in aged care planning activities.

This attachment summarises some of the arrangements that are in place to support the objects of the Act, with a particular focus on those special needs groups and those issues where the Committee has requested additional information.

This attachment also addresses the following questions asked by the Committee: 13-19 and 27.

13. What recognition and support has been given to the challenges for rural, remote and indigenous services in this legislation?
14. Is there the capacity to increase the accommodation subsidy for rural, remote and indigenous services whose viability may be impacted by this legislation, in addition to the viability supplement?
15. What scope is there to create more generous and flexible eligibility criteria for other supplements such as the workforce supplement, for these providers?
16. Can the Department advise what issues have been identified by the Aged Care Funding Instrument (ACFI) Monitoring Group regarding the financial impact of ACFI changes on regional, rural and remote services? What response has the government made in the Living Longer Living Better package to Monitoring Group's concerns?
17. Has the government undertaken modeling of the effects of the Living Longer Living Better package on the financial circumstances or viability of regional, rural and remote service providers? If so, please advise the committee of the methods and results of that modeling.
18. What arrangements are you intending to put in place for the special needs group of the homeless?
19. Why isn't there a separate supplement?
27. Has the Department undertaken work on measures to prevent faith-based discrimination in aged care on grounds of sexuality, and in particular on the merits of including a prohibition in either aged care legislation or sex discrimination legislation? If so, can you describe that work and outcomes to date?

Rural and remote services

Service delivery in rural and remote areas is generally more challenging and more expensive than service delivery in urban centres.

Under the ACFA's operating framework ACFA is charged with reporting annually to Government on financing issues affecting the aged care sector. This advice is required to include consideration of the impacts of special needs groups including rural and remote services, the homeless, indigenous Australians and people of Culturally and Linguistically Diverse (CALD) backgrounds.

Operating costs

The Government pays a viability supplement to aged care services operating in remote regions, as well as services that specialise in the delivery of care to Indigenous Australians or to people with a history of (or who may be at severe risk of) homelessness. An expected $280

million in viability supplement will be paid over the five years from 1 July 2012 through to 30 June 2017.

The eligibility criteria for the viability supplement are based on the size of the service and the remoteness of the service. From 1 July 2012 to 31 December 2012, 391 residential aged care services received the viability supplement due to their size and remoteness.

A number of stakeholders have claimed that the recent changes to the Aged Care Funding Instrument (ACFI) have reduced funding for care and services in rural areas. These claims are unfounded. The ACFI Monitoring Group, which includes representatives from aged care provider peak bodies, providers themselves, consumers and clinicians, has been closely monitoring the impact of the changes on the sector, including on specific groups. As shown in the data below, presented to the April ACFI Monitoring Group meeting, the average subsidies (ie before application of the Viability Supplement) for providers in all regional classifications continues to grow.

Remoteness	**Average Subsidies 2011-12**	**July 2012-January 2013**	**Change**
Major City	$133.62	$138.07	3.33%
Inner Regional	$125.06	$128.67	2.89%
Outer Regional	$123.45	$129.04	4.52%
Remote	$106.20	$110.28	3.84%
Very Remote	$124.02	$125.76	1.40%

Capital costs

Rural and remote services cannot always access sufficient capital funding to enable the maintenance or improvement of their capital stock. This is in part due higher construction costs, but lower property values in rural and remote areas also mean that consumers have lower assets and historically pay lower accommodation bonds which are a major source of capital financing for aged care services under the current arrangements.

The proposed legislative changes in relation to accommodation payments will improve the availability the capital financing for rural residential aged care services. All residential aged care services will determine the price/s to be charged for the accommodation offered by the service. The new arrangements will assist residents to pay, and providers to receive, appropriate prices for the accommodation on offer.

- Currently the contribution of high care residents to the cost of their accommodation is limited to the accommodation charge ($33.29 per day). This will no longer be the case, and all residents who can afford to do so will be eligible to pay the accommodation price determined by the service.
- Residents will have greater flexibility in how they pay for their accommodation. This includes the option of paying a combination of a refundable accommodation deposit and a daily accommodation payment. This effectively mirrors the current arrangement whereby low care residents pay an accommodation bond and the service deducts a retention amount. In contrast to current arrangements however, there will be no limit on the amount on the daily payment other than the overall accommodation price as determined by the service.

In addition there are greater incentives for investment in new or improved facilities. From 1 July 2014, the Government accommodation supplement paid to aged care providers for supported residents (ie those who cannot afford to pay for their accommodation) will increase by more than 50% from approximately $32 per day to approximately $50 per day (2012 prices) for newly built or significantly refurbished services.

For services that still cannot generate or attract sufficient capital investment as a result of these changes will be able to apply for a capital grant. The Government has combined two previous capital grant programs into the Rural, Regional and Other Special Needs Building Fund. The Fund commenced in 2012-13 and approximately $51 million (indexed) will be available annually.

In addition, around $150 million in Zero Real Interest Loans has been advertised through the 2012-13 Aged Care Approvals Round and targeted at services in non-metropolitan areas, as well as services with a focus on Indigenous or CALD clients. This builds on three previous rounds of Zero Real Interest Loans, through which around $450 million in loans have been made available to assist providers establish residential aged care services in areas of high need.

Services that are built or significantly refurbished utilising a Commonwealth grant or Zero Real Interest Loan will then be able to access the higher level of Government accommodation supplement from 1 July 2014.

Multipurpose services

The *Aged Care Act 1997* also supports the delivery of flexible service models, including Multi-Purpose Services. The Multi-Purpose Service Program is a joint initiative of the Australian Government and state/territory governments, which aims to deliver flexible and integrated health and aged care services for small rural and remote communities. A Multi-Purpose Service is generally established when the local population is not large enough to support separate services – such as a hospital, a residential aged care service and home and community care services. Under the Program, Australian Government funding for aged care is combined with state/territory health services funding, and can be applied flexibly to offer more health and aged care service choices specific to the needs of the local community. As at 30 June 2012, funding was being provided for 3337 MPS aged care 'places' across 137 Multi-Purpose Services.

Specific questions from the Committee

14. Is there the capacity to increase the accommodation supplement for rural, remote and Indigenous services?

> Rural, remote and Indigenous services that are new or significantly refurbished will be eligible for the new higher level of accommodation supplement. This includes services that are built or refurbished using commonwealth funding under the Rural, Regional and Other Special Needs Building Fund or the Zero Real Interest Loans program.

15. What scope is there to create more generous and flexible eligibility criteria for other supplements such as the workforce supplement?

> Supplements provide funding for a specific purpose or to achieve a specific outcome. Some are based on the care needs of individual residents (eg the existing Oxygen and Enteral Supplements and the new Dementia and Veterans' Supplements). For others,

eligibility is determined based on features of the service (eg the existing Viability Supplement and the new Workforce Supplement). The Viability Supplement is the appropriate mechanism to provide additional funding to services with higher costs as a result of, for example their location. It would inequitable to offer more generous or flexible criteria for rural and remote services in relation to the other supplements which relate to the specific care needs of individuals or a specific purpose payment in the case of workforce.

Indigenous services

Services that specifically cater for the needs of Aboriginal and Torres Strait Islander people experience many of the same challenges as rural and remote services. Additional funding and support is provided through many of the same strategies.

Indigenous services funded under the *Aged Care Act 1997* are also eligible for the viability supplement. In 2011-12 there were 21 homes specialising in caring for Indigenous and/or homeless clients which received the supplement, totaling $4.4 million. Indigenous services are also eligible for support with capital costs through the Rural, Regional and Other Special Needs Building Fund and Zero Real Interest Loans initiative. New or significantly refurbished Indigenous services will be eligible for the higher accommodation supplement from 1 July 2014 (including those where the build or refurbishment was supported by Australian Government funding).

In addition to having access to aged care services funded under the Act, Aboriginal and Torres Strait Islander people also have access to services funded through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. These services are funded and operated outside of the regulatory framework of the Act to deliver a mix of residential and home care services. Under this program, there are currently 28 services located across Australia, which collectively deliver 647 places. Through the *Living Longer Living Better* reforms, an additional $43.1 million over five years has been committed to expand the program by 200 places.

Services for homeless people

Subsidy and supplements

The Australian Government provides additional support for aged care services specialising in the delivery of care to the homeless and those at risk of homelessness through the viability supplement. This funding is in addition to that available under the Aged Care Funding Instrument (ACFI).

Homeless services are likely to receive a higher than average benefit from the new Dementia Supplement for residential aged care because of the high rates of severe behavioural and psychological symptoms exhibited by their clients. This recognises the additional costs associated with providing effective care to these clients.

The Department has established an ACFI Monitoring Group to work closely with national peak bodies and aged care stakeholder groups to ensure that recent changes to the ACFI, introduced on 1 July 2012, are implemented as intended and to address any unintended outcomes. The Group includes representation from homeless providers, and has a strong focus on monitoring the impact of the changes on homeless services.

As part of the monitoring the impact of the recent changes to the Aged Care Funding Instrument (ACFI), members have noted a divergence from the Department's estimate of the impact of the 1 July 2012 changes on services specialising in the care of people who are at risk of homelessness. It is unclear whether this reflects a true impact on subsidy levels below that originally anticipated or whether it can be attributed to variation in the resident mix of the relatively small homeless resident population. It was also noted that there is significant variation in the effect of the changes between homes servicing this population.
Further investigation and monitoring is required to determine the impact of the change on these providers. The Department is looking closely at the data for homeless providers to look at factors affecting this impact and will be working with representatives of homeless providers to get a better understanding of the factors contributing to this change in data.

Other strategies

As part of the LLLB aged care reforms, the Australian Government has committed an additional $7.3 million (GST inclusive) over five years to expand the Assistance with Care and Housing for Aged (ACHA) program. The ACHA program assists older people who have insecure housing, or are homeless, to remain in the community by facilitating access to a range of community support services.

A national expansion funding round for the ACHA program was recently conducted targeting outer regional, remote or very remote locations and an additional 13 ACHA services were funded through this process.

Services that specialise in meeting the needs of people who are, or are at risk of being, homeless are also eligible to apply for capital grants through the Rural, Regional and Other Special Needs Building Fund.

Lesbian, gay, bisexual, transgender and intersex people

Preventing discrimination

Charter of Residents' Rights and Responsibilities under the *Aged Care Act 1997* explicitly states that people living in aged care homes have the right to be treated with dignity and respect, and to live without exploitation, abuse, discrimination or victimisation.

A *National Lesbian, Gay, Bisexual, Transgender and Intersex Ageing and Aged Care Strategy* was released on 20 December 2012 after extensive work with stakeholders.

The Government is providing support for training within aged care services regarding the specific needs of older lesbian, gay, bisexual, transgender and intersex (LGBTI) people. Aged care providers will be better equipped with the necessary skills to address their care needs. The training will also facilitate social inclusion, decrease discrimination, ensure older LGBTI people are visible in an aged care setting, and improve sensitivity amongst aged care service providers. The National LGBTI Health Alliance has been contracted to deliver the national rollout of the LGBTI aged care awareness training.

It is not possible to amend the exemption provision in the *Sex Discrimination Act 1984* in relation to faith-based organisations via changes to the *Aged Care Act 1997*. To do so would create a conflict between two laws of the Commonwealth.

Dementia and Mental Health

Introduction

The purpose of the Dementia supplement is to provide additional financial assistance to Approved Providers in recognition of the additional costs associated with caring for people with dementia and mental health conditions. Approved Providers will be able to claim the supplements on top of the basic subsidies for care recipients who meet the relevant eligibility criteria.

The Department has released a consultation paper on the proposed guidelines for the new dementia and veterans' supplements in Home Care Packages, Residential Aged Care and other programs which will apply from 1 July 2013. This attachment summarises the arrangements that are intended to apply when determining eligibility for the supplements based on the consultation paper.

This attachment addresses the following questions asked by the Committee: 20-22.
20. Will a diagnosis of dementia be required to access the dementia supplement?
21. What diagnosis procedure will accompany the dementia supplement, some submitters have suggested it should be a behavioural supplement, rather than requiring a medical diagnosis of dementia – how do you respond to this?
22. Some submitters are concerned that the focus on dementia is at the detriment of recognising and funding appropriate supports for mental health needs – how do you respond to this?
i. What provisions are there to address mental health issues?
ii. Could mental health be a separate special needs category?

Dementia Supplements

Two dementia supplements are proposed: one in Home Care and one in Residential Aged Care. Each supplement has different eligibility requirements.

Home Care

In home care, care recipients who are assessed as having cognitive impairment may attract the dementia supplement at the rate of 10 per cent of the level of the Home Care Package they are receiving. A medical diagnosis is not required to receive the Dementia supplement in home care. However, to ensure a comprehensive and integrated care plan is implemented; Approved Providers should also make every effort to encourage care recipients to seek a medical diagnosis if one does not already exist. Information about efforts to get a diagnosis should be recorded.

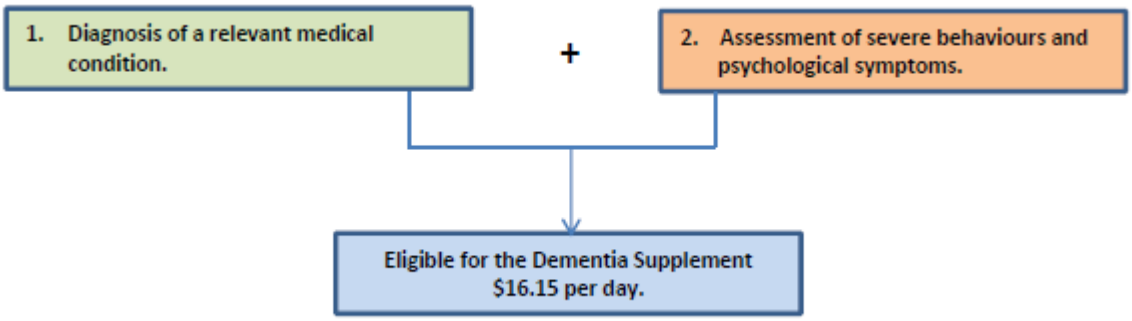
The Approved Provider has responsibility for ensuring an assessment of cognitive impairment is undertaken and documented prior to claiming the dementia supplement. The assessment must be undertaken using one of the three prescribed and validated assessment tools:

- The Psychogeriatric Assessment Scare – Cognitive Impairment Scale (PAS-CIS) for the general population;
- The Rowland Universal Dementia Assessment Scale (RUDAS) for people from culturally and linguistically diverse backgrounds; and
- The Kimberley Indigenous Cognitive Assessment (KICA-Cog) for Indigenous Australians when other instruments are not appropriate.

Residential Care

In residential aged care, dementia care is already funded through the Aged Care Funding Instrument (ACFI). However, the ACFI does not fully capture people with severe and complex behaviours and psychological symptoms associated with dementia and mental illness.

Although named a dementia supplement, the eligibility requirements in residential aged care will focus on identifying those residents with severe behavioural and psychological symptoms associated with dementia as well as other mental health conditions. Two eligibility requirements are proposed to claim the dementia supplement in residential care: a medical diagnosis; and an assessment of the severity of behaviours and psychological symptoms. Residents must satisfy both assessment criteria to attract the dementia supplement.



The medical diagnosis must be one of the listed Aged Care Assessment Program (ACAP) mental and behavioural conditions. These are listed in **Appendix 9a** and include behavioural conditions other than dementia.

In residential aged care, when severe behaviours and psychological symptoms are associated with dementia or mental illness, it is proposed that the *Neuropsychiatric Inventory – Nursing Homes (NPI-NH)* assessment tool be used to determine eligibility for the dementia supplement. It is also proposed that the assessment be carried out by a registered nurse, clinical nurse consultant, nurse practitioner, medical practitioner or specialist trained in the application of this tool and where it is within their scope of practice.

Comments and feedback from stakeholders on the consultation draft will inform the final guidelines for these supplements and relevant subordinate legislation. Actual arrangements may change following consideration of comments received through the consultation process.

Mental health services

It is important to note that the dementia supplement either in residential care or home care is not intended to fund the provision of mental health services. Older people living with mental health issues continue to be eligible for mental health services like anybody else in the community.

The supplements recognise the additional costs of providing aged care to people with behavioural and psychological symptoms associated with dementia or other conditions. It is important to distinguish the presence of a behavioural condition and the severity of the behavioural and psychological symptoms that a small group of residents in aged care homes are displaying. These severe symptoms require additional care to ensure the safety of the

person and the wellbeing of other residents and staff in the aged care service.

It is not intended at this time to include care recipients with mental health conditions as a special needs group.

Additionally, as part of the assessment process to determine eligibility for home care and residential care, Aged Care Assessments Teams will assess a person's medical, physical, social and psychological needs to determine the person's care needs and the type of services that would be most appropriate to meet those needs. The level of package approved in Home Care would reflect the relative care needs of the person, including their psychological needs. In residential care, the Aged Care Funding Instrument classifies residents based on the frequency of their behaviours, including where the person may have underlying mental health issues.

Appendix B: List of Mental and Behavioural Disorders[10].

Aged Care Assessment Program codes	
Dementia in Alzheimer's disease (500) • Dementia in Alzheimer's disease with early onset (<65 yrs) • Dementia in Alzheimer's disease with late onset (>65 yrs) • Dementia in Alzheimer's disease, atypical or mixed type • Dementia in Alzheimer's disease, unspecified **Vascular Dementia (510)** • Vascular Dementia of acute onset • Multi-infarct Dementia • Subcortical vascular Dementia • Mixed cortical & subcortical vascular Dementia • Other vascular Dementia • Vascular Dementia—unspecified **Dementia in other diseases classified elsewhere (520)** • Dementia in Pick's disease • Dementia in Creutzfeldt-Jakob disease • Dementia in Huntington's disease • Dementia in Parkinson's disease • Dementia in human immunodeficiency virus (HIV) disease • Dementia in other specified diseases classified elsewhere **Other Dementia (530)** • Alcoholic Dementia • Unspecified Dementia (includes presenile & senile Dementia) **Delirium (540)** • Delirium not superimposed on Dementia • Delirium superimposed on Dementia • Other delirium • Delirium–unspecified	**Psychoses & depression/mood affective disorders (550)** • Schizophrenia • Depression/Mood affective disorders • Other psychoses (includes paranoid states) **Neurotic, stress-related & somatoform disorders (560)** • Phobic & anxiety disorders (includes agoraphobia, panic disorder) • Nervous tension/stress • Obsessive-compulsive disorder • Other neurotic, stress-related & somatoform disorders **Intellectual & developmental disorders (570)** • Mental retardation/intellectual disability • Other developmental disorders (includes autism, Rett's syndrome, Asperger's syndrome, developmental learning disorders, specific developmental disorders of speech and language, specific developmental disorder of motor function (e.g. dyspraxia). **Other mental & behavioural disorders (580-599)** • Mental and behavioural disorders due to alcohol & other psychoactive substance use (includes alcoholism, Korsakov's psychosis (alcoholic) • Adult personality & behavioural disorders • Speech impediment (i.e. stuttering/ stammering) • Other mental & behavioural disorders n.o.s or n.e.c (includes harmful use of non-dependent substances e.g. laxatives analgesics, antidepressents, eating disorders e.g. anorexia nervosa, bulimia nervosa, mental disorders not otherwise specified)

[10] Code list is based on the ICD-10-AM classification.
http://www.aihw.gov.au/publication-detail/?id=6442467400 Appendix H

Productivity Commission Inquiry

Introduction

In April 2010, the Australian Government asked the Productivity Commission (the Commission) to examine Australia's aged care system. The Government asked the Commission to provide options for redesigning the system to address current issues and to ensure it can meet the challenges in the coming years.

During the inquiry process the Department of Health and Ageing (the Department) worked closely with the Commission providing extensive information and a number of technical papers on the aged care system.

During the inquiry process the Commission received 925 formal submissions, two from the Department and held 13 public hearings nationally.

On 8 August 2011, the Commission released their final report, *Caring for Older Australians*. The Commission proposed an integrated reform package with 58 recommendations, to fundamentally change the structure and dynamics of Australia's aged care system.

This attachment specifically addresses the following questions asked by the Committee: 28 and 29.

28. In the government's response to the Productivity Commission report, it stated:
While the Commission projected that its proposals would achieve savings over the forward estimates, this projection was based on a number of problematic assumptions. Firstly, there are errors in the modelling which means that the business as usual scenario the Commission modelled did not accurately reflect likely future expenditure in the absence of reforms; and secondly, the modelling of their proposal was not consistent with the timing of how it could be implemented.
The Department of Health and Ageing estimates that fully implementing the Commission's proposals would involve a significant cost to the Budget.
Can the Department please provide more detail on the errors referred to, and an explanation of the mismatch between the modelling and the timing of implementation. On what date did the government first become aware of possible errors in the modelling? What steps were taken to discuss or resolve these errors with the Commission?

29. It has been suggested that the Government did not proceed with adopting an entitlement approach, as recommended by the Productivity Commission, because the public was not ready for it. Is this the reason and if so, what facts, circumstances, modeling, or evidence was relied upon by the Government to reach this conclusion?

Governments Response to the Commission's Report

The Government either fully or partially supported 48 of the 58 recommendations in the Commission's final report. Of the 58 recommendations in the Productivity Commission's report 10 recommendations were not supported by the Government because:

- some pose significant cost to consumers, like the inclusion of the family home in means testing arrangements;
- some pose too great a cost on Australian tax payers, like the option for a Government backed home credit scheme and the creation of a new super regulatory agency; and
- the remaining were not considered viable options once implementation issues were explored.

A detailed Government response to the Commission's Report is available on the Departments website, at:
http://www.health.gov.au/internet/main/publishing.nsf/Content/EE950B492C67A4FDCA2579EA001699A9/$File/D0769-Australian-Government-Response.pdf

Adopting the Commission's Recommendations

The *Living Longer Living Better* aged care reforms not only have their foundations built on the recommendations of the Productivity Commission report, they are shaped on extensive consultation undertaken on the most effective way of implementing the reforms.

The Government's reforms also took into consideration the National Aged Care Alliance Blueprint and are closely aligned with many of its recommendations.

The reform package focuses on the need to protect existing consumers and aged care providers from disruptive changes and enables a smooth and phased transition. This was supported by the Commission, which itself called for gradual change.

Specific questions from the Committee

28. In the Government's response to the Productivity Commission report, it stated:
'While the Commission projected that its proposals would achieve savings over the forward estimates, this projection was based on a number of problematic assumptions. Firstly, there are errors in the modelling which means that the business as usual scenario the Commission modelled did not accurately reflect likely future expenditure in the absence of reforms; and secondly, the modelling of their proposal was not consistent with the timing of how it could be implemented. The Department of Health and Ageing estimates that fully implementing the Commission's proposals would involve a significant cost to the Budget'.

Can the Department please provide more detail on the errors referred to, and an explanation of the mismatch between the modelling and the timing of implementation. On what date did the government first become aware of possible errors in the modelling? What steps were taken to discuss or resolve these errors with the Commission?

> The Department worked closely with the Productivity Commission on the development of its model throughout the inquiry - providing access to data and assistance with model design.
>
> The Department was not aware of the claim (page XLIII) in the PC's final report that the Commission's proposals would cost less than current arrangements over the period of the forward estimates until the final report was provided to the Government on 28 June 2011.
>
> The Department immediately contacted officers at the Commission to discuss this claim and clarified the Commission's projections that their proposals would achieve savings over the forward estimates based on the assumption that the new means test would be introduced for all care recipients (including existing care recipients) on 1 July 2012.
>
> The Department pointed out to the Commission that this assumption was not in line with the Commission's recommendation, which was that the new means test should

not be introduced until 1 July 2014 at the same time as the proposed expansion in the supply of care commences.

The officers at the Commission acknowledged this discrepancy but indicated that the purpose of the comparison was to offer an analysis of the long run effect of the two policies. Senior officers in the Department also spoke to Commissioner Wood about the discrepancy.

29. It has been suggested that the Government did not proceed with adopting an entitlement approach, as recommended by the Productivity Commission, because the public was not ready for it. Is this the reason and if so, what facts, circumstances, modelling, or evidence was relied upon by the Government to reach this conclusion?

The Commission recommended that the Government should replace the current system of discrete care packages across community and residential care with a single integrated, and flexible, system of care entitlements. The Commission recommended in addition that this expansion would be gradual over a number of years.

The Government, in its response to the report, largely supported this recommendation.

The Minister for Mental Health and Ageing, in working with the Department, established a National Aged Care Alliance (NACA) working group that examined the issue of assessment, choice, consumer-oriented care and moving toward an entitlement model.

Through this working group and through other consultations it was noted that an effective aged care gateway and critical reforms to aged care assessment processes were needed to enable a move toward an entitlement model. It was also noted that the creation of new levels of home care packages (an intermediate care level between CACPs and EACH) and changes to improve the supply of packages to reduce the level of unmet demand would be necessary to create an environment where consumer entitlement would work.

The aged care reform package implements changes to address these issues by:

- Creating an integrated aged care system:
    - increasing the supply of home care packages;
    - creating two new care levels in home care, with two new dementia and Veterans' supplements; and
    - consolidating the existing HACC program for older people with the NRCP, the Assistance with Care and Housing for the Aged Program (ACHA) and the Day Therapy Centres program.
- Providing significant improvements in access to information and assessment services:
    - building a new aged care Gateway; and
    - streamlining aged care assessments.

Through the Aged Care (Living Longer Living Better) Bill 2013, a major review will occur five years into the implementation of the package. The review will need to consider if these changes were effective and if further reforms can by undertaken to move toward a supply driven or consumer entitlement model.

Australian Government

Department of Health and Ageing

Mr Patrick Reid
Chief Executive Officer
Leading Age Services Australia
Unit 2, 4 Torrens Street
Braddon ACT 2612

Dear Mr Reid

I refer to your correspondence of 5 April 2013 in relation to amendments to the Aged Care Principles and Determinations to implement the *Living Longer Living Better* reforms.

Your letter contends that much of the detail of the implementation of reform measures will not be known until amendments to the Principles and Determinations are tabled in Parliament. I do not agree that this is the case. The amendments will reflect the policy settings of the reform package as announced. Significant levels of detail are reflected in existing documents including the explanatory memoranda for the *Living Longer Living Better* bills, and in the implementation engagement that has been occurring with industry through many working groups on which your organisation and other interested parties are represented.

You also note that little development of Principles' documents can be undertaken until the passage of the legislation. This is also not correct. While the Principles cannot be tabled formally in the Parliament until the legislation receives royal assent, considerable development work can occur and has been occurring in close collaboration with the sector, since the announcement of the reform package in April last year.

You will be aware that a number of guidelines are currently out for consultation in the areas of home care and consumer directed care, dementia and veterans' supplements and the workforce supplement. These guidelines have been developed hand in hand with the sector and include coverage of the composition and categories of home care subsidies, a matter which you have raised.

I note that the other specific issues you raise in your letter were also listed in your submission to the Senate Inquiry into the legislation. The Committee asked that we provide a document summarising what information is already available on each of these issues. We will provide this document to the Committee as part of a supplementary submission, but I am also attaching it for your information.

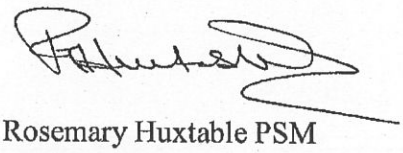
One of the issues you have identified as an area of concern is the way in which the permitted uses of refundable accommodation deposits and accommodation bonds and prudential standards will be framed in Principles. To clarify, these areas are not being amended as part of the *Living Longer Living Better* reforms but have been subject to a separate engagement process through the Prudential Advisory Group, of which I understand Ms Kay Richards from LASA is a member. They are the result of ongoing efforts to improve the operation of these parts of the regulatory framework. I have asked Mr Iain Scott, First Assistant Secretary, Office of Aged Care Quality and Compliance, to provide an individual briefing to you on these issues.

The timing of the development and amendments of the various Principles, especially for the 1 July 2013 changes, is tight. That is why the proposed arrangements have been developed in consultation with stakeholders and draft guidelines released for public consultation. The Principles will reflect the draft guidelines that are currently out for consultation, and the results of that consultation.

The Department is acutely aware of the need to ensure opportunities for broader consultation and timely advice to the sector on arrangements. Further detailed information regarding the nature and timing of the changes to the Principles is being developed and will be released before the end of May.

Consultation and collaboration has been, and continues to be, central to the reform process, and LASA has been involved at every step. I acknowledge the important role that your organisation will play in supporting your members to help shape the future arrangements by engaging with the current and future consultation processes.

Yours sincerely



Rosemary Huxtable PSM
Deputy Secretary
Department of Health and Ageing
10 May 2013

Attached: Response to Attachment 1 to LASA Submission

Response to Attachment 1 – LASA Submission to Senate Inquiry

Leading Age Services Australia (LASA) states that the list of programs below are matters where, "No precise detail of what will be contained in the instruments is available":

1. ***Amendment of the accommodation bond retention mechanism contained in the User Rights Principles.***

   On 20 April 2012, the Government announced, in line with the recommendations of the Productivity Commission, that providers would not be able to deduct retention amounts from Refundable Accommodation Deposits paid by residents who enter care from 1 July 2014.

   On 21 November 2012, the Department of Health and Ageing (the Department) released a paper providing an overview of the proposed legislative changes. The removal of retention amounts was clearly detailed in this paper as a legislative change to be, made to the *Aged Care Act 1997*, and carried through into subordinate legislation.

   In parallel with this process the Minister for Mental Health and Ageing reconfirmed on 21 December 2012 that, in line with the final recommendations of the Aged Care Financing Authority, the formula for accommodation payments should no longer refer to retention amounts.

   The Department has consistently and clearly outlined the Government's intent to remove retention amounts. Amendments to the *User Rights Principles 1997* will be in line with the announced policy and proposed amendments to primary legislation.

2. ***Amendments to the contents of the Specified Care and Service Schedule contained in the Quality of Care Principles to describe what is to be provided to all residential aged care residents.***

   The Department, together with the National Aged Care Alliance (NACA), has established a Specified Care and Services Reference Group including provider, consumer, union, and health professional representatives to provide advice on the Schedule of Specified Care and Services. LASA is a member of this group.

   The Reference Group has met six times since August 2012 to discuss the sector's views about expected levels of 'standard' and 'additional' care and services in an environment in which there is no low care / high care distinction. The Reference Group throughout these meetings has noted that aged care providers are currently able to negotiate with residents to include in the resident agreement fees for 'additional services' above the care and services required by the Schedule.

   NACA is expected to make preliminary recommendations on amendments to the Schedule by late June 2013. Recommendations that have potential cost implications will be referred to the Aged Care Financing Authority for analysis by the end of December 2013.

   These recommendations will inform the drafting of legislation to support the removal of the low care / high care distinction on 1 July 2014.

3. ***What constitutes the 'significant refurbishment' of premises?***

The Aged Care Financing Authority finalised its recommendations on the definition of significant refurbishment to the Minister for Mental Health and Ageing on 21 November 2012. These recommendations have been accepted by Minister and were announced on 21 December 2012.

These recommendations and the Minister's decision are published on the *Living Longer Living Better* website. Amendments to legislation will give effect to the Significant Refurbishment criteria as announced. In addition, guidelines on the application process are currently being developed and will be released for consultation.

4. ***The purposes to which refundable deposits and accommodation bonds may be put.***

Permitted uses to which refundable deposits may be put under the proposed legislative changes will be the same as for accommodation bonds i.e. the approved provider must comply with certain prudential requirements to ensure that the care recipient's lump sum payment is used appropriately and kept safe.

There will also be rules that are specific to lump sum accommodation payments. These rules were released for public consultation on 21 November 2012 as part of the overview paper, and are detailed on the *Living Longer Living Better* website.

In response to industry requests the Minister has agreed to amend the *User Rights Principles 1997* to expand the range of permitted uses for accommodation bonds from 1 July 2013 to include, in addition to current permitted uses:

- loans made for the purpose of refunding accommodation bond balances or entry contribution balances;
- loans made to repay debt accrued for the purposes of capital expenditure or refunding accommodation bond balances; and
- investment in Religious Charitable Development Funds.

The expanded range of permitted uses will apply to both accommodation bonds from 1 July 2013. They will also apply to refundable deposits when they commence in 1 July 2014.

5. ***The prudential standards that must be met by approved providers.***

Minor amendments will be required to the Disclosure Standard and the Governance Standard as a consequence of the expansion of the range of permitted uses for accommodation bonds from 1 July 2013.

6. ***With the removal of the flexible care provisions, the period of time in which a care recipient must be provided with care is in accordance with the approval of care recipient principles that have yet to be seen.***

&

7. ***The period of time in which a care recipient must be provided with care, in accordance with (unseen) approval of care recipient principles.***

The Explanatory Memorandum to the Living Longer Living Better Bill 2013 explains that, in order to promote better access to services and improve efficiencies with respect to approvals, it is proposed that from 1 July 2014 approvals for home care and residential care will not lapse.

As set out in item 57 of schedule 3 to the Bill, approvals to receive flexible care will continue to lapse within the entry period specified in the Approval of Care

Recipients Principles or, if no such period is specified, the period of 12 months starting on the day after the approval was given. This preserves the status quo in relation to approvals to receive flexible care.

The *Approval of Care Recipients Principles 1997* currently specify that the entry period for an approval of a person as a recipient of flexible care in the form of transition care is 4 weeks beginning on the day after the approval is given under subsection 22-1(2) of the Act. It is not proposed to make any changes to this provision.

In relation to the lapsing of approvals for other kinds of flexible care, the *Approval of Care Recipients Principles 1997* do not currently specify a period other than the current default period of 12 months specified in the Act. It is not proposed to change this current position.

8. ***The criteria for granting extra service status, to be contained in Extra Service Principles.***

The arrangements relating to new applications for extra service status and the granting of extra service status will remain largely the same. Applications for extra service status will continue to be competitively assessed.

The key differences in granting Extra Service status were provided in detail in both the overview of proposed legislative changes document (page 12) released on 21 November 2012 and the Question and Answer document (page 19). Both documents are available on the *Living Longer Living Better* website. Amendments to the *Extra Service Principles 1997* will support the announced policy.

9. ***The precise nature by which accommodation payments and accommodation contributions have yet to be determined. These will be contained in yet to be seen fees and payment principles.***

On 9 April 2013, the Department released a consultation document on the proposed accommodation pricing guidelines. The paper outlines the proposed guidelines that will support the new arrangements for accommodation payments in residential aged care, which will apply for new entrants to residential care from 1 July 2014.

This included the arrangements for justifying prices and for those seeking approval from the Aged Care Pricing Commissioner for level 3 prices. The consultation document is available on the *Living Longer Living Better* website.

Changes to subordinate legislation will be drafted in line with the agreed policy following finalisation of the consultation process.

10. ***The unknown criteria to receive the two new supplements for dementia and veterans.***

On 1 May 2013, the Department released a Consultation Paper on the *Living Longer Living Better* website, describing the proposed guidelines for the new dementia and veterans' supplements in Home Care Packages, Residential Aged Care and other programs which will apply from 1 July 2013.

The draft guidelines were developed in partnership with the Dementia and Veterans' Supplement Working Group. Once finalised, these guidelines will form the basis of the subordinate legislation.