The Senate

Community Affairs Legislation Committee

Aged Care (Living Longer Living Better) Bill 2013 [Provisions] and related bills

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43rd Parliament

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ABBREVIATIONS

AASW	Australian Association of Social Workers
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAR	Aged Care Approval Rounds
ACAT	Aged Care Assessment Team
ACFA	Aged Care Financing Authority
ACFI	Aged Care Funding Instrument
ACiA	Attendant Care Industry Association
ACPC	Aged Care Pricing Commissioner
ACSA	Aged and Community Services Australia
Act	*Aged Care Act 1997*
Alliance	National LGBTI Health Alliance
ANZ	Australia and New Zealand Banking Group Limited
CACP	Community Aged Care Packages
CALD	Culturally and linguistically diverse
CDC	Consumer Directed Care
CEO	Chief Executive Officer
CHF	Consumers Health Forum of Australia
COPO	Commonwealth Own Purpose Outlays
CVS	Community Visitors Scheme
DAP	Daily Accommodation Payment
Department/DoHA	Department of Health and Ageing
DHS	Department of Human Services
DVA	Department of Veterans Affairs

EACH	Extended Aged Care at Home
EACHD	Extended Aged Care at Home – Dementia
EBA	Enterprise Bargaining Agreement
EM	Explanatory Memorandum
Guarantee Scheme	Accommodation Bond Guarantee Scheme
GRAI	GLBTI Retirement Association Incorporated
Guild	The Aged Care Guild
HACC	Home and Community Care
LASA	Leading Aged Services Australia
Levy Bill	Aged Care (Bond Security) Levy Amendment Bill 2013
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
LLLB	Living Longer. Living Better.
MDFA	Macular Disease Foundation Australia
MPIR	Maximum Permissible Interest Rate
NACA	National Aged Care Alliance
NCOSS	Council of Social Services New South Wales
NDIS	National Disability Insurance Scheme
NPAC	National Presbyterian Aged Care Network
NSA	National Seniors Australia
PC	Productivity Commission
RAC	Refundable Accommodation Contribution
RAD	Refundable Accommodation Deposit
SCC (Vic)	Southern Cross Care (Victoria)
SWAG	Strategic Workforce Advisory Group
WACC	Weighted Average Cost of Capital

LIST OF RECOMMENDATIONS

Recommendation 1

3.55 The committee recommends that, as part of the arrangements for ACFA monitoring of the reforms that are recommended by the committee in chapter 4, evidence be sought on any impacts of the design of the fee scales on care recipient welfare.

Recommendation 2

3.64 The committee recommends that the government closely monitor the take up of home care packages and any signs of changes to demand for HACC-type packages.

Recommendation 3

4.65 The committee recommends that the Minister direct the ACFA to report regularly to the Minister on the impact of the reforms on providers (for example, the number and distribution of care recipients choosing DAPs and RADs). ACFA's brief should include specific consideration of the impacts on different types of providers (e.g. current low-care-only providers, small providers, and rural providers).

Recommendation 4

4.66 The committee recommends that the Government immediately put in place arrangements to monitor the impact on low care providers, and prepare to make available transitional support along the lines recommended by the Productivity Commission, including support services for providers seeking assistance in transitioning to the new system.

Recommendation 5

5.21 The committee recommends that the government consider amending the legislation to create a statutory timeline to make a decision regarding whether industry will be subject to a levy to recoup a loss.

Recommendation 6

6.24 The committee recommends that the dementia supplement be renamed as the *Dementia and Behavioural Supplement,* in both residential and home care.

Recommendation 7

6.28 The committee recommends that the bill be amended to include parents separated from their children by former adoption practices.

Recommendation 8

6.40 The committee recommends that the government create a Homeless Supplement.

Recommendation 9

6.53 The committee recommends that the Senate amend the bill in the terms described in the government's tabled amendment.

Recommendation 10

6.67 The committee recommends that the ministers responsible for Disability Care Australia and the aged care reforms acknowledge the issue identified in the both Senate committee inquiries into these reforms, and urges ministers to continue their work to ensure that the two systems meet the needs of all people ageing with disability.

Recommendation 11

7.31 The committee recommends that the government examine whether it may be appropriate to revise the Supplement Guidelines to permit in some circumstances the use of the workforce supplement in meeting employee entitlements.

Recommendation 12

7.55 The committee recommends that references to the workforce supplement be retained as they appear in the proposed legislation.

Recommendation 13

8.25 It is recommended that ACFA be established by the Minister for Mental Health and Ageing as a committee under section 96-3 of the *Aged Care Act 1997*.

Chapter 1

Referral of the *Living Longer Living Better* reform Bills

1.1 On 14 March 2013, the Senate referred to the Aged Care (Bond Security) Amendment Bill 2013, the Aged Care (Bond Security) Levy Amendment Bill 2013, the Aged Care (Living Longer Living Better) Bill 2013, the Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013, and the Australian Aged Care Quality Agency Bill 2013 (the *Living Longer Living Better* Bills) for inquiry and report by 17 June 2013. The committee elected to report by 31 May 2013.

Conduct of inquiry

1.2 The committee advertised the inquiry in *The Australian* newspaper. Details of the inquiry, the Bills and associated documents were also placed on the committee's website.

1.3 The committee wrote to over 200 organisations and individuals seeking the submissions by 22 April 2013. Submissions were received from 112 individuals and organisations, as listed in Appendix 1.

1.4 Public hearings were held between 29 April and 2 May 2013. A list of witnesses who appeared at the hearings is in Appendix 2.

1.5 The committee thanks those organisations and individuals who made submissions to the inquiry, and those who gave evidence at the public hearings. The committee is particularly grateful to both the Department of Health and Ageing and other witnesses who responded to an unusually large number of questions on notice.

Background

1.6 According to a survey conducted by Australian Bureau of Statistics, 7.7 million Australians were aged 45 years or older in 2007. Of these, 3.1 million Australians were retired and over 1 million planned to retire in the next decade. Of the 3.9 million employed Australians aged 45 years or over, one in seven had not yet begun planning for retirement.[1] Four years on, 3.2 million Australians aged 45 years and over were retired. Approximately half were aged 70 or more years (50 per cent of retired men and 41 per cent of retired women). The average age of retirement in 2011 was 53.3 years. The number of Australians aged 45 years or over in the workforce had increased from 3.9 million to 4.9 million.[2]

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1 Australian Bureau of Statistics, *4102.0 - Australian social trends - Retirement and retirement intentions*, March 2009, http://www.abs.gov.au/AUSSTATS/abs@.nsf/Lookup/4102.0Main+Features50March%202009 (accessed 18 April 2013).

2 Australian Bureau of Statistics, *6238.0 - Retirement and retirement intentions, Australia*, July 2010 to June 2011, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/6238.0Main%20Features3July%202010%20to%20June%202011?opendocument&tabname=Summary&prodno=6238.0&issue=July%202010%20to%20June%202011&num=&view (accessed 18 April 2013).

1.7 The Productivity Commission has also reported that the number of older persons as a percentage of Australia's population is projected to increase. Commenting in 2011, the Commission reported that it is estimated that the number of Australians aged 85 or more years will increase from 0.4 million in 2010 to 1.8 million by 2050. It is anticipated that by 2050, every year over 3.5 million Australians will access aged care services.[3]

1.8 The Government has concluded that the current aged care system is 'ill–equipped to meet the needs of retiring baby boomers and their parents who are living longer and healthier lives'.[4] Announcing its intention to redesign the delivery of aged care services in Australia, in April 2012 Government reported that the current system is flawed, undermined by pricing inequalities, complex care service structures, and the limited availability, and therefore limited choice, of services for older Australians.[5]

1.9 The proposed aged care reforms would establish a new administrative and pricing structure for the delivery of aged care services in Australia. It is intended that the legislative and non–legislative measures proposed to redesign the aged care system will increase access to services, streamline the system so that it is easier to navigate, and improve service delivery standards.[6] It is projected that the reforms will be implemented over a 10 year timeframe from 1 July 2012,[7] and will cost $3.7 billion over five years from 2012–13.[8] As indicated in the April 2012 announcement of the aged care reforms, this will be comprised of:

- $1.9 billion to improve access to aged care services;
- $1.2 billion over five years to address critical shortages in aged care workforce;
- $80.2 million to 'improve aged care linkages with the health care system';

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3 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxvi.

4 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

5 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012; Department of Health and Ageing (DoHA), *Living Longer. Living Better. Aged care in Australia is changing*, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/B80915E5F55CA15BCA257B330082915F/$File/Accessible%20pdf%20version%20of%20brochure%20for%20web.pdf (accessed 16 April 2013).

6 DoHA, *Questions and Answers Regarding the Legislative Changes*, p. 10, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/ageing-legislative-questions-and-answers-toc (accessed on 16 April 2013).

7 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

8 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 3.

- $54.8 million to support carers;
- $268.4 million for dementia services; and
- $19.2 million 'to support the diverse care of Australia's ageing population'.[9]

1.10 Key components of the reform package include the introduction of the Home Care Packages Program, designed to assist people to remain in their homes if they so choose. It is expected that $880.1 million will be allocated to the program over five years, to increase the total number of Home Care packages from approximately 60,000 to 100,000. From 2017–18 to 2021–22, is anticipated that an additional 40,000 home care packages will be introduced.[10] The Government has undertaken to review the adequacy of the number of home care packages after five years.[11] The program will provide 'four levels of home-care options covering basic home care all the way through to complex home care'.[12]

1.11 The reforms also target the delivery of aged care services in residential care facilities. In contrast to current practice, the reforms will remove the distinction between low-level residential care and high-level residential care, and existing barriers to purchasing additional services and amenities. It is intended that from 1 July 2014, approvals for placement in residential care will not distinguish between high and low care. Residents will, however, be given the option of purchasing additional services.[13]

1.12 The Government also announced its intention to overhaul the pricing structure for aged care services, through introducing an 'income tested care fee' for home care services and a 'means tested fee' for residential care.[14] The fee structures are intended

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9 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

10 DoHA, *Living Longer Living Better –Consumer directed care and home care packages* http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Consumer-Directed-Care-Home-Care-Packages (accessed 18 April 2013).

11 DoHA, *Living Longer Living Better – Detailed questions and answers: Home care*, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/ageing-legislative-questions-and-answers-toc~ageing-legislative-questions-and-answers-home-care (accessed on 16 April 2013).

12 DoHA, *Living Longer – Detailed questions and answers: Home care*, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/ageing-legislative-questions-and-answers-toc~ageing-legislative-questions-and-answers-home-care (accessed on 16 April 2013).

13 DoHA, *Questions and Answers Regarding the Legislative Changes*, p. 19, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/ageing-legislative-questions-and-answers-toc (accessed on 16 April 2013).

14 DoHA, *Living Longer Living Better - Worked examples of income/Means tested care fees*, March 2013, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/03D821705DC80059CA257B3C0007304E/$File/Hand%20out%20-%20Worked%20examples%20of%20income%20&%20means%20tested%20care%20fees.pdf (accessed 16 April 2013).

to give effect to the Government's policy of providing a fair and equitable aged care payment system.[15]

1.13 To oversee the transition to the new arrangements, the Government has established an Aged Care Reform Implementation Council. The independent Council is responsible for advising the Minister on the progress of the reforms, to ensure that the reforms are implemented 'coherently and consistently'. The Council will also oversee a formal evaluation of the implementation of the reforms, to be conducted from 2013 to 2015.[16]

Productivity Commission report

1.14 The Government has advised that the reforms respond to concerns identified by older Australians and their families, as well as to the findings of the Productivity Commission's review of the aged care system.[17]

1.15 In April 2010, the then Assistant Treasurer, Senator Nick Sherry, and the then Minister for Ageing, Justine Elliot MP, tasked the Productivity Commission with developing options to redesign Australia's aged care system to meet the needs of older Australians in the coming decades.[18] Over the course of the approximately 18 month inquiry, the Commission received 925 submissions and held 13 public hearings.[19] The Commission's analysis also drew on previous reviews of Australia's health care system, including the 2004 Hogan Review, the 2009 National Health and Hospitals Reform Commission Report, and the 2010 Henry Review of Australia's taxation system.[20]

1.16 Reporting in August 2011, the Commission concluded that Australia's aged care system is plagued by 'many weaknesses', and will be unable to meet future challenges arising from an ageing Australian population.[21] Accordingly, the Commission found that there is an established case and a clear need for 'fundamental and wide-ranging reform'.[22] The Commission reported that the aged care system is

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15 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

16 DoHA, *Aged Care Reform Implementation Council: Terms of reference*, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Terms-of-Reference (accessed 18 April 2013).

17 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

18 The Assistant Treasurer, Senator Nick Sherry, and the Minister for Ageing, Justine Elliot MP, 'Productivity Commission inquiry into aged care', Media release 068, 21 April 2010.

19 Productivity Commission, *Caring for older Australians – Public inquiry*, http://www.pc.gov.au/projects/inquiry/aged-care (accessed 18 April 2013).

20 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxv.

21 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxvi.

22 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxv.

complex and difficult to navigate, and is perceived by older Australians as unresponsive to their changing care needs. Key weaknesses were identified with residential care services, community care services, and the current administration of the aged care system.

1.17 Weaknesses identified with residential care included excessive waiting times, limited choice of care providers, variable quality of services and lack of incentives for providers to improve service delivery. Providers also reported challenges accessing finance, in particular, finance to build additional high care residential facilities.[23] The practice of charging low level fees for high care accommodation was also identified as an area of concern.[24]

1.18 Problems with community-based care services were also highlighted, with the Productivity Commission identifying a lack of continuity of care. Rather than seamlessly responding to changing care needs, the Productivity Commission found that 'changes in an older person's care needs can lead to a change in the "care package", care provider, and personal carer'.[25] The review also found that community-based care is predominantly provided on an informal basis from family, friends and neighbours, with approximately 80 per cent of community-based care provided by informal carers.[26]

1.19 While noting that the aged care workforce is 'generally appropriately skilled', deficiencies were also identified. It was concluded that service delivery is currently undermined by the variable quality of staff training and staff shortages, which were attributed to low wages, strenuous work environments, limited employee-development opportunities and high administrative workloads.[27]

1.20 The current governance and administrative framework for the aged care system was also criticised, with the Productivity Commission particularly noting the burden imposed by 'complex, overlapping and costly' regulations.'[28]

1.21 To address these weaknesses, the Productivity Commission endorsed an objectives-based framework for the aged care system. The Commission recommended that the aged care system should aim to support the following objectives.

- Promoting the independence and wellness of older Australians, and their continuing contribution to society.
- Ensuring that all older Australians needing care and support have access to person–centred services that can change as their needs change.

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23 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxv.

24 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxv.

25 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxv.

26 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxiv.

27 Productivity Commission, *Caring for older Australians – Overview*, August 2011, pp xxv–xxxvi.

28 Productivity Commission, *Caring for older Australians – Overview*, August 2011, p. xxxvi.

- Consumer directed, allowing older Australians to have choice and control over their lives and to die well.
- Treating older Australians receiving care and support with dignity and respect.
- Being easy to navigate, with older Australians knowing what care and support is available and how to access those services.
- Assisting informal carers to perform their caring roles.
- Affordability; being affordable for those requiring care and society more generally.
- Providing incentives to ensure the efficient use of resources devoted to caring for older Australians and broadly equitable contributions between generations.

1.22 To give effect to these objectives, the Productivity Commission made a further 57 recommendations for change to Australia's aged care system.[29] The recommendations aimed to improve the cost of aged care, access to aged care services, the quality of aged care and aged care accommodation, including at–home accommodation, provide additional support to carers, strengthen the aged care workforce, and streamline the regulation and administration of aged care system.[30]

Government response

1.23 In its 48 page response to the Productivity Commission's report, the Government accepted in principle the Productivity Commission's findings about the state of Australia's aged care system. However, as noted in the May 2012 government response, the Government concluded that the widespread structural reforms recommended by the Commission were not financially feasible in the current fiscal environment.[31] The Government disputed the Productivity Commission's estimate that the proposed reforms would reduce the cost of aged care, arguing that the costings were based on 'problematic assumptions'.[32]

1.24 Accordingly, the Government did not accept all recommendations. Rather, the Government drew on the Commission's findings and analysis of the aged care system to develop the *Living Longer Living Better* aged care reforms.[33] As the Government's response indicates, the *Living Longer Living Better* reforms are intended to give effect

29 Productivity Commission, *Caring for older Australians – Recommendations*, August 2011, p. LXIII–LXXXI.

30 Productivity Commission, *Caring for older Australians – Recommendations*, August 2011, p. LXIII–LXXXI.

31 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, May 2012, p. 1.

32 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 1.

33 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 1.

to the principles underpinning the Productivity Commission's report while having due regard to the practicalities of implementing major health care reforms:

> The Government's aged care reform package, *Living Longer Living Better*, seeks to address the problems identified by the Commission but gives greater weight to the potential difficulties the sector would face in absorbing and responding to significant structural changes in the short to medium term…While the proposed reform package moves in the same direction as that proposed by the Commission, it adopts a more graduated approach that seeks to significantly enhance the well-being of Australians and their carers and better position the aged care sector for the possibility of further reforms in the future.[34]

1.25 Of the Productivity Commission's 58 recommendations, the Government did not support nine, namely:

- the creation of an Australian Age Pensioners Savings Account scheme;[35]
- the inclusion of the relevant share of the person's former principal residence in the total assets test;[36]
- the creation of a government backed Australian Aged Care Home Credit scheme;[37]
- Australian government set scheduled fees for the delivery of certain subacute residential care services;[38]
- independent review of the Medicare rebate for residential care medical services provided by general practitioners;[39]
- the creation of the new independent regulatory agency – the Australian Aged Care Commission;[40]
- a new independent statutory Community Visitors Program for residential aged care facilities;[41]

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34 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 1.

35 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 5.

36 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 12.

37 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 1.

38 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 19.

39 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 20.

40 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 33.

- amendments to the missing resident reporting requirements;[42] and
- the provision of grants to existing small approved residential care providers to assist the transition to the proposed new aged care system.[43]

Purpose of Bills

1.26 Collectively, the five Bills would introduce the legislative aspects of the Government's proposed *Living Longer Living Better* aged care reforms.

The Aged Care (Living Longer Living Better) Bill 2013

1.27 The Aged Care (Living Longer Living Better) Bill 2013 would amend the *Aged Care Act 1997* to introduce reforms in the following three key areas: residential care, home care, and governance and administration. The Bill would also make minor and technical amendments to address current drafting anomalies and inconsistencies in the Aged Care Act.[44]

Residential care

1.28 The Bill would introduce the following key changes to the provision of residential care services.[45]

- *Removal of the distinction between low-level and high-level residential care*: Under the reforms proposed, approval for permanent residential care would entitle a person to access any residential care service appropriate to his or her needs.
- *A new system for contributing to the cost of residential care*: Currently, aged care recipients living in residential care may be charged an upfront accommodation bond. The Bill would introduce new payment arrangements for residential care. Residents may pay for their accommodation by periodic payment, known as the Daily Accommodation Payment (DAP), by lump sum, referred to as a Refundable Accommodation Deposit (RAD), or through a combination of both. The Bill would also introduce a means test combining income and asset tests, and new annual lifetime caps on means tested fees.
- *New subsidies*: The Bill would introduce an additional dementia supplement, a new veterans' affairs mental health supplement and a workforce supplement available to eligible providers from 1 July 2013.

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41 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 35.

42 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 37.

43 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 41.

44 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 3.

45 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, pp 1–2.

- *Transitional arrangements*: For people currently in residential care, the Bill would provide for existing residents to continue their current service arrangements. However, the proposed new residential care framework would apply if existing residents leave residential care for more than 28 days or move between services and elect to adopt the proposed new aged care arrangements.

Home care

1.29 The Bill would also create a new category of aged care services, known as 'home care'. The following would be the key features of the proposed home care scheme.[46]

- *Repeal of existing community–based services arrangements*: From 1 July 2013, home care services will replace existing Community Aged Care Packages and some forms of existing flexible care services delivered in a person's home.
- *New subsidies*: The Bill would introduce an additional dementia supplement, a new veterans' affairs mental health supplement and a workforce supplement available to eligible providers from 1 July 2013.
- *Visitors schemes*: The Bill would extend the existing community visitor scheme for residential care recipients to recipients of home-care services.
- *A system for contributing to the cost of residential care:* For persons who receive home-care services from 1 July 2014, costs will be calculated according to an 'income tested care fee'. The Explanatory Memorandum notes that under the proposed new 'income tested care fee' some residents may be required to contribute more to the cost of their care. However, the Bill would introduce safeguards to ensure that full rate pensioners will not pay an income tested care fee. Further, the Bill would introduce new annual and lifetime fee caps.
- *Transitional arrangements*: For people currently receiving care services in their homes, the Bill would provide for existing arrangements to continue. However, the proposed new home care framework would apply if existing recipients leave care for more than 28 days or move between services and elect to adopt the proposed new aged care arrangements.

Arrangements for persons currently receiving aged care services

1.30 The Bill would introduce the terminology 'continuing care recipients' to distinguish persons currently receiving aged care services from persons who enter the aged care system on or after 1 July 2014. As noted, for people currently receiving care services in their homes or residential care, the existing aged care system will continue to govern their receipt of aged care services. Effectively, the aged care reforms will not replace the current aged care system in its entirety. Persons currently receiving aged care services can elect to continue to receive services under existing

46 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 2.

arrangements. This policy is intended to ensure that changes do not disrupt established financial arrangements for continuing care recipients.[47]

1.31 To give effect to this policy, and the intended continuity, Schedule 5 of the Aged Care (Living Longer Living Better) Bill 2013 would introduce new legislation – the *Aged Care (Transitional Provisions) Act 1997*. This Act would substantially mirror the Aged Care Act in its current form, that is, prior to the amendments contemplated under the Aged Care (Living Longer Living Better) Act (if enacted). The new Act would govern arrangements for fees, subsidies and payments for continuing care recipients.[48]

1.32 To ensure that the proposed new legislation can be easily identified as a counterpart to the new aged care arrangements, the Bill would suspend the operation of section 39 of the *Acts Interpretation Act 1901* which requires Acts to be numbered in sequential order according to the year they were passed. The new Act would be taken to have been enacted the same year as the Aged Care Act. Accordingly, both Acts will be dated as being passed by Parliament in 1997.[49]

Governance and administration

1.33 The Bill would also establish an Aged Care Pricing Commissioner, who would be tasked with making 'decisions on certain pricing issues within the legislative framework and broad policy frameworks set by the Minister.'[50] Additionally, the Bill would establish a mechanism for independent review of the reforms, requiring a report to be tabled in both Houses of Parliament by 30 June 2017.[51]

The Australian Aged Care Quality Agency Bill 2013

1.34 The Australian Aged Care Quality Agency Bill 2013 would establish the Australian Aged Care Quality Agency, the Aged Care Quality Advisory Council, and the Quality Agency Principles. It is intended that the Act (if enacted) would commence on 1 January 2014.[52]

1.35 Under the direction of the Chief Executive Officer, the Australian Aged Care Quality Agency would be responsible for:

- accreditation of residential care services;
- conducting quality reviews of home-care services from 1 July 2014;
- registering quality assessors of residential and home care services;

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47 DoHA, *Questions and Answers Regarding the Legislative Changes*, p. 16, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/ageing-legislative-questions-and-answers-toc (accessed on 16 April 2013).

48 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 125.

49 Aged Care (Living Longer Living Better) Bill 2013, Schedule 5, Item 1.

50 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 2.

51 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 2.

52 Australian Aged Care Quality Agency Bill 2013, clause 2.

- promoting high quality care, innovation and quality management, and continuous improvement amongst approved providers of aged care services; and
- providing information, education and training to approved providers of aged care.[53]

1.36 The Aged Care Quality Advisory Council would be responsible for advising the Chief Executive Officer of the Australian Aged Care Quality Agency about the agency's functions. Advice may be given at the Council's discretion, at the request of the Chief Executive Officer of the Australian Aged Care Quality Agency or at the Minister's direction.[54] To be appointed to the Council, members would be required to satisfy eligibility criteria focused on the candidates' knowledge or experience in relevant fields such as the evaluation of quality management systems, geriatrics, aged care consumer issues, and adult education.[55]

1.37 The Australian Aged Care Quality Agency Bill 2013 would also authorise the Minister to make, by legislative instrument, Quality Agency Principles about matters under the Act (once enacted) or necessary or convenient to give effect to the Act.[56] The Australian Aged Care Quality Agency is to have regard to these principles when undertaking its legislative functions.[57] The Explanatory Memorandum explains that the principles will include Accreditation Standards and Home Care Standards against which the Australian Aged Care Quality Agency will assess the performance of residential and home care service providers and register quality assessors.[58]

The Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013

1.38 The Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013 would establish a new framework for the administration of the aged care services registration and quality assurance scheme proposed under the Aged Care (Living Longer Living Better) Bill 2013 and the Australian Aged Care Quality Agency Bill 2013. The Bill would repeal the operation of the existing healthcare authority, the Aged Care Standards and Accreditation Agency Limited, and transfer its functions to the proposed Australian Aged Care Quality Agency. The Bill contemplates that the Australian Aged Care Quality Agency would assume functions for residential aged care services from 1 January 2014, and home care services from 1 July 2014. In the interim, functions relating to home care services would be performed by the Department of Health and Ageing.[59] It is intended that the Act (if enacted) would

53 Australian Aged Care Quality Agency Bill 2013, clause 12.

54 Australian Aged Care Quality Agency Bill 2013, clause 30.

55 Australian Aged Care Quality Agency Bill 2013, clause 30.

56 Australian Aged Care Quality Agency Bill 2013, clause 58.

57 Australian Aged Care Quality Agency Bill 2013, clause 12.

58 Australian Aged Care Quality Agency Bill 2013, Explanatory Memorandum, p. 4.

59 Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013, Explanatory Memorandum, p. 1.

commence at the same time as the Australian Aged Care Quality Agency Act (if enacted).[60]

The Aged Care (Bond Security) Amendment Bill 2013

1.39 The Aged Care (Bond Security) Amendment Bill 2013 would amend the *Aged Care (Bond Security) Act 2006* to extend the existing Accommodation Bond Guarantee Scheme to the new lump sum residential accommodation payments proposed under the Aged Care (Living Longer Living Better) Bill 2013. This would ensure existing protections are afforded to accommodation payments made on or after 1 July 2014.[61] It is intended that the Act (if enacted) would commence on 1 July 2014.[62]

The Aged Care (Bond Security) Amendment Bill 2013

1.40 The Aged Care (Bond Security) Levy Amendment Bill 2013 would amend the *Aged Care (Bond Security) Levy Act 2006* to authorise the Commonwealth to recover the cost of guaranteeing the proposed new residential accommodation payments. To recover any payments made in the event that an approved residential care provider becomes insolvent and is therefore unable to refund a bond, the Commonwealth would be authorised to charge a levy against approved providers.[63] It is intended that the Act (if enacted) would commence on 1 July 2014.[64]

Views of Parliamentary legislative scrutiny committees

1.41 The *Living Longer Living Better* Bills have been the subject of comment by two Parliamentary committees tasked with examining proposed legislation to ensure compliance with established Commonwealth legislative principles and requirements.

Parliamentary Joint Committee on Human Rights

1.42 The Parliamentary Joint Committee on Human Rights is tasked with examining proposed legislation to ensure compatibility with human rights standards.[65] The committee examined the Aged Care (Living Longer Living Better) Bill 2013, noting its concern with two aspects of the proposed legislation.

1.43 First, the committee drew attention to the proposed means test for aged care services and the consequent potential reduction in the level of services provided to certain individual recipients. The committee advised that:

60 Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013, clause 2.

61 Aged Care (Bond Security) Amendment Bill 2013, Explanatory Memorandum, pp 1–2.

62 Aged Care (Bond Security) Amendment Bill 2013, clause 2.

63 Aged Care (Bond Security) Levy Amendment Bill 2013, Explanatory Memorandum, p. 1.

64 Aged Care (Bond Security) Levy Amendment Bill 2013, clause 2.

65 *Human Rights (Parliamentary Scrutiny) Act 2011*, s. 7.

> [a] reduction in the amount of subsidies or other support provided to individual recipients encroaches on a person's enjoyment of the relevant right, and may be viewed as a retrogressive measure.'[66]

1.44 The Minister's advice was sought regarding the impact of the proposed means test and justification for what the committee considered may be a retrogressive measure under the International Covenant on Economic, Social and Cultural Rights.

1.45 Second, the committee sought further information about the protections provided where a person faces a possible subsidy reduction if he or she fails to produce information or documents at the Minister's request. It was noted that compliance with directions to produce documents may be difficult for elderly persons, particular persons with poor health.[67]

1.46 As of the time of tabling this report, no response from the Minister had been published.

Senate standing committee for the scrutiny of bills

1.47 The Senate scrutiny of bills committee identified a number of issues for clarification with the Minister in its fifth alert digest of 2013.[68]

1.48 In relation to the Aged Care (Living Longer Living Better) Bill 2013, the committee noted:

> The bill includes numerous provisions allowing determinations to be made by way of legislative instruments. Unfortunately, however, the explanatory memorandum does not contain sufficient information to enable a consideration of the appropriateness of these delegations of legislative power.[69]

1.49 In relation to the Australian Aged Care Quality Agency Bill 2013, the committee asked questions regarding the disclosure of personal information:

> The Statement of Compatibility appears to conclude that the overall approach to personal information does limit the human right to protection against arbitrary interference with privacy but that any limitations 'are reasonable, necessary and proportionate'. However, it appears to the committee that there is insufficient information included in the explanatory memorandum (at pages 15 to 17) to adequately assess this conclusion. In particular, the defences available to the offence for disclosing protected information in clause 48 are not explained. Similarly, the necessity of authorising the disclosure of protected information for other purposes pursuant to clause 48 is not elaborated. In addition, the bill envisages that important matters, in the form of further instances of authorised disclosure,

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66 Parliamentary Joint Committee on Human Rights, *Fourth of report 2013*, March 2013, p. 30.

67 Parliamentary Joint Committee on Human Rights, *Fourth of report 2013*, March 2013, p. 31.

68 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest No.5 of 2013*, http://www.aph.gov.au/Parliamentary_Business/Committees/Senate_Committees?url=scrutiny/alerts/2013/index.htm (accessed 24 May 2013)

69 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest No.5 of 2013*, p. 5.

> will be able to be included in delegated legislation rather than being included in the primary act.
>
> The committee therefore requests additional information from the Minister's about these matters and, in particular, about the appropriateness of allowing for the creation of further instances of authorised disclosure of personal information through the Quality Agency Principles (ie regulations) as envisaged by paragraph 49(j).[70]

1.50 In the same manner as was the case for the main bill, the committee also raised questions about the delegation of legislative power.[71] As of the time of tabling this report, no response from the Minister had been published.

Outline of report

1.51 This report comprises eight chapters:

- Chapter 2 outlines the broad support for aged care reform and discusses public consultation.
- Chapter 3 is about home care
- Chapter 4 is about residential care
- Chapter 5 concerns the bond levy guarantee
- Chapter 6 concerns supplements and special needs groups
- Chapter 7 covers the workforce supplement
- Chapter 8 discusses governance.

70 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest No.5 of 2013,* pp 10–11.

71 Senate Standing Committee for the Scrutiny of Bills, *Alert Digest No.5 of 2013,* p. 11.

Chapter 2

General views on the reforms and consultation

2.1 The Living Longer Living Better (LLLB) package of bills represents a significant step on a process of reform that has been underway for several years. The changes have been long-awaited, with many believing them overdue. There has been consultation with stakeholders throughout the process, and the programme supplied by the department is attached to this report as Appendix 3. The committee received evidence criticising the consultation. The criticism will be addressed in this chapter. The committee is aware that there will never be a perfect consultation mechanism and again, the issues raised in this enquiry must be noted by the department for future processes.

Aged care forms – general views

2.2 All stakeholders agreed with the need for change to the aged care system, with most supporting the overall model put forward by the Productivity Commission.[1] Service providers in particular appeared to prefer the Productivity Commission's blueprint to the government's partial adoption of that blueprint in the Living Longer Living Better package.

2.3 Consumer organisations were generally supportive of the reforms. COTA Australia supported the bills and asked that they be passed as soon as possible:

> COTA is strongly urging multi-partisan support for the passage of the Bills so these important reforms can start on time on 1 July 2013. If these Bills do not pass in this session then aged care reform is at risk and older Australians will miss out on the benefits.[2]

> COTA comes here to say in the strongest terms that the bills before the parliament should be passed this session. Living Longer Living Better from a consumer perspective has a number of extremely positive elements. It will bring more packaged care to support older people to remain living independently in their own home. It will bring a greater range of that care, as we have argued for over years, although it does not go as far as we would argue. It does introduce greater choice and control for older people through consumer directed care, for which all packages will be converted over time. We would like to go further than that in terms of our arguments and the Productivity Commission's arguments for entitlement, but this is a significant step in that direction and in fact perhaps one of the most underestimated steps in the reform process.[3]

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1 See, for example, Leading Aged Services Australia, *Submission 58*, p. 1, Aged Care Services Australia, *Submission 67*, p. 4.

2 COTA Australia, *Submission 87*, p. 4.

3 Mr Yates, Chief Executive, COTA Australia, *Committee Hansard*, 2 May 2013, p. 30.

2.4 The Consumer Health Forum stated 'CHF supports the introduction of the Living Longer Living Better aged care reform package and welcomes the development of the Bills'.[4] National Seniors Australia supported many elements of the package but were concerned about a number of issues, particularly whether there would continue to be shortfalls in funding and investment.[5] A number of groups commented only on specific aspects of the package, reflecting their constituencies, but were broadly supportive of the reforms. These included the National LGBTI Health Alliance[6] and the Young People in Nursing Homes Alliance[7] amongst others.[8] The Australian Blindness Forum considered:

> The primary objectives of the announced reforms to facilitate greater community based, in home support, and greater individual choice in terms of service and service provider is long overdue.[9]

2.5 The Aged Care Guild, representing several of the major for-profit providers, supported the reform agenda (though they raised issues regarding investment in the sector):

> The Guild supports the need for industry reform and broadly agrees with many aspects of the proposed legislative changes. It sees Living Longer Living Better (LLLB) as an important step of a much bigger reform journey.[10]

2.6 The Attendant Care Industry Association, the peak body for attendant care service providers, stated that it was:

> strongly supportive of the LLLB reforms, especially the focus on providing more opportunity for support to be delivered to people in their own homes, enabling them to age in place and to provide many more alternatives to residential aged care.[11]

2.7 While noting some areas of the reforms still need to be finalised, Anglicare posited that the legislation should proceed:

> It is our belief that we should go ahead and that there are some things that can be altered along the way. There seems to be quite a degree of agreement in the submissions that we have read around some of those corrections, qualifications, reviews and those kinds of areas. It is our view that there is

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4 Consumers Health Forum of Australia, *Submission 29*, p. 1.

5 National Seniors Australia, *Submission 68*, p. 1.

6 National LGBTI Health Alliance, *Submission 88*.

7 Young People in Nursing Homes Alliance, *Submission 108*, p. 2.

8 Dr Comfort, Chair, Gay Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52; Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 25.

9 Australian Blindness Forum *Submission 16*, p. 3.

10 Aged Care Guild, *Submission 46*, p. 2.

11 Attendant Care Industry Association, *Submission 31*, p. 4.

> enough right in this legislation to actually get this reform happening. It has been a long time coming and we have all been advocating for it for a long time. So it is our view that we should not hold this legislation up over these concerns.[12]

2.8 Other submitters such as Catholic Health Australia offered qualified support but argued that the proposed legislation fell short of the recommendations made by the Productivity Commission or the National Aged Care Alliance:

> Catholic Health Australia supports these Bills. They are the next step in progressive reform to support the future sustainability and quality of aged care services. … Catholic Health Australia acknowledges that the thrust of the Government's response to the Productivity Commission recommendations, as reflected in Living Longer Living Better package, works towards the creation of a system that fulfils the above policy aims, but remains concerned that not all of the Productivity Commission's recommendations were adopted.[13]

2.9 Despite these reservations, Catholic Health Australia wanted to see the bills passed:

> Our view is that it is very, very important that the legislation proceeds. It has been a hard won gain to get to where we are and we would hate to see it slip away.[14]

2.10 Catholic Health Australia's reservations were echoed by Kincare in their opening statement to the Committee:

> We have been broadly supportive of the reforms and the principles behind them in the context that we believe that they are a step in the right direction. We were disappointed at the time that the reforms were announced that they did not go the distance that the Productivity Commission had recommended. We believe that a lot of the challenges that we are facing in the legislation, both in terms of transition and the basic regulation of the aged-care sector, would actually have been dealt with if we had moved towards a full entitlement based system in a way that the productivity commission had envisaged it.[15]

2.11 Some support for the bills was contingent on specific actions taking place to address information gaps in the reforms.[16] Leading Aged Services Australia (LASA) recommended:

> Unless the Department of Health and Ageing (the Department) publishes:

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12 Ms Chambers, Executive Director, Anglicare, *Committee Hansard*, 2 May 2013, p. 46.

13 Catholic Health Australia, *Submission 55*, p. 3-4. See also Lutheran Community Care Queensland, *Submission 104*, p. 2.

14 Mr Mersiades, Director – Aged Care, Catholic Health Australia, *Committee Hansard,* 2 May 2013, p. 46.

15 Mr Howie, Kincare, *Committee Hansard,* 30 April 2013, p. 19.

16 For example Lutheran Aged Care Residential Network South Australia, *Submission 14*.

> (a) specific dates as to when the draft (or a consolidated) principles documents will be presented for consultation;
>
> (b) a reasonable consultation period to facilitate appropriate and effective consultation; and
>
> (c) a summary of the subject matters to be dealt with in the draft
>
> prior to the publication of the Committee's report, the Committee should not recommend that the Bill proceed during the life of this Parliament.[17]

2.12 The committee notes that this request by LASA was met in part by the department in its answers to questions on notice to the committee, though the answer did not specify what would be the consultation period for draft principles released in the week commencing 20 May 2013.

2.13 A few service providers opposed the bills unless there were significant changes, particularly concerning how funds would flow to the aged care sector:

> I think the fundamentals of the PC report have been lost in the legislation: people have been silenced; people have not been given time to participate; a variety of ways have not been given for people to participate; entitlement has not been enabled; the concepts of enablement and wellbeing of older Australians are already being used as ways and excuses for reducing services to them; only a limited amount of new funding has been provided and is yet to appear, and that will undermine the success of the reform package as it is currently proposed.
>
> In our view, unless we are given a longer time to debate this legislation, unless we are given much more detail about the principle and determination documents, we would like the legislation to be delayed or withdrawn.[18]
>
> I am writing to request that far more information be provided on these bills before they are even considered by Parliament… As a small rural health provider I am alarmed by the actions taken by this Government. This started with funding… Then consider the Productivity Commission report, and as per usual the Government has cherry picked a few of the options without an integrated approach. One of the major points was the declaration that there would not be any bailouts for providers. Options were presented as to the future, which may be fine in cities, but are not realistic in small rural communities. There are not any provisions allowed for transition for the new model. Vertical integration and other models are quite simply not available in many rural communities… Quite simply, funding does not match the true cost of care in rural Australia.[19]

2.14 The department reported to the committee that the legislation and the process strikes a necessary balance between the wishes of different stakeholders:

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17 Leading Aged Services Australia, *Submission 58*, p. [2].

18 Dr Morris, CEO, Baptistcare, *Committee Hansard*, 29 April 2013, p. 15.

19 Yackandandah Bush Nursing Hospital, *Submission 35*.

> I know there are some stakeholders who feel that the reforms do not go far enough and would like to push ahead further and faster. Conversely, others are feeling rushed and they would like more time to consider the changes.[20]

The consultation process

2.15 The department argued that 'the package was developed hand in glove with the sector and they continue to work incredibly closely with us on shaping the implementation.'[21] In brief, it was reported to the committee that:

> [T]he 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.[22]

2.16 It was readily recognised that the consultation process is a complex undertaking:

> One of the challenges we face is that when you are dealing with a complex change agenda, as we are—and I think I said this in my opening statement—there needs to be an effective way to reach those who are impacted. That is not only providers but also consumers. We have done what we can to reach to providers. We also need the peaks to be part of that reaching to providers because they are the ones whose members, obviously, have a lot of concerns.[23]

2.17 The department outlined the consultation process that was undertaken to help develop the LLLB reforms. It was reported by the department that following the release of the Productivity Commission (PC) report, *Caring for Older Australians*, the government worked with the National Aged Care Alliance (NACA) and established several key working groups to examine specific issues. The working groups considered: quality of care; workforce; wellness approach; financing, care and accommodation; assessment, choice and consumer-oriented care; and palliative care.[24] In addition to the NACA working groups, the government also relied on 12 advisory groups, the:

- Aged Care Reform Implementation Council;
- Aged Care Financing Authority;
- Strategic Workforce Advisory Group;
- Minister's Dementia Advisory Group;

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20 Ms Huxtable, Deputy Secretary, Department of Health and Ageing (DoHA), *Committee Hansard,* 2 May 2013, p. 61.

21 Ms Huxtable, Deputy Secretary, DoHA, *Committee Hansard,* 2 May 2013, p. 61.

22 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), p. 6.

23 Ms Huxtable, Deputy Secretary, Department of Health and Ageing, *Committee Hansard,* 2 May 2013, p. 79.

24 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), p. 1.

- Aged Care Funding Instrument Monitoring Group;
- Aged Care Funding Instrument Technical Reference Group;
- Dementia and Veterans' Supplement Working Group;
- Aged and Community Care Officials;
- Gateway Consultation Forum; the National Aboriginal and Torres Strait Islander Aged Care Reference Group;
- Lesbian, Gay, Bisexual, Transgender, and Intersex Advisory Group; and
- Culturally and Linguistically Diverse Advisory Group.[25]

The Aged Care Commissioner has also been involved in the development of the LLLB reforms.[26]

2.18 As well as consulting through the NACA working groups, the department also provided evidence of holding extensive sector/industry briefings, providing information including videos and answers to frequently asked questions via the LLLB website, and through seeking submissions and comments on papers and proposed legislation changes.[27] Furthermore the committee heard:

> 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.[28]

2.19 The department indicated that throughout the process it provided service providers, peak bodies and other interested organisations with regular email updates of upcoming briefings, opportunities to be involved in the consultation process, and updates on the reforms.[29]

Criticisms of the consultation process

2.20 Throughout the inquiry the committee regularly heard concerns about the consultation process that was undertaken by the Government in preparing the LLLB reforms. Although the consultation process appears to have been relatively comprehensive and thorough, there were a number of issues raised, particularly regarding the pace at which consultation was undertaken. Baptistcare commented that

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25 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), p. 3.

26 Office of the Aged Care Commissioner, *Submission 5*, p. 2.

27 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), p. 4.

28 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), p. 4.

29 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), p. 5.

many of the concerns of industry may have been mitigated through a more sedate reform and consultation process:

> I think that the current Living Longer Living Better package could have got greater traction if the time frame had been extended, if more information be made available, and the consultation process beyond NACA and beyond the peaks had been given full capacity and opportunities for participation, and then you would have been able to iron out a lot of these wrinkles.[30]

2.21 Edgarley Home Inc. similarly argued that more time was required for industry to understand the changes that were being made:

> We spoke about consultation and getting information out. As an industry, we have been surviving on short timeframes. With the principles, which are obviously going to contain a whole heap of information, I believe that if we do not have six months of clear air to actually digest what is in those principles then it is grossly unfair to expect the industry to try to get its head around that within some of the short timeframes that we have been operating on.[31]

2.22 This point was echoed by the Australian Association of Social Workers (AASW) who contended that reforms of such scope require a longer period of integration to allow providers to prepare for upcoming changes:

> We are concerned that with this major paradigm shift, which is starting with consumer directed places in home care in June, the guidelines were issued a few days ago. That is a six-week period for consultation, getting comments, reintegrating them into the guidelines and being ready to go in June. That is nowhere near enough time to make the kind of shift that is required in the sector.[32]

2.23 It was also noted that for peak bodies it can be difficult to respond to short time-frames due to the need to have all the members sign-off on an approach.[33]

2.24 Kincare noted that longer consultation periods may have been cheaper for some providers to engage with.[34] On the other hand Baptistcare argued that longer consultation periods mean that – even when flights and accommodation is refunded – the organisation still foregoes the work output of that individual for the consultation period, and typically it is a very senior or specialist person who is required for such engagements.[35]

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30 Dr Morris, Chief Executive Officer, Baptistcare, *Committee Hansard*, 29 April 2013, p. 18.

31 Mr Toope, Chief Executive Officer, Edgarley Home Inc, *Committee Hansard*, 1 May 2013, p. 61.

32 Ms Stojanovic, Member – National Social Policy Committee, Australian Association of Social Workers, *Committee Hansard*, 2 May 2013, p. 6.

33 Mr Yates, Chief Executive, COTA Australia, *Committee Hansard*, 2 May 2013, p. 37.

34 KinCare, *Committee Hansard*, 16 May 2013, p. 26.

35 Baptistcare, answer to question on notice, 29 April 2013 (received 10 May 2013), p. 8.

2.25 The committee heard some providers express concerns that on-the-ground expertise was not being utilised or consulted with:

> One of the things—I mentioned it earlier—is the lack of detail and lack of consultation with real providers on the ground, in saying, 'This is what we want to road test; this is what we want to do. How will it work in the real world?'[36]

2.26 The committee heard strong criticism of the consultation process from Baptistcare who argued that the government did not listen to feedback, and that there was an undue reliance on NACA:

> 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.[37]

2.27 In response to the concerns raised by Baptistcare, the department noted that Baptistcare had not submitted any comments to the department regarding the proposed legislative changes during the initial concentration period that commenced on 21 November 2012.[38]

Praise for consultation process

2.28 While the committee did hear a number of criticisms of the government and the department, there was also a significant amount of praise regarding the conduct and scope of the consultation process undertaken.

2.29 In relation to the consultation about the workforce compact, United Voice argued that the consultation process was sound:

> I see the process that the minister went through as an absolute classic, proper, policy-making process. It started with lobbying by the various industry associations, the peak councils, about the serious problems with aged care. There was a reference to the Productivity Commission. We all went through a lengthy process of submitting to the Productivity Commission and, from our point of view, trying to get them to focus on the problem besetting the workforce in this sector. They came up with a report that we thought was very favourable to our way of thinking. They, unusually for a pretty neoliberal institution, really focused on the issue of wages, the way in which people were paid in this sector and the need to do something about that.
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> Notably, what happened then was an intense process of consultation with the sector. The minister and various other government officials went round

36 Mr Sheldon-Stemm, General Manager, Kalyna Care, *Committee Hansard,* 1 May 2013, p. 61.

37 Dr Morris, Chief Executive Officer, Baptistcare, *Committee Hansard,* 29 April 2013, p. 13.

38 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), p. 6.

> the country talking to individual providers, talking to us, talking to our members, talking to the peak councils. We went through a process of trying to build a consensus around a reform agenda. As far as we are concerned we did participate in that process, sat down with employers, tried to agree on what were the fundamental problems besetting the sector and come up with agreed solutions. That is what we think has happened.[39]

2.30 National Seniors Australia put on record their praise for the Government's comprehensive and inclusive consultation process:

> We would like to thank the government for their efforts in ensuring that the voices of consumers, healthcare professionals and providers are heard through extensive consultations.[40]

2.31 While recognising that the government had, for the most part, done a good job, there was some concern regarding the publication of information and policies:

> They have done a very good job in my view. I am a former public servant from way back. I have been in aged care since 1974, which is a long time. Originally I was a public servant in WA. My perspective is that, whilst the sessions were very well presented, they still got to many points where they were saying, 'The guidelines will be issued later.' We never got the full story. That was the problem for me.[41]

2.32 The department informed the committee that answers to questions are available on the LLLB website, and in a case where a presenter was not able to provide immediate answers to questions posed during an information session, answers would subsequently be provided on the LLLB website.[42]

Availability of the principles

2.33 The other major concern raised during the inquiry was that the delegated legislation that complements the bills was not available, and as such it was not

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39 Mr Crosby, National President, United Voice, *Committee Hansard*, 2 May 2013, pp 3–4.

40 Mr Carvosso, Chairman, National Seniors Australia, *Committee Hansard*, 2 May 2013, p. 28.

41 Mr Bertram, Chief Executive Officer, Shepparton Retirement Villages Inc., *Committee Hansard*, 1 May 2013, p. 24.

42 Mr Murray, Assistant Secretary, Department of Health and Ageing, *Committee Hansard*, 2 May 2013, p. 78.

possible to fully appreciate how the legislation would function. This, it was argued, was contributing to a sense of uncertainty in the sector.[43]

2.34 Delegated (also known as subordinate) legislation is legislation made not directly by an Act of the Parliament, but under the authority of an Act of the Parliament. Parliament delegates to the Government limited power to make certain regulations under Acts. Delegated legislation is necessary and often justified by its facility for adjusting administrative arrangements without undue delay, its flexibility in matters likely to change regularly or frequently, and its adaptability for other matters such as those of technical detail. Once Parliament has by statute laid down the principles of a new law, the Government may by means of delegated legislation work out the application of the law in greater detail within those principles. Delegated legislation is required to be laid before each House, thereby becoming subject to parliamentary scrutiny and the Parliament's ultimate power of veto.[44]

2.35 COTA noted that it is good procedural practice to have many things in subordinate legislation so that necessary amendments can be made with greater speed than is the case with primary legislation, and that the principles themselves are also subject to scrutiny:

> We understand that the process of having principles is an established process in this and other areas, that you do not spell out everything in legislation, otherwise the providers would then be complaining that every time something needed to go up, or something, you had to change the act. As I said earlier, we are confident that the processes in which we are currently engaged do engage the sector in a way that I certainly have not seen in many years of involvement in this sector and they feed into what will be the principles. The principles, I do not need to remind you, are disallowable instruments and parliament gives them scrutiny. We and others would make our views known if we were not happy, probably well before they appeared but certainly when they appeared.[45]

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43 Mr Taylor, Director, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, p. 1; Mr Prior, Chief Executive Officer, Hall and Prior Aged Care Organisation, *Committee Hansard*, 29 April 2013, p. 2; Dr Morris, Chief Executive Officer, Baptistcare, *Committee Hansard*, 29 April 2013, p. 13; Mr Kemp, Chief Executive's Advisor, ECH Inc., *Committee Hansard*, 29 April 2013, p. 47; Ms Kumar, Senior Policy Officer, Council of Social Services of New South Wales, *Committee Hansard*, 30 April 2013, p. 13; Mr Pintado, Board Director, Masonic Care Alliance, *Committee Hansard*, 30 April 2013, p. 36; Mr Sadler, Chief Executive Officer, Presbyterian Aged Care New South Wales and Australian Capital Territory, *Committee Hansard*, 30 April 2013, p. 37; Professor Kelly, Chief Executive Officer, Aged and Community Services Australia, *Committee Hansard*, 30 April 2013, p. 47; Mr Clark, General Manager, Parkwood Aged Care Services Pty Ltd., *Committee Hansard*, 1 May 2013, p. 20; Mr Sheldon-Stemm, General Manager, Kalyna Care, *Committee Hansard*, 1 May 2013, p. 52; Mr Toope, Chief Executive Officer, Edgarley Home Inc., *Committee Hansard*, 1 May 2013, p. 52; Mr Riley, Deputy Chairman, Leading Age Services Australia, *Committee Hansard*, 2 May 2013, p. 48; Cobden District Health Service Inc., *Submission 12*, p. 1.

44 I. C. Harris, eds., *House of Representatives: Powers, Practice and Procedure*, 5th ed., Department of the House of Representatives, 2005, pp 398 – 400.

45 Mr Yates, Chief Executive, COTA Australia, *Committee Hansard*, 2 May 2013, p. 37.

2.36 The department informed the committee that most of the proposed 19 pieces of delegated legislation – the principles – are consequential:

> We are amending 19 sets of principles, so each of those will have to be a separate amending instrument. The vast majority of those amendments are consequentials: if the bills are passed and there is a decision to move away from community care and towards home care then those would be consequential amendments to the principles and determinations.[46]

2.37 The committee heard at its public hearing in Canberra that four of the sets of principles will have 'more substantive issues in them'.[47] The principles in question are the:

- Draft Accommodation Pricing Guidelines;
- Home Care Packages Program Guidelines – Consultation Draft;
- Dementia and Veterans' Supplement in Aged Care Consultation Paper; and
- Drafted Aged Care Workforce Supplement Guideline.[48]

2.38 Although these principles were made available during the course of this inquiry, their release schedule did mean that stakeholders did not have the benefit of them when preparing their submissions to this inquiry. It was however noted by both Catholic Health Australia and COTA that they had a good idea, prior to their release, of what the principles would include.[49]

2.39 Given the extensive consultation that the department has undertaken in preparing the bills under consideration, it is to be expected that a similar level of diligence will be applied to the consultation in preparing and finalising the principles. UnitingCare Australia indicated that they were anticipating working with the government on the final shape of the principles:

> The detail will come in the principles under the act. So we are looking forward to a vigorous policy debate with the government…We would anticipate being able to work with government on the development of those principles – that they would not be developed and presented to us in a completed fashion but that we would be able to input into the development,

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46 Ms Balmanno, Assistant Secretary, DoHA, *Committee Hansard,* 2 May 2013, p. 69. The number was subsequently revised. See DoHA, answer to question on notice (received 31 May 2013).

47 Ms Huxtable, Deputy Secretary, DoHA, *Committee Hansard,* 2 May 2013, p. 70.

48 DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013), pp 4–5.

49 Mr Mersiades, Director – Aged Care, Catholic Health Australia, *Committee Hansard,* 2 May 2013, p. 43; Mr Yates, Chief Executive, COTA Australia, *Committee Hansard,* 2 May 2013, p. 35.

> given the concerns we have got here about the operational detail that fall out of the legislative framework.[50]

2.40 The committee also notes the undertakings given by the department, noted earlier in this chapter, regarding timetables for the release of draft delegated legislation.

Committee view

2.41 Based on the evidence provided to the committee, it appears that the consultation process undertaken by the department has been comprehensive and thorough.[51] However, the preferred duration of the consultation period varied from provider to provider, and evidently not all found the process suited to their needs. Given the very large scale of the reforms and the number of competing arguments, the committee considers that the department has made considerable efforts to ensure that all stakeholders have had the opportunity to comment and engage in the process.

2.42 It is important to recall that the bills have not been introduced without any prior processes involved in their preparation. On the contrary, the bills represent a stage in a process that has taken several years, and included consultation and discussions by the Productivity Commission, as well as the large number of government and aged care sector working groups.

2.43 The committee does accept that some of the consultation deadlines were short and meant that smaller providers may not have had the time they would have liked to prepare fulsome comments. The committee also understands that short time-lines make it harder for peak bodies to properly engage with member organisations.

2.44 For its part, this committee wishes to put on record its appreciation for the large number of organisations who took the time to provide written submissions and appear at the committee's public hearings in addition to their other contributions to the development of this important policy reform.

2.45 The committee understands that the LLLB reform package is a complex piece of legislative work and that it is standard practice for many details of legislation to be spelt out in delegated legislation. Delegated legislation provides a useful service to ensure that laws operate as was intended by the Parliament. This committee has a long standing concern about the process of consideration of legislation that has significant detail in delegated legislation, regulations, guidelines or principles, when they are not available during the enquiry process. As it did during the National Disability Insurance Scheme Bills inquiry, the committee will continue to raise this issue and reflect the evidence of many submitters about the need for access to the detail if review is to be effective. The department provided a schedule for the release for

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50 Ms Hatfield Dodds, National Director, Uniting Care Australia, *Committee Hansard*, 30 April 2013, p. 69.

51 DoHA, *Consultation undertaken by the Department of Health and Ageing on the 'Living Longer Living Better' reforms*, tabled 2 May 2013; cf. DoHA, Attachment 3, answer to question on notice, 2 May 2013 (received 14 May 2013).

consultation of delegated legislation and the process of community consultation. This is attached as Appendix 4.

Chapter 3
Home care

3.1 As outlined in Chapter 1, the Australian Government announced a series of reforms to aged care, known as 'Living Longer Living Better' package, in April 2012. One of the key features of the package is a significant expansion in home care to assist people to remain living at home for as long as possible, and the introduction of more choice and flexibility for people receiving care at home.[1]

3.2 Proposed changes include a new system of home care packages, government subsidy structure, care recipient fee structure, supplements, hardship provisions and access to the Community Visitors Scheme (CVS). The government also intends to move to Consumer Directed Care (CDC), allowing consumers and their carers to have greater control over their own lives by providing for choices about the types of care accessed and the delivery of those services, including who would deliver the services, and when.[2]

3.3 Many submitters were broadly supportive of the increased focus on home care and consumer directed care, and these views were from across the sector:

> We also support the increased emphasis on community based Home Care compared to residential aged care from 1 July 2013. The enhanced number and levels of packages will assist older Australians to stay in their own home for longer. The focus on consumer directed care will allow the consumer greater choice and control over who will provide which services other than providers controlling access to the care packages.[3]
>
> …
>
> [The Attendant Care Industry Association] is strongly supportive of the LLLB reforms, especially the focus on providing more opportunity for support to be delivered to people in their own homes, enabling them to age in place and to provide many more alternatives to residential aged care. ACiA also endorses the principles of consumer directed care, as our membership has witnessed the profound and positive effect this has had on Service Users (recipients) with disability, including the aged, in various funded programs who have exercised their choices to ensure the support they receive leads to tangible achievements in their community. The reforms as a whole, therefore, are supported by ACiA as we believe they constitute a positive and constructive move in the right direction, so people who are ageing can look forward to remaining in their own home connected

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1 DoHA, *Submission 92*; DoHA, *Home Care Packages Program Guidelines, Consultation Draft,* April 2013, p. 5.

2 DoHA, *Submission 92*, p. 17; DoHA, *Home Care Packages Program Guidelines, Consultation Draft,* April 2013, p. 8.

3 National Seniors Australia, *Submission 68*, pp. 1–2.

> to their family, friends and community, even as they may experience a decline in their health and functional abilities.[4]
>
> [Southern Cross Care (Vic)] agrees with the broad reform proposals contained in "Living Longer, Living Better" including greater consumer choice, control and easier access to services. SCC (Vic) is specifically supportive of the significant increase in supply of approved places for home care packages and the removal of the distinction between low and high care in the Aged care Act.[5]

3.4 As the package of bills would introduce many major changes to home care, submitters sought clarification around a range of issues and raised some concern about how the new system would operate. It is to those that the committee now turns.

Home Care Packages Program

3.5 Should the bills pass, from 1 July 2013 a new type of care, home care, will replace community care (Community Aged Care Packages (CACP)) and some forms of flexible care delivered in a person's home (Extended Aged Care at Home (EACH) and Extended Aged Care at Home – Dementia (EACHD)).[6]

Home care is defined as care consisting of a package of personal care services and other personal assistance provided to a person not being provided with residential care.[7] Four levels of home care packages would be established to cover a continuum of home care options from basic home care through to complex home care.[8] The submission from the Department of Health and Ageing (the department) outlined the levels of care as follows:[9]

LEVEL	**Description**
1	Basic care package
2	Low level care package
3	Intermediate level care package
4	High level care package

3.6 Home Care Levels 1 and 2 would cover the same types of care currently available under a CACP, plus other services required to maintain a person at home. The key difference between Level 1 and Level 2 would be the amount or quantum of

4 Attendant Care Industry Association (Australia) Ltd, *Submission 31*, p. 4

5 Southern Cross Care Victoria, *Submission 39*, p. 1.

6 DoHA, *Submission 92*, p. 16.

7 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 25.

8 DoHA, *Submission 92*, p. 16.

9 DoHA, *Submission 92*, p. 16.

services that can be provided. Similarly, Home Care Levels 3 and 4 would cover the same types of care as the current EACH package, plus other services required to maintain a person at home. Higher levels of service would be reflected in higher subsidies.[10]

3.7 The total number of home care packages is expected to increase from around 60 000 to almost 100 000 over the next five years with each home care package being required to be delivered on a CDC basis by 1 July 2015.[11] Under CDC, Home Care Packages will have the following key design and operational elements:

a) An individualised and transparent budget;

b) A control and decision making framework; and

c) An ongoing management and communication approach.[12]

3.8 Under CDC, consumers would access a Home Care Package in a similar way to the previous CACP, EACH and EACHD packages. People will need to be assessed and approved as eligible for Home Care by an ACAT (or known as Aged Care Assessment Service in Victoria), and then offered a Home Care Package by an approved provider.[13]

3.9 The contrast between CDC and non-CDC Home Care Packages is illustrated by the department in the following flowchart[14]

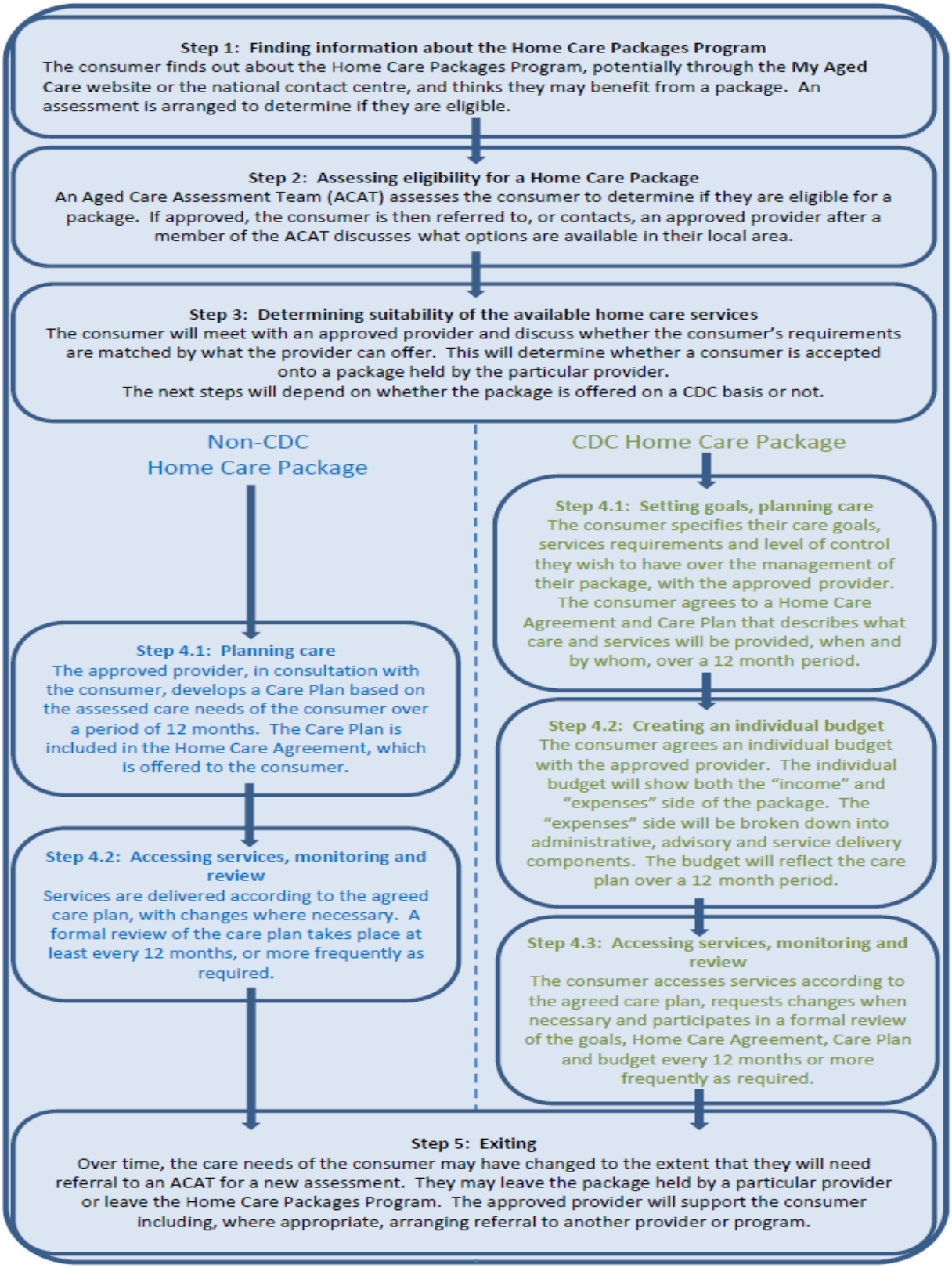
10 DoHA, *Home Care Packages and Consumer Directed Care, Program Overview*, November 2012, p. 4.

11 DoHA, *Submission 92*, pp. 16-17.

12 DoHA, *Home Care Packages and Consumer Directed Care, Program Overview*, November 2012, p. 4.

13 DoHA, *Home Care Packages Program Guidelines, Consultation Draft,* April 2013, p. 21.

14 DoHA, *Home Care Packages Program Guidelines, Consultation Draft,* April 2013, p. 13.



3.10 All new ACAT approvals would be broadbanded at two assessment points (Level 1 and 2, and Level 3 and 4) which means consumers could move between levels 1 and 2 or between levels 3 and 4 without requiring a new ACAT assessment. Additionally all ACAT assessments (unless specifically stated) would no longer lapse

after 12 months, although a consumer or provider would retain the ability to request a new assessment at any time should their needs change.[15]

3.11 Whilst there was broad support for the principles of CDC it was noted by the Council of Social Services New South Wales (NCOSS) 'that many service providers are unsure about the process of implementation of self-directed approaches.'[16] Consequently NCOSS recommended that:

> …some core principles relating to Consumer Directed approaches needs (sic) to be given legislative effect in the Aged Care Act as well as through the Principles and Determinations in relation to the Act.[17]

3.12 A number of submitters[18] raised the issue that in areas with very few providers, particularly those in rural and remote Australia, offering a choice of providers to consumers under the CDC model was not practicable. On this issue the National Rural Health Alliance drew the committee's attention to the 2011 report of the Productivity Commission Inquiry into Aged Care, which found that:

> …rural and remote areas generally do not have the population density or demand to sustain many types of aged care services that are available in urban areas. The Commission's proposed reforms to increase choice may have limited applicability in rural and remote areas where there are relatively small target populations and it is generally only feasible for one or two service providers to operate.[19]

3.13 Anglicare shared this concern and urged the government to take this into consideration when determining funding arrangements in the delegated legislation:

> We understand that the needs of people living in remote communities will be recognised in some of the Principles. We stress that one size does not fit all and there needs to be consideration on how services can be accessed especially in relation to consumer directed care.[20]

3.14 There were also concerns from some providers[21] and peak bodies[22] that the current version of the Allocation Principles, in addition to the fixed ratios of home care places, effectively rationed the number and types of packages for which providers could qualify. Kincare argued that the capping of places under the Aged Care

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15 DoHA, *Home Care Packages Program Guidelines, Consultation Draft,* April 2013; DoHA, *Home Care Packages and Consumer Directed Care, Program Overview*, November 2012, p. 5.

16 Council of Social Service of New South Wales, *Submission 96,* p. 8.

17 Council of Social Service of New South Wales, *Submission 96,* p. 8.

18 National Rural Health Alliance, *Submission 100*; Department of Health, Victorian Government, *Submission 101*.

19 Productivity Commission Report 2011 as quoted by the National Rural Health Alliance, *Submission 100*, p. 5.

20 Anglicare, *Submission 75*, p. 3.

21 Kincare, *Submission 42*; Baptistcare, *Committee Hansard,* 29 April 2013.

22 COTA, *Submission 87*; National Aged Care Alliance, correspondence, (received 11 May 2013).

Approvals Rounds (ACAR) would continue to create a 'mismatch' between the supply of, and demand for, the levels of home care packages needed in many areas.[23]

3.15 It was also argued that some care recipients would be forced to change care providers, or even move into residential care, in order to access higher levels of care if their current provider could not offer the service or did not have the required place available. This raised concerns for a number of submitters in terms of continuity of care and the impact a change of provider may have on health and welfare.[24] COTA and the National Aged Care Alliance (NACA), in particular, were concerned that 'consumers will not have an entitlement, based on assessed need, to the services and support they need'[25] and recommended changes to reflect the Productivity Commission Report and the NACA Blueprint in that the 'number and mix of places for residential care and home care should cease to be controlled.'[26]

3.16 It was observed by the Aegis Aged Care Group[27] that the move to encourage care recipients to stay in their own home may cause people to delay entering residential care until they required high care and that this would increase the proportion of high care residents in residential care facilities. This claim was echoed by National Seniors Australia:

> The shift to provide extended care in clients' own homes will raise further the age at which most residents enter facilities, with a likely increase in demand for higher levels of clinical care and dementia services.[28]

3.17 The committee heard that, when the Government was approached about the continued rationing under the ACAR systems their response to COTA was 'that the continued rationing, and the subsequent lack of entitlement for consumers, was in response to the immaturity of the aged care system at present.'[29] As noted earlier in this report the government has recognised that further reforms may be needed, and that the 'Living Longer, Living Better' package is intended to facilitate this.

3.18 The department acknowledged in their submission that:

> Generally, it can be more challenging to establish services in smaller, rural areas, where providers have a smaller pool of prospective residents and are therefore vulnerable to fluctuation in occupancy levels. Additionally access

23 Kincare, *Submission 42*, p. 6.

24 Kincare, *Submission 42*; Baptistcare, *Committee Hansard*, 29 April 2013; COTA, *Submission 87*; National Aged Care Alliance, correspondence, (received 11 May 2013).

25 COTA, *Submission 87*, p. 12; National Aged Care Alliance, correspondence, (received 11 May 2013).

26 COTA, *Submission 87*, p. 12.

27 Mr Taylor, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, pp. 6–7.

28 National Seniors Australia, *Submission 68*, p. 4.

29 COTA, *Submission 87*, pp. 9-10.

> to an appropriately trained workforce can limit the type of services that providers can offer.[30]

3.19 The government is addressing these issues in a number of ways. The classification of rural and remote areas as a special needs group is being maintained and viability supplements would continue under the reforms. The Multi-Purpose Service Program, designed for rural and remote areas, will also continue to operate. The workforce supplement would make working in the sector more attractive across all locations.

Committee view

3.20 The committee supports the improved degree of choice offered in the home care packages program. Most of the concerns raised by submitters do not relate to the reforms within the bills, but rather reflect existing challenges in the provision of aged care, and often in the provision of community services more generally.

3.21 The committee acknowledges that changing providers can present challenges, and choice is not always available, particularly in regional and remote areas. However the committee believes that the significant expansion in home care places, together with the continuation of special recognition of rural and remote areas, should lead to substantial improvement to the availability of aged care in the home.

Supplements

3.22 The primary supplements that are currently available for home care recipients include the oxygen supplement and the enteral feeding supplement. The provision of these services to care recipients is based on clinical need.[31]

3.23 From 1 July 2013 approved providers who deliver home care at any of the four home care package levels would be able to receive a new dementia supplement or veterans' supplement if the care recipient meets certain eligibility requirements. An additional workforce supplement would also become available from this date in order to support providers to attract and retain sufficient numbers of skilled and trained workers.[32] Existing viability supplements in relation to geographical isolation in rural and regional areas would continue.[33]

3.24 Submitters broadly welcomed the introduction of the new supplements, however many believed that the introduction of a homeless supplement, CALD Supplement, and a People with Disability supplement would also be useful and justified.[34] These are further discussed in Chapter 6. Concerns regarding the workforce supplement and its effect on fees, subsidies and providers are discussed in Chapter 7.

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30 DoHA, *Submission 92*, p. 41.

31 DoHA, *Home Care Packages Program Guidelines, Consultation Draft,* April 2013.

32 DoHA, *Submission 92*, pp. 17–18.

33 DoHA, *Home Care Packages Program Guidelines, Consultation Draft,* April 2013.

34 Wintringham, *Submission 11*; Kincare, *Submission 42*.

Fees

3.25 From 1 July 2014 there would be changes to the calculation of the home care subsidy and fees for care recipients who enter home care on or after that date. Changes would include requiring some care recipients with greater means to contribute more to the cost of their care through an income tested care fee.[35] However, there would be no asset test for home care.

3.26 Government funding for community care packages is currently provided through subsidies and supplements paid in respect of individuals, with the level of the care subsidy determined by the type of community care package. These supplements are not means tested. Care recipients can be asked by the provider to contribute to the cost of the care services they receive up to a maximum level set by the Government. Care recipients may pay up to 17.5 per cent of the basic pension ($3,240 per annum). In addition, they may also be asked to pay up to 50 per cent of the care recipient's income above the pension. These contributions do not change the subsidy paid by the Government. Very few care recipients are currently charged the additional income tested fee and, on average, providers charge residents a Basic Fee of $1,800 per annum for all types of community care packages (or 10 per cent of the basic pension).[36]

3.27 The proposed scheme would mean that a care recipient, entering care from 1 July 2014, may be asked to pay one or more of the following components toward the cost of their care:[37]

- A basic daily fee (Basic Care Fee). Consistent with current arrangements, care recipients may be asked to pay a basic daily fee. This is an amount that is negotiated between the care recipient and the approved provider, and can be up to 17.5 per cent of the basic single age pension amount.
- An income tested care fee (Income Tested Care Fee). This is an amount based on an income test (conducted by the Department of Human Services), which a care recipient with sufficient income can be asked to pay toward the cost of their care.
- Any other amounts agreed between the care recipient and the approved provider.

3.28 The Government's contributions to home care costs would be comprised of three parts:[38]

- The basic daily subsidy amount (Government Subsidy). The amount of subsidy would depend on the type of home care package provided.

35 DoHA, *Submission 92*, p. 21.

36 DoHA, *Submission 92*, p. 35.

37 DoHA, *Submission 92*, p. 21.

38 DoHA, *Submission 92*, p. 21.

- Any primary supplements (Primary Supplements). For example, the oxygen supplement and the enteral feeding supplement.
- Any other supplements (Other Supplements) such as the viability supplement and the hardship supplement.

3.29 Under the proposed scheme the amount of income tested fee paid by the care recipient would reduce what the Government pays in subsidy and primary supplements. For every dollar of income a person earns above the income free area, the Government would reduce its contribution by 50 cents. This would be known as the care subsidy reduction.[39] An approved provider would be able to recoup this reduction in subsidy by charging the care recipient an income tested care fee of up to the same amount.[40]

3.30 The scheme is structured so that, should it be implemented:[41]

- no full rate pensioner will pay an income tested care fee for home care;
- no care recipient will be asked to contribute more than the cost of their care;
- no care recipient's home or other assets will be included in assessing their capacity to pay an income tested care fee for home care;
- no care recipient will be asked to pay more per year in income tested fees than their annual cap; and
- no care recipient will be asked to pay more income tested care fees than the lifetime cap.

Annual and lifetime caps

3.31 New annual and lifetime caps on income tested care fees would apply from 1 July 2014.[42] The annual cap on income tested care fees in home care would be specified in a determination, however the following estimates have been announced by Government: [43]

Annual caps

- $5,000 (indexed annually) for part-pensioners or those with annual income greater than $22,701 but not greater than $43,186 (March 2012 prices); and

39 Note – this care subsidy reduction does not include any reductions in subsidy due to the care recipient receiving compensation which includes a component to support home care – ie compensation payment reduction. DoHA, *Submission 92*, p. 21–22; Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 69–70; DoHA, Attachment 5, Appendix 5a, answer to written question on notice, (received 14 May 2013).

40 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 70.

41 DoHA, *Submission 92*, p. 22.

42 The caps apply to means tests or income tested care fees paid on or after 1 July 2014 by care recipients who are not continuing care recipients.

43 DoHA, *Submission 92*, p. 22.

- $10,000 (indexed annually) for self-funded retirees with annual income greater than $43,186 (March 2012 prices).

Lifetime cap

- the lifetime cap of $60,000 (indexed).[44]

3.32 If a care recipient moves from home care to residential care, the income tested care fees the care recipient paid in home care would count towards both the residential care annual cap and the lifetime cap. Likewise, if a person moves from residential care to home care, any means tested care fees that the person paid in residential care would be taken into account in determining whether the person meets the annual and lifetime caps on the income tested fees for home care.[45]

3.33 Once a care recipient reaches the annual cap, they would not be asked to pay any more income tested care fees until their next anniversary date. Similarly, once a care recipient reaches the lifetime cap they would not be asked to pay an income tested (or means tested) care fee for the rest of their life. However, in both cases they could still be asked to pay the basic fee which would not count toward the caps.[46]

3.34 The Department of Human Services will administer the annual and lifetime caps for each care recipient, with the payment system automatically increasing the Government subsidy and primary supplements once a care recipient reaches their respective cap.[47]

3.35 COTA articulated their support for caps on payments by care recipients indicating that 'Annual and Lifetime caps on what people pay for aged care are an essential part of the new user contributions regime'.[48]

3.36 Despite also being clear in their support of an annual and a lifetime cap on fees the Council of Social Service of New South Wales (NCOSS) articulated their concerns about the financial implications to care recipients of not including in the caps fees paid for services provided by services such as the Home and Community Care Program (HACC) and the proposed Commonwealth Home Support Program:

> We are deeply concerned that not including those fees in the annual lifetime cap might create a deterrent to people accessing home care packages where there needs might escalate.[49]

3.37 NCOSS were also concerned about the issue of indexation requesting that the:

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44 DoHA, *Submission 92*, p. 22.

45 DoHA, *Submission 92*, p. 22.

46 DoHA, *Submission 92*, p. 22.

47 DoHA, *Submission 92*, pp. 22–23.

48 COTA, *Submission 87*, pp. 13–14.

49 Mr Kumar, Council of Social Service of New South Wales, *Committee Hansard*, 30 April 2013, p. 10.

> …level of indexation needs to be specified in the Act, to ensure that the annual and lifetime caps escalate appropriately. NCOSS recommends that the caps be escalated in line with the Consumer Price Index.[50]

3.38 Consumer groups such as National Seniors Australia (NSA) and COTA were cautious but generally supportive of the change in user fees and charges for care, with COTA indicating that:

> User contributions are an important part of the future sustainability of aged care and are a key component of a market based system. It is vital to start changing the culture and expectations now but user contributions must be affordable and equitable.[51]

3.39 However both COTA and NSA specifically emphasised the need for close monitoring of these changes:

> …the equity, efficacy and impact on access of the new user charges, in particular in relation to in home and community (home support) care and support services, needs to be monitored closely by the sector and the ACRIC from 1 July 2014, not waiting until the 2016 review. If there are serious problems in terms of disadvantage then government will need to address them early.[52]

NSA were particularly concerned with the need to evaluate and review the impact of income tested fees on part pensioners and people just above the upper thresholds to ensure that recipients of aged care services are not adversely or inequitably affected by the means testing arrangements.[53]

3.40 Whilst the department indicated that the Consumer Price Index is a factor considered in calculating the rate of indexation across Government expenditure in aged care, it indicated that many other factors including the minimum wage decisions of the Fair Work Commission are also considered. They have stated that, with regard to the annual and lifetime caps:

> 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).[54]

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50 Council of Social Service of New South Wales, *Submission 96,* p. 6.

51 COTA, *Submission 87*, p. 14.

52 COTA, *Submission 87*, p. 14.

53 National Seniors Australia, *Submission 68,* p. 2-3; National Seniors Australia, answer to question on notice, 2 May 2013, (received 10 May 2013), p. 1.

54 DoHA, Attachment 5, answer to written question on notice, (received 14 May 2013), p. 8.

Committee view

3.41 The committee supports the implementation of annual and lifetime caps and agree with the comments by COTA that the caps are 'a key way of protecting the overall affordability for individual consumers'.[55]

Income testing

3.42 Income testing would be performed by the Department of Human Services using the income test fee calculator. Providers would be advised of the maximum income tested fee they can charge each care recipient.[56]

3.43 Safeguards are built into the calculator to limit the amount of income tested care fees a care recipient could be asked to pay (the first cap and the second cap). The first cap would apply to those on a part pension or equivalent income and the second cap to those who are not eligible for any age pension. In addition, the lifetime cap may also limit the amount that could be paid.[57]

3.44 The Income tested care fee calculator would be structured as follows:[58]

> Step 1. Work out the care recipient's total assessable income on a yearly basis using section 44-24 of the Act. This is the definition of income that is currently used for residential care.
>
> Step 2. Work out the care recipient's total assessable income free area using section 44-26 of the Act. For a single, this is $22,700.60 in March 2012 rates.
>
> Step 3. If the care recipient's total assessable income does not exceed the care recipient's total assessable income free area, the care recipient cannot be asked to pay an income tested care fee.
>
> Step 4. If the care recipient's total assessable income exceeds the income free area but not the income threshold ($43,186 for a single), the income tested care fee is equal to the lowest of the following:
>
> (a) the sum of the basic subsidy amount for the care recipient and all primary supplements for the care recipient;
>
> (b) 50% of the amount by which the care recipient's total assessable income exceeds the income free area (worked out on a per day basis); and
>
> (c) the first cap (ie $5,000 per year or $13.74 per day).
>
> Step 5. If the care recipient's total assessable income exceeds the income threshold ($43,186 for a single), the income tested care fee is equal to the lowest of the following:

55 COTA, *Submission 87*, p. 14.

56 DoHA, *Submission 92*, pp. 21, 47.

57 DoHA, *Submission 92*, p. 47.

58 DoHA, *Submission 92*, p. 47.

(a) the sum of the basic subsidy amount for the care recipient and all primary supplements for the care recipient;

(b) 50% of the amount by which the care recipient's total assessable income exceeds the income threshold (worked out on a per day basis) plus the amount of the first cap (ie $13.74 per day);

(c) the second cap (ie $10,000 per year or $27.47 per day).

3.45 Other submitters[59] shared the NSA's concerns about the potential impact of this model of income testing on people with low to moderate incomes. In particular, concerns were raised that this cohort appears to be paying a higher percentage of their income on care fees. UnitingCare Australia submitted that:

> We acknowledge that care recipients who can contribute to their cost of care should do so. However, we are concerned that the level of co-contribution may be prohibitive for many people and that the scaling of fees for part-pensioner is too aggressive. … While the proposed methodology is based on income, it does not seem to take account of any additional costs of living at home, including for people with a disability or chronic condition.[60]

3.46 UnitingCare Australia provided the committee with information highlighting what they considered to be the disproportionate contribution towards fees, in the proposed model, by those at the lower end of the income threshold. The graphs supplied by UnitingCare Australia also suggested an alternative scaling approach which they believe would result in a fairer outcome for those on low incomes.[61]

The following table highlighted the percentage fees to income at different levels of income:[62]

Annual total income	$23,543	$32,864	$35,000	$43,186	$50,000	$55,952	$81,952
Basic fee	$3,163	$3,163	$3,163	$3,163	$3,163	$3,163	$3,163
Care fee	$0	$4,661	$5,000	$5,000	$8,407	$10,000	$10,000
Total fee	$3,163	$7,824	$8,163	$8,163	$11,570	$13,163	$13,163
% income	13%	24%	23%	19%	23%	24%	16%

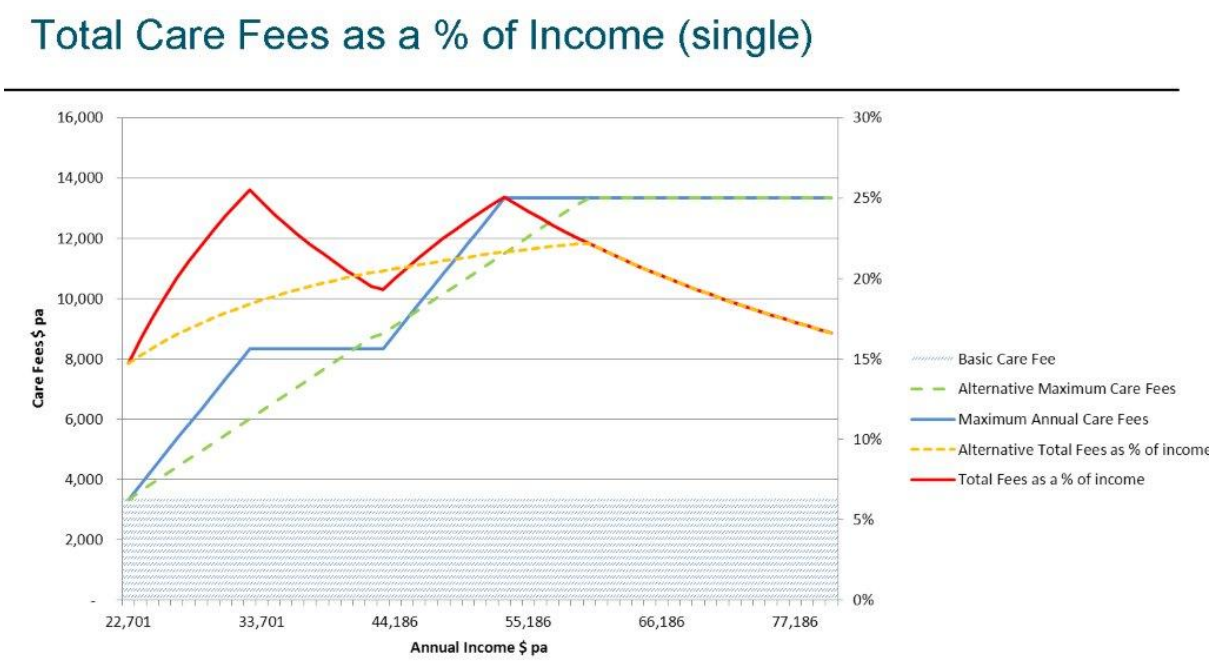
The following graphs gave a visual representation of the tabled data and presented UnitingCare Australia's alternative proposal:[63]

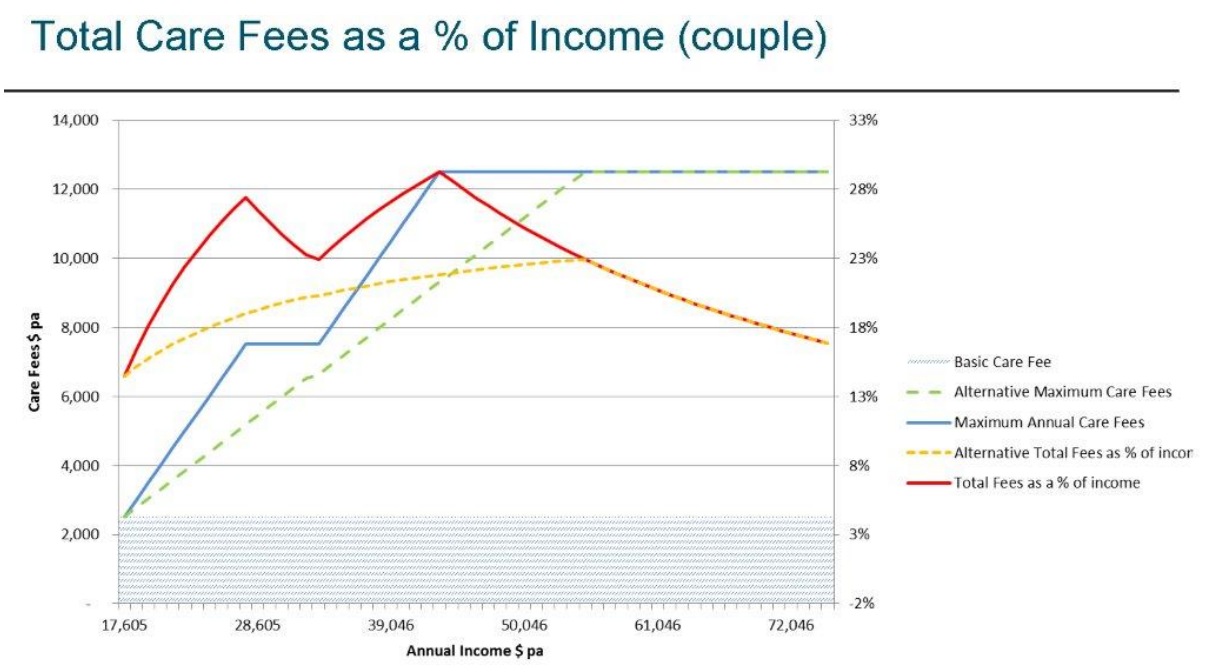
59 UnitingCare Australia, *Submission 59*; The National Presbyterian Aged Care (NPAC) Network, *Submission 37*; Kincare, *Submission 42*.

60 UnitingCare Australia, *Submission 59*, pp. 6–7.

61 UnitingCare Australia, *Submission 59*, p. 6; UnitingCare Australia, *Tabled Documents*, (received 30 April 2013).

62 UnitingCare Australia, *Submission 59*, pp. 6.





3.47 The position taken by UnitingCare Australia was supported by NCOSS, The National Presbyterian Aged Care (NPAC) Network and echoed by ECH Inc., Eldercare Inc. and Resthaven Inc who stated:

> We believe the taper rate and income threshold for part pensioners is inequitable in that it discriminates against those part pensioners on the lower end of the income threshold. Specifically, all part pensioners with incomes between $32,701 and $43,186 will pay the maximum of $5,000 a

63 UnitingCare Australia, *Tabled Documents*, (received 30 April 2013).

> year as an income tested home care fee. We believe this is unfair to part pensioners on lower incomes.[64]

3.48 Whilst not directly disputing UnitingCare Australia's modelling of the proposed income testing arrangements the department suggested that using the average basic fee ($1,800) rather than the maximum potential basic fee ($3,163) would provide a more accurate representation of costs faced by low to moderate income earners. They suggested that Uniting Care Australia's table highlighting the percentage fees to income at different levels of income could be represented in the following way:[65]

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	$21,743	$26,403	$28,200	$36,386	$39,793	$44152	$70,152

3.49 The department also suggested that the concern about issues such as the cost of living pressures may be 'better considered' by focusing on the remaining income after the fees have been paid as opposed to fees as a proportion of total income.

> 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 they had not earned that extra dollar.[66]

3.50 The department indicated that the lower taper rate modelled by Uniting Care would mean that:

> 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 coast but would also accordingly come with a substantial cost to the Government.[67]

Committee view

3.51 The committee notes that there was agreement by many submitters that home care recipients who can afford to contribute towards their care should do so.

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64 ECH Inc., Eldercare Inc. and Resthaven Inc, *Submission 41*, p. 4.

65 DoHA, Attachment 5, answer to written question on notice, (received 14 May 2013), p. 4.

66 DoHA, Attachment 5, answer to written question on notice, (received 14 May 2013), p. 4.

67 DoHA, Attachment 5, answer to written question on notice, (received 14 May 2013), pp. 3–4.

3.52 The committee expects that that the government will monitor closely the effects of the reforms on affordability, balanced with the need for a more equitable system. The committee notes that the thresholds can be varied by regulation as required.

3.53 The committee is of the view that the proposed model for income testing will provide more equity, in that different care recipients with the same incomes and receiving the same care will no longer be charged different fees. It notes that the combination of proposed thresholds, tapering and scaling appears to create the potential for some low to moderate income earners to pay a higher proportion of their income on fees than some higher income earners, however it notes that this effect is modest in scope.

3.54 The effects of changes to fees and the financing of aged care are potentially significant, and the need for vigilance during the transition is discussed in more detail in the next chapter, on residential care. The committee concluded that it is important for monitoring of, and response to, financial changes in the situation of providers to take place continuously following the reforms, and not to be left until the statutory review three years after the key provisions commence.

Recommendation 1

3.55 The committee recommends that, as part of the arrangements for ACFA monitoring of the reforms that are recommended by the committee in chapter 4, evidence be sought on any impacts of the design of the fee scales on care recipient welfare.

Implications of income fees on decisions about care

3.56 Concerns were also raised by a number of submitters[68] about the impact of the proposed income test fee on care recipients in terms of their decisions about care. The primary concern expressed was that many home care recipients may be forced because of financial limitations to accept a lower care level, rely more heavily on the hospital system, or choose not to receive care at all.

> Consumers who are not capable of making basic fee and care fee payments according to the schedules proposed may be unable or unwilling to gain access to aged care services as their care needs would otherwise require.[69]

> We share the concerns of some other not-for-profit home care providers that the phase-in of these fees for part-pensioners may prove difficult for some older people to afford. They may also create problems in encouraging people to move from Home and Community Care services with much lower fees onto Home Care Packages, which may be more appropriate for their needs.[70]

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68 UnitingCare Australia, *Submission 59*; Kincare, *Submission 42*; The National Presbyterian Aged Care (NPAC) Network, *Submission 37*; Council of Social Service of New South Wales, *Submission 69*; Aged and Community Services Australia, *Submission 67*.

69 UnitingCare Australia, *Submission 59*, p. 7.

70 The National Presbyterian Aged Care (NPAC) Network, *Submission 37*, p. 3.

> Often, the higher fees for community packaged care are a deterrent to people using a more appropriate level of support. NCOSS is concerned that the additional supports available to community packaged care users, particularly case management, is not being made available due to the additional financial burden this would impose.[71]

3.57 Aged and Community Services Australia (ACSA) thought that care recipients were being asked to pay too much:

> ACSA finds the level of co-contribution to be excessive and the scaling of fees for part pensioners too uncompromising which will result in consumers being unable or unwilling to access community care and therefore refuse services…If consumers refuse services they will often require greater assistance via the acute health care services (at an average cost of $1500 per day) or required admission to a RACF sooner.[72]

3.58 NCOSS was concerned that the fee schedule could encourage more people to seek HACC care rather than more appropriate home care:

> NCOSS is concerned that the implementation of a higher fee schedule and means testing arrangements would create a further deterrent for older people who require a higher level of support, and would, in turn, result in further demands on HACC services (which will, after 2015, become part of the Home Support Program).[73]

3.59 Pensioners and Superannuants Association of New South Wales Inc. echoed this sentiment in their evidence before the committee:

> …the way the fee structure operates is that clients will have an incentive to take a lower level care package because they simply cannot afford the higher level care packages, particularly if they are not eligible for financial hardship reductions in fees.[74]

Committee view

3.60 Clearly the committee, like the government, wants to ensure that older Australians obtain care most suitable to their circumstances. While the committee understands the nature of the issue raised by submitters, there did not appear to be concrete evidence that the levels of proposed co-contributions would cause people to seek cheaper care that would not be appropriate to their circumstances. Between the modest level of contribution being sought, and the existence of hardship supplement provisions,[75] it seems unlikely that this will be a significant issue. The committee also believes that overwhelmingly people will seek out the right level of care rather than cheap but inappropriate care.

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71 Council of Social Service of New South Wales, *Submission 96*, p. 10.

72 Aged and Community Services Australia, *Submission 67*, p. 24.

73 Council of Social Service of New South Wales, *Submission 96*, p. 10.

74 Ms Crowe, Pensioners and Superannuants Association of New South Wales Inc., *Committee Hansard*, 30 April 2013, p. 35.

75 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 75.

3.61 The committee notes that under consumer-directed care, there is also some scope for enhanced competition amongst service providers to encourage price-based competition and to ensure the provision of services is as efficient as possible.

3.62 The committee recognises that those seeking care who have incomes greater than the pension will be asked to make a larger contribution to the cost of care. It believes that these reforms are fair and will ensure greater access to home care on an equitable basis.

3.63 The take up of the packages will need to be closely monitored, as will the effects on HACC programs.

Recommendation 2

3.64 The committee recommends that the government closely monitor the take up of home care packages and any signs of changes to demand for HACC-type packages.

Economic Risk for Providers

3.65 Kincare and Uniting Care raised concerns about what could occur should a consumer fail to make a necessary co-contribution under the new arrangements. The legislation[76] would require providers to deliver services regardless of people's ability to pay, raising the prospect of providers being obliged to continue to provide services and bear the costs whilst pursuing payment options, moving to reduce services, or awaiting possible hardship supplements. In these circumstances many providers feel they are carrying too great an economic risk as these processes may take some time.[77]

> It just creates a whole lot of new dilemmas for providers, restructuring the system in that way – potentially losing quite a lot of income but also having to make those sorts of decisions about continuing to provide care to people or not.[78]

3.66 The possibility that, in these circumstances, a hardship payment would be denied, elicited great concern. The perception of some providers[79] is that, under the proposed system, the provider would be forced to take on an increasing debt collector role in order to recover costs. This may have flow-on effects through providers seeking to reduce their exposure to such risks:

> Implementation of means-testing, without an adequate subsidy level that meets the true cost of services, is likely to reduce the incentive for Home Care package providers to accept clients with a low income.[80]

3.67 Kincare provided the committee with examples of potential issues a provider might face as a result of non-payment.[81]

> Example 1
>
> Joseph has signed a contract with his provider. He has been means tested and understands he will be paying $27.47 per day towards the cost of his care. However, Joseph has a gambling problem. Within 3 months of commencing his package, Joseph defaults on his payments and admits he is no longer able to honour his contract.

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76 This legislative requirement is located in Principle 23.92(1) in the *User Rights Principles 1997* and as Right 7(d) of *The Charter of Rights and Responsibilities* located within Schedule 2 of the *User Rights Principles 1997*.

77 Kincare, *Submission 42*, p. 10–11, UnitingCare Australia, *Submission 59*, p. 4.

78 Ms Held, UnitingCare Australia, *Committee Hansard*, 30 April 2013, p. 66.

79 Kincare, *Submission 42*; UnitingCare Australia, *Submission 59*; Council of Social Service of New South Wales, *Submission 96*.

80 Council of Social Service of New South Wales, *Submission 96*, p. 10.

81 Kincare, *Submission 42*, p. 11.

> Providers are unable to view the details governing the hardship subsidy. Would Joseph qualify? How long will it take for Joseph's financial situation to be reviewed? How should the provider support Joseph in the meantime? KinCare currently carries a bad debtor as consumers who are financially disadvantaged are not denied a service. What is a fair process? Who bears the financial risk if a care recipient is unable to pay?
>
> Example 2
>
> Joseph has been advised he needs to contribute $27.47 per day to the cost of his care. Joseph has advised his service provider that he will organise unpaid carers to support him in all activities that would otherwise be financed by his $27.47 per day. Joseph does not want to pay any money to his provider.
>
> Will Joseph still be entitled to receive the total amount of his care subsidy from the government, even though he is not contributing any money himself? It is difficult to gauge full impact of proposed changes without understanding eligibility and implementation.

3.68 The committee received no specific evidence to suggest hardship payments would be denied in relevant cases, and remained unclear as to why some service providers were expressing anxiety about this being something that would present a qualitatively different issue in the new system compared to the existing one.

3.69 Furthermore, the fundamental responsibility to pay fees will not change. Under the existing *User Rights Principles 1997*, a community care service user has the responsibility:

> (a) to pay any fees as specified in the agreement or negotiate an alternative arrangement with the provider if any changes occur in his or her financial circumstances
>
> (b) to provide enough information for the approved provider to determine an appropriate level of fees[82]

3.70 The committee notes that the principles are proposed to be revised under the new system:

> …clarifying that a recipient of home care may place his or her security of tenure at risk if they do not meet the responsibilities of a care recipient set out in the Charter of rights and responsibilities for home care, for example, if they do not pay their care fees for a reason that is within their control, or they do not allow safe and reasonable access for care workers.[83]

82 *User Rights Principles 1997*, Schedule 2.

83 DoHA, *Overview of proposed changes to the Aged Care Principles and Aged Care Determinations made under the Aged Care Act 1997*, p. 21, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Proposed-Legislative-Changes-overview-proposed-changes (accessed 27 May 2013).

Conclusion

3.71 The Living Longer Living Better aged care reforms respond to known issues in the aged care sector: the challenges of increased numbers needing care, falling numbers of informal carers, low wages and staff retention problems, and the preference expressed by most people to stay in their homes for as long as is practical. All of these factors require an expansion of home care and a strengthening of the financial base on which it occurs. Put simply, there needs to be more home care, and more money to pay for it.

3.72 The committee believes that the Living Longer Living Better reforms represent a key step in delivering more and better home care, while acknowledging there may need to be both fine tuning of these reforms as they are implemented, and possibly future reform as the sector matures and develops.

Chapter 4

Residential aged care

4.1 Residential care services provide accommodation and support for people who can no longer live at home. This Chapter provides an overview of issues raised throughout the course of this inquiry into the proposed changes to residential care under the Living Longer, Living Better (LLLB) aged-care reform.

The new pricing paradigm

4.2 Under the proposed amendments to the *Aged Care Act 1997* (Act), residential care recipients may incur three kinds of costs:

- a basic fee of up to 85 per cent of the single basic pension;
- means tested accommodation payments;
- means tested care payments; and if applicable
- other amounts agreed between the care recipient and the approved provider, such as the Extra Service Fees.

4.3 Changes are also proposed to the arrangements through which residential care providers can collect and retain fees, as well as the purposes for which capital can be utilised.

Means tested accommodation and care fees

4.4 Aged care residents will be required to pay a fee of no more than 85 per cent of the single basic pension. At the present time, this equates to $15 364.[1] In addition, care recipients with income above the maximum income for a full pensioner and assets exceeding the asset free threshold will be required to pay means tested care and accommodation fees.[2] These fees will reduce the amount the government contributes to the cost of the resident's aged care services.[3] A resident's mean tested contribution will first be distributed towards accommodation costs. After the full cost of

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1 DoHA, *Living Longer. Living Better – Fairer means testing arrangements for residential care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-3.htm (accessed 10 May 2013). Currently, residents whose income exceeds the pension income test may be asked to make additional contributions to the cost of their care. The additional contributions are calculated at 5/12ths of the residents of resident' assessable income above the income tested free threshold - See DoHA, *Information Sheet 11 – Income tested fees for residential aged care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-publicat-qcoa-11info.htm (accessed 10 May 2013).

2 DoHA, *Living Longer. Living Better – Fairer means testing arrangements for residential care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-3.htm (accessed 10 May 2013).

3 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 55.

accommodation is paid, the remaining means tested contributions will go towards the cost of care.[4]

4.5 It is intended that a person's income will be calculated according to the rules applied by the Department of Human Services for pension purposes.[5] The method of calculating the value of a person's assets would be based on criteria in section 44–10 of the Act, but the existing test would be modified. Chiefly, refundable deposit balances will be considered an asset, and houses that are not occupied by a 'protected person' will be included in the asset test up to a maximum value determined by the Minister. The asset test will also be applied with reference to the Subsidy Principles rather than the Residential Care Subsidy Principles as is currently the case.[6] The Explanatory Memorandum to the Aged Care (Living Longer Living Better) Bill 2013 states that the inclusion of refundable deposit balances is consistent with the current treatment of accommodation bonds.[7] The government has indicated that, at present, it is intended that for the purposes of the asset test the value of a person's house will be capped at $144 500.[8]

4.6 For persons whose income and assets exceed the minimum levels, the maximum means tested contribution will be:

- 50 per cent of **income** above the income threshold; and
- 17.5 per cent of the **value of assets** between $40,500 and $144,500; and
- 1 per cent of the **value of assets** between $144,500 and $353,500; and
- 2 per cent of the **value of assets** above $353,500.[9]

4.7 The government subsidy will be reduced by this amount. Service providers may recover that reduction by charging residents by up to this same amount. There are further effects on the calculation of subsidies and care fees in cases where a resident is

4 DoHA, *Living Longer. Living Better – Fairer means testing arrangements for residential care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-3.htm (accessed 10 May 2013).

5 DoHA, *Living Longer. Living Better – Fairer means testing arrangements for residential care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-3.htm (accessed 10 May 2013).

6 Aged Care (Living Longer Living Better) Bill 2013, proposed section 44–26A; Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 63.

7 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 63.

8 DoHA, *Living Longer. Living Better – Fairer means testing arrangements for residential care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-3.htm (accessed 10 May 2013).

9 DoHA, *Living Longer. Living Better – Fairer means testing arrangements for residential care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-3.htm (accessed 10 May 2013).

eligible for supplements such as respite supplement, dementia supplement, or veterans supplement.[10]

4.8 Residents will not be required to pay a means tested fee, and will not have their care subsidies reduced, if their means test amount is equal to or less than their accommodation supplement.[11] Means tested care fees will also be capped at the lesser of an annual and lifetime amount determined by the Minister[12] or the actual cost of the resident's care.[13] Currently, it is proposed that the means tested care contribution will be capped at $25 000 per year, and not exceed an accumulated total of $60 000.[14]

Accommodation and hardship supplements

4.9 Proposed section 44–28 would establish the eligibility criteria for accommodation supplements. Notably, the Minister has discretion to determine supplement amounts according to the income of the care recipient, the value of assets held by the care recipient, the status of the residential aged care facility, or any other matter specified in the Subsidy Principles. The Explanatory Memorandum to the Bill notes that this is intended to allow the Minister to provide higher supplements for new or significantly refurbished aged care residential facilities.[15] The Department advised that this capacity to adjust payments is designed to encourage investment in residential aged care facilities.[16] The Minister would also be authorised to vary the supplement to reflect a residential aged care recipient's means.[17]

4.10 An aged care residential recipient would be eligible for an accommodation supplement if also the subject of a financial hardship determination. Pursuant to proposed section 52K–1, the criteria for determining financial hardship status would be established under the Fees and Payments Principles. An applicant would have 28 days in which provide any additional information requested by the Secretary of the Department. If the additional information is not received within this time, the application for financial hardship status would be taken to have been withdrawn.[18]

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10 Aged Care (Living Longer Living Better) Bill 2013, proposed sections 44–5, 44–21. Aged Care (Living Longer Living Better) Bill 2013, proposed section 52C–3; Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 55.

11 Aged Care (Living Longer Living Better) Bill 2013, proposed section 44–21; Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 55.

12 DoHA, *Living Longer. Living Better – Fairer means testing arrangements for residential care*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-review-measures-factsheet-3.htm (accessed 10 May 2013).

13 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 55.

14 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 86.

15 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 65.

16 DoHA, answer to question on notice, 7 May 2013 (received 14 May 2013).

17 Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 65.

18 Aged Care (Living Longer Living Better) Bill 2013, proposed subsections 52K–1(7)-(8); Aged Care (Living Longer Living Better) Bill 2013, Explanatory Memorandum, p. 91.

Residential care providers–collection and retention of fees

4.11 The Aged Care (Living Longer Living Better) Bill 2013 contemplates comprehensive changes to the aged care pricing structure and payment framework.

4.12 Proposed Division 52–G of the Bill would impose a ceiling on the cost to residents of refundable accommodation deposits (RADs) and daily accommodation payments (DAPs). In particular, proposed section 52G–2 would prohibit residential aged care providers from charging an accommodation payment for respite care, and for residents with a means tested amount less than the maximum accommodation supplement the person would be eligible to receive. Further, proposed section 52G–2 would limit the amount that could be charged. An accommodation payment could not exceed the maximum amount determined by the Minister or approved by the Aged Care Pricing Commissioner.

4.13 Under existing arrangements, aged care recipients living in residential care may be charged an upfront accommodation bond (or lump sum) if they are entering low care or an extra service place. There is no fixed amount for a bond. The amount of the bond is to be agreed between a resident and the approved provider (as part of a bond agreement) but cannot be of a value that would leave them with less than 2.25 times the basic pension amount (minimum permissible asset value). Residents can choose to pay a bond via a lump sum; periodic payment (fortnightly or monthly) or a combination of both. The bond balance (i.e. the bond minus retention amounts and any other allowable deductions) must be refunded to the resident or their estate when they leave the aged care home.[19]

4.14 The current arrangements permit aged care providers to collect retention amounts from bonds and to earn income from the bonds through investments. There is no restriction on the use investment income, however, by law a provider can only use the bond itself for the following purposes: capital expenditure, refunding bonds, refunding debt accrued for capital expenditure and refunds, investment in particular financial products and loans for capital works or investment in particular financial products.[20]

4.15 If a resident is entering high care under the current system they are not required to pay a bond but may be asked to pay an accommodation charge, which is a daily charge fixed from the date of entry into care and approved by the Department based on an asset test.[21] People receiving respite care do not have to pay any accommodation charges or bonds.

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19 DoHA, *Submission 92,* p. 36*;* DoHA, *Accommodation Bonds for Residential Aged Care*, Information Sheet no.16 http://www.health.gov.au/internet/main/publishing.nsf/Content/391640A07DB6A554CA256F19001007B2/$File/Info-Sheet-16-SEPT12.pdf (accessed 27 May 2013).

20 DoHA, *Accommodation Bonds for Residential Aged Care*, Information Sheet no.16 http://www.health.gov.au/internet/main/publishing.nsf/Content/391640A07DB6A554CA256F19001007B2/$File/Info-Sheet-16-SEPT12.pdf (accessed 27 May 2013).

21 DoHA, *Submission 92*, p. 36.

4.16 The proposed changes to how care recipients in residential care pay for their aged care would only apply to those who have the capacity to contribute to the cost of their accommodation. Those with low means would have their accommodation costs met by the Government in part or in full via the accommodation supplement.[22]

4.17 From 1 July 2014 there would be three types of payments a residential care provider may receive towards the cost of accommodation, determined by the resident's means. These are:

- Accommodation supplement: This is a Government contribution toward the cost of accommodation for residents with low means.
- Accommodation contribution: This is an amount paid by residents who can afford to pay some of the cost of their accommodation, with the difference paid by the Government in the form of an accommodation supplement.
- Accommodation payment: This is an amount paid by residents who are able to meet their accommodation costs.[23]

4.18 Those residents making an accommodation contribution or accommodation payment would be able to pay for their accommodation by periodic payment, known as the Daily Accommodation Payment (DAP), by lump sum, referred to as a Refundable Accommodation Deposit (RAD), or through a combination of both.[24]

4.19 Equivalent RAD and DAP prices would be able to be determined using an interest rate up to the maximum permissible interest rate (MPIR).

4.20 Under the reforms, and in line with the proposed removal of the low care/high care distinction, there would be opportunity for RADs to be paid by residents entering what is currently high care, This means there would be an additional 94,000 places for which RADs would now be able to paid.[25] People receiving respite care will continue to not have to pay any accommodation fees.

4.21 Under the proposed legislation the maximum amount of a RAD that a resident would be required to pay must leave the resident with at least the minimum permissible asset level (currently $41,500).[26] Daily Payments would be able to be paid by the resident from external sources or can be drawn down from a RAD that the resident has paid to the provider. In this case the provider could increase the DAP by an amount that compensates for the impact of the decreasing RAD balance.[27]

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22 DoHA, *Submission 92*, p. 57.

23 DoHA, *Submission 92*, p. 25.

24 DoHA, *Submission 92*, p. 57.

25 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 3.

26 This is calculated as 2.25 times the basic age pension amount at the entry time, which is the same formula currently used. DoHA, *Submission 92*, p. 57.

27 DoHA, *Submission 92*, p. 57.

4.22 A RAD would able to be used by the provider in substantially the same way a provider is currently permitted to use bonds with the proposed addition of the following permitted uses under the *User Rights Principles 1997*:

- Loans made for the purpose of refunding accommodation bond balances or entry contribution balance;
- Loans made to repay debt accrued for the purposes of capital expenditure or refunding accommodation bond balance; and
- Investment in Religious Charitable Development Funds.[28]

4.23 There would also continue to be no restrictions on the use of income derived from investing refundable deposits, accommodation bonds or entry contributions, however, the collection of retention amounts from the bond or RAD will no longer be possible.[29]

4.24 Under existing arrangements, residential aged care providers may deduct what is called a retention amount from accommodation bonds for residents who enter into low care or extra service aged care. While residential care providers have discretion to determine the fee deducted, this bond retention amount cannot exceed government specified caps. A retention amount may be deducted from an accommodation bond for a maximum of five years, which generally commences on the day the resident enters the aged care facility as a permanent resident.[30] Since July 2012, the maximum retention amount for residents whose bonds are above approximately $39 000 is $323 per month. It is less for those with smaller bonds.

4.25 Under the proposed changes to Australia's aged care system, residential care providers would no longer be able to charge a retention amount. Consequently the only deductions that can be made from RADs are those made with the resident's agreement. Providers will be able to retain interest earned on RADs.[31]

4.26 Residential care providers would be required to enter into an accommodation agreement with the proposed care recipient before, or no later than 28 days after, the person enters residential care.[32] Proposed section 52F–2 would also specify the matters that must be included in an accommodation agreement. Accommodation agreements would be required to include a clause that 'within 28 days' after entering the residential care facility, the recipient must choose the method of paying for their accommodation. The recipient would have a choice between a DAP, a RAD or a combination of both. Before the election is made, residential care recipients will be

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28 DoHA, Attachment 11, answer to written question on notice, (received 14 May 2013), p. 2.

29 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 92.

30 DoHA, *Accommodation Bond Retention*, http://www.health.gov.au/internet/main/publishing.nsf/Content/AD6E12E88312973ECA256F19000F6C61/$File/bond_retention_amounts2012.pdf (accessed 10 May 2013).

31 The Hon. Mark Butler MP, Minister for Mental Health and Ageing, *Correspondence to Committee Deputy Chair, Senator Rachel Siewert* (received 29 April 2013), p. 2.

32 Aged Care (Living Longer Living Better) Bill 2013, proposed section 52F–2.

required to pay a DAP. If after 28 days the care recipient has not made an election, by default the care recipient will continue to pay a DAP.

4.27 All providers would be required to set their accommodation prices according to the Accommodation Pricing Guidelines and requisite Principles under the Act. Providers would also be required to publish their accommodation prices, however providers and residents may agree to an amount less than the published price as part of an accommodation agreement.[33]

4.28 The proposed accommodation payment arrangements would only apply to residents entering on or after 1 July 2014. The arrangements for existing residents continue under their old provisions, unless the resident re-enters care after leaving care for a period of 28 days or more, or if they move facilities and decide to enter under the new arrangements.[34]

4.29 Consumer groups such as COTA and NSA were very supportive of the payment provisions in the proposed legislation:

> Consumers strongly support the LLLB provisions that provide for real choice of method of payment for accommodation between periodic payment, a refundable lump sum, or a mix of both; and also the requirement to publicly advertise accommodation rates - both periodical payments and lump sums. Consumers strongly object to the current system where the price is often set based on the consumers' total assets. This has led to cherry picking consumers based on the amount they can afford to pay.[35]

Residential providers' concerns of the proposed new pricing arrangements

4.30 Residential providers noted several areas of concern with the proposed introduction of a new pricing framework. These concerns included a proposed ceiling on DAPs and the possible flow on effect to the value of RADs; the risk of care recipients moving from RADS to DAPs; the necessity of prohibiting bond retention and the 28 day requirement. Some providers argued that these matters would have an effect on the means by which they could remain commercially viable and restrict the funding available for aged care infrastructure. This was of particular concern for low care-only providers, providers in rural and remote areas and small providers where values of bonds are already considered relatively low and there are ongoing difficulties in maintaining a financial base for development and refurbishment of infrastructure and beds.

Restrictions on RAD and DAP fees

4.31 Throughout a significant portion of this inquiry it was proposed by the government that DAPs would be split into three levels:

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33 DoHA, *Submission 92*, pp 57–58.

34 DoHA, *Submission 92*, p. 59.

35 COTA, *Submission 87*, p. 15.

> Level 1 extends from $0 to the maximum amount of the Government accommodation supplement. This is $50 per day in 2012 prices and is indexed. The equivalent Refundable Accommodation Deposit is $238,845.
>
> Level 2 ranges from the Government accommodation supplement to $85 per day and will be indexed. The equivalent Refundable Accommodation Deposit is $406,037.
>
> Level 3 prices are all amounts above Level 2 and must be pre-approved by Government.[36]

4.32 A number of providers expressed the view that setting an effective ceiling of $85/day on DAP would be uncommercial and many were quite strong in their assessment of the effect this would have, with Vasey RSL Care Ltd stating that the pricing limits are a 'recipe for disaster' and would remove 'much of the mechanisms of a free market'[37] whilst the National Presbyterian Aged Care (NPAC) Network saw them as 'counterproductive in restricting providers unnecessarily from setting fee levels which allow development of new residential care facilities'.[38]

4.33 Throughout a significant portion of this inquiry it was proposed that equivalent RAD values would be calculated from anchored DAP values using an interest rate up to the maximum permissible interest rate (MPIR).[39] There was strong concern that as a consequence of this methodology the equivalent RAD value would also be limited compared with what could be achieved under the current system or even the value that could have been achieved under ACFA draft recommendations.[40]

> The decision by the Minister to not accept the recommendation of the Pricing Commission relating to accommodation payments and to "with a stroke of a pen" reduce the maximum Level 2 price to $85/day – effectively $406,000 against their recommendation of $500,000 is of great concern.[41]

4.34 Many providers felt that under the proposed system RADs would also be subject to 'volatility' to the extent that it would 'bear no relationship to the cost of accommodation.'[42] Much of this concern stemmed from the fact that a quarterly determined Maximum Permissible Interest Rate (MPIR) as opposed to a Weighted Average Cost of Capital (WACC) would be used in combination with the anchored DAP value to calculate the RAD.[43] This generated significant concern that with a

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36 DoHA, *Submission 92*, p. 58.

37 Vasey RSL Care Ltd, *Submission 23*, p. 1.

38 The National Presbyterian Aged Care (NPAC) Network, *Submission 37*, p. 2.

39 DoHA, *Submission 92*, p. 57.

40 Retirement Aged Care Management Pty Ltd, *Submission 22*, p. 2; Southern Cross Care Victoria, *Submission 39*, p. 1; Rose Lodge, *Submission 10*, p. 2; Aged and Community Services Australia, *Submission 67*, p. 19.

41 Rose Lodge, *Submission 10*, p. 2.

42 ECH Inc., Eldercare Inc. and Resthaven Inc, *Submission 41*, Attachment A.

43 The National Presbyterian Aged Care (NPAC) Network, *Submission 37*; ANZ, *Submission 94*; ECH Inc., Eldercare Inc. and Resthaven Inc, *Submission 41*.

anchored DAP, fluctuations in the MPIR would result in unmanageable and more frequent fluctuations in the value of RADs.[44]

> In particular we raise concern over the proposed method of calculating the equivalent Refundable Accommodation Deposit (based on the Daily Accommodation Payment and the Maximum Permissible Interest Rate.) This method will lead to significant fluctuations in the Refundable Deposits over time with changes to the interest rate possibly leaving the provider to make up losses incurred when one resident leaves and the new resident arrives under a higher interest rate scenario. This will cause uncertainty to cash flows and funding for infrastructure.[45]
>
> The proposal to adopt DAP as the primary price reference has the unintended consequence that in a rising interest rate environment, RADs will reduce and DAPs stay fixed which will further exacerbate a provider's liquidity shortfall in the event that consumers elect to shift to DAP from RAD…[46]

4.35 In contrast some providers perceived the proposed controls on DAPs and RADs were a positive factor in in that the relative wealth of the consumer would not be an allowable factor in determining accommodation prices:

> We also support Daily Accommodation Payments (DAP) and Refundable Accommodation Deposits (RAD) being introduced and being based on the quality of the accommodation provided, not the assets of the individual (as used by some Providers in assessing accommodation bonds).[47]

4.36 This perspective was shared by the Department of Health and Aging (the department) who explained that the change to the pricing structure is intended to promote fairness, by ensuring that client costs are based on the services provided rather than a resident's financial status:

> The system will move from one where the value of an accommodation bond varies depending on the means of the prospective resident, to one where it is based upon the value of the accommodation on offer.[48]

4.37 It was noted by the department that at the core of much of the confusion and angst surrounding the new DAP and RAD measures was the fact that that some submitters[49] were erroneously treating the ceiling on daily accommodation payments

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44 The National Presbyterian Aged Care (NPAC) Network, *Submission 37*; ANZ, *Submission 94*; ECH Inc., Eldercare Inc. and Resthaven Inc., *Submission 41*; Aged and Community Services Australia, *Submission 67*; Advantaged Care, *Submission 95*; Aged Care Gurus, *Submission 86*; Embracia Communities Pty Ltd., *Submission 66*.

45 Anglicare Australia, *Submission 75*, pp 3–4.

46 ANZ, *Submission, 94*, p. 4.

47 Cookcare Group, *Submission 30*, p.1; Aegis Aged Care Group, *Submission 7*, p. 2.

48 DoHA, *Submission 92*, p. 26.

49 See: UnitingCare Australia, *Submission 59*; ANZ, *Submission 94*; Vasey RSL Care Ltd, *Submission 23*.

as effectively being a cap or limit. The existence of a cap was refuted by the department:

> 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.[50]

4.38 The department likewise rejected claims [51] of a cap on RADs or lump sum payments:

> …lump sum payments (known as refundable accommodation deposits) will be able to be charged at any level provided the price has been set in accordance with accommodation pricing guidelines…[52]

4.39 The department went on to explain that providers could apply for Level 3 pricing, in line with the proposed Fees and Payments Principles, if they felt they needed to exceed the $85/day DAP ceiling:

> 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.[53]

4.40 In their response to the influence of the MPIR, the department indicated that 'the methodology and use of the MPIR was recommended by the Aged Care Financing Authority after consultation with industry' as it 'broadly reflects the treatment of a lump sum payment as unsecured finance' and 'creates a relationship between accommodation payments and the financial market.'[54] The WACC was seen to not be applicable in these circumstances as it 'varies between businesses' and 'is not a fixed rate across industry.'[55]

4.41 In response to concerns in relation to volatility the department indicated that over the longer term the MPIR would 'move in both directions' which would result 'in

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50 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 6.

51 Taverners Group, *Submission 103*; Department of Health, Victorian Government, *Submission 101*; Rose Lodge, *Submission 10;* Alliance Care Services Pty Ltd, *Submission 57.*

52 DoHA, Attachment 1, answer to written question on notice (received 23 May 2013).

53 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 7.

54 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 6.

55 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 6.

RAD values that will also rise when interest rates fall.'[56] They also stated that a variable MPIR could be counteracted by adjustments to the DAP. They stated:

> …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.[57]

4.42 The Aged Care Financing Authority (ACFA) examined the issue and consulted with stakeholders. It reported:

> The dependency of the industry on funding by bonds (RADs) is causing alarm amongst sections of the industry and financiers as to the consequence of a potential net drop in the level of such funding. Although DAPs and RADs are by calculation financially equivalent, providers are not indifferent to the consumers' choice. This is because DAPs impact revenue and profitability, whilst RADs provide cornerstone balance sheet funding and access to interest receipts thereon and for bonds received prior to 30 June 2014, retention income for up to five years.
>
> ACFA commissioned KPMG to undertake scenario modelling to provide estimates of the possible impacts from each of the pricing and method of payment changes in the currently different low and high care sectors. At an aggregate industry level, a net fall in RAD funding appears unlikely. However at a facility or provider level, short and medium term changes may cause transitional funding contractions that may not be easily replaced by incremental third party debt or equity contributions.[58]

4.43 In response to concerns from the sector, ACFA recommended some changes to the way in which providers could calculate the value of DAPs and RADs.[59] In undated correspondence to ACFA the Minister has indicated that he will accept a number of their recommendations including:

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56 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 5.

57 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 6.

58 Correspondence between Ms Lynda O'Grady, ACFA, and the Hon. Mark Butler MP, 17 May 2013, Attachment 1, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Communique-advice-to-minister.

59 Correspondence between Ms Lynda O'Grady, ACFA, and the Hon. Mark Butler MP, 17 May 2013 http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Communique-advice-to-minister

> That for a transition period until 1 July 2017, and subject to the outcome of the review described in recommendation 3, the equation using the MPIR as "conversion factor" be anchored in the RAD so that providers can determine a RAD price and then convert that to a DAP price based on the MPIR. The DAP price would then adjust each quarter with movements in the MPIR with the RAD price remaining constant. From 1 July 2017 the anchor point would change to the DAP with the RAD adjusting with movements in the MPIR, subject to the findings of the review. As already announced both RAD and DAP prices and combination options would need to be published by the provider.[60]

4.44 As a consequence of this proposed change in methodology the previously indicated levels of DAP/RAD pricing could be impacted as could the process involved in determining Level 3 pricing approvals. The correspondence from the Minister to ACFA has indicated that the impact on the pricing approval process will be considered as part of the process involved in finalising the Accommodation Pricing Guidelines.[61]

Committee View

4.45 Evidence before the committee highlighted that there is significant concern among stakeholders about the implications of the new funding arrangements on their provision of services, especially in relation to regulation of DAP and RAD values. The committee recognises that for some providers the proposed changes may initially necessitate changes to their existing business model.

4.46 While remaining cognisant of the concerns of some providers, the committee believes that these measures are consistent with the objective of increasing transparency and equality within the aged care pricing system,[62] and that at least some of the concerns were based on the superseded pricing model initially proposed by the Department, as well as misapprehensions about how the system will operate. The committee believes the review by ACFA, and the Minister's positive response, will alleviate some key concerns.

Movement from RADs to DAPs

4.47 With consumers being offered more choice in terms of how they could pay their accommodation fees and with significant changes to the means testing arrangements proposed, concerns were raised about the impact of potential movement

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60 Correspondence between The Hon. Mark Butler MP and Ms Lynda O'Grady ACFA. http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Communique-ministers-response

61 Correspondence between Ms Lynda O'Grady, ACFA and the Hon. Mark Butler MP, 17 May 2013 http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Communique-advice-to-minister; Correspondence between The Hon. Mark Butler MP and Ms Lynda O'Grady ACFA. http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Communique-ministers-response

62 DOHA, *Submission 92*, p. 26.

by consumers to a DAP as opposed to a lump sum payment in the form of a RAD. It was thought that many consumers would find such an option more financially viable, to the detriment of the providers. In the absence of indicative financial modelling, ANZ argued:

> A significant shift from RAD to DAP would potentially have adverse consequences for the financial viability of many providers as well as curtailing investment appetite…if $12 billion of RADs were replaced tomorrow by $12 billion of DAP, it is estimated that an equity gap of around $5 billion would exist in the industry…It is unlikely that providers have access to such equity pools.[63]

4.48 Catholic Health Australia drew on the Productivity Commission report to illustrate their concerns with relation to a potential loss of lump sum payments

> The Productivity Commission's report noted that a significant shift to daily payments by new residents could pose a liquidity risk for providers whose balance sheets are heavily leveraged on lump sum payments, at least for a transition period, because withdrawn lump sums that are not replaced would need to be refinanced. In some cases, this could lead to loan covenants being compromised, with implications for ongoing operations. Some financial institutions have also informally noted that the sector and the financial markets are not mature enough to assemble the capital required for the expansion of services without a significant injection of capital through refundable deposits.[64]

4.49 It was also suggested that these changes were a push to see RADs permanently replaced by DAPs in order to reduce the 'potential contingent liability' faced by the Australian Government:[65]

> The measures are also intended to encourage a transition from lump sum deposits to annuity payments (effectively rent) to reduce the Government's exposure to bond payment defaults.[66]

4.50 The department rejected the implication of a policy change in this direction, stating:

> The reforms enabling consumer choice of payment method are not designed to reduce the Government's potential bond liability but instead reflect the policy view that individuals should be able to choose a payment method that best takes into account their own personal circumstances and preferences - a significant and important policy objective of the reforms. In fact modelling by KPMG suggests that the total bond liability may grow as a result of the reforms.[67]

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63 ANZ, *Submission 94*, p. 3.

64 Catholic Health Australia, *Submission 55*, p. 12.

65 Taverners Group, *Submission 103*, p. 2; ANZ, *Submission, 94*, p. 2.

66 Grant Thornton, *Submission 6*, p. 5.

67 DoHA, Attachment 1, answer to written question on notice (received 23 May 2013).

4.51 It was acknowledged by the department that there was a possibility that there could be a movement from RADs to DAPs by consumers, which could result in a reduction in RADs, particularly in low care. However they felt that the losses claimed by some submitters were excessive:

> The KPMG modelling suggests that there may be a movement of around 33% from bonds to daily payments in low care based on a pure financial consideration of the choice by the individual. This is significantly less than the 60% assumed by the Guild.[68]

4.52 The department also indicated there would be an increase in RADs at the high care end of the spectrum which would counteract any losses experienced in the low care end of the spectrum.

> 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).[69]

4.53 The department referred to KPMG modelling to further illustrate the potential increase in bonds through high care RADs, stating there would be:

> …an increase in bonds in high care of $3.4 billion and an increase in revenue of $93 million compared to an estimated decrease in bonds in low care of $403 million and a decrease in revenue of $68 million in low care (not accounting for a potential increase in revenue from combination payments).[70]

4.54 Some submissions suggested that residents who are requiring high care are unlikely to pay a RAD due to expectations of a short time spent in care.

> Behaviourally, it is counter intuitive that high care residents will pay RADs - instead it is much more likely DAPs will be paid. High care residents' typical length of stay is 6 -12 months given higher frailty whereas low care residents who presently pay RAD bonds typical length of stay is 2 -3 years. So the time period available for high care residents to be organised to pay RADs is much reduced compared to current RAD paying low care residents. Further low care residents typically take significantly longer to arrange their entry to residential care (thus greater planning time) given their lower acuity and greater ability to continue residing in the family home. Conversely, high care resident admission is much more event driven (sudden ill health, sub acuity event etc) and planned sale of the family home before admission is much less likely.[71]

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68 DoHA, Attachment 2, answer to written question on notice (received 23 May 2013).

69 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 3.

70 DoHA, Attachment 3, answer to written question on notice (received 23 May 2013).

71 ANZ, *Submission, 94*, p. 4.

4.55 Whilst the department acknowledged that 'stays are on average shorter in high care', they indicated 'the difference is not anywhere as stark as many submissions imply and many high care residents have long stays (e.g. residents with dementia).'[72]

> 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.[73]

4.56 The department also informed the committee of other proposed changes which could potentially encourage care recipients to use the RAD option, such as the ability for the consumer 'to make the agreed accommodation payment by drawing down a DAP from a RAD'.[74] They also reiterated that there was a range of existing non-financial factors unique to each consumer that may mean a RAD may be the preferred option independent of any financial advice to the contrary:

> …including estate planning considerations as well as the desire to simplify arrangements and personal affairs.[75]

4.57 The department was also concerned at the general perspective taken in a number of submissions in relation to the new payment options:

> 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.[76]

4.58 Consumer groups such as COTA and NSA were doubtful that there would be a shift away from RADs but urged monitoring of the situation:

> COTA does not think there will be big shift away from RADs in the short term. If it does that will be an expression of consumer preference, which is the purpose of the reform. However this should be closely monitored and

72 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 3.

73 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 3.

74 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 6.

75 DoHA, Attachment 3, answer to written question on notice (received 23 May 2013).

76 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 2.

> government should be prepared to provide bridging finance or loan guarantees as part of an industry adjustment package.[77]

4.59 The department indicated that such monitoring was a key aspect in the implementation of the reforms:

> The Government intends to monitor the impact of the reforms and seek ongoing advice from ACFA on the impacts of the reforms on the sector generally and on different parts of the sector.[78]

4.60 ACFA has also stated in its correspondence to the Minister that they will

> …examine further the impact of current financial arrangements on capital formation and investor confidence, including superannuation funds, in future annual reports.[79]

Committee View

4.61 The committee has noted the concerns of the industry regarding the possible impact of a large exodus from RADs to DAP. However, the ability for residents to choose payment methods reflects the recommendations of the Productivity Commission to make the system more transparent and ensure appropriate consumer choice.[80] The modelling done by KPMG, an interim report on which was prepared specifically because of the committee's concerns in this area,[81] provides reassurance while also identifying areas for attention.

4.62 The committee considered that modelling and reached a similar view to that of Catholic Health Australia, which in a supplementary submission argued:

> …the accommodation payment reforms may pose transitional financial risks for low care and 'ageing in place' services, and hence risks for the residents for whom they care, because their business models are based on receiving bonds. Mostly not-for-profit providers share this risk as their resident profiles are often dominated by residents who enter care as low care bond payers who 'age in place' for as long as their care needs can be safely met.[82]

4.63 The committee notes that the Productivity Commission was aware of the potential need for transitional arrangements in some cases:

> During the transition period, however, the Commission is cognisant of the liquidity risk to smaller providers from its proposed changes and the

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77 COTA, *Submission 87*, pp 15–16.

78 DoHA, Attachment 2, answer to written question on notice (received 23 May 2013).

79 Correspondence between Ms Lynda O'Grady, ACFA and the Hon. Mark Butler MP, 17 May 2013 http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Communique-advice-to-minister, p. 5.

80 DOHA, *Submission 92*, p. 26.

81 KPMG, *Scenario analysis of selected LLLB financial arrangements – Interim report*, prepared for Aged Care Financing Authority, May 2013, p. 9.

82 Catholic Health Australia, *Supplementary submission 55*.

> possible disruption this might cause to consumers. In this context, a small and targeted assistance package for certain providers could be desirable over the transition period…This is not, however, a proposal to prop up insolvent providers, which have an obligation under corporations law to cease trading.[83]

It recommended some limited transition support:

> The Australian Government should provide, during the transition period, capped grants to existing smaller approved residential care providers, on a dollar-for-dollar basis, for financial advice on business planning to assist in assessing their future options.
>
> Subject to an audit to demonstrate solvency, the Australian Government should offer — during the transition period — existing smaller approved residential care providers a loan facility for the repayment of accommodation bonds. The Government should charge an interest rate premium on the facility to discourage its use when private sector options are available.[84]

4.64 The committee believes that the KPMG modelling has begun to quantify and clarify the nature of some of those transitional risks, and recent correspondence between the Minister and ACFA, discussed earlier in this chapter, demonstrates that the government and regulators are alert to many of the issues. It is important that the financing of the sector receive close attention during the transition, because if significant problems arise, they cannot be allowed to continue until the statutory review, that is not due until three years after the commencement of Schedule 1 of the main Bill.

Recommendation 3

4.65 The committee recommends that the Minister direct the ACFA to report regularly to the Minister on the impact of the reforms on providers (for example, the number and distribution of care recipients choosing DAPs and RADs). ACFA's brief should include specific consideration of the impacts on different types of providers (e.g. current low-care-only providers, small providers, and rural providers).

Recommendation 4

4.66 The committee recommends that the Government immediately put in place arrangements to monitor the impact on low care providers, and prepare to make available transitional support along the lines recommended by the Productivity Commission, including support services for providers seeking assistance in transitioning to the new system.

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83 Productivity Commission, *Caring for Older Australians*, volume 2, p. 492.

84 Productivity Commission, *Caring for Older Australians*, volume 2, recommendation 17.3.

Removal of the option to charge a bond retention amount

4.67 Some residential aged care providers questioned the decision to remove bond retention amounts, arguing that it may make providers less viable and inadvertently raise the cost of accessing care for older Australians.

4.68 The policy was challenged on the basis that it will lead to financial uncertainty for providers. Edgarley Home Inc, South West Alliance reasoned that bond retentions are an integral part of a residential care facility's financial base:

> The other point I want to raise is about bond retentions. We believe that they should stay. The reason is that they give us certainty over a period of time: we know over a five-year period we are going to get X amount of dollars.[85]

4.69 The proposal to remove bond retention amounts was further challenged on the basis that it is likely to increase the difficulty for elderly Australians to access the aged care services they need. Some residential aged care providers argued that the removal of the option to retain part of a bond amount, or a RAD, would be likely to increase accommodation costs:

> There is also potential that the removal of the bond retention amount will result in higher bond prices, which will make up for lost revenue. From an economics viewpoint this will certainly be the case. We need to ensure that this will not leave residents unable to pay accommodation bonds, particularly those on low-income levels.[86]

4.70 The department acknowledged that a way to make up for the loss of the retention monies would be for a provider to change accommodation pricing at their discretion:

> …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...a resident can [now] 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.[87]

4.71 The department provided an example of how this could work in practice:

> 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.

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85 Mr Steven Toope, Chief Executive Officer, Edgarley Home Inc, South West Alliance, *Committee Hansard*, 1 May 2013, p. 53.

86 Mr Graeme Prior, Chief Executive Officer, Hall and Prior Aged Care Organisation, *Committee Hansard*, 1 May 2013, pp 2–3.

87 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), pp 4–5.

> 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.[88]

4.72 UnitingCare Australia acknowledged that the effects of removing the option to charge a bond retention amount was not as they had first anticipated:

> 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.[89]

4.73 While there will no longer be bond retention amounts, there will remain the capacity to retain interest earned on the bonds, and with median and mean bond values in the sector currently over $200 000[90] this is a significant source of income.

Residential providers' concerns about the 28 day requirement

4.74 Some residential aged care providers expressed strong concern about the requirement to include in accommodation agreements a clause specifying that within 28 days after entering an aged care service care recipients must choose how to pay for their accommodation. As Grant Thornton Australia advised, the requirement was considered a significant departure from current practice:

> Currently, residents and providers agree on the basis of payment for accommodation (a lump sum bond or annuity equivalent) before the person enters the facility. Under the proposed Aged Care (Living Longer Living Better) Bill 2013, this decision would be deferred up to 28 days after the person enters the facility.[91]

4.75 Residential aged care providers argued that the requirement was commercially unsound. Multiple aged care providers argued that the capacity to take possession of property before determining whether to rent or to buy is contrary to established commercial practice. Leading Aged Services Australia argued that '[c]ommercial certainty requires that both parties have properly determined the commercial

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88 DoHA, Attachment 4, answer to written question on notice, (received 14 May 2013), p. 5.

89 Mr Teulen, UnitingCare Australia, *Committee Hansard*, 30 April 2013, p. 67.

90 DoHA, *Report on the Operation of the Aged Care Act 1997 - 1 July 2011 to 30 June 2012*, p. 50.

91 Grant Thornton Australia, *Submission 6*, p. 3.

relationship, including mode of payment, before it has commenced.'[92] Similarly, as Mr Ross Johnston, Chairman, Aged Care Guild, hypothesised:

> [W]e would be just "Bed for sale", and 28 days after the resident comes in they would tell us how they will pay us. What business operates like that? I do not know.[93]

4.76 Comparing the proposal with residential property transactions, Mr Darrell Clark, General Manager, Parkwood Aged Services Pty Ltd, commented:

> An analogy would be the property developer was building some units, he is going to finish it, build it, make it lovely. People are going to move into it, and 28 days after they move in they are going to tell this property developer whether they are going to rent it or buy it from him.[94]

Shepparton Retirement Villages Inc was of a similar view.[95]

4.77 The comparison of the proposed arrangement with the residential property market was common throughout the representations made by residential aged care providers regardless of their location. Representing over 25 aged care residential services in Perth, Western Australia, Mr Geoff Taylor, Director, Aegis Aged Care Group, submitted:

> It is uncommercial. We are talking about residences here. If you are looking at a residence with a view to moving in there you have to make a decision on whether you are going to rent or buy it before you move in. You do not make that decision after you have moved in…If they are not making a decision on whether they are going to pay a lump sum or a daily payment until four weeks after they have moved in, and you have a bond to repay to someone going out, then you have a problem.[96]

4.78 It was argued that this apparent deviation from standard business practice would undermine the financial stability of residential aged care providers. Mr Bertram, Shepparton Retirement Villages Inc., advised that the 28 day requirement would lead to a 'cash shortfall' for service providers.[97] Mr Taylor, Aegis Aged Care Group also advised that the requirement would lead to financial uncertainty.[98]

4.79 Such views were not limited to smaller aged care providers, but were held by representatives of larger aged care residential services. Mr Johnston, Aged Care Guild, stated that the 28 day requirement would lead to the following situation:

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92 Leading Aged Services Australia, *Submission 58*, p. 20.

93 Mr Ross Johnston, Chairman, Aged Care Guild, *Committee Hansard*, 1 May 2013, p. 37.

94 Mr Darrell Clark, General Manager, Parkwood Aged Services Pty Ltd, *Committee Hansard*, 1 May 2013, p. 18.

95 Mr Kevin Bertram, Chief Executive Officer, Shepparton Retirement Villages Inc., *Committee Hansard*, 1 May 2013, p. 18.

96 Mr Geoff Taylor, Director, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, p. 5.

97 Mr Bertram, Shepparton Retirement Villages Inc., *Committee Hansard*, 1 May 2013, p. 18.

98 Mr Taylor, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, p. 5.

> [Residential aged care providers] would lose control of how we sell our beds…We would lose control of our capital structure, where our cash and assets are; we will have to find this massive cash outflow…it runs the risk that there will be a serious capital outflow.[99]

4.80 Some of the concerns regarding the 28 day rule appear to have arisen due to a misunderstanding of the intended operation of the reforms. For example, it was put to the committee that the requirement would prevent aged care residents from making payments, either through a DAP or a RAD, before the 28 days have expired.[100] This is not correct. It was also suggested that the requirement would allow residents to choose after a 28 day period.[101] Again, the committee understands this is not correct.

4.81 The wording of Bill makes clear that a payment decision is to be made 'within 28 days'. The proposed section requires aged care recipients to be given a window in which to determine their preferred payment method. However, the proposed section does not prohibit payments being made before the 28 days have expired. As the Department advised, section 52F–3 of the Bill would ensure that '[c]are recipients will have *up to* 28 days after entering an aged care facility to decide how to pay for their accommodation' (emphasis added).[102] The proposed section is directed at the decision about how to pay. However, residents could reach agreement with the provider on payment method at the point of entry, if they have the necessary information available to them.

4.82 Furthermore, the 28 day rule was supported by those advocating for older Australians, with some even calling for a longer decision making period. National Seniors Australia commented that 28 days may be insufficient for persons wishing to sell their home, and accordingly recommended that in such circumstances the timeframe should be extended.[103] Consumer representatives particularly commented on the feasibility of the 28 day timeframe for rural and regional areas. Ms Charmaine Crowe, Senior Policy Adviser, Combined Pensioners and Superannuants Association of New South Wales Inc., advised that a 28 day timeframe would be insufficient for elderly Australians seeking to sell their homes in rural and regional Australia. Ms Crowe advised that 'in reality people are going to need much longer'.[104]

4.83 It was also questioned whether the 28 day timeframe is sufficient for the completion of income and asset assessments. Aged and Community Services Australia

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99 Mr Johnston, Aged Care Guild, *Committee Hansard*, 1 May 2013, p. 37.

100 Mr Taylor, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, p. 6; Aegis Aged Care Group, *Submission 7*, p. 5.

101 Mr Bertram, Shepparton Retirement Villages Inc., *Committee Hansard*, 1 May 2013, p. 18.

102 DoHA, *Submission 92*, p. 27.

103 Mr David Carvosso, Chairman, National Seniors Board, National Seniors Australia, *Committee Hansard*, 2 May 2013, p. 29.

104 Ms Charmaine Crowe, Senior Policy Adviser, Combined Pensioners and Superannuants Association of New South Wales Inc, *Committee Hansard*, 30 April 2013, p. 34.

advised of reports of 'considerable delays' experienced with government income and asset assessments. It was further submitted that delays can be particularly acute in rural and regional areas.[105]

4.84 In response to submitters' concerns, the Department advised that that there are existing protocols between the Department, the Department of Human Services (DHS) and the Department of Veterans' Affairs for means assessments. Under current arrangements, approximately 97 per cent of means assessments are conducted within 14 days of the date the means test application is received by the DHS. Additional time may be required if applicants do not provide all necessary information. The committee was advised that the proposed income and asset assessments will be conducted according to existing protocols. It is not anticipated that additional time will be required to conduct the assessments.[106]

Committee View

4.85 The committee supports the introduction of a 28 day window in which residential aged care recipients can evaluate which payment method, or combination of methods, is right for them. The new requirement would disentangle the burden of securing needed services from the pressure that can accompany significant financial decisions, particularly where entry into care is unplanned. The window will provide security and certainty for Australians needing residential care, and the necessary space in which to carefully evaluate financial choices.

4.86 Evidence before the committee highlighted that there is confusion among stakeholders about the meaning and effect of the proposed 28 day rule. Two areas of particularly significant confusion were evident. First, it appeared that there is widespread misunderstanding of the application of the 28 day window. It would be contrary to the intent of the reforms were residents to be informed that payments cannot be made before 28 days after entering a residential care facility. Such a system is also unlikely to be inefficient, and carries with it the financial concerns raised by residential care providers. It is of concern to the committee that there is such widespread misunderstanding. It is incumbent upon the department to clarify any misunderstandings of the application of the 28 day rule.

4.87 To this end, the department may wish to revise the Explanatory Memorandum to the Aged Care (Living Longer Living Better) Bill 2013 to expressly state that proposed section 52F–2 would not prohibit residents from commencing payments before the 28 days have passed. Rather, it prohibits residents from being required to commence payments within this timeframe. Similar clarifying statements should be included on the Living Longer Living Better website and any relevant explanatory publications.

4.88 The committee notes concerns, particularly in rural and regional areas, that additional time may be required. However, on the basis of information presented to the committee, there is insufficient evidence to support a legislative change. The

105 Aged and Community Services Australia, *Submission 67*, p. 25.

106 DoHA, answer to question on notice, 7 May 2013 (received 14 May 2013).

committee notes that selling a property is not the only way in which the needed capital could be raised, so the capacity to complete the sale of a residence, even where it is the person's only substantial asset, need not be completed on the 28 day timeframe. Nevertheless, the adequacy and any negative effects of the 28 day timeframe on rural and regional residents should be monitored and considered as part of the independent review of the Living Longer Living Better reforms.

Accommodation agreements and enforcement of financial obligations

4.89 The committee further heard concerns that the integrity of the aged care residential system could potentially be compromised by the introduction of a 28 day window in which clients may determine which payment method to adopt. Put simply, it was argued that the 28 day timeframe would provide clients unfettered access to accommodation but would not impose any obligation for the clients to pay for the accommodation and services received.[107]

4.90 In response to concerns, the committee was advised that the Living Longer Living Better reforms would not change existing debt arrangements. The committee was informed that pursuant to the *User Rights Principles 1997*, providers may ask a resident to leave the facility if the resident has not paid an agreed fee within 42 days of the due date.[108] However, suitable alternative accommodation must be available.[109]

4.91 Specifically, the *User Rights Principles 1997* state:

> The approved provider must not take action to make the care recipient leave, or imply that the care recipient must leave, before suitable alternative accommodation is available that meets the care recipient's assessed long-term needs and is affordable by the care recipient.[110]

4.92 As Ageis Aged Care Group and Parkwood Aged Care Services submitted, it was questioned whether providers could enforce a resident's payment obligations after the 28 day period. Mr Clark, Parkwood Aged Services Pty Ltd, commented:

> Residents are going to move in and, after 28 days, they are going to say whether they can or cannot [pay]. In this letter from Mr Butler…he is saying that if they…are going to walk in and, if they do not pay, you are allowed to kick them out. That does not happen. He is saying that in the letter but, in reality, I have never heard of that. It is written there, but I cannot understand how it can be used.[111]

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107 See, for example, Mr Taylor, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, p. 6.

108 The Hon. Mark Butler MP, Minister for Mental Health and Ageing, *Correspondence to Committee Deputy Chair, Senator Rachel Siewert (received 29 April 2013)*, p. 2.*User Rights Principles 1997*, r. 23.5(3).

109 The Hon. Mark Butler MP, Minister for Mental Health and Ageing, *Correspondence to Committee Deputy Chair, Senator Rachel Siewert (received 29 April 2013)*, p. 2

110 *User Rights Principles 1997*, r. 23.6(3).

111 Mr Clark, Parkwood Aged Services Pty Ltd, *Committee Hansard*, 1 May 2013, p. 18.

4.93 Ageis Aged Care Services also questioned the practicality of the debt arrangements:

> There will be some unscrupulous families who will play it to their advantage and not pay. Then you will be chasing them. Our only right of recourse is if the fees are unpaid for 42 days. You can then ask them to leave but you have to find them somewhere else to go. You are in a no-win situation because you will have these people there who will not pay and cannot be asked to leave. Who else is going to take them if the reason you want to move them on is because they are not paying their fees? It is just inequitable to do this.[112]

Committee view

4.94 The committee notes that there are no substantive changes to providers' capacity to recover debts.

4.95 A few providers appeared unclear about the options available to residential aged care providers to respond to unpaid fees. The committee notes that the concerns expressed with the requirement to determine whether there is existing suitable alternative accommodation were not commonly raised. Further, no data was provided to demonstrate the extent of any problem. On the basis of evidence presented the committee, it is not clear that the concerns are shared across the residential aged care service provider community.

Financially disadvantaged residents supplement

4.96 Currently, the Residential Care Supported Resident Ratio requires residential aged care facilities to ensure that a proportion of their services are provided to supported, concessional and assisted residents. The required proportion varies according to geographic location. At present, the New South Wales Far North Coast has one of the lowest ratio requirements, at 17.10 per cent, while Darwin, Alice Springs and Barkly in the Northern Territory, and the Pilbara in Western Australia are required to have 40 per cent supported residents.[113]

4.97 In its inquiry into the aged care system, the Productivity Commission commented on the arrangement by which a 25 per cent discount to the full rate of the accommodation supplement is applied to facilities that do not have more than 40 per cent supported residents. The Commission recommended that this arrangement be abolished. The Government provided in–principle support for measures to ensure a basic standard of residential aged care for underprivileged Australians. However, the Government did not expressly endorse the Productivity Commission's recommendation. Rather, the Government committed the Aged Care Financing

112 Mr Taylor, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, p. 6.

113 DoHA, *Residential care: Supported Resident Ratios*, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-resident-ratios (accessed 16 May 2013).

Authority to examine the ongoing appropriateness of the current supported residents arrangements.[114]

4.98 The Government has committed to increasing the accommodation supplement for supported residents. The committee was advised that from 1 July 2014, the Government accommodation supplement paid to aged care providers for supported residents will increase from approximately $32 per day to approximately $52 per day (2012 prices). The increased accommodation supplement will, however, be available only for 'newly built or significantly refurbished services.'[115] Additionally, for non–supported residents, residential aged care facilities would also have the capacity to increase accommodation fees for refurbished facilities.[116]

4.99 The ANZ supported the proposed new accommodation supplement, describing the supplement as 'a plus for the industry'.[117] However, several residential aged care providers speculated that the rules regarding access to the new supplement would negatively affect the industry.

Capacity to attract 40 per cent supported residents

4.100 The 40 per cent requirement was characterised as a potential constraint on industry development.[118] Grant Thornton submitted that the 40 per cent requirement is as inappropriate as it is unrealistic:

> Across Australia, there are simply not enough financially disadvantaged people to meet this ratio on a national basis and facilities would be penalised in more affluent areas where there is still demand for services by people with limited financial means. This creates a disincentive to accommodate poorer people who need these services.[119]

4.101 Mr Taylor, Aegis Aged Care Group, also questioned whether the ratio requirement is feasible:

> Mathematically, this is not possible. We argued this at the introduction of the Aged Care Act in 1997. If the government is saying that to get the full concessional supplement you need to have more than 40 per cent concessionals, it is not possible for everybody to have 40 per cent concessionals when there is only 21 per cent out there. So you are controlled by what other providers do. In some areas within a region there might be a lot more than 21 per cent concessionals—there might be 30 per

114 Australian Government, *Australian Government response: Productivity Commissions caring for older Australians report*, p. 1.

115 DoHA, answer to question on notice, 7 May 2013 (received 14 May 2013).

116 DoHA, answer to question on notice, 7 May 2013 (received 14 May 2013).

117 Mr Richard Gates, Head of Healthcare Banking, Corporate Banking, Australia and New Zealand Banking Group Ltd, *Committee Hansard*, 2 May 2013, p. 14.

118 See, for example, Mr Robert Curley, Federal Director, Policy Development and Advocacy, and New South Wales President, Association of Independent Retirees, *Committee Hansard*, 2 May 2013, p. 56.

119 Grant Thornton Australia, *Submission 6*, p. 5.

> cent or 40 per cent—but in other pockets of that region there might be very few.[120]

4.102 Mr Graeme Prior, Chief Executive Officer, Hall and Prior Aged Care Organisation, advised that '[o]f the six in New South Wales only one meets the ratio.' Mr Prior further submitted that the issue is of long-standing:

> I have sat in meetings with departmental officials at various times over the last 12 years on this issue. It seems to be an issue that has suffered from an inability to get more traction around the equities or inequities of this issue.[121]

4.103 The committee was also informed that there can be a high degree of reliance on the additional income the supported resident supplement provides:

> It is an issue that could lead to the failing, in some cases, of a facility. Your cost structures are set—they are so high—and your funding from the Commonwealth is under very tight formulas and under extreme scrutiny the whole time. This is an area where a facility could fail at some time in the future if it falls beneath 40 per cent and it gets penalised. That happens all the time.[122]

4.104 The residential aged care providers also questioned the rationale behind limiting the supplement to new or significantly refurbished facilities. Shepparton Villages argued that the requirement to significantly refurbished existing facilities before being entitled to access the supported resident supplement was 'too severe and will not provide financial incentives to upgrade and add beds'.[123]

Implications for supported residents

4.105 Additionally, evidence before the committee indicated a reluctance on the part of some providers to continue offering services to disadvantaged clients. As comments by Rose Lodge revealed, it is evident that there is concern within the industry that the contemplated changes to the pricing framework will make offering services to disadvantaged Australians commercially unviable:

> The lack of retentions and also the limit on the maximum bond that our facility can charge will require Rose Lodge to look towards more Accommodation payments than it currently takes. The impact upon our community is that there will not be as many available places for financially-disadvantaged residents as we will not be able to cross-subsidise their places.[124]

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120 Mr Taylor, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, pp 4–5.

121 Mr Graeme Prior, Chief Executive Officer, Hall and Prior Aged Care Organisation, *Committee Hansard*, 29 April 2013, p. 5.

122 Mr Prior, Hall and Prior Aged Care Organisation, *Committee Hansard*, 29 April 2013, p. 5.

123 Shepparton Villages, *Submission 18*, p. 2.

124 Rose Lodge, *Submission 10*, p. 2.

4.106 UnitingCare Australia also claimed that the reforms may have 'unintended consequences':

> The arrangements for "significant refurbishment" may have unintended consequences for services that currently cater for people on low to moderate incomes. The higher accommodation payment and supplement that applies to significantly refurbished facilities provides an incentive to upgrade facilities. While we support the provision of high quality services to all older people regardless of their income and assets, the traditional resident base of these facilities may no longer be able to afford to access the upgraded services. An inability to adapt to the changes may lead to more service failures.[125]

4.107 Such concerns were raised alongside calls for additional support for disadvantaged Australians. It is a platform of the Living Longer Living Better reforms that older Australians 'will be able to get aged care they want and need, no matter where they live and their financial means.'[126] The committee received submissions that, while supporting the objects of the reforms, argued that increased funding is needed to ensure that aged care residential services are in a financial position to provide services to vulnerable Australians. In particular, it was argued that current funding arrangements are inadequate for facilities that provide residential services for homeless Australians.[127]

Committee view

4.108 The committee notes that most of the issues relating to the supported residents supplement are longstanding policy issues in the sector, dating back to the late 1990s, and only indirectly related to the current bills. It notes that the Aged Care Financing Authority has previously considered some matters relating to the refurbishment criteria, and currently has under review the matter of the threshold of 40 per cent supported residents. It understands that the Aged Care Financing Authority is to report to the government on this by the end of 2013, in advance of implementation of the new higher levels of accommodation supplement.

4.109 The committee acknowledges a number of potential issues to which submitters have referred, particularly

- The 'all or nothing' nature of the 25 per cent discount that takes effect if a facility has below 40 per cent supported residents, with no graduated scales involved; and

125 UnitingCare Australia, *Submission 59*, p. 11.

126 The Hon. Mark Butler MP, Minister for Mental Health and Ageing, Second Reading Speech: Aged Care (Living Longer Living Better) Bill 2013, *House of Representatives Hansard*, 13 March 2013, p. 1835.

127 Mr Bryan Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 25; Ms Netty Horton, Prime Minister's Council on Homelessness, and Territorial Social Program Director, The Salvation Army, *Committee Hansard*, 1 May 2013, p. 26.

- the possibility that refurbishment incentives could lead to higher fees, affecting accessibility to residents on low to moderate incomes.

4.110 However, given that aspects of both existing and proposed policy are designed to address these kinds of problems; mindful that matters are currently being considered by the Aged Care Financing Authority; and noting that most aspects of this matter lie outside the bills; the committee does not have further comments on the issue.

Chapter 5
Bond Levy Guarantee

5.1 The Aged Care (Bond Security) Levy Amendment Bill 2013 (Levy Bill) and the Aged Care (Bond Security) Amendment Bill 2013 propose to amend the *Aged Care (Bond Security) Act 2006* giving effect to the *Living Longer Living Better* (LLLB) aged care reform package.

Bond Security

5.2 Currently under the *Aged Care Act 1997* certain residential aged care services may charge care recipients accommodation bonds for entry into residential aged care services. These accommodation bonds (less any allowable deductions made by the approved provider) are required to be refunded to care recipients when they leave the aged care service.

5.3 If an approved provider becomes insolvent and is unable to refund the accommodation bond balances that are owing to the care recipients, the *Aged Care (Bond Security) Act 2006* provides a mechanism by which the Commonwealth may repay the outstanding bond balances to the care recipients. This scheme is known as the Accommodation Bond Guarantee Scheme (Guarantee Scheme). The *Aged Care (Bond Security) Levy Act 2006* enables the Commonwealth to recover the costs of refunding these bond balances (along with administrative costs) from approved providers via a levy.[1]

5.4 UnitingCare Australia provided some operational insight into this policy measure:

> Under the Accommodation Bond Guarantee Scheme established under the Aged Care (Bond Security) Act 2006, the Commonwealth guarantees the repayment of bonds in the event of default by a Provider. Other Providers holding bonds may be required to pay a levy to the Commonwealth to compensate it for bond payments made under the Aged Care (Bond Security) Levy Act 2006.
>
> …
>
> In the event of a Levy being imposed under the Levy Act, Approved Providers will be obligated to pay the Commonwealth an amount up to the equivalent of the amount incurred by the Commonwealth.[2]

5.5 The committee learnt that there is currently approximately $24.5 million of debt that is outstanding which the Commonwealth could theoretically levy the

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1 Aged Care (Bond Security) Levy Amendment Bill 2013 – Explanatory Memorandum, p. 1.

2 UnitingCare Australia, *Submission 59*, p. 12.

industry to cover.[3] This contingent liability is subject to the Minister's discretion and may be imposed at any time.[4]

Aged Care (Bond Security) Levy Amendment Bill 2013

5.6 As discussed in Chapter 4 of this report, LLLB enables care recipients to elect to pay for their accommodation by periodic payment, lump sum, or by a combination of both. The inclusion of the Levy Bill in the LLLB reform package is to ensure that the bonds of care recipients who enter care on or after 1 July 2014 – and pay either a lump sum Refundable Accommodation Deposit (RAD) or a Refundable Accommodation Contribution (RAC) – have the same protections as those currently in effect.[5]

5.7 The protections provided to the Commonwealth under the current regime are also extended by the Levy Bill to cover any costs that may accrue to the Commonwealth should a provider become bankrupt or insolvent under the LLLB scheme.[6] As clarified by the Explanatory Memorandum:

> In the event that an approved provider becomes bankrupt or insolvent and defaults on their obligation to repay care recipients' accommodation payment balances, the Commonwealth would assess the impact of recovering costs from all approved providers that held such lump sum amounts ten days before the default event declaration was made. The Commonwealth has the legislative capacity to recover costs from approved providers in instalments over a number of years. This will minimise the potential impact on approved providers.[7]

Issues

Levying registered providers and Ministerial discretion

5.8 Although the LLLB does not propose to impose any new levy on industry, the operation of the levy was an important concern of several stakeholders, and as such is considered in this chapter.

5.9 It was put to the committee that it was unfair for the industry to have to cover the debts of failed competitors:

> The primary position is we do not believe it is fair. We do not know whether Qantas paid for Ansett's failure, but in our case we do not believe we should be paying for other people's failures or the failure of government,

3 Professor Kelly, Chief Executive Officer, Aged and Community Services Australia, *Committee Hansard,* 30 April 2013, p. 54; Aged and Community Services Australia, *Submission 67,* p. 27.

4 UnitingCare Australia, *Submission 59*, p. 12.

5 Aged Care (Bond Security) Levy Amendment Bill 2013 – Explanatory Memorandum, p. 3.

6 Aged Care (Bond Security) Levy Amendment Bill 2013 – Explanatory Memorandum, p. 2.

7 Aged Care (Bond Security) Levy Amendment Bill 2013 – Explanatory Memorandum, p. 2.

> if it wants to guarantee bonds, to provide effective prudential monitoring and control. That is the starting point.[8]

5.10 Grant Thornton similarly emphasized the importance of improving the monitoring and evaluation of provider financial performance and prudential management in order to create a sustainable aged care system.[9]

5.11 Although acknowledging that the levy had been in place previously, it was argued by Aegis Aged Care Group that the levy creates uncertainty for industry:

> The levy has always been in place. What is being done now is just a continuation of that. It is just that the industry has never been levied for the defaults that there have been in the past. The government is entitled to levy us based on the bonds that we hold. In answer to the question, if providers go into liquidation and they owe bonds and are not able to pay them back then those bonds will be paid from the guarantee fund. The liquidator will then be getting proceeds to cover the bonds from the sale of the facilities. If facilities do not have bonds and they go into liquidation, there is no obligation on the government or the industry to pay levies for them. It is another thing that brings uncertainty into the industry—that is all.[10]

5.12 Although the Commonwealth has the power to place a levy on industry to recoup the costs incurred through repaying the bonds of a failed registered provider, it is not required to do so. This discretion was an additional cause of concern for some providers. UnitingCare Ageing NSW ACT for instance argued that:

> Our network represents a significant percentage of all accommodation bonds held in Australia—I would expect somewhere in the order of at least five per cent. So when we have a levy which can be applied, if you like, for failure of certain organisations to meet their financial observations, we face the situation that, first of all, we are uncertain as to when those events might occur, we do not know at present what the value of those events might be and we do not know whether the government is going to apply the provisions of the levy or not. I know in our own organisation we currently have a contingent liability of almost $1 million waiting to see whether the government is going to send us a bill…That is just UnitingCare Ageing NSW ACT. If you take that across our network, you are talking probably in the order of $1½ million. In that situation, we do not see that we are funded in order to do that.[11]

5.13 It was suggested by UnitingCare Australia that the legislation should create a 12-month deadline for the Minister to make a decision regarding whether or not the

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8 Mr Teulen, Director, UnitingCare Ageing – New South Wales and Australian Capital Territory, *Committee Hansard*, 30 April 2013, p. 68.

9 Grant Thornton, *Submission 6*, p. 6.

10 Mr Taylor, Director, Aegis Aged Care Group, *Committee Hansard*, 29 April 2013, p. 10.

11 Mr Teulen, Director, UnitingCare Ageing – New South Wales and Australian Capital Territory, *Committee Hansard*, 30 April 2013, p. 68.

Commonwealth would levy industry following the failure of a registered provider,[12] with the rationale being:

> …providers need certainty. They need certainty in terms of timing. They need certainty in terms of the limits of the exposure that they can be exposed to.[13]

Protecting capital of bond-holders

5.14 Aged and Community Services Australia's (ACSA) submission argued that the levy should not be extended to Residential Accommodation Deposits (RAD), but did not explain how the capital of older Australians would be protected.[14]

5.15 The government had previously considered requiring providers to take out insurance on RAD collected to protect residents against capital loss in the case of provider insolvency or bankruptcy.[15] ANZ argued that this policy position was taken as 'Treasury apparently sees this $12 billion RAD liability as an unacceptable contingent liability of Government'.[16] Following a four-week consultation period at the end of 2012, the Department of Health and Ageing (the department) explained:

> …the Government subsequently decided not to pursue private insurance arrangements for accommodation bond/payments. Instead the Bills seek to extend the current Government-backed bond guarantee scheme to cover new types of lump-sum deposits for accommodation being introduced through the reforms.[17]

5.16 The department offered the following rationale for this decision:

> After consulting with industry and consumers the Government has decided not to introduce private insurance arrangements for accommodation payments from 1 July 2014. This decision has been largely based on the lack of availability of a developed private market to insure accommodation payments, creating significant uncertainty around costs for providers and potential flow on costs to consumers.[18]

5.17 The bond guarantee and associated levy was widely regarded by stakeholders as a better system than accommodation bond insurance[19]:

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12 UnitingCare Australia, *Submission 59*, p. 12.

13 Mr Teulen, Director, UnitingCare Ageing – New South Wales and Australian Capital Territory, *Committee Hansard*, 30 April 2013, p. 68.

14 Aged and Community Services Australia, *Submission 67*, p. 27.

15 DoHA, *Submission 92*, p. 28.

16 ANZ, *Submission 94*, p. 3.

17 DoHA, *Submission 92*, p. 12.

18 DoHA, *Submission 92*, p. 28.

19 Alliance Care Services Pty Ltd, *Submission 57*, p. 5; UnitingCare Australia, *Submission 59*, p. 11; COTA, *Submission 87*, p. 18.

> We were gratified to see that the Government has dropped its proposal to require refundable accommodation deposits and contributions to be insured…and has decided instead to extend the Bond Security legislation to cover these new payments.[20]

5.18 Although it appears that the government has made the decision to continue using the prospect of a levy to guarantee future RAD and accommodation bonds, Anglicare raised concerns that the system would be reviewed in 2016:

> While the Government has continued to guarantee repayment of the accommodation deposit and dropped the proposal for the provider to obtain private insurance, the legislation provides for the option of private insurance to be considered in the review. We do not support private sector insurance of accommodation deposits, due to increased risk for the consumer and insurance costs for the provider. We believe all reference to this private insurance should be removed from the legislation and not an issue for consideration in the review.[21]

Committee view

5.19 The committee is of the view that it is important that older Australians who have paid bonds are provided with the protections the community expects, while at the same time ensuring that the aged care industry remains viable. To this end, the committee recognises that the Government has responded to industry concerns and moved away from considering an insurance scheme and retained they levy system.

5.20 The committee does agree that the Government should consider establishing a timeline for making a decision to impose a levy on providers. This would enable providers to operate their businesses with additional certainty regarding their liabilities. However, the committee is aware that business and legal proceedings that culminate in a debt being incurred can be protracted and complex, and timeframes should not be set in place that unnecessarily restrict the Commonwealth's ability to await legal clarity around debts it may acquire.

Recommendation 5

5.21 The committee recommends that the government consider amending the legislation to create a statutory timeline to make a decision regarding whether industry will be subject to a levy to recoup a loss.

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20 National Presbyterian Aged Care Network, *Submission 37*, p. 2.

21 Anglicare, *Submission 75*, p. 3.

Chapter 6
Disability support and special categories of care

6.1 This chapter discusses issues relating to ageing with a disability, the dementia and veterans' supplements, and special segments of society with special needs such as the homeless and lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

Dementia and veterans' supplement

6.2 The Aged Care (Living Longer Living Better) Bill 2013 (Bill) proposes to create two new categories of supplements for individuals in addition to the existing supplements – respite, oxygen, and enteral feeding:

- The dementia supplement; and
- The veterans' supplement.[1]

6.3 This section provides some background information on the proposed operation of these two subsidies, and the following section discusses some of the issues raised by stakeholders in relation to them.

6.4 The Minister for Mental Health and Ageing the Hon. Mark Butler explained that these supplements are in recognition of the greater needs of some veterans and people with mental illnesses:

> These supplements will be available across all care levels for consumers whose care needs might be greater due to dementia, and for veterans with mental health conditions who may also need greater support.[2]

6.5 One of the key reasons that the supplements have been proposed is the growing number of people who are expected to suffer from dementia and other mental illnesses in Australia, and the high costs and challenges of supporting those individuals. The Department of Health and Ageing (the department) reported to the committee that it was anticipated that by 2050 there will be 980 000 people living with dementia in Australia.[3]

6.6 The department's submission explains that the new supplements will apply to both home and residential care from 1 July 2013:

> Approved providers who deliver home care at any level (ie. 1, 2, 3 or 4) will be able to receive a new dementia supplement or veterans' supplement if the care recipient meets certain eligibility requirements. This additional funding will allow home care providers to provide additional and more appropriate care to care recipients with dementia and eligible veterans.

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1 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 52.

2 The Hon. Mr Butler, Minister for Mental Health and Ageing, *House of Representatives Hansard*, 13 March 2013, p. 1835.

3 Ms Huxtable, Deputy Secretary, DoHA, *Committee Hansard*, 2 April 2013, p. 61.

> These supplements will also be available in residential care from 1 July 2013.[4]

Supplements in Home Care

6.7 From 1 July 2013 all existing packaged care places will transition to home care. Extended Aged Care at Home Dementia (EACHD) packages will transition to Level Four home care packages with a dementia supplement.[5] Both the Dementia and Veterans' supplements provide a ten per cent increase on the home care package basic subsidy; level one would attract an additional $750, while a level four recipient would receive an additional $4550 per annum.[6]

6.8 It was explained to the committee that the dementia supplement in home care is to help with the extra costs of dealing with cognitive impairments in the home:

> The dementia supplement in home care has been designed to capture the additional costs of caring for an individual with cognitive impairment. In the current community care system, this extra cost is only acknowledged at the highest level of package in the [EACHD] packages. The proposed supplement will provide important additional funds for individuals at all four levels of packages.[7]

6.9 The committee learnt that:

> Veterans, who have a mental health condition accepted by the Department of Veterans' Affairs (DVA) as associated with their service, will automatically attract the Veterans' Supplement worth 10 per cent of the basic subsidy amount of their Home Care Package...While veterans may be eligible for both the dementia and veterans' supplement, the Approved Provider may claim only one supplement per care recipient.[8]

6.10 In contrast to the Veterans' Supplement for which eligibility will be assessed by DVA, the eligibility assessment for the Dementia Supplement for other care recipients will be the responsibility of an Approved Provider. The assessment must be undertaken by a registered nurse, clinical nurse consultant, or nurse or medical practitioner.[9]

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4 DoHA, *Submission 92*, p. 17.

5 DoHA, *Submission 92*, p. 16.

6 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 2.

7 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 2.

8 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, pp 3, 4.

9 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 2.

Supplements in Residential Care

6.11 Currently the costs associated with sufferers of dementia in residential care are funded through the Aged Care Funding Instrument (ACFI). The committee heard however, that:

> ACFI does not fully capture people with severe and complex behaviours and psychological symptoms associated with dementia and mental illness. Residents with these conditions are a small and difficult to define group and because of their challenging behaviours are less likely to be accepted into residential care facilities. Because of their high care needs, there are demands on resources and difficulties in co-locating these residents with others. They are also more likely to move around the health system in acute and subacute care and mental health facilities because of the complexity of their care needs and the difficulties in placing them in appropriate care.[10]

6.12 The eligibility requirements for the dementia supplement in residential aged care will focus on identifying those residents with severe behavioural and psychological symptoms associated with dementia or mental illness. To attract the dementia supplement, a resident must have a medical diagnosis. The diagnosis must be one of the listed Aged Care Assessment Program (ACAP) mental and behavioural conditions, and may include conditions other than dementia such as schizophrenia and obsessive compulsive disorder.[11]

6.13 Approved Providers are required to review a resident's eligibility for the dementia supplement every 12 months to ensure it is not paid for residents who no longer have severe symptoms because of the progression of their disease.[12]

6.14 Any veteran in residential care with a mental health condition accepted by DVA as associated with their service will attract a veterans' supplement.[13]

Issues raised throughout the inquiry in relation to the supplements

6.15 The inclusion of the dementia supplement in LLLB was widely regarded as a positive reform to recognise the additional requirements of caring for a person with dementia and the special needs of veterans.[14] Alzheimer's Australia (AA) noted for instance: 'I think that Living Longer Living Better is positive, because it recognises

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10 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 6.

11 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, pp 7, 12.

12 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 9.

13 DoHA, *The Dementia and Veterans' Supplements in Aged Care – Consultation Paper*, April 2013, p. 10.

14 Consumers Health Forum of Australia, *Submission 29*, p. 4; COTA, *Submission 87*, p. 9; Mr Shepherd, Professional Officer, Queensland Nurses Union, *Committee Hansard*, 30 April 2013, p. 57.

for the first time the need to recognise the extra costs of dementia care.'[15] AA went on to say:

> The dementia supplement which has been proposed for residential aged care will address long standing concerns that the [ACFI] does not capture the cost of providing care for individuals with the most severe behavioural symptoms.[16]

6.16 The Attendant Care Industry Association noted that: 'The veteran loses out beyond every other person in the community, so I am glad to see them included in this legislation.'[17] National Seniors Australia similarly noted that 'support to veterans through a behavioural and mental health supplement is long overdue'.[18]

6.17 Several stakeholders put it to the committee that additional clarity needed to be provided to stakeholders regarding what the dementia home care and residential supplements covered.[19] AA suggested that this process may be assisted by the use of more appropriate nomenclature:

> There is a need for greater clarity in the sector on the two supplements that are available. It would be prudent for the [department] to rename the supplements according to their purpose instead of referring to both as "dementia supplements". The dementia supplement proposed in community care could be referred to as a "cognitive impairment" supplement. The dementia supplement proposed in residential aged care has the purpose of providing the additional funding required to support individuals with the most severe behavioural symptoms and could be referred to as "severe behaviour" supplement.[20]

6.18 It was pointed out to the committee that not all facilities were appropriately equipped to deal with the requirements of dementia patients:

> We are already seeing a lot of complaints coming through the complaints commission with regards to dementia residents mixing with non-dementia residents in older facilities. Putting a fence around something, and a lock on the gate, does not make that a dementia-specific facility. It is not designed

15 Mr Rees, Chief Executive Officer, Alzheimer's Australia, *Committee Hansard*, 2 April 2013, p. 23.

16 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 1.

17 Ms Merran, Board Director, Attendant Care Industry Association, *Committee Hansard*, 30 April, p. 7.

18 Mr Carvosso, Chairman, National Seniors Australia, *Committee Hansard*, 2 May 2013, p. 29.

19 Dr Morris, Chief Executive Officer, Baptistcare, *Committee Hansard*, 29 April 2013, p. 36; Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 3; Mr Shepherd, Professional Officer, Queensland Nurses Union, *Committee Hansard*, 30 April 2013, p. 58.

20 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 3.

> for their special needs. It is not staffed for their special needs. It is a huge area of unmet need.[21]

6.19 Some stakeholders argued that the dementia supplement should only be available to aged care facilities that are certified as capable of providing the services required for people with dementia and other challenging problem behaviours:

> It is [AA's] view that this supplement should be linked to specific requirements to ensure that facilities have the capacity to provide appropriate care for these individuals for example in respect to regular review of care plans, medication use and environmental design.[22]

6.20 The Queensland Nurses Union argued that the dementia supplement 'should be dependent upon a provider's employment of competent, registered nurses to coordinate and provide the care that is being given by the enrolled nurses and carers.'[23]

6.21 The committee heard the importance of ensuring adequate collaboration between intergovernmental and intersectoral services to ensure a high level of care for people with mental health conditions:

> Part of the difficulties stem from the gap between the aged-care system and the mental health system. Some states do that better than other states. I would agree with you that, in terms of implementing Living Longer Living Better, one of the things that has to be worked on is looking at how the 3,000 or so people who have really severe psychiatric conditions and dementia get assistance from both the aged-care system and the mental health system.[24]

6.22 The committee received a number of submissions that were prepared without the benefit of having access to the *Dementia and Veterans Supplements* consultation paper which was tabled by the department on 2 May 2013. Consequently, a number of key concerns such as the inclusion of other mental illnesses in the Dementia supplement, and assessments of eligibility under the supplements, appear to have been addressed by the department.

Committee view

6.23 The committee notes the general support for the additional supplements to help ensure that older veterans and people with mental illness receive the care that they need and that the community would expect for these people. The committee agrees with the stakeholders who raised concerns regarding the naming of the dementia supplement, noting that it is not sufficiently clear.

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21 Mrs Christensen, Chief Executive Officer, Narrogin Cottage Homes, *Committee Hansard*, 29 April 2013, p. 49.

22 Alzheimer's Australia, answer to question on notice, 2 May 2013 (received 8 May 2013), p. 1.

23 Mr Shepherd, Professional Officer, Queensland Nurses Union, *Committee Hansard*, 30 April 2013, p. 57.

24 Mr Rees, Chief Executive Officer, Alzheimer's Australia, *Committee Hansard*, 2 April 2013, p. 23.

Recommendation 6

6.24 The committee recommends that the dementia supplement be renamed as the *Dementia and Behavioural Supplement,* in both residential and home care.

Special categories

6.25 Special categories are defined in the Allocation Principles. The Allocation Principles help ensure that the people who comprise the special categories have access to aged care services by distributing the available care places according to certain needs. If the Government is of the opinion that particular types of care places need to be allocated in a geographical location, it has the power to redress imbalances by directing the allocation of care type places. That is, the Government, by having the power to allocate funded places and types of funded places, will have direct control of the care places approved providers can provide.[25]

6.26 The Bill amends section 11-3 of the *Aged Care Act 1997* (Act) with the effect that all of the following categories of people will be deemed to be 'people with special needs':

- People from Aboriginal and Torres Strait Islander communities;
- People from culturally and linguistically diverse backgrounds;
- People who live in rural or remote areas;
- People who are financially or socially disadvantaged;
- Veterans;
- People who are homeless or at risk of becoming homeless;
- Care-leavers;
- Lesbian, gay, bisexual, transgender and intersex people; and
- People of a kind (if any) specified in the Allocation Principles.[26]

6.27 The committee has worked with a range of these special needs groups in the course of some of its previous inquiries, most notably care-leavers. It supports the identification of people who may require assistance from time to time in ensuring they are receiving appropriate care in the aged care system. The committee's inquiry into the Commonwealth contribution to former forced adoption practices recognised the traumatic experiences, health issues and socio-economic disadvantage that parents affected by those adoption practices were disproportionately likely to face. Accordingly, the committee would add to the above list parents separated from their children by former adoption practices.

25 Aged Care (Living Longer Living Better) Bill 2013 – Bills Digest, May 2013, p. 26

26 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 10.

Recommendation 7

6.28 The committee recommends that the bill be amended to include parents separated from their children by former adoption practices.

Homelessness

6.29 The committee heard that providing aged-care services for homeless people presented unique challenges around funding, services, access and restrictions.

6.30 The last census by the Australian Bureau of Statistics (ABS) estimated that there were about 14 000 elderly homeless people across Australia. There are currently around 700 beds in residential services specifically for homeless people spread across 16 facilities (10 in Melbourne, three in Sydney, two in Western Australia and one in Adelaide).[27]

6.31 The physical and emotional demands of homelessness mean that people who are homeless need to access care sooner than people who have not experienced homelessness. The head of Wintringham – a large provider of homeless aged-care services – reported to the committee that: 'I have very rarely found any of our homeless clients of 50, or certainly 60 plus, who have not needed some aged care intensively or at least minimally.[28]

6.32 It was reported that 'many of [the elderly homeless] are in situations that would be very surprising and very unacceptable to most of the community',[29] one example of which was provided by Wintringham:

> Our guys, when our outreach workers find them, are often in appalling condition. For example, we recently picked up someone who was sleeping in a urinal because he needed electricity to run his oxygen. It was the only place he could get any, so he slept in a urinal in Carlton for something like two years before he was found…This is a 65-year-old, fairly frail man. Obviously, needing oxygen, he is not in great shape.[30]

6.33 Mr Lipmann, Chief Executive Officer of Wintringham, explained to the committee that homeless people tend to be more expensive to care for due to their lack of access to informal supports, complex medical requirements, and classification under the existing funding structure. As summarised by Wintringham:

> In the situation where a person is homeless and has no ability to make any contribution and has no family members to help them through any of the types of things that we all do for our parents when they are in care—visiting them, taking them out, helping them with purchases and whatever—it becomes very difficult to financially manage that. The other issue is that

27 Ms Horton, Member, Prime Minister's Council on Homelessness, *Committee Hansard*, 1 May 2013, p. 26.

28 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 31.

29 Ms Horton, Member, Prime Minister's Council on Homelessness, *Committee Hansard*, 1 May 2013, p. 26.

30 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 29.

> our guys invariably suffer from different types of aetiologies and symptoms than mainstream.[31]

6.34 The committee heard from the Prime Minister's Council on Homelessness that due to the practical operation of the ACFI, aged-residents who were homeless attract a lower subsidy than residents of some other services:

> The average daily subsidy across the industry as a whole—whether you are large, small, rural, remote or whatever—was $135.84 per resident per day. If you were a homeless service provider in receipt of the viability supplement your average subsidy is $100.18 a day. As Brian has already articulated, that is a $35 difference. The average payment of the homeless viability supplement is $14.55 per day. That brings you up to about the $115 mark.[32]

6.35 The reason for this was explained to the committee as result of the way the effects of homelessness can manifest in residents:

> With regards to the dementia supplement, my mum would be touching you all the time and showing nervous responses like that. They were all claimable because there is constant effort required in looking after a person like that. Our guy would sit for three or four months perfectly calmly and then have a flare-up where he will charge through and knock people over. The police would be called and capsicum spray would be used and he would be locked up. Eventually, he would return. He would be perfectly calm for months afterwards but everyone was on tenterhooks not knowing when the flare-up was going to happen again…All of that tenterhooks time is not claimable under ACFI.[33]

6.36 Although the committee heard that the department has consistently and constructively engaged with providers of services to the homeless, there remains a funding gap between what mainstream and homeless providers receive. The committee heard that this may jeopardise the ongoing viability of services to the homeless:

> I hope, when you read the submission, you do not think I am being a bit dramatic, but we are actually on a slow death. We will not survive with $20 a day less than the industry, given that we have got harder clients to deal with and no bonds to support us. I would suggest that virtually everyone you are going to be speaking to during your inquiry is going to be earning, on average, $20 a day more than us, with far less complex clients. It is a simple fact.[34]

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31 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 25.

32 Ms Horton, Member, Prime Minister's Council on Homelessness, *Committee Hansard*, 1 May 2013, p. 26.

33 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 28.

34 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 25.

6.37 The current funding situation of aged-care for homeless people also seriously limits their ability to access mainstream services, as the following hypothetical that was presented to the committee highlights:

> Could you imagine being the CEO of XYZ aged-care service and you go to the board and say, 'I want to have some homeless people in our organisation.' You end up having a huge discussion with the board about whether homeless people would fit in et cetera, and then they finally say, 'By the way, I'm going to lose $20 or $30 for each one I have.' It is not going to happen. There is no financial incentive. It would have to be a stupid financial decision to do it.[35]

6.38 The committee heard the suggestion that a special category should be created for homeless people due to the specialised arrangements that can be required in order to give them effective care. The committee notes that homeless people and people who are at risk of becoming homeless are included on the list of people with special needs.

Committee view

6.39 The dementia supplement is designed to cover behavioural difficulties in residential care across a number of ailments. While recognising that the behavioural challenges associated with dementia and other mental illnesses are often similar to those exhibited by homeless residents,[36] there are differences as well. There is also a significant shortage of aged care for people experiencing homelessness. Based on the evidence the committee received from Wintringham, it appears that there is a case to ensure that a supplement be provided for residential beds for homeless people. This should help ensure the viability of facilities providing this specialised and challenging form of care.

Recommendation 8

6.40 The committee recommends that the government create a Homeless Supplement.

Sexual diversity

6.41 The committee heard from a number of groups that highlighted the special needs of people who identify as LGBTI.

6.42 Overall, the LLLB reforms were well received, in particular the inclusion of LGBTI elders as 'people with special needs' in the bill:

> First, the fact that lesbian, gay, bisexual, trans and intersex people are now to be included within paragraph 11-3 as people of special needs is to be applauded and indicates that this bill recognises the specific and unique needs of this group, who too often are marginalised and ignored. This is an

35 Mr Lipmann, Chief Executive Officer, Wintringham, *Committee Hansard*, 1 May 2013, p. 32.

36 Mr Rees, Chief Executive Officer, Alzheimer's Australia, *Committee Hansard*, 2 April 2013, p. 23.

> important principle of the bill, and now we need to ensure that it is carried out in practice.[37]

6.43 The National LGBTI Health Alliance (Alliance) noted:

> This [is] an important step in increasing visibility of LGBTI Australians within the aged care sector and improving access to culturally appropriate, inclusive and non-discriminatory services…By including all special needs groups in one location under the legislation, the Parliament is sending a clear non-partisan message that all special needs groups should be viewed to be of equal importance to the aged care sector.[38]

6.44 The operation of the special needs category as it relates to LGBTI people was not entirely clear. The committee heard that :

> It must be remembered that for older LGBTI people it is not always easy to declare their sexuality at a vulnerable time in their lives such as when dealing with aged-care providers. Indeed, they may not wish to do so.[39]

6.45 The committee received evidence that in spite of this advancement of the position of LGBTI people in the aged-care system, barriers to accessing appropriate services remain as a result of past-experience and the availability of appropriate care.

6.46 The committee learnt that many LGBTI people were apprehensive about accessing aged-care and other services. The Alliance explained that for many older LGBTI people much of their life was punctuated by discrimination, harassment, criminalisation, and at times involuntary medical treatment.[40] An example illustrating how a person's previous experiences may influence the way they view institutional care was provided by GRAI;

> [T]his guy was taken by his family and committed to a mental institution. He had electric shock treatment because he was a homosexual. Later on in his life, he was locked up by the police – and so on and so on. This is the age group that we are potentially dealing with and their historical experience is very different from perhaps what you think now. I think that is the main point we would like to get across: that you need to be cognisant and sympathy to what has gone on for those people who were growing up.[41]

6.47 The composition of the aged-care system may contribute to these apprehensions held by some people. As the Alliance explained:

> Around 33% of aged care services are provided by faith-based organisations nationally. However on a local level this ranges somewhere between 25% – 100% in a particular aged care region. Most if not all religious aged care providers are committed to providing high quality

37 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

38 National LGBTI Health Alliance, *Submission 88*, pp 1–2.

39 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

40 National LGBTI Health Alliance, *Submission 88*, p. 2.

41 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

> person centred care irrespective of the client's sexual orientation, gender identity or intersex status. However, many older LGBTI people are fearful of accessing a faith-based provider. This presents a unique problem in aged care, as some LGBTI people will have restricted geographical access to an alternative provider exacerbated by the lack of availability of service in most areas.[42]

6.48 The Alliance's written submission noted that while most faith-based providers have publicly stated their non-discriminatory policies towards LGBTI people – and some have actively sought to engage with LGBTI people – such policies do not provide necessary assurances for LGBTI people to be confident that these services are appropriate for them. As the Alliance explained:

> Many older people have difficulty recognising the distinction between a church body who espoused opposition to their basic human rights over the years and the care arm affiliated with that church. Accordingly…older LGBTI people are hesitant to access faith-based aged care services knowing that such an organisation has a legal right to discriminate against them.[43]

6.49 In 2012 the Government released the Exposure Draft of the Human Rights Anti-Discrimination Bill 2012 (Anti-Discrimination Bill). One of the proposed amendments included in the Anti-Discrimination Bill were provisions to limit the ability of Commonwealth-funded aged care services from being able to discriminate in the provisions of these services.[44] The Senate Legal and Constitution Affairs committee received comments for and against these provisions, but agreed with the approach taken by the Commonwealth, noting that 'it is fundamentally important that all older Australians maintain the right to access aged care services on an equal basis.'[45]

6.50 A number of submissions to the inquiry into the Anti-Discrimination Bill demonstrate why some older LGBTI people may still have cause for concern in accessing faith-based aged care facilities. For example, the Australian Catholic Bishops Conference stated that:

> People considering a move into a church aged care residential facility have an expectation that the particular ethos of that church will be upheld at the facility. If a resident is not prepared to abide by that ethos, the Church aged care facility should have the freedom to refuse to accept that person.[46]

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42 National LGBTI Health Alliance, *Submission 88*, p. 2.

43 National LGBTI Health Alliance, *Submission 88*, p. 3.

44 National LGBTI Health Alliance, *Submission 88*, p. 3.

45 Senate Legal and Constitutional Affairs Legislation Committee, *Exposure Draft of the Human Rights and Anti-Discrimination Bill 2012*, February 2013, pp 62, 94.

46 Senate Legal and Constitutional Affairs Legislation Committee, *Exposure Draft of the Human Rights and Anti-Discrimination Bill 2012*, February 2013, p. 64.

6.51 The Alliance recommended legislating anti-discrimination provisions for aged-care to protect the rights to access of older LGBTI people. This view was also articulated by the GLBTI Retirement Association Incorporated (GRAI), who argued:

> There should be no exemptions given to providers who are receiving government support in their provision of service. This applies specifically to faith-based agencies…We therefore ask the committee to recommend that the Aged Care (Living Longer Living Better) Bill 2013 include provisions that will ensure that faith-based providers of aged care do not have recourse to exemption under the Sex Discrimination Act if they receive Commonwealth support.[47]

6.52 Toward the end of the committee's inquiry, the government tabled a proposed amendment to its Sex Discrimination Amendment (Sexual Orientation, Gender Identity and Intersex Status) Bill 2013. This bill is at the time of writing still under consideration by parliament. Discrimination legislation currently exempts religious organisations from a range of anti-discrimination provisions when they engage in ' an act or practice that conforms to the doctrines, tenets or beliefs of that religion or is necessary to avoid injury to the religious susceptibilities of adherents of that religion'. The proposed amendment would remove religious organisations from the shield of that exemption when they are providing Commonwealth-funded aged care.

Recommendation 9

6.53 The committee recommends that the Senate amend the bill in the terms described in the government's tabled amendment.

Other disabilities

6.54 Older Australians have a higher rate of disability than those of younger age cohorts. The Australian Bureau of Statistics reports that:

> The disability rate increases steadily with age, with younger people less likely to report a disability than older people. Of those aged four years and under, 3.4% were affected by disability, compared with 40% of those aged between 65 and 69 and 88% of those aged 90 years and over.[48]

6.55 The increased prevalence of certain disabilities among the aged is highlighted by figures provided by Vision Australia that quantify the incidence of blindness and low vision in the general population over the age of 60:

- 60-69yo – 3.39 per cent;
- 70-79yo – 5.67 per cent;
- 80-89yo – 9.59 per cent; and

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47 Dr Comfort, GLBTI Retirement Association Inc., *Committee Hansard*, 29 April 2013, p. 52.

48 Australian Bureau of Statistics, *4430.0 – Disability, Ageing and Carers, Australia: Summary of Findings, 2009*, http://www.abs.gov.au/ausstats/abs@.nsf/Latestproducts/4430.0Main%20Features22009?opendocument&tabname=Summary&prodno=4430.0&issue=2009&num=&view (accessed 8 May 2013).

- 90+yo – 14.82 per cent.[49]

6.56 As these figures illustrate, there is a strong correlation between ageing and disability, and any effective aged care system needs to take this fact into account.

6.57 The committee heard concerns that Australians ageing with a disability may fall through the cracks of the embryonic National Disability Insurance Scheme (NDIS) and the *Living Longer, Living Better* (LLLB) reforms:

> Vision Australia submits that, without changes to Living Longer, Living Better reforms, senior Australians who are blind or have low vision…will fall through the cracks between the aged-care system and disability care. We have been unable to identify any meaningful response that will give effect to ensuring that seniors will have access to the specialist disability supports they need to achieve their right to stay safe, independent and active in a manner remotely comparable to that which will be afforded younger Australians under disability care.[50]

6.58 Similarly, the Macular Disease Foundation Australia told the committee:

> Despite repeated statements by the Prime Minister and Minister Macklin as recently as yesterday that the NDIS is for all Australians, the legislation explicitly excludes people who acquire a disability after the age of 65. As such, they will be denied the support services and aids which otherwise would have been provided by the NDIS as an entitlement for life had they acquired the disability at, say, 64 years and 11 months. These people will be required to access support services and aids via the aged-care system and will have to co-contribute to this support.[51]

6.59 Anglicare also questioned how the new aged care regime would address the needs of people over the age of 65 who acquired a disability.[52] The National Council of Social Services (NCOSS) cautioned that:

> [T]here are significant numbers of people with disability who will not have access to the NDIS, and who will instead need to rely on aged care services. Aged care services have historically not been able to support people with non-ageing-related disabilities appropriately, nor are they funded to do so.[53]

6.60 Vision Australia argued to the committee that vision related disability is not currently well supported by the aged care sector, and that the LLLB policy does not seem to address this concern:

> [Aged] care has never adequately provided for the needs of vision related disability, and nothing that we have seen in the bills before this committee

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49 Vision Australia, *Submission 81*, p. 6.

50 Mr Ah Tong, Vision Australia, Policy and Public Affairs Advisor, *Committee Hansard*, 2 April 2013, pp 21–22.

51 Mr Cummins, Research and Policy Manager, Macular Disease Foundation Australia, *Committee Hansard*, 2 April 2013, p. 57.

52 Anglicare, *Submission 75*, p. 3.

53 Council of Social Services New South Wales, *Submission 69*, p. 1.

> promote a shift from this. We are talking about a real paradigm shift about active ageing. Change needs direction, leadership and nurturing, and we do not see it here.[54]

6.61 MND Australia also noted that the aged care sector as it is currently is not equipped to deal with the needs of elderly people with a disability:

> From experience we know that the needs of people living with rapidly progressive neurological diseases such as [motor neuron disease] cannot be met by existing or traditional aged care services or facilities. Even with the proposed improvements and changes to the aged care system the focus remains on addressing needs related to ageing.[55]

6.62 The committee also heard that people who acquire a disability are more likely to be forced prematurely into residential care. A report by the Centre for Eye Research Australia concluded that:

> [Vision] impairment prevents healthy and independent ageing and is associated with the following: risk of falls doubles; [and] risk of hip fractures increased four to eight times.[56]

6.63 The Australian Blindness Forum attributed this to 'the failure of the aged care system to adequately address the specific needs associated with disability.'[57] Given that one of the goals of the LLLB reforms is to allow people to remain in the community for a longer period of time before entering residential care, it would appear that there is a need to consider the impact disability has on the ability of those ageing with a disability to remain in the community.

6.64 Vision Australia's submission argued that government support for vision impaired individuals was inadequate, and emphasized that although 70 per cent of their clients were over 65 years of age, only five per cent of the organisation's operating budget came from government aged-care funding.[58]

6.65 Vision Australia and the Macular Disease Foundation Australia (MDFA) both argued that the LLLB package of reforms should include a low-vision supplement in recognition of the needs of that cohort of individuals.[59]

Committee view

6.66 The committee notes that issues regarding the articulation between the aged care and disability care systems were also raised during the committee's inquiry into

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54 Mr Ah Tong, Vision Australia, Policy and Public Affairs Advisor, *Committee Hansard*, 2 April 2013, p. 22.

55 Motor Neurone Disease Australia, *Submission 27*, p. 2.

56 Vision Australia, *Submission 81*, p. 6.

57 Australian Blindness Forum, *Submission 16*, p. 3.

58 Vision Australia, *Submission 81*, p. 7.

59 Mr Cummins, Research and Policy Manager, Macular Disease Foundation Australia, *Committee Hansard*, 2 April 2013, p. 60; Mr Ah Tong, Vision Australia, Policy and Public Affairs Advisor, *Committee Hansard*, 2 April 2013, p. 22.

the NDIS bills. The Government needs to monitor carefully the adequacy of supports being provided for people ageing with a disability.

Recommendation 10

6.67 The committee recommends that the ministers responsible for Disability Care Australia and the aged care reforms acknowledge the issue identified in the both Senate committee inquiries into these reforms, and urges ministers to continue their work to ensure that the two systems meet the needs of all people ageing with disability.

Chapter 7

Workforce supplement

Introduction

Workforce issues in aged care

7.1 The aged care workforce currently accounts for 2.7% of all employees in Australia.[1] As the number of Australians aged 70 years and older continues to rise, there is a corresponding need for growth in the aged care workforce. The Department of Health and Ageing (the department) noted in 2012 that:

> Based on estimated demand projections and assuming models of care are maintained, there will need to be approximately 827,100 aged care workers by 2050 (up from 304,000 in 2010).[2]

7.2 The need for increased support to boost the capacity of the aged care workforce is recognised across the sector. Aged care workers are traditionally low paid, despite increasing recognition that the work is labour intensive and that a well-qualified workforce is imperative to the delivery of quality aged care. As United Voice noted:

> The effect of low pay in the aged care sector is well-documented in our work. The two key issues of low pay are high staff turn-over, and the difficulties that providers experience in recruiting and retaining staff. …
>
> United Voice members in aged care live the experience of poor pay and conditions every day. The labour market disadvantage they suffer has been well-documented. In addition, the reform process has consistently outlined the challenges the sector faces in attracting and retaining staff as the aged care sector rapidly expands.[3]

Providers also raised the issue of low wages in the sector. UnitingCare Australia noted that:

> UnitingCare Australia has always argued for a better deal for aged care staff who are crucial to quality care and currently poorly paid but committed to caring for older people.[4]

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1 DoHA, *Living Longer. Living Better – Aged Care Reform Package*, April 2012, p. 17 of 44, http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-aged-care-reform-measures-toc (accessed 13 May 2013).

2 DoHA, *Living Longer. Living Better – Aged Care Reform Package*, April 2012, p. 15 of 44, http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-aged-care-reform-measures-toc (accessed 13 May 2013).

3 United Voice, *Submission 84*, p. 2.

4 UnitingCare Australia, *Submission 59*, p. 13.

Workforce supplement

7.3 As part of the *Living Longer Living Better* reform package, Government has announced its intention to introduce a workforce supplement to address critical shortages in aged care workforce. The supplement would to be used to increase wages of employees in aged care. 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.[5]

7.4 The workforce supplement will be available to both residential and home based aged care providers who meet eligibility requirements. While providers are free to choose whether or not to apply for the additional funding, those wishing to access the supplement are required to meet a number of conditions to be considered eligible for the funding. In particular, supplement monies are required to be passed on in full to aged care workers in the form of higher wages. To ensure that all supplement monies are passed onto workers, providers are required either to have an enterprise agreement in place that meets the eligibility criteria, or, if the provider is a home care provider, a residential care provider with fewer than 50 operational places, or a provider of a specified program, they will need to certify that their working arrangements meet the eligibility criteria. These include:

- Writing to employees to signal the intention to apply for the supplement
- Taking part in the Aged Care Workforce Census and Survey
- Minimum wage requirements[6]
- Enhanced Training and education opportunities
- Improved career structures, and
- Improved career development and workforce planning.

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5 DoHA, *Submission 92*, p. 18.

6 DoHA, *Aged Care Workforce Supplement Guidelines – Consultation Draft*, 9 May 2013, p. 6.

Minimum requirement for wage increases:

(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;

(b) wages will 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 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 associated with implementing the supplement are to be borne by individual providers.[7]

7.5 Payments from the workforce supplement will be available to providers from 1 July 2013. The supplement would be paid through the Conditional Adjustment Payment mechanism or amendments to funding agreements, depending upon the type of provider accessing the supplement. The supplement will not be calculated as a proportion of a provider's wages bill, though it is to be used for the purpose of wage increases. According to the Aged Care Workforce Supplement Guidelines Consultation Draft version 2, released on 9 May 2013, the supplement will be calculated as a percentage of either the daily Aged Care Funding Instrument (ACFI) subsidy rate, the daily Resident Classification Scale (RCS) saved rate, the daily residential respite care rate or a default rate for new residents, depending on which applies to the provider. The rate does not include any supplements.[8] The draft eligibility criteria require that a provider must undertake to, if they received the supplement, deliver wage increases above those in their certified agreement (or equivalent) by a minimum of 1 per cent each year to 2015–16 and 0.5 per cent in 2016–17. The supplement must only be used for the purposes of wage increases.[9] The draft guidelines also state that:

> 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…and provision for leave.[10]

7.6 The workforce supplement lies largely outside the scope of the bills, apart from one matter that is addressed later in this chapter. However, its regular discussion during the inquiry warranted some consideration by the committee.

Funding the workforce supplement

7.7 The government has announced its intention to provide up to $1.2 billion over five years to better support the people who work in aged care. This funding will be made available to providers through the Addressing Workforce Pressures Initiative which consists of two parts: the workforce supplement, and an Aged Care Workforce Development Plan to be developed during 2013.[11]

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7 DoHA, *Aged Care Workforce Supplement Guidelines – Consultation Draft*, p. 7. On-costs include superannuation (including the Superannuation Guarantee Charge) and provision for leave.

8 Aged Care Workforce Supplement Guidelines Consultation Draft version 2, 9 May 2013, p. 26.

9 Aged Care Workforce Supplement Guidelines Consultation Draft version 2, 9 May 2013, p. 18.

10 Aged Care Workforce Supplement Guidelines Consultation Draft version 2, 9 May 2013, pp 7, 13.

11 DoHA, *Submission 92*, p. 42.

7.8 In announcing the full package of aged care reforms in 2012, the Prime Minister noted:

> We are deliberately taking the opportunity today to make this announcement well in advance of the Federal Budget, because whilst this policy has some fiscal impacts, it's not a budget measure per se, there's some new funding here, but for the most part, the funding for the package comes from a combination of redirected funding and means testing.[12]

7.9 The new funding for the *Living Longer Living Better* package was approximately $500 million. The majority of new funding is intended to be introduced in 2015-17.[13] Changes to the ACFI, which came into effect on 1 July 2012 as a result of the aged care reform package, make up the largest proportion of redirected aged care funding, comprising $1.6 billion of the total $2.5 billion over five years.[14] The department notes that:

> These changes are designed to bring future growth in care subsidies back to historic growth rates of between 2% to 3% above indexation and to enable funds to be redirected to other elements of the package. These changes have been developed following extensive consultation with the sector since December 2011.[15]

7.10 In the budget announcement for the Addressing Workforce Pressures Initiative, the Government noted that:

> The Aged Care Workforce Compact will be funded by redirecting funds currently provided through the Aged Care Funding Instrument so that the funding claimed by aged care providers better matches the level of care being offered.[16]

7.11 Some providers raised concerns regarding the nature of funding for the workforce supplement. These are discussed below.

Broad support for workforce funding reform

7.12 The committee notes that there has been broad support for wage increases across the aged care sector. There is also broad support for a specific measure directed

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12 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

13 Aged and Community Services Australia, *Submission 67*, p. 7.

14 DoHA, *Aged Care Funding Instrument*, http://www.health.gov.au/acfi (accessed 14 May 2013); and, *Living Longer. Living Better – Aged Care Reform Package*, April 2012, p. 38 of 44, http://www.health.gov.au/internet/publications/publishing.nsf/Content/ageing-aged-care-reform-measures-toc (accessed 14 May 2013).

15 DoHA, *Aged Care Funding Instrument*, http://www.health.gov.au/acfi (accessed 14 May 2013).

16 Commonwealth of Australia, *Budget Paper No. 1 2012-13*, 8 May 2012, pp 1–27.

to wage increases. In February 2012 the National Aged Care Alliance (NACA) published its 'Blueprint for delivering positive aged care reform'.[17] This Blueprint was a consensus document developed by peak provider, health services and union groups. The blueprint recommended that:

> To … prepare a foundation for expanding and developing the workforce there is a need for:
>
> - a bridging supplement for payment of fair and competitive wages for nurses, allied health professionals, personal carers and support staff;
> - the Government, unions and provider representative organisations to sign a Heads of Agreement which ensures the bridging supplement is paid to aged care providers for increased wages; and
> - incorporation of the wage increases into a registered industrial agreement to enable the supplement to be paid to individual aged care providers and ensure it is used solely to pay fair and competitive wages.[18]

7.13 The Blueprint also noted that:

> Wages are only one, albeit major, issue that needs to be addressed. Career structures, training (including in specialist areas such as dementia and palliative care), use of technology and flexible models of care to enhance service delivery efficiency and effectiveness must be considered as part of an overall aged care workforce strategy. To do this the Alliance recommends:
>
> Establishing a Ministerial Aged Care Workforce Taskforce including provider, union and consumer representatives.[19]

7.14 The government set up a Strategic Workforce Advisory Group (SWAG) comprising representatives from providers and employees with the following terms of reference:

> …to develop a Compact for Government endorsement to improve the capacity of the aged care sector to attract and retain staff through:
>
> - Higher wages
> - Improved career structures
> - Enhancing training and education opportunities
> - Improved career development and workforce planning
> - Better work practices[20]

17 National Aged Care Alliance, *Blueprint for Aged Care Reform*, February 2012, p. 1.

18 National Aged Care Alliance, *Blueprint for Aged Care Reform*, February 2012, p. 7.

19 National Aged Care Alliance, *Blueprint for Aged Care Reform*, February 2012, p. 7.

7.15 The final report of the SWAG noted that there was in principle agreement by providers and employee groups on all areas of a workforce compact apart from the mechanism for realising higher wages (enterprise agreements) and the quantum of wage increases.[21] However, because these were two key elements of workforce reform, unions and provider groups could not agree to the compact.[22] Despite the failure of these parties to reach agreement over the compact, the workforce supplement retains the majority of features that were agreed to during negotiations. United Voice noted that:

> After six months of negotiation for a Compact, key employer groups removed their support for the final outcome. This was evidenced by a letter sent from employer groups to government in January 2013…
>
> Despite this letter, the evidence stands that there was strong support for the vast majority of the elements of the Supplement late into the negotiation process. This is evidenced by the nature of the final terms and conditions. Many of the key terms and conditions reflect status quo terms and conditions in the sector. During the negotiations, these terms and conditions were nominated and agreed by key employer representatives. …there was strong support from the clear majority of employers for a large proportion of the terms and conditions enclosed in the Compact, now known as the Supplement.[23]

7.16 The committee was presented with a range of view about the supplement itself. Concerns raised by various provider groups over aspects of the supplement are outlined below.

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20 Ms Anne Gooley, Fair Work Commissioner, *Final Report of the Strategic Workforce Advisory Group*, 19 October 2012, p. 1 of 10, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/758F9F05D1812E2CCA257AFB0014F049/$File/Commisioner-Gooley-Final-Report-Workforce-Compact.pdf (accessed 15 May 2013).

21 Ms Anne Gooley, Fair Work Commissioner, *Final Report of the Strategic Workforce Advisory Group*, 19 October 2012, pp 4–6 of 10, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/758F9F05D1812E2CCA257AFB0014F049/$File/Commisioner-Gooley-Final-Report-Workforce-Compact.pdf (accessed 15 May 2013).

22 Ms Anne Gooley, Fair Work Commissioner, *Final Report of the Strategic Workforce Advisory Group*, 19 October 2012, p. 2 of 10, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/758F9F05D1812E2CCA257AFB0014F049/$File/Commisioner-Gooley-Final-Report-Workforce-Compact.pdf (accessed 15 May 2013).

23 United Voice, answer to question on notice, 2 May 2013 (received 13 May 2013).

Concerns over funding of the workforce supplement

Concerns about redirection of funding from ACFI monies

7.17 A number of organisations expressed disappointment that the workforce compact was to be funded through redirected aged care funding, and not 'new money'. In particular, some residential aged care providers considered that the redirection of ACFI funds to other areas of aged care, including the workforce supplement, could cause financial hardship, particularly for some smaller and rural or regional providers. Catholic Health Australia claimed that:

> The Workforce Supplement in residential care will be created by quarantining a percentage of the forward estimates for residential care subsidies. These estimates are based on a reduction in growth rates to be achieved by changes to the Aged Care Funding Instrument (ACFI) which applied from 1 July 2012 ie reducing the per capita annual growth in care subsidy per resident to 2.7% real per annum. The Workforce Supplement is inclusive of the reduced forward estimates for residential care subsidies.[24]

7.18 The Western Australian branch of Aged & Community Services Australia argued that:

> To take away funds from ACFI, which essentially belong to our residents, and then transfer them to workers, is wrong in principle. And it is particularly wrong in an environment where a consumer direction will be the future. Also it is futile, because robbing Peter to pay Paul does not generate more money in the system, sustainably, to pay higher wages.[25]

7.19 Southern Cross Care (Victoria) were concerned that:

> This real reduction in ACFI care subsidy will have a direct impact on our ability to maintain service levels to residents.[26]

7.20 The committee notes that the government has been up-front in announcing that the aged care reforms, including the workforce supplement, are to be funded for the most part from redirected aged care funds and income testing. Reducing the growth of the ACFI has contributed to the pool of aged care funds to be redirected into the aged care reform package. While changes to the growth of the ACFI may have financial implications for some residential care providers, this seems to be a separate issue to the affordability of implementing higher wages through the workforce supplement. Concerns over the affordability of the supplement for aged care providers are dealt with in the following sections.

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24 Catholic Health Australia, *Submission 55*, p. 7, and Attachment A, 'The ACFI Compact Money Trail'.

25 Mr Raymond Glickman, Aged and Community Services Association, Western Australia, *Committee Hansard*, 29 April 2013, p. 35.

26 Southern Cross Care (Victoria), *Submission 39*, p. 2.

Concerns that the compact is not 'fully funded'

7.21 On-costs arising from wage increases under the workforce supplement are to be borne by employers accessing the additional funding. The department notes that these can be covered through resulting productivity gains arising from wage increases and improved conditions, and in decreased staff turnover.[27] Providers, however, were concerned that, combined with the potential loss in revenue due to the reduction of ACFI monies, the imposition of on-costs would result in an added burden that would particularly cause difficulties for smaller providers to meet the criteria of the supplement. A number of providers wanted the supplement to be 'fully funded', and to cover on-costs associated with wage increases. Aged and Community Services Australia (WA), argued that:

> (The workforce supplement) should be rejected because the proposition is not fully funded. So, in addition to recycling existing funds, so we have no more money, it does not cover on-costs. That includes numerous expensive expenditure items that will be part of the overall deal. Our calculations suggest that the cost will outweigh the income by two to one. That seems extraordinary, but it is true once you add up all the elements. We have an example from the bush, where to gain $17,000 will cost $30,000.[28]

7.22 Narrogin Cottage Homes also asserted that they are not considering signing up for the supplement as they believe they will be unable to afford the on costs associated with the higher wages afforded by the supplement:

> I am very happy to let the committee know right now that we will be one of those who will not be signing up for the workforce supplement. We cannot afford it … in my particular case, if you look at our on costs, I think you will find that it is 3.25 for one. I am running at a loss now. I am hoping we will balance the books next year. I cannot afford anything else.[29]

7.23 Hall and Prior Aged Care Organisation had initially considered that signing up to the supplement would be cost neutral to their organisation:

> Our high-level analysis of the Workforce Compact has indicated that it will be cost neutral to us in both WA and New South Wales after taking into consideration all employee entitlements and oncosts. This assumes the workforce supplement continues beyond the 2016-17 financial year. It will be cost neutral to us as we have a very high level of resident acuity and already pay wages well above the margin for the relevant award rates… in

27 DoHA, *Submission 92*, p. 44.

28 Mr Raymond Glickman, Aged and Community Services Association, Western Australia, *Committee Hansard*, 29 April 2013, p. 35.

29 Mrs Julie Annette Christensen, Chief Executive Officer, Narrogin Cottage Homes, *Committee Hansard*, 29 April 2013, p. 42.

> summary, we thus support the Workforce Compact and we feel it will invigorate the aged-care workforce.[30]

7.24 Shortly before the committee was to table its report, Hall and Prior representative Graeme Prior wrote to the committee stating:

> At the time of my appearance before the Senate Committee I indicated that our initial modelling was that the Workforce Supplement would be cost neutral to our organisation. However, based on the information in the consultation paper, this is no longer the case. It appears that if we were to sign up to the Workforce Supplement it would cost our organisation $2.1 million over the next four years (in addition to the annual financial increases passed on to employees).

7.25 In answers to questions on notice, United Voice argued that a large proportion of on-costs that providers associate with the supplement will already have been accounted for under existing plans for wage increases either under an enterprise agreement, or under the current award for aged care workers:

> …aged care providers, on average, are providing wages at a margin over the award of 3.99%. United Voice assumes that most, if not all, providers are competent and execute their fiduciary duties well, and thus would plan to provide salary increases for their staff along with the attendant on-costs forming part of their calculations.
>
> Average Weekly Ordinary Time Earnings over the last 5 years and recent Fair Work Commission minimum wage adjustments have been running between 3% and 4.5%. We therefore assume that the majority of aged care providers (through their internal budget planning processes) are well equipped to contend with the salary increases' (and associated on-costs') component of the Supplement – that is, the requirement to provide a minimum of 2.75% per year or the Fair Work Commission minimum wage adjustment, whichever is higher.[31]

7.26 United Voice also considered that on-costs can be borne by employers through increases in productivity and decreased turnover:

> In terms of the wages' on-costs associated with the Supplement funding, there are productivity gains to be made through reduced staff turnover and decreases in the costs of utilising agency staff by providers. In terms of personal and community care and support staff, United Voice estimates, given the assumptions made above, that the effect of the Supplement proportion of salary on-costs to be approximately 0.25% - 0.3%. These figures do not take into consideration efficiencies gained from reduced turnover or a reduction in the use of agency staff.

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30 Mr Graeme Prior, Chief Executive Officer, Hall and Prior Aged Care Organisation, *Committee Hansard*, 29 April 2013, p. 1.

31 United Voice, answer to question on notice, 2 May 2013 (received 13 May 2013), p. 7.

> With the average provider having a net profit margin of approximately 8%, United Voice believes that the on-costs for the Supplement funding component can be met by aged care providers. The assertion made in relation to providers putting in $3 for every $1 of funding from the Workforce Supplement does not make sense in light of the calculations performed above.[32]

7.27 A number of providers told the committee that they could not be sure of the effects of the supplement until they had seen more detail about its requirements. The committee notes that comprehensive draft guidelines were released for consultation with the sector after the conclusion of hearings for this inquiry.[33]

7.28 There appeared to be some confusion about the on-costs associated with accessing the workforce supplement. Based on the evidence available, it appears that in referring to 'on costs', some providers were including wage increases required to be made in order to qualify for the supplement. These are not 'on costs', but the consequences of the policy intention on which the rules governing eligibility for the supplement are based: namely, to increase wages in the sector.

Committee view

7.29 The committee notes that consultation around the Workforce Supplement Draft Guidelines is ongoing.[34] The committee agrees on the importance of increasing wages in the sector. There was mixed evidence about the costs to providers of securing the supplement.

7.30 The committee acknowledges the issues around the workplace supplement and the link to increased wages, and notes the need for continuing discussion around the implementation in the workplace, and the full payment of entitlements.

Recommendation 11

7.31 The committee recommends that the government examine whether it may be appropriate to revise the Supplement Guidelines to permit in some circumstances the use of the workforce supplement in meeting employee entitlements.

Intervention in industrial agreements

7.32 As discussed above, to access the supplement, providers must have an enterprise agreement, or working arrangements in place that meet the conditions of the

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32 United Voice, answer to question on notice, 2 May 2013 (received 13 May 2013), p. 7.

33 These guidelines are available at: http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/270C98226F770308CA257B5D000770AB/$File/Workforce%20Supplement%20Guidelines_Version2.pdf.

34 DoHA, Attachment 6, answer to written question on notice, (received 14 May 2013), p. 2.

supplement. This is to ensure that funding from the workforce supplement is passed on in full as higher wages for aged care workers. The Department noted that:

> The mechanism which was identified in the NACA blueprint was to use an industrial agreement as a mechanism to ensure that that payment flowed through.[35]

7.33 Some providers objected to this choice of mechanism, claiming that it went against a principle of government not intervening into industrial agreements. Catholic Health Australia argued that:

> …behind this there is also a much bigger policy issue: is there a role for governments in setting wage rates? Current policy is that wage levels should be negotiated by parties at the local level, using a legislated industrial framework and taking into account local operating circumstances. We think that compromising this policy principle is also a factor affecting our members' attitude to the supplement. If a government wishes to increase wages, it should do so by proposing increases in the various aged-care awards and funding the increases it seeks.[36]

7.34 Some providers were also concerned that prescribing enterprise agreements as a condition to receiving the workforce supplement would have negative consequences for local arrangements and the flexibility that local arrangements can provide. ACSA argued that:

> The funding arrangements as proposed place wage determination mechanisms in a national industrial framework to the exclusion of allowing the continuation of negotiations in the 'local' context. This compromises individual negotiation within workplaces, informed by local circumstances.[37]

7.35 Some homecare providers also expressed concern over a potential loss of flexibility when using enterprise agreements prescribed under the supplement guidelines. KinCare were concerned that:

> There is more cost to an organisation in the home care sector around loss of flexibility than there is around increase age (sic) rates for the most part. When you start to talk about negotiating enterprise agreements, the more flexibility that you can build into them… the easier they are to manage. Where we find that a lot of costs are built into the system is around things like minimum starts and the way that mileage, or travel time, might be included and the way that breaks have to be applied to work, and so on. It can add quite a significant percentage to the total cost of the workforce.

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35 Ms Rosemary Huxtable, Deputy Secretary, DoHA, *Committee Hansard*, 2 May 2013, p. 66.

36 Mr Nicholas Mersiades, Director, Aged Care, Catholic Health Australia, *Committee Hansard*, 2 May 2013, pp 39–40.

37 Aged and Community Services Australia, *Submission 67*, p. 17.

> …Our analysis at the moment would indicate that the amount of money that is being provided as part of the Workforce Compact is not compensating for the increased cost across the workforce. Of course, there is the added consideration of needing to negotiate with a third party, which will have a third party's agenda, rather than working with a workforce that has an agenda which is related to the organisation.[38]

7.36 As shown above, however, some providers recognised the opportunities for flexibility inherent in enterprise agreements as opposed to the modern award process. KinCare also noted that:

> As the award stands at the moment, we have lost some flexibility as part of the modern award process. We have been supportive of the award modernisation process because we believe that in the long term it makes sense for us to have a national structure. But it has been a fairly expensive process for a lot of organisations to work through as they have transitioned from the old state based awards, which were built around the industry, to a much more standard template, which has been applied across industries without necessarily understanding the unique nature of what happens in the community care sector.
>
> Senator FURNER: Surely that may lead to an incentive for you to wish to consider enterprise bargaining, to come up with greater flexibility, if you have issues around that in the modern award?
>
> Mr Howie: We are certainly considering that.[39]

7.37 Union groups were adamant that the supplement and its requirement for enterprise agreements preserved and enhanced flexibility for aged care employers and workers. United Voice noted that:

> The requirements to receive the Supplement are not prescriptive in terms of mandated outcomes, or prescribed content and wording for enterprise agreements or equivalent. Instead, the Supplement provides a framework through enterprise bargaining - and it is up to the local workplace level discussions between employers and employees to determine in what form the requirements will be met in their workplace.
>
> Evidenced by the uptake of workplace enterprise agreements in the aged care sector, the flexibility of these bargains indicates a preference for this method of industrial regulation over the industry award… Employer evidence to the Aged Care Low Paid Bargaining hearings indicate "bargaining under the act [Fair Work Act] is actually flourishing…" The Compact's requirements are such that there remains workplace flexibility as to how the workplace will best meet these commitments. This ensures that the enterprise agreements or equivalents are specific to the local circumstances and are flexible to meet the needs of the workplace.[40]

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38 Mr Jason Howie, Chief Executive Officer, KinCare, *Committee Hansard*, 30 April 2013, 25.

39 Mr Jason Howie, Chief Executive Officer, KinCare, *Committee Hansard*, 30 April 2013, 25.

40 United Voice, answer to question on notice, 2 May 2013 (received 13 May 2013), p. 5.

7.38 Union groups and the Department also pointed out that the use of enterprise agreements as the mechanism for delivering increased wages is based on the NACA Blueprint, which was supported by all major organisations across the sector. In developing its Blueprint for Aged Care Reform, NACA also published a number of papers to provide additional advice to government on features of the *Living Longer Living Better* reforms. In its paper on the aged care workforce, NACA noted that there:

> needs to be a transparent, accountable and enforceable mechanism to deliver fair and competitive wages through the Government funded bridging supplement.
>
> Use of existing industrial processes, such as certified/enterprise agreements, are the most appropriate mechanism to ensure that fair and competitive wages are established and maintained.
>
> …
>
> While other options were identified the Alliance believes the mechanism it proposes is the most effective way to deliver fair and competitive wages because it:
>
> - is consistent with the existing system of enterprise bargaining in which unions and providers are already engaged;
> - clearly ties increased funding to increased wages and will hold providers accountable for the flow on to workers; and
> - provides certainty for providers that funding will be made available.[41]

7.39 The committee considers that providers were given an opportunity to raise in principle objections to tying workforce funding to industrial agreements during the development of the NACA Blueprint.[42] Given both the prevalence of enterprise agreements across the sector, and the provision for smaller residential providers and home care providers to satisfy the requirements of the supplement by ensuring employments arrangements meet the minimum requirements, the committee does not consider the workforce supplement to be an unreasonable interference by government into industrial relations between employers and employees. The committee rejects the suggestion by ACSA that the policy would 'place wage determination mechanisms in a national industrial framework to the exclusion of allowing the continuation of negotiations in the 'local' context'. To the contrary, the policy explicitly supports bargaining at the enterprise level. At the other extreme were suggestions that if the government wished to improve wages it should do so through award increases that it should then fund. Apart from being unrealistic, this would go directly counter to most providers' preference to maintain enterprise bargaining, and also be inconsistent with one of the main policy intentions behind the reforms (supported by all major stakeholders), which is to ensure the financial sustainability of the sector.

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41 National Aged Care Alliance, *Aged Care Reform Series – Workforce*, February 2012, pp 4–5.

42 See generally, comments on consultation in Chapter 2 of this report.

Claims regarding union recruitment

7.40 During the inquiry, an article was published by *The Australian* newspaper which claimed that:

> …unions have been recruiting on the back of government-funded pay-rise offers in childcare and aged care, telling workers to expect pay rises of up to $10,571 a year under the government schemes as long as they follow a three-step plan that starts with joining a union'.[43]

7.41 Departmental representatives were asked about the newspaper article and the idea that a pay rise might be linked to union membership:

> Ms Huxtable: …I believe that there might be a link being drawn between eligibility for the supplement and union membership which I do not believe is there, and I do not believe it is in the material that we have produced.
>
> Senator FIERRAVANTI-WELLS: You have to join and you have to have an EBA—
>
> Ms Huxtable: Sorry, Senator, but I think they are two somewhat separate things...For facilities of a certain size an EBA would need to be in place which covers the terms of the supplement. But an EBA can cover the extent of a workforce. You do not have to be a member of a union. That is my understanding.[44]

7.42 Union representatives were also asked about these claims. They rejected the statements in the article, both in respect of the magnitude of possible pay rises and the claim that unions had suggested securing a pay rise was contingent on joining. Union officials stated that they began bargaining processes by seeking to recruit members, but made no suggestion that a pay rise was contingent on membership:

> *The Australian* seeks to attack United Voice on the basis that it is starting the enterprise bargaining process by asking workers to join the union. I find it hard to understand this criticism. Our credibility and capacity depends on the number of members we have. In bargaining and representation, we take our instruction from members - no-one else. Our resources come from the membership dues of members - no-one else. How then is it expected that we would launch an enterprise bargaining process? Convene meetings of non-members? Ask cleaners, security guards and health care workers to pay to have bargaining done for a group of non-members in aged care? Pretend to the employers that we can speak authoritatively about the concerns of their employees when we represent no-one? The idea is ridiculous. Rule 1 of any collective bargaining process is to first establish a collective. That is all we are doing. To then be attacked as opportunistic or in some way

43 Sid Maher, 'Butler hits aged-care "stuff-up"', *The Australian*, 26 April 2013, p. 1.

44 *Committee Hansard*, 2 May 2013, pp 65–66.

> corrupt when we ask workers to join and be represented at the bargaining table simply betrays the animus of our critics.[45]

7.43 The Nurses Federation representative stated:

> We have been bargaining in the aged-care industry for 20 years. As we pointed out in our submission, most nurses in the aged-care sector are covered by agreements. We do not discriminate between members and non-members in that process. The fact is, Senator, that most nurses in aged care are already in the union and always have been.[46]

7.44 On the quantum of possible pay increases, witnesses indicated that the figure in the newspaper report was not relevant to aged care, with correspondence from United Voice indicating how the misapprehension may have arisen: 'the article in the *Australian* mistakenly links the $10,571 package in the Early Childhood Education and Care Sector with the Aged Care settlement'.[47]

Inclusion in the list of primary supplements

7.45 The workforce supplement is included in the list of primary supplements for residential providers and homecare providers in new sections 44(5) and 48(3) of the Act. Residential aged care providers have expressed concern that the inclusion of the workforce supplement in this list of primary supplements could lead to their clients contributing to the payment for the supplement. ECH, Resthaven and Eldercare claimed that:

> The effect of this is that the workforce supplement will be taken into account in applying the new means test to the calculation of means tested care fees in residential care and the income tested fee for home care. As a result, if a care recipient's care subsidy reduction exceeds the sum of the basic subsidy and all primary supplements applying to that care recipient, they will be fully subsidising the workforce supplement.
>
> …it now appears that a proportion of care recipients will be subsidising the government's workforce supplement (along with all other primary supplements potentially), on top of the cut to ACFI funding.[48]

7.46 During a committee hearing in Perth, ECH explained these concerns further:

> If a person is of wealthier means, the means test could result in them paying for their care or having their care subsidy reduced by an amount that includes all of the primary supplements. Again, we are talking about wealthier people but, nevertheless, they would contribute to the cost of the workforce supplement by virtue of the fact that it is a primary supplement.

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45 United Voice, answer to question on notice, 2 May 2013 (received 13 May 2013), pp 10–11.

46 Mr Nick Blake, Australian Nursing Federation, *Committee Hansard*, 2 May 2013, p. 10.

47 United Voice, answer to question on notice, 2 May 2013 (received 13 May 2013), p. 11.

48 ECH, Resthaven and Eldercare, *Submission 41*, p. 2.

> We had not understood that that would be the case; we had understood the government's position was that the workforce supplement would be fully funded from the $1.2 billion that is being redirected from the Aged Care Funding Instrument subsidy to providers. Although it may not be a huge amount of money, we were a bit surprised that some residents could actually end up contributing to the cost of the supplement as well.[49]

7.47 The other supplements included in the list of primary supplements in the Bill are the respite supplement, the oxygen supplement, the enteral feeding supplement, the dementia supplement, and the veterans' supplement. Unlike the workforce supplement, each of these primary supplements relates directly to an individual's care requirements. The workforce supplement is not targeted to individual care recipients, but addresses the broader systemic issue of aged care workforce capacity. The above providers recommended that the workforce supplement be removed from the list of primary supplements in the Act and transferred to a list of 'other supplements', which are not included in the calculation of the care subsidy reduction.[50]

7.48 It appears clear that classifying the workforce supplement as a primary supplement will lead to certain residential care recipients, who are subject to means testing, paying increased fees. At this stage, however, it is difficult to determine the financial impact on fees payable by individuals. The detail as to when the supplement will apply and how it is to be worked out will be contained in the new 'Subsidy Principles' and legislative instruments to be made by the Minister. As the new Subsidy Principles and legislative instruments are not available at this time, it is currently difficult to predict the financial impact of including the workforce supplement in the list of Primary Supplements.

Committee view

7.49 The committee considers that the workforce supplement should be retained as an important element of the *Living Longer Living Better* aged care reforms. There is a pressing need to ensure that an adequate and capable aged care workforce exists to meet the present and future requirements of an ageing population. The committee also accepts that reform in the aged care system must be sustainable. In this regard, the committee therefore does not consider that the workforce supplement is less viable because it is being funded from monies that were previously directed to other areas of aged care. While some residential care providers may experience a decrease in revenue from changes to the ACFI, the committee considers this to be a separate issue to the viability or affordability of the workforce supplement.

7.50 The committee has considered arguments raised around costs that might be incurred by providers seeking to access the supplement. While accepting that there are

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49 Mr David Kemp, Chief Executive's Adviser, ECH Inc, *Committee Hansard,* 29 April 2013, pp. 47–48.

50 ECH, Resthaven and Eldercare, *Submission 41*, p. 3.

costs involved in negotiating enterprise agreements, there are also benefits, and in fact negotiating to secure efficiency gains is one of the main purposes of bargaining. The committee does not consider the choice of these as the main mechanism for delivering supplement monies to be either an inappropriate intervention into industrial arrangements, or an undue burden on providers. The extent of the aged care workforce covered by enterprise agreements is considerable, and the NACA recommendation discussed above demonstrates that, until recently, the mechanism had support from providers. The committee also considers that there are adequate concessions made for non-residential and smaller residential providers, who are able to certify that they meet the requirements of the supplement by other means.

7.51 The committee recognises that some providers may choose not to access the supplement, and it is conceivable that these will be smaller, less profitable organisations that may already face financial difficulties across their operation. However the committee has also received evidence that the majority (up to two thirds) of the aged care workforce is covered by enterprise agreements, and that the majority of these agreements more than meet the requirements in the compact. According to United Voice, most of the compact/supplement requirements actually reflect current practice, due to the consensus nature of the consultation process involving NACA and SWAG. The committee also heard evidence that a considerable number of providers already pay wages that are well above award rates. These providers will also find it easier to meet the requirements of the supplement.

7.52 It is also important to note that the supplement is an initial, interim, measure to address workforce pressures in aged care. The recommendation from the NACA Blueprint was to put in place a bridging supplement to immediately begin to address wage concerns, and then work towards longer term reform options. This is the structure that has been followed in the Addressing Workforce Pressures Initiative, which first introduces the workforce supplement, and then provides for the Aged Care Workforce Development Plan to be developed during 2013, to address longer term, systemic issues. The supplement is a bridging measure to begin to attract and retain aged care workers before engaging in 'longer-term work that must be done on a wages structure that will allow a quality workforce to grow'.[51] During the SWAG process it was noted that:

> While some participants expressed a preference for some targeting of the compact monies, the unions and providers agreed that the monies should flow to all employees equally as it would be difficult to develop an

51 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

> enterprise agreement which was supported by all employees at the workplace if some groups were disadvantaged vis a vis other groups.[52]

7.53 The committee expects the Addressing Workforce Pressures Initiative to specifically address workforce shortages for individual smaller, regional, rural and remote providers through the Aged Care Workforce Development Plan. In the meantime, regional, rural and remote providers are able to access specific funding through the viability supplement.

7.54 Finally, the committee notes the argument made for removing the workforce supplement from the list of primary supplements, and placing it in the list of 'other supplements' which do not count towards a reduction in the ACFI care subsidy. While the workforce supplement appears different in nature to the other proposed primary supplements in new section 44-5 of the Act, the committee accepts that care recipients who can afford to, should contribute to wage increases for the workers who care for them. This accords with the general emphasis on revised income testing throughout the *Living Longer Living Better* reform package. The use of income testing is designed to ensure that the aged care system 'recognises a simple reality that those who can support themselves, and contribute a bit more should, and that we must look after the needs of those who can't'.[53] This will be the principal effect of including the workforce supplement in the bill, and as such should be supported.

Recommendation 12

7.55 The committee recommends that references to the workforce supplement be retained as they appear in the proposed legislation.

52 Ms Anne Gooley, Fair Work Commissioner, *Final Report of the Strategic Workforce Advisory Group*, 19 October 2012, p. 3 of 10, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/758F9F05D1812E2CCA257AFB0014F049/$File/Commisioner-Gooley-Final-Report-Workforce-Compact.pdf (accessed 15 May 2013).

53 The Hon. Julia Gillard MP, Prime Minister of Australia, the Hon. Mark Butler MP, Minister for Mental Health and Ageing, 'More choice, easier access and better care for older Australians', Media release, 20 April 2012.

Chapter 8
Governance

8.1 From 1 January 2014 there will be two Commissioners undertaking functions under the Aged Care Act 1997 – the existing Aged Care Commissioner (ACC) and the new Aged Care Pricing Commissioner (ACPC).[1]

8.2 From 1 January 2014 accreditation of aged care services will be undertaken by the new Australian Aged Care Quality Agency (Quality Agency) which will replace the existing Aged Care Standards and Accreditation Agency.[2]

8.3 The Aged Care Financing Authority (ACFA) was established in August 2012.[3]

Aged Care Commissioner

8.4 The Aged Care Commissioner (ACC) currently has the power to examine complaints about the conduct of the Quality Agency relating to its responsibilities under the Accreditation Grant Principles 2011, or the conduct of a person carrying out an audit or undertaking an assessment contact under those Principles.[4] The ACC can also review certain decisions and processes made under the Aged Care Complaints Scheme and make recommendations to the Secretary of the Department.

8.5 As part of the establishment of the new Quality Agency, the ACC will not review complaints about the conduct of Quality Agency employees in relation to its responsibilities under the Accreditation Grant Principles.[5] However, under the proposed provisions the ACC will be able to:

- examine complaints about the Quality Agency's processes relating to accrediting residential care services and conducting quality reviews of home care services (as described in the Australian Aged Care Quality Agency Act 2013); and
- examine, on the Aged Care Commissioner's own initiative, the Quality Agency's processes relating to accrediting residential care services and conducting quality reviews of home care services.[6]

Following any such examination of processes the ACC may make recommendations to the CEO of the Quality Agency.[7]

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1 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 30.

2 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 26.

3 DoHA, *Submission 92*, pp 9,10.

4 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 29.

5 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, pp 29–30.

6 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 26.

8.6 As is the case now the Commissioner may not consider a complaint about the merits of a particular decision because there will be separate processes for reconsideration of accreditation and review decisions along with opportunities for providers to seek review by the Administrative Appeals Tribunal.[8]

8.7 The Aged Care Commissioner was supportive of the change.

8.8 From 1 July 2013 the ACC power under the Complaints Principles will be increased to give the Commissioner greater power and independence in relation to examining decisions made by the Aged Care Complaints Scheme's officers.

> Specifically the Commissioner will be able to direct the Scheme to:
>
> - undertake a new complaints resolution process taking into account the Commissioner's views following an examination of a Scheme decision;
> - require the Scheme to provide the Commissioner with information requested in respect of a matter under examination; and
> - provide a report directly to the relevant Minister if the Commissioner is not satisfied with the response of the Scheme in undertaking a new complaints resolution process.[9]

The Commissioner's current powers to examine complaints about the Scheme's processes for handling matters will remain unchanged.[10]

8.9 The Aged Care Commissioner was very supportive of the changes:

> In my view, enhancing the powers of the Aged Care Commissioner, who is independent from the Department-based scheme will give the public greater confidence that it is worthwhile exercising their appeal rights.[11]

Committee View

8.10 The Committee supports the draft amendments to the *Complaints Principles 2011* to strengthen the powers of the Aged Care Commissioner.

Aged Care Pricing Commissioner

8.11 From 1 July 2014 the Aged Care Pricing Commissioner (ACPC) will be established to make decisions on certain pricing issues within the legislative framework and broad policy framework set by the Minister.[12] These include:

- approval of extra service fees

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7 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 29.

8 DoHA, *Submission 92*, p. 20*;* Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 29.

9 DoHA, *Submission 92*, p. 18.

10 DoHA, *Submission 92*, p. 18.

11 Office of the Aged Care Commissioner, *Submission 5*, p. 2.

12 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 2.

- approval of accommodation payments higher than the maximum amount determined by the Minister
- other functions as determined by the Minister or contained in the Act or any the law of the Commonwealth.[13]

8.12 The ACPC is an independent statutory officer and all decisions will be made under the ACPC's authority. The bill allows the ACPC to delegate in writing all or any of his or her functions to an Australian Public Service employee in the Department of Health and Ageing (the department).[14]

8.13 Concerns were raised about the delegation capacity of the ACPC in respect of possible conflicts of interest:

> The role of the Pricing Commissioner is approving extra service fees and accommodation payments is for fees that are higher than in the maximum amount determined by the Minister which may in fact result in a conflict of interest between the functions of DoHA in its recommendations and advice to the Minister and the role of the Pricing Commissioner….DoHA has stated that the Commissioner reports directly to the Minister however remains an employee of DoHA, governed by the Public Service Act. This requires clarification about the independence of the Commissioner and how this will be guaranteed.[15]

8.14 The department indicated in response to these concerns that:

> 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…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.[16]

8.15 It was also indicated that 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.[17]

8.16 The majority of submitters gave broad support to the establishment of 'an independent body to assess pricing and costs in aged care services'.[18] Some submitters considered that a wider scope of powers for the ACPC may be desirable:

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13 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, p. 31.

14 Aged Care (Living Longer Living Better) Bill 2013 – Explanatory Memorandum, pp 33–34.

15 Aged and Community Services Australia, *Submission 67*, p. 14.

16 DoHA, answer to written question on notice, (received 14 May 2013), p. 7.

17 DoHA, answer to written question on notice, (received 14 May 2013), p. 7.

18 Council of Social Service of New South Wales, *Submission 96*, p. 3.

- Approval of fees and charges under the policy framework approved by the Minister. This could include approving the Schedules of Fees and Charges for Home Care and residential care established under the Principles and Determinations, the pricing and services offered as 'additional amenities'.[19]
- Monitoring of the interactions between assessment under the Aged Care Funding Instrument and subsequent fees and charges.[20]
- Notification to and review of complaints made to the Aged Care Complaints Scheme in relation to financial matters, including fees and charges.[21]
- The ability to receive feedback directly from consumers regarding aged care pricing.[22]
- Monitoring of input cost increases and other pricing matters as proposed by the Productivity Commission.[23]

8.17 Grant Thornton Australia and Thomas Holt in contrast thought that the ACPC was unnecessary and would add another layer of regulation.[24]

Committee view

8.18 The committee supports the establishment of a statutory pricing commissioner. The committee does not wish to see the sector overburdened with oversight and believes that the current responsibilities for the ACPC are sufficient. These issues can however be considered further at the time of the statutory review.

The Aged Care Financing Authority

8.19 The Aged Care Financing Authority (ACFA) was established in August 2012 to provide transparent, independent advice to the Government on pricing and financing issues in aged care, informed by consultation with consumers, and the aged care and finance sectors.[25]

8.20 Since the ACFA was established it has undertaken 'several rounds of consultation to enable them to provide advice to Minister Butler on several key financing issues.'[26]

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19 National Seniors Australia, *Submission 68*, p. 3; Council of Social Service of New South Wales, *Submission 96*, p. 5; Aged and Community Services Australia, *Submission 67*, p. 14.

20 National Seniors Australia, *Submission 68*, p. 3.

21 Council of Social Service of New South Wales, *Submission 96*, pp 5, 11.

22 Council of Social Service of New South Wales, *Submission 96*, p. 11.

23 Aged and Community Services Australia, *Submission 67*, p. 14.

24 Grant Thornton Australia, *Submission 6*, p.6; Thomas Holt, *Submission 74*, p. 3.

25 DoHA, *Submission 92*, pp 9,10; DoHA, Living Longer, Living Better, Aged Care Financing Authority, http://www.health.gov.au/internet/main/publishing.nsf/Content/ageing-aged-care-acfa (accessed 30 May 2013).

26 DoHA, *Submission 92*, p. 9.

8.21 Although there was support for the establishment and operation of the ACFA there were concerns about the true independence of the authority and its relationship with the new Aged Care Pricing Commissioner:

> UnitingCare Australia believes that the Aged Care Financing Authority (ACFA) and the Pricing Commissioner should be truly independent from Government to ensure a fair and equitable aged care system. In the current reforms there is no requirement for the Minister to take the advice of ACFA, and the Pricing Commissioner's role is very limited. There is also the potential for overlap between these two roles.[27]

8.22 Both LASA and COTA were also supportive of the ACFA, however both were concerned about its non-statutory nature in light of the importance of its role:

> COTA strongly supports the role and functions of the ACFA, which has already undertaken substantial work to advance the reforms…COTA therefore proposes that the ACFA be established by the addition of a clause to that effect in the Bill, and that provision be made for a Principle that prescribes the Operating Framework of the ACFA… [28]

> The Aged Care Financing Authority should be established under the Aged Care Act, as a Committee, with responsibility to ensure, amongst other things, the continued sustainability of the aged care sector.[29]

8.23 Under section 96-3 of the *Aged Care Act 1997*, the Minister can establish committees on a statutory basis. The committee understands there are no committees under the Act at present.

Committee View

8.24 The committee has noted the very valuable work performed by the Pricing Authority, including during the course of this inquiry. It agrees that the Authority should be put on a statutory footing, and that section 96-3 provides a suitable vehicle for this purpose.

Recommendation 13

8.25 It is recommended that ACFA be established by the Minister for Mental Health and Ageing as a committee under section 96-3 of the *Aged Care Act 1997*.

Senator Claire Moore
Chair

27 UnitingCare Australia, *Submission 59*, p. 10.

28 COTA, *Submission 87*, p. 13.

29 Leading Aged Services Australia, *Submission 58*, p. 15.

COALITION SENATORS DISSENTING REPORT

Executive Summary

1.1 Coalition Senators are very concerned about the negative impacts this legislation will have on many aspects of the aged care sector and will be proposing amendments to the Bills.

1.2 After 18 long months of consultations, deliberations, considerations and preparations, the Minister is now rushing forward with his response to the extensive work of the Productivity Commission and has produced his legacy legislation in the dying days of the Gillard Government.

1.3 The *Living Longer Living Better* aged care package was announced on 20 April 2012, following a Productivity Commission report which was initiated on 21 April 2010. Incredibly, meaningful debate in the House of Representatives only started on 14 May 2013.

1.4 The Productivity Commission report was provided to the Government on 28 June 2011 and released on 8 August 2011. After sitting on the Productivity Commission report for more than 250 days, the Government announced its *Living Longer Living Better* package on 20 April 2012.

1.5 The Government then waited another 327 days before tabling five (5) Bills before the House of Representatives thereby forcing the sector to accept these incomplete and potentially widespread damaging Bills within the next 16 days of parliamentary session –that's 18 months of procrastination and 16 days of action.

1.6 The Coalition referred these 5 Bills to the Senate Community Affairs Legislation Committee to examine the full impact of how these changes will affect providers, older Australians, their families and carers. The reporting date was initially set for the 17 June 2013, however a majority of Labor/Green Senators on the Senate Community Affairs Committee voted to bring the reporting date forward to 31 May 2013, thereby contracting further the period for meaningful consideration of the evidence before the Committee.

1.7 Coalition Senators also point out that the Senate is not scheduled to sit again until 17 June 2013, so even had the Senate Committee maintained its original reporting timeframe, the report would have been available in time for the Senate's first available opportunity to consider the bills, namely 17 June 2013.

1.8 Despite the work being undertaken by the Senate Committee, it was unfortunate that a media release from Alzheimer's Australia dated 22 May 2013, with the headline *'Senate committee set to stall aged care reforms'* and a copy of a placard referring to this and inviting people to join an online protest was promulgated.

1.9 While the Coalition acknowledges the importance of organisations such as Alzheimer's Australia expressing its views about the Bills and the policy changes

generally, it is disappointed the media release contained a number of misleading inaccuracies and misunderstandings of the parliamentary process and the Senate Committee's deliberations to date.

1.10 The Coalition refutes this misleading assertion. On the contrary, the Bills were referred to and considered by the Senate Committee even before the Bills were passed in the House of Representatives.

1.11 Coalition Senators pushed for the Senate Committee to write to Alzheimer's Australia advising that it conducts its inquiries at the Senate's request, and has no authority to 'stall legislation', as the legislative timetable is a matter for the government and for each chamber of Parliament. While the committee has the discretion to bring forward a reporting date, it has no control of parliamentary deliberation on bills.

1.12 The difficulty for the Coalition and for the aged care sector is that we are expected to vote on these complicated Bills without sufficient time to consider the bulk of the changes which are actually in delegated legislation. During the Committee hearing, senators were advised by departmental officials that there are 19 pieces of delegated legislation. Unfortunately, some have been provided only recently as exposure drafts and key others are yet to be provided.

1.13 During the Senate Committee inquiry, powerful examples as to how these proposed changes will impact ageing services, particularly those in rural and regional Australia, were given by many of the witnesses called to appear.

1.14 Despite protestations by the Government supporting its own version of consultation, there was clear criticism of how effective this was. Indeed, the complexity of issues has resulted in a large volume of material provided to the Senate Committee after the hearing with some presenters even having to retract evidence because they misunderstood key aspects of the changes, such as the workforce supplement. In the absence of proper and meaningful consultation, it is clear that the Minister wants to railroad the sector instead of working in partnership with it.

1.15 Most aspects of this legislation are not due to commence until after July 2014 and components that do have an earlier start date can already be actioned using existing Principles without the need to accelerate the passing of the legislation.

1.16 The Senate inquiry has reaffirmed what the Coalition has been saying for a long time – that this package was nothing more than a cherry picking of a small portion of the Productivity Commission report with the key plank being the imposition of a workforce supplement. This is nothing more than a union driven industrial process, dressed up as administrative change.

1.17 The workforce compact process was designed to be an agreement between the Government, providers and unions. The negotiation process collapsed. Indeed, aged care providers boycotted the Minister's announcement of the workforce compact on 5 March 2013, with the Minister unable to even find an aged care facility to host his announcement! It is not surprising that aged care providers boycotted the announcement as they will now be forced to subsidise union membership growth in the aged care sector.

1.18 Coalition Senators accept that wage rises are good and well justified for hard working staff, but they need to be affordable and sustainable. If the aged care providers are not viable now, how can they afford to pay the increases?

1.19 Had it been worth the wait for bills that essentially followed the guidance of the Productivity Commission, the Coalition would be far more confident of the future of the aged care sector.

1.20 While it is acknowledged there are worthwhile aspects in the package, Coalition Senators are very concerned at the overall impact of the Bills on the viability of the sector.

1.21 The last major review of the aged care sector was in 1997 when the Howard Government introduced the *Aged Care Act* and forever changed the way care and accommodation services are developed and delivered in Australia.

1.22 With the increasing demands and expectations of the baby-boomer generation, the increasing impact of dementia, extended life expectations of older Australians, it is no wonder that aged care in Australia today is very different to the situation that existed in 1997.

1.23 Therefore, it is not surprising that industry, consumers and the workforce have held great expectations on how the Government would respond to the many and wide-ranging recommendations of the Productivity Commission.

1.24 Industry has held hopes that changes would improve the financial viability for providers. Consumers wanted greater choice and continued improvements in the quality of care and accommodation services. The hard-working staff across all sections of the industry wanted higher wages, improved conditions, greater security and better job-satisfaction.

1.25 Achieving these outcomes in an environment where the government of the day has very little new money with which to fund radical change was always going to result in questions of balance, trade-offs and compromise.

1.26 It is long acknowledged that neither the Government nor the industry has the financial capacity to fund the major changes necessary to achieve the hoped for perfect solution. In this three-cornered exercise, it is only consumers who have a remote capacity to draw on the lifetime of financial resources to make any additional contribution to change. The Gillard Government is experiencing Budget pressures from many quarters. The aged care industry has been stretched to its limits – and sometimes beyond reasonable, good business situations.

1.27 The Productivity Commission recognised this dilemma and formed its recommendations in light of these harsh realities.

1.28 *Living Longer, Living Better* is the culmination of the Government’s response and the $577 million of new money in their ten-year plan is simply not good enough.

1.29 In its response to the Productivity Commission's report, the Government accepted in principle the Productivity Commission's findings about the state of Australia's aged care system, but its May 2012 response asserted the PC's assumptions were not correct and that the Government did not proceed with the key

recommendation of the PC to move from a rationing system to an entitlements system because the Australian public was not ready for it. Regrettably, the Government has failed to substantiate these assertions and produce evidence to this effect. At this stage, other than limited modelling done by KPMG undertaken as a knee-jerk reaction to criticism during the Senate inquiry and which relates only to accommodation payments, no other modelling has been provided.

1.30 The general industry consensus is that the Government has cherry picked only about 5-6% of the PC's recommendations. Having said this, the sector will be pleased with the relaxation of rules on bonds and the removal of the high care/low care distinction.

1.31 Consumers will be pleased with the minimal changes to policies around assets – especially those relating to the family home; but many won't be pleased that those who have accumulated healthy assets are going to have to pay more for their accommodation costs and daily living services. Consumers will also welcome additional home care services and the new focus on dementia care.

1.32 However, these improvements contributing to aged care reform are swamped by far too many negative aspects that will seriously affect the financial sustainability of many aged care providers – big and small; private and not-for-profit operations. It is our contention that there must be balance in any reform agenda - especially one that has so many competing and, at times, opposing aspects.

1.33 It is also concerning to Coalition Senators that the underlying structure of these bills reinforces the Government's consistent approach that in aged and community care it is very much "one-size-fits-all". If such an approach was ever justifiably appropriate for the aims and expectations of older Australians, it is certainly not appropriate in the way in which aged and community care is delivered today.

1.34 The Senate Committee inquiry process has been extensive with large numbers of individual written submissions and witness statements at hearings in Perth, Melbourne, Canberra and Sydney.

1.35 However, the Coalition Senators note with concern that the one body on which the Government (and the Minister) appear to stake great reliance – the National Aged Care Alliance (NACA) – has not made a collective submission to the Committee, despite being invited to do so. The obvious divisions in thinking and attitudes within NACA resulting in an inability to reach consensus on a submission then leads to questioning of why the Government puts so much stock into its reliance on advice from NACA and its skewed positions on key issues.

1.36 In summary, the concerns of Coalition Senators relate to:

(a) Workforce Supplement;

(b) ACFI Appraisal;

(c) Lifetime Contribution Caps;

(d) Dementia Supplement;

(e) Accommodation Payments;

(f) Pricing Commissioner; and

(g) Rural and Regional.

Chapter 2

Workforce Supplement

2.1 Of primary concern to the Coalition - and one raised by a significant number of written submissions and personal witness statements - is the issue of the Workforce Supplement.

2.2 The Workforce supplement is listed as a primary supplement in the new Sections 44-5 and 48-3 with the Minister being able to determine by legislative instrument the detail of the supplement.

2.3 As the proposed Workforce Supplement does not include the relevant on-costs, the supplement in its current form has very serious potential to further impede the commercial aspects of operating an aged care facility.

2.4 Mr Ray Glickman, CEO of Amana Living – Western Australia raised four reasons why the workforce supplement should not go ahead:

- It is wrong in principle. To take away funds from ACFI, which essentially belong to our residents, and then transfer them to workers, is wrong in principle. And it is particularly wrong in an environment where a consumer direction will be the future. Also it is futile, because robbing Peter to pay Paul does not generate more money in the system, sustainably, to pay higher wages.
- This measure is secondly wrong because it industrialises what is essentially a funding issue. It centralises industrial arrangements and takes away the outcomes that one negotiates individually as an enterprise. It also seems designed to promote the interests of the unions by driving clauses that have been rejected by many employers in their own enterprise bargaining arrangements. Many of the initiatives that have to be included are also costly and do not directly benefit the residents, or clients.
- Thirdly, it should be rejected because the proposition is not fully funded. So, in addition to recycling existing funds, so we have no more money, it does not cover on-costs. That includes numerous expensive expenditure items that will be part of the overall deal. Our calculations suggest that the cost will outweigh the income by two to one. That seems extraordinary, but it is true once you add up all the elements. We have an example from the bush, where to gain $17,000 will cost $30,000.
- The fourth reason it should be rejected is that it is discriminatory. The majority of regional, remote and rural providers will not be able to

> comply with the requirements - and they are the organisations who are most in need.[1]

2.5 Modelling undertaken by industry groups and provided to the members of the Committee suggests that each dollar of wage increase flowing from this legislation will cost the employer at least $1.70 on top of the $1 received by the employee. The Coalition is convinced that such an impost on the industry is not sustainable – short or long term.[2]

2.6 Submissions referred to the Committee indicate that around 60% of all aged care providers are currently operating in severe financial stress with no capacity to cover additional expense through increased salary on-costs without the corresponding increases in the supplement or other subsidies.

2.7 In their written submission, LHI Retirement Services (Lutheran Aged Care Residential Network Members) raised concerns about the significant additional costs associated with the Workforce Supplement:

> The Workforce Compact will be a huge cost impost for facilities given that the current COPO indexation was zero and estimated to be 1.5% for 2013/14. What income stream is available to fund these additional costs, plus on-costs, and what opportunities are there to increase income in a tightly regulated environment? One LACRN member has estimated that the additional cost to them of the Compact will be an additional $240,000 per year on top of the government funding of $140,000. Based on the above information this could only be achieved by a significant reduction in staffing (equivalent to 8 full-time staff). Another member reports the increases will cost a minimum of $116,000 in the first year and up to $272,000 p.a. by the fourth year. This proposal alone threatens the whole aged care system, which would appear to be the real objective of government. LACRN urges the Senate to commission a full independent review of the assumptions upon which the Compact calculations were based. [3]

2.8 The very real risk associated with the workforce supplement is that many providers would have to reduce staffing levels to release the additional funds to meet the higher unfunded salary expenses. Coalition Senators do not believe this is acceptable as it challenges their very viability.

2.9 Dr Lucy Morris, Chief Executive Officer of Baptistcare – Western Australia, made the following statement to the inquiry about their concerns with the additional on costs which are not covered under the workforce supplement:

> I think that the way the current workforce supplement is constructed is not going to be helpful because, for every dollar that we apparently will get

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1 Mr Ray Glickman, Chief Executive Officer - Amana Living – Western Australia, *Committee Hansard,* 29 April 2013, p. 35

2 Adj Prof John Kelly, Chief Executive Officer, Aged & Community Services Australia

3 LHI Retirement Services (Lutheran Aged Care Residential Network Members), *Submission 8,* p.4

> from government if we sign off on all the other caveats that we have to sign up to, we will have to put in an extra $3 to top that up, and there is the compounding effect of that increase year by year as it goes forward. We are losing money out of the system faster than we are getting money in.[4]

2.10 Further concerns were put to the enquiry by the National Presbyterian Aged Care Network supported by similar comments from other employer groups. These highlighted that the outcomes of the compact negotiations did not really end up with a compact. What did result was a Minister making certain decisions based on negotiations that, in the view of the providers, created a really awkward position where providers support the intention to have better wages but the mechanism that has actually been decided by the government leaves unfunded the on costs that were referred to by the Lutheran Network.[5]

2.11 In their written submission, LHI Retirement Services (Lutheran Aged Care Residential Network Members) also raised concerns about the impact of the non-direct wage conditions associated with the workforce supplement:[6]

> The additional non-direct wage conditions associated with the Workforce Supplement eligibility is a significant industrial relations issue for facilities and must be removed so that there is a clear separation of wage and non-direct wage issues. The additional non-direct wage costs include:
>
> - Enhanced training and education opportunities,
> - Improved career structures, career development, and workforce planning,
> - Review part-time hours
> - Casual staff conversion to part-time
> - Workload management
> - Work health and safety
> - Disciplinary matters.
>
> These non-direct wage items add significant unfunded costs to the facilities operations; add another layer of administrative responsibility and costs while the majority provide no direct benefit to the staff.
>
> These matters are also covered by Accreditation requirements, conditional adjustment payments, industrial awards, Fair Work Australia and work health and safety legislation and add another level of cost and compliance to providers that is not necessary. The above must be deleted from the requirements for eligibility for the Workforce Supplement.

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4 Dr Lucy Morris, Chief Executive Officer, Baptistcare – Western Australia, *Committee Hansard*, 29 April 2013, p. 19

5 Mr Paul Sadler, Chief Executive Officer, Presbyterian Aged Care NSW/ACT, National Presbyterian Aged Care Network, *Committee Hansard*, 30 April 2013, p. 38

6 LHI Retirement Services (Lutheran Aged Care Residential Network Members), *Submission 8*, p.4

Government campaign on workforce supplement is misleading

2.12 Subsidised aged care operations are controlled by the Government ranging from the setting of fees paid by residents and charges levied by providers, fixing wage rates for employees by controlling and managing subsidies; allocating the number of places available in a region; determining the quality and standards of care and accommodation and so many other operational, administrative and clinical processes. Whether the provider is privately owned or a mission-based operation of a church or charitable organisation, these businesses are very limited in the commercial decisions able to be made in the best interests of their business operations.

2.13 Leading Age Services Australia in their written states that:

> The Government has proposed a workforce supplement to be enacted through subordinate legislation to give effect to a 'workforce compact' designed to encourage workforce participation and retention.
>
> However, unfortunately the use of the term 'compact' is a misnomer as there is no general agreement between all the relevant stakeholders.[7]

2.14 There is no doubt that the hard-working staff employed in all areas of residential aged care facilities are worthy of increased pay rates when compared to their contemporaries in other industries. This is a view expressed by many witnesses to the hearings and in many written submissions.

2.15 Aged & Community Services – Western Australia stated that:

> ACSWA acknowledges that there is a need to attract and retain aged care staff though improved remuneration and career structure, and a need to enhance their skills to provide the complex care of incoming residents with increased acuity. … the Workforce Supplement adds a significant cost impost for providers, and unnecessary complexity in industrial relations management.[8]

2.16 It appears to the Coalition that the Workforce Supplement process is using the sensitive issue of promised wage increases for staff as a clear attempt to open the way for mandatory union participation in any wage-setting process in residential aged and community care. At the same time, in the same process, the lack of any recognition of the high cost to employers who choose to access the wage supplementation processes because of the unfunded on-costs of those increases is the key to the question of the poor sustainability of these wage proposals.

2.17 In their written submission, LHI Retirement Services (Lutheran Aged Care Residential Network Members) summarised that this was a false campaign trying to create the impression that the Government are fully funding the wage increases through the Supplement:[9]

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7 Leading Age Services Australia, *Submission 58*, p.20

8 Aged & Community Services – Western Australia, *Submission 77*, p.3

9 LHI Retirement Services (Lutheran Aged Care Residential Network Members), *Submission 8*, p.4

> The Workforce Compact is obviously a campaign to shift the cost increase associated with the pay and conditions for low paid workers onto the aged care providers with only a token supplement from government, while intending to create the impression that the government is providing all of the funding for the increases.

2.18 There is no incentive for many operators in the sector to commit to any increase when the significant on-costs could lead to further financial stress to an already constrained business environment. The potential loss of more jobs through the closure of businesses is a very real and worrying concern.

2.19 In the absence of any certainty that there will be universal uptake of the workforce supplement, the Coalition was dismayed to hear that the Department arranged for information to be posted direct to individual staff in aged care facilities promoting the payment of wage and salary increases from July 2013. This action completely disregarded the appropriate processes that will be required before there is any possibility that any such increases might be paid to workers. Indeed, the Government was forced to write to both ACSA and LASA apologising for the Department's error in undertaking such a letter campaign.

2.20 The Minister too is not innocent of similar inappropriate promotion of his workforce supplement with the recent insertion of a paid advertisement in a magazine for the retirement community. This advertisement was endorsed by the Minister and clearly states that "*From July, $1.2 billion will flow into the pay packets of 350,000 aged care workers across Australia thanks to Federal Labor."*

2.21 That is an outrageously false statement designed to give the false impression that the Government is responsible for pay rises.

False expectations from the workforce supplement

2.22 The Workforce Supplement is intended to improve productivity, worker attraction and retention in the sector. However, to qualify for the supplement, providers must have enterprise bargaining agreements in place, pay above minimum wages, and commit to minimum annual increases. It is difficult to see how the proposed changes will actually improve wages, conditions and career structures when the service providers most likely to participate are those that already meet the criteria i.e. have an EBA in place. It is expected many organisations will not adopt the Workforce Compact in its current form.

2.23 Catholic Health Australia advised that they surveyed all their facility managers and the results revealed that 40% 'would not' or were 'unlikely' to sign up to the workforce supplement. Compounding this was the stunning response from the remaining 60% who reported as being uncertain about the proposal. From an organisation of this size and geographical spread, a 100% lack of commitment is a very strong indication of the high levels of anxiety and uncertainty within the aged care industry.

Lack of specific industry consultation

2.24 Kincare[10] made particular mention of their concerns about the lack of consultation with industry over such a significant issue of primary importance to providers. Rather than a consultation process, the Department of Health and Ageing distributed employee fact sheets and advice on how to meet the Workforce Supplement pre-conditions directly to staff without any discussion or consultation with the aged care sector peak bodies or individual providers

Workforce supplement adding to the industrial complexity of facilities

2.25 In their written submission, LHI Retirement Services (Lutheran Aged Care Residential Network Members) raised concerns about the workforce supplement adding to the industrial complexity:

> It must be recognised that the Workforce Compact process adds significant complexity of the industrial relations processes within an aged care facility, which is avoidable. [11]

Workforce supplement issues for Rural, Regional and Remote (RRR) providers

2.26 Dr Lucy Morris from ACSWA, reminded the committee that the not-for-profit providers where the predominant providers in regional, rural and remote place.

> We mentioned earlier issues around recruitment costs, retention costs, the cost of training and the cost of accessing allied health. Employers also often find that they have to provide accommodation for staff when they come in. The supplement does not come close to addressing those fundamental issues around living and providing services in rural and regional areas.
>
> We also have a heightened awareness about lower incomes in rural and regional areas generally.[12]

Summary and overview on the Workforce Supplement

2.27 In summary, St Paul's Lutheran Homes Hahndorf stated that:

> The Workforce Compact is a farcical regime to impress staff working in aged care however it doesn't stack up against the funding or constraints within the financial ability of a Provider.[13]

2.28 Capecare also disagrees with the fundamentals of the Workforce Supplement and made these following comments in their submission:

> Capecare fundamentally disagrees with the Workforce Supplement announcements and how the current Federal Government has funded it … and as a matter of principle, does not support a framework that diminishes

10 Kincare, *Submission 42*, p.19.

11 St Paul's Lutheran Homes – Hahndord, *Submission 70*, p.3

12 Dr Lucy Morris, ACS - WA, *Committee Hansard*, 29 April 2013, p. 35

13 St Paul's Lutheran Homes – Hahndord, *Submission 70*, p.4

> aged care funding to providers in order to channel funds to supplement wage increases.[14]

2.29 Mr Ray Glickman from Amana Living summaries his objections to the workforce compact with the following statement:

> … this supplement is a very poor piece of public policy. Let us not call it a compact, because it certainly has not been agreed with provider organisations. It takes money from care to return to some employers who can strike a deal.[15]

Updating Workforce Supplement Modelling

2.30 It's interesting to note, that during the Inquiry on 29 April 2013, Mr Graeme Prior, Chief Executive Officer of Hall and Prior Aged Care Organisation made the following statement:

> Our high-level analysis of the Workforce Compact has indicated that it will be cost neutral to us in both WA and New South Wales after taking into consideration all employee entitlements and on costs.
>
> This assumes the workforce supplement continues beyond the 2016-17 financial year. It will be cost neutral to us as we have a very high level of resident acuity and already pay wages well above the margin for the relevant award rates… in summary, we thus support the Workforce Compact and we feel it will invigorate the aged-care workforce.[16]

2.31 However, in a letter to the Senate Community, one month later, Mr Graeme Prior acknowledges that his statement at that the Workforce Supplement would be cost neutral to his organisation and informed the Senate that to sign up to the Workforce Supplement over the next four years would cost his organisation an additional $2.1 million:

> At the time of my appearance before the Senate Committee I indicated that our initial modelling was that the Workforce Supplement would be cost neutral to our organisation. However, based on the information in the consultation paper, this is no longer the case. It appears that if we were to sign up to the Workforce Supplement it would cost our organisation $2.1 million over the next four years (in addition to the annual financial increases passed on to employees).[17]

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14 Mr Greg Holland, Chief Executive Officer - Ray Village Aged Services (Inc) t/a Capecare – Western Australia, *Submission 76*, p.6

15 Mr Ray Glickman, Chief Executive Officer - Amana Living – Western Australia, *Committee Hansard,* 29 April 2013, p. 35

16 Mr Graeme Prior, Chief Executive Officer, Hall and Prior Aged Care Organisation, *Committee Hansard,* 29 April 2013, p. 1

17 Hall & Prior Residential Health & Aged Care Organisation, *Letter to the Committee*, 29 May 2013

Recommendation

Given the major concerns expressed by so many submitters about the workforce supplement, the deleterious effect it will have on residents and the sector; and in the absence of general agreement between all the relevant stakeholders, all provisions in the package of bills referring to the workforce supplement should be removed.

Chapter 3

Aged Care Funding Instrument (ACFI) Appraisal

3.1 The current wording of the section in the legislation requires that a substantial number of appraisals must be involved before invoking the Secretary's powers to suspend providers from making ACFI appraisals

3.2 The proposed change is to remove the words 'substantial number'.

3.3 The Coalition is concerned that the proposed change to remove the wording *"… substantial number …"* will provide greater opportunity for the Secretary of the Department of Health and Ageing to suspend an Approved Provider based on any false, misleading or inaccurate information.

3.4 It is our contention that the current wording provides sufficient scope and capacity for the Secretary of DoHA to take necessary action in any situation where such intervention is required.

3.5 Our position on this issue is supported by evidence from, Dr Lucy Morris from ACSWA, who gave the following evidence during the hearing in Perth:

> But now with the proposed removal of the word 'substantial' it means that you can make one mistake and get pinged for it, whereas the current system says that it could be several and you have time and room to work stuff out and make sure that it was a genuine mistake and correct it. Now there is the capacity under the proposed legislation with the removal of that word to, in theory, get done after one mistake. It means that the accreditation can be quite inconsistent between assessors. So there is a lot more room for error on both sides. [1]

3.6 Mr David Kemp from ECH Inc, has similar concerns:

> *Our final, main concern is around the ACFI appraisals and the proposal to remove the word 'substantial' number of claims and make the sanctions provisions, if I can call them that, apply* in the case where after, I think, a first warning, if there is a second offence, if you like, a provider could be suspended from making appraisals. We think that is quite a radical shift away from what is now a word of 'substantial' to a term of 'just one or more cases,' which might just be an inaccurate claim. It could be an inadvertent error. [2]

3.7 Masonic Care Alliance, Board Director, Mr Felix Pintado has these reservations:

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1 Dr Lucy Morris, Aged & Community Services WA, *Committee Hansard*, 29 April 2013, p.39.

2 Mr David Kemp, Chief Executive's Adviser, ECH Inc, *Committee Hansard*, 29 April 2013, p.47.

> The legislation proposes to impose sanctions on providers if they make a single mistake in appraising or reappraising that person's level of care. We believe that that is excessive and punitive to providers. We see no evidence to suggest that there is a large proportion of providers in the current system who have been sanctioned because of errors they have made in claiming for ACFI[3].

3.8 Adjunct Professor John Kelly, CEO ACSA states that the current legislation provides procedural fairness and that there is no need to change:

> We would recommend that we stick with the existing legislation. The secretary has wide powers currently. The major difference- we are approaching it from a procedural fairness point of view- is currently the secretary would have to show that there are substantial numbers of appraisals that are involved in a process where you might consider a suspension of that approved provider status. To change it to 'false, misleading or inaccurate on any one or more occasions' is just in our view not procedurally fair. You may make a mistake in you ACFI statement- it may not be fraudulent; it may be an innocent misrepresentation - yet that would count as the first strike, if you like, of a process that could lead to sanctions. We feel that it is going too far and that the current powers of the secretary are sufficient for her to carry out her responsibilities under the act.[4]

Recommendation

That the current wording and intent of the existing legislation regarding 'Suspending an Approved Provider from ACFI Appraisals' be retained.

3 Mr Felix Pintado, Board Director, Masonic Care Alliance, *Committee Hansard*, 30 April 2013, p.36.

4 Adj Professor John Kelly, Chief Executive Officer, Aged and Community Services Australia, *Committee Hansard*, 30 April 2013, p.50

Chapter 4

Lifetime contribution caps

4.1 Many submissions raised concerns that the proposal to set annual and lifetime caps on contributions at $60,000 does not recognise the increasing trends in life spans of older Australians and the benefits to residents of the quality of care and services that are the foundations of these longer stays in residential care.[1]

4.2 Coalition Senators are concerned that this proposal has been ill-considered and backed-up with insufficient financial modelling to ensure confidence and certainty of the economics of the proposal.

4.3 The government's own program is called *Living Longer, Living Better* and is at odds with the fact of this proposal.

4.4 In a simple calculation using the Standard Resident Contribution of $44.54 per day, the proposed limit of $60,000 will be reached in around 44 months. In another example, using the proposed level 2 threshold of $85 per day, the cap will be reached in less than two years.

4.5 At issue, the cap in contributions is for those costs related to care. Simply doing the sums with the current fees and charges and the current average length of stay demonstrates the inadequate amount of consideration given to this proposal.

4.6 It is an unavoidable fact that the aged care budget is under extreme pressures. The proposed level of lifetime contribution caps will undoubtedly increase those pressures in the future.

4.7 Coalition Senators are concerned that the Government and those external organisations that support this proposal have not completed the necessary detailed modelling and essential considerations.

4.8 Our position on this issue is supported by evidence from Ms Julie Christensen, CEO of Narrogin Cottage Homes who states:

> Although the average time a resident will reside in an aged care home has reduced substantially over the years as a reflection of "staying at home for as long as possible", many RRR facilities due to a complex admission methodology involving distance, access to services, transport, housing etc appear to have longer residency stays. This data should be available from the Medicare data bank.
>
> As such, there is we feel a real need to extend this life span to $80,000 or there is risk that the burden on the public purse will be greater than anticipated.[2]

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1 Aged and Community Services Australia, *Submission 67*, p.29

2 Narrogin Cottage Homes Inc, *Submission 82*, p.4.

Recommendation

That the lifetime cap and its specified level be reconsidered subject to further modelling and analysis of the impact of the lifetime cap on consumers and the industry.

Chapter 5

Dementia Supplement

5.1 This proposed supplement is to cover the "… *additional costs involved in caring for people with dementia and other mental health issues*."

5.2 The Coalition is concerned at the lack of sufficient definition to determine the level of cognitive impairment how it will be valued and/or costed and the lack of clarity about who will make such a determination.

5.3 It is accepted that complex behaviours add to the load of staff within residential aged care. But it is also an emerging issue for care services delivered to residents who remain in their own homes and it needs to be evaluated and considered in that setting as well.

5.4 The Coalition believes that further clarification and expansion of the definition is required.

5.5 The Coalition believes that the name should reflect those targeted older Australians that may be eligible for the supplement. The Act indicates that the supplement is in recognition of the additional costs involved in caring for people with dementia and *other mental health issues.*

5.6 Evidence from Dr Roderick McKay from the Royal Australian and New Zealand College of Psychiatrists states that:

> The idea is that the funding for residential aged care should be sufficient to provide the mental health care. There are two things explicitly wrong with that. Firstly, mental-health care requires time and we know that the funding does not allow that time. Secondly, it needs skilled staff; nor does it provide for that. The third thing is that it is exacerbated even further by the fact that people with mental-health needs are not there is a list of people with special needs and those with mental-health conditions are not listed. There are many ways it has gone backwards. The recognition of people with mental health conditions as a special needs group I believe is within the scope of this. I think that would be a very good starting place in at least recognising those needs, because then those needs actually will be evaluated as to whether they are being met. Hopefully some of them will therefore be better met and, if they are not being met, there will be a driver for better planning for these things. If you look at the analysis of the aged-care funding instrument data, in very rough terms what it shows is that coming into residential care about 50 per cent of people have dementia and 50 per cent of people have mental illness, with a 50 per cent overlap between those groups. So it is not actually that one is a bigger problem than the other. They are equivalent sized problems but we are only planning for one. I can answer that directly. On the psychogeriatric assessment scales, as I understand, the cognitive assessment scale is being considered for use for assessing eligibility for cognitive impairment in terms of access to the

> dementia supplement in the community. So there is no measurement of behaviour or mental health in terms of eligibility for that supplement in the community.[1]

5.7 Dr Lucy Morris from Aged and Community Services Association, Western Australia has the following concerns around the impacts of the new arrangements and that the need for the supplement to appropriately cover all the complex behaviour aspects:

> There is the issue around the dementia supplement. The fact that we are taking cuts to level 2 and level 4 under the new arrangements is going to impact. We are losing money out of that provision to pay for the dementia supplement. There is the fact that the dementia supplement does not cover the issues of complex behaviour care, and it is inappropriately named. We have issues around who will be able to diagnose and whether GPs actually want to diagnose people with dementia. That means that you are going to have issues around exclusion et cetera.[2]

5.8 In addition, the proposed delegated legislation deals with the dementia, veterans and workforce supplements in the one instrument. Given the concerns raised about definition and proper reflection of behavioural problems, the three supplements should be dealt with in separate instruments.

Recommendations

That the mechanisms for determining the Dementia Supplement are made transparent and that the name more accurately reflects the broader aspects of the issues that impact on the eligibility.

That any delegated legislation relating to the dementia, veterans and workforce supplements are separate and not combined in delegations in any way.

1 Dr. Roderick McKay, Chair, Faculty of Psychiatry of Old Age, Royal Australian and New Zealand College of Psychiatrists, *Committee Hansard,* 1 May 2013, p.7.

2 Dr Lucy Morris, Aged and Community Services Association, Western Australia, *Committee Hansard,* 29 April 2013, p. 36.

Chapter 6

Accommodation payments

6.1 Coalition Senators have noted the significant number of submissions and witness statements that raised concerns with the proposed accommodation payment arrangements.

6.2 Coalition Senators support the general notion that came through clearly in many submissions and witnesses to the hearing that reform in aged care is required but any change must be sustainable and take a direction that will set up the industry for the future.

6.3 Accommodation pricing is one of those areas where the Coalition Senators believe robust but responsible changes should be made.

6.4 It is acknowledged that the Minister has reacted to recently raised concerns and sought urgent advice from the Aged Care Financing Authority with a related analysis undertaken by KPMG.

6.5 However, the KPMG report outlines issues addressing reforms but without any supporting evidence that adequate consideration has been given to the impact of those reforms. The future Budget impact of the Lifetime Caps illustrates this point.

6.6 The Coalition questions the assumptions associated with many aspects of the KPMG assessment report and notes:

- There is inadequate cash flow modelling in the KPMG report and it only attempts to deal with it in aggregate at industry level, with no attempt to model a selection of provider types;
- There are no details to support the proposed 'bonds in high care';
- It does not address the impacts of a change in consumer preference;
- It does note (page 43) the current bond pool turned over $4,133bn in FY2011/12 year (3 years) and that this turnover will increase with bonds in High Care (we believe to every 2 years);
- Providers with bonds that are not replaced with like for like will be under severe financial distress; and
- Providers lose their choice under the proposed legislation and there is concern that this is not addressed in the KPMG report.

6.7 The Government based its justification for its new arrangements to protect consumers from the so-called 'super bonds'.

6.8 At a media conference on 20 April 2012, the Prime Minister and Minister Butler jointly announced the Government's new 10 year aged care plan with specific mention of "… *bonds which can cost up to $2.6 million and bears no resemblance to the actual cost of accommodation* …"

6.9 In other evidence provided in written submission, ACSA CEO Adjunct Professor John Kelly, suggests that concerns are ill-founded about wide-spread existence of super bonds:

> ACSA members consider that this response is the Governments reaction to so-called 'super bonds'. It is however evident from the data that the incidence of these bonds is very low and there is no widespread problem. Presently, there are in the order of 21,127 accommodation bonds in Australia. The incidence of so-called 'super' bonds is very low with 124 bonds between $750,000 and $1million and 33 in excess of $1 million which represents approximately 0.7 per cent of all residential aged care accommodation bonds.[1]

6.10 In addressing a problem he perceived about super bonds – a problem which never existed - the Minister has relied largely on information he claimed in April 2012 about the prevalence of these super bonds and relies now on the KPMG report that has been questioned and criticised in some areas. He has reacted to ill-informed scare-mongering to justify the subsequent variations he has now announced to the original arrangements set out in in the bills.

6.11 The Government's assertions about so-called super bonds are at odds with the facts and the statistics provided in evidence to the Committee.

6.12 National Seniors, the largest organisation representing those over 50, advised the enquiry that it was aware of claims where new residents were encouraged by aged care facilities to provide details of their assets in order to calculate a higher bond amount from the total assets. Currently, a resident is not compelled to disclose assets on the understanding that they will pay higher default amounts for additional fees and charges.

6.13 Coalition Senators are also gravely concerned that the Government has failed to adequately consider the impacts of the proposed means testing treatment of the family home versus the treatment of the Refundable Accommodation Deposit. We believe the proposed different treatment depending on whether the asset is held in the family home or as cash in the bank leads to inequities and discrimination. This could easily result in some older Australians facing high costs when considering a move into residential aged care. The Coalition Senators recognise that this may lead to some older people putting off the decision to make that move when everything else suggests that residential care is the right option at the right time.

6.14 The clear lack of adequate analysis and detailed broad-ranging modelling ought to have been undertaken prior to these bills being presented to the Parliament.

6.15 Once again, the aged care goal posts have been shifted mid-game creating even further uncertainty for the aged care sector.

6.16 From evidence provided to the Committee, the Coalition considers it essential that further time needs to be taken to enable reconsideration of the new arrangements

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1 Adj Professor John Kelly, Chief Executive Officer, Aged and Community Services Australia, *Submission 67*, p22.

and reassess the impact on the operation of these accommodation payment arrangements on aged care services given that there was little wrong with previous arrangements and there are flaws in the justification for these new arrangements.

6.17 The Coalition is further concerned that while prices will be published, there is a requirement that the potential resident and the provider must agree before entry on the maximum accommodation price to be paid and that the resident understands the various payment options. The resident can then take up to 28 days to decide on the method of payment. If no decision is made by that time, the default option is a Daily Accommodation Payment (DAP). The Coalition contends that the default should be a Refundable Accommodation Deposit (DAP – formerly a bond) as this would benefit both the resident and the provider in that it provides better sustainability of the overall bond pool.

6.18 The proposed DAP default has a strong potential to impact on cash-flows due to a very real potential for a run-down in the current $12 billion bond pool as more residents choose a DAP or make no decision and the default option applies.

6.19 Over-riding this situation is the option for a new resident to take up to six months to make a RAD payment, thus creating further financial stress to the provider.

6.20 Complicating the situation yet even further is the ability for a resident to drawdown DAPs from a RAD. The requirement to top-up the RAD "from other sources" may not be possible for all residents and there will be resultant whittling down of the RAD in these situations – once again disadvantaging the provider.

6.21 There is considerable evidence from elsewhere in the aged care sector supporting the Coalition's concerns.

6.22 Mr David Kemp from ECH Inc. expressed concerns about the relationships between the different payment types and the effects that these changes will have on part-pensioners:

> … our main concerns focus on, in particular, the rules about and the relationship between the daily accommodation payments and the refundable deposits and the use of the minimum permissible interest rate; and means testing in residential care where it excludes the value of the family home, other than the first $144,500, but does include the full value of any refundable deposit that a person might pay and excludes the rental income from the means test should someone retain their house and choose to rent it out. There are some concerns about aspects of the income testing for home care, particularly the way in which it seems to discriminate a bit against part-pensioners who are on the lower end of the scale in terms of income.[2]

6.23 Adjunct Professor John Kelly ACSA CEO raises valid questions in relation to the 28 day cooling off period and the extra regulatory burden this will have on providers:

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2 Mr David Kemp, Chief Executive's Adviser, ECH Inc, *Committee Hansard*, 29 April 2013, p.47.

> They are setting up a process where a provider and a potential resident, a consumer, must agree on the refundable accommodation deposit, the daily accommodation payment and the opportunity to straddle that, if you like, in any particular way that the consumer may wish. That all has to be discussed and decided before entry into a facility. Then there is this wonderful 28-day cooling off period that I think both sides of the argument can raise pros and cons for. There is the 28-day period during which the daily accommodation payment is kicking over.
>
> In fact - and this is the point that we want to make in our submission - what tends to happen is that the Centrelink processes in terms of income and assets testing assessments just take longer often and particularly, my feedback from our rural regional members is that they said they have enough trouble getting ACAT assessments let alone trying to get the Centrelink assessment side of things once a residential care resident is being considered.
>
> So the issue is that, at the end of that 28 days, the automatic default is to continue paying a daily accommodation payment. There is an argument that this may lead more consumers to lock into that rather than renegotiate or reconsider paying a bond. We are being speculative everyone will take their own investment advice on that as they move forward - but it just adds to the complexity and, if you like, the extra regulatory burden that will be thrown on providers as a part of this process. [3]

6.24 Mr Mark Andrew Sudholz from the Aged Care Guild raises concerns about moving accommodation bonds from a free market position to a RAD/DAP relationship:

> When the initial submissions were made by the guild the concept on the accommodation bond was around the 95th percentile of bonds, which the industry saw was going to come out at about $490,000 or something like that. It then fell down to another cap, which was around $406,000. Now it has fallen down to a mechanism where the bond is not the driver but the DAP is the driver. We supported a free market position because that is how it has worked and worked very well in the previous environment. Now that we are in the RAD/DAP relationship there are some serious implications around that. As you look at the DAP and setting the DAP in the tiers and you have the interest rate applied to that, our projection and we have not seen any projections on this from government; it is a really big concern is that you are going to finish up with a bond of somewhere between $170,000 and $230,000 or something like that. There are two implications. It is the implication of: if you have bonds in your facilities at $400,000, you are just faced immediately or very close to immediately, with a requirement to pay $200,000 out of your own balance sheet. So, the resident that moves out gets paid back the $400,000. The resident that moves in under the assessment program will pay $200,000. The industry has to pay $200,000.[4]

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3 Adj Professor John Kelly, Chief Executive Officer, Aged and Community Services Australia, *Committee Hansard*, 30 April 2013, p.52.

4 Mr Mark Andrew Sudholz, Director, Aged Care Guild, *Committee Hansard*, 1 May 2013, p.38

6.25 ANZ is the major lender to the aged care sector and provided important evidence at the Committee hearing. As indicated in its submission, ANZ holds $2billion of the $5billion debt in the sector.

6.26 Mr Richard Gates, Head of Health Care Banking at ANZ gave evidence as to the effect on future sector financing of the refundable accommodation bonds, or RADs as currently described in the draft legislation. The ANZ provided a significantly detailed explanation of their concerns touching on key points:[5]

> In relation to accommodation bonds, Mr Gates raised the following concerns:
>
> - that the proposed changes to the legislation will adversely affect Refundable Accommodation Deposits (RADs);
> - there is a major bias in favour of daily payment bonds;
> - a reduction in refundable bonds as the principal source of capital funding for the industry resulting in serious financial consequences;
> - a significant and surprising shift from Refundable Accommodation Deposits to Daily Accommodation Payments with this change certainly not becoming evident until very recently, when the explanatory notes to the draft legislation were released;
> - any significant shift from Refundable Accommodation Deposits to Daily Accommodation Payments will likely have a major financial impact on individual operators, the industry generally and possibly bank appetite to fund;

6.27 Mr Gates also noted that refundable bonds have been the dominant source of capital funding for both greenfield and brownfield projects in the industry over the last decade or so. This has been so particularly in the for-profit sector, which has been the main builder of new aged-care infrastructure in the last decade. Furthermore, over 90 per cent of bonds or about $12 billion today, are refundable bonds, and the vast majority of that has gone into the creation of new infrastructure.

6.28 On the debt and equity issue, Mr Gates is concerned that shifts in how accommodation is paid for by residents will impact on the established patterns of debt and equity. This will have likely negative impacts for bankers and negatively affect the past relationships and practices with their clients:

> Bank debt supporting the industry is estimated at circa $4 – 5 billion. A material reduction in RAD bonds replaced by DAP bonds will inevitably require significant bank funding. If so, this will need to be gradual and measured so the bank market can be engaged with proper planning and consultation.[6]

6.29 At the Committee hearing, Mr Gates outlined his concerns about debt and equity:

> Typically debt and equity which goes into projects is fully repaid after two years post construction. Equity can then be released to go into the next

5 Mr Richard Gates, Head-Healthcare Banking, ANZ, *Committee Hansard*, 2 May 2013, p. 14.

6 Mr Richard Gates, Head – Healthcare Banking, ANZ, *Submission 94*– p3

> project; that is the form of capital creation. A project wholly funded by daily payment bonds, if that ever happened, would take at least seven years before a provider's equity could be released to go into the next project, so there would be a fundamental shift.

6.30 Another point that Mr Gates highlighted in his evidence is that refundable bonds have been invested in hard assets and that "they do not sit out there in cash."

6.31 On the issue of interest earnings, Mr Gates stated:

> But daily payment bonds right now earn service providers the maximum permissible interest rate [MPIR] which is only seven per cent. As this is almost the same rate as the bank charges for debt funding, this small margin is not acceptable from a bank point of view. Banks typically require greater than two times debt service cover before we fund. So a material shift from refundable bonds to daily charge bonds will have an adverse effect on bank lending ratios. Interest service will potentially be adversely affected, and so will the loan-to-value ratio. A material transition from refundable bonds to daily bonds say, greater than 10 per cent over a short time frame for all operators who currently operate on a moderate to high level of bonds will clearly have a significant capital outflow, and this needs to be considered and assessed.

6.32 Mr Gates also raised ANZ concerns on the complex issue of MPIR (Maximum Permitted Interest Rate) and WACC (Weighted Average Cost of Capital) in determining ways and means of addressing the equity shortfall that will likely result from the move from RAD bonds to DAP bonds as mentioned. In evidence he stated:

> A core element of the problem is that the daily charge rate, which is the MPIR, is around seven per cent, whereas the financially equivalent return to a provider, which is their weighted average cost of capital, is more like 14 to 16 per cent. But, if the weighted average cost of capital of 14 per cent were adopted as the maximum permissible rate, that would clearly be unacceptable to residents and families.

6.33 Mr Gates suggested that any new means test be neutralised to avoid the apparent skew to DAP bonds.

6.34 He noted that proper modelling of resident profiles would provide this neutrality so as to avoid a material shift from refundable bonds to daily bonds provided that refundable bonds become the primary reference point for pricing enabling the DAP to move up and down with interest rates. This is how the arrangements work currently. Transitional backstop financing could be considered if there is an unintended shift from RAD bonds to a DAP with a resultant liquidity shortfall disrupting the market.

Impact on residents – treatment of the family home

6.35 Continuing with expert evidence from ANZ, Mr Gates suggests the most obvious proposed change which may see DAP preferred over RAD are changes to the asset and income test when determining the proposed care co–contribution, the family home will be included to a value cap of $144,500 but no such cap applies to a RAD –

this proposed differentiated treatment of the family home versus the RAD is not logical.

6.36 A likely consequence of this will be that a better financial outcome for many resident profiles will be either:

- to pay a DAP (retain the family home - home not sold to pay a RAD); or alternatively
- to pay a reduced RAD topped up by a DAP.

6.37 This seems to be the view of expert financial planners who caveat this conclusion on the basis that the proposed income and assets test changes are yet to be fully disclosed.

6.38 In this scenario, the RAD does not vary for a resident who has already entered into care. It only goes up at the next entry date unlike home mortgages, which go up and down based upon the market. It is more consumer friendly in that regard.

6.39 At the time of entry into aged care, they or their family make the decision that if the RAD is too high and they cannot afford to pay the DAP, they will sell the family home and pay the refundable bond.

6.40 The Coalition agrees that residents do need options for a range of payment arrangements to best meet their individual financial situation. However, such options should not be at the financial disadvantage of the provider or the whole system runs the risk of collapse. This proposal creates too much uncertainty for providers if providers have their financial future eroded any further.

6.41 It has been stated that an approved provider must consider many aspects of risk when determining further financial investment. In addition to the obvious costs of care, other factors such as the quality of the proposed capital works, existing capital investment, local competition are all part of the overall business risk assessment. The cost of the invested capital is measured as the Weighted Average Cost of Capital (WACC) and this is significantly different to MPIR which will produce a lower equivalent periodic payment. Use of the MPIR and its lower resulting periodic payment will naturally be attractive to potential residents.

6.42 The use of the MPIR in any formula to calculate individual bond levels will erode the overall bond pool and impact on the available security for the necessary financial capital arrangements.

6.43 Further instability will flow from the quarterly changes in the MPIR forcing wild movements in RADs and rapid changes in fees and charges. This alone will add more administrative burden to providers and in difficult financial times will mean less care, less staff and poorer services due to the tightening of financial situations for providers.

6.44 The end result will be a lowering of the RAD pool of funds and thus less incentive for providers to take risks with further capital investment.

6.45 On this issue, Adjunct Professor John Kelly, CEO, ACSA, states:

> Simplistically, I understand the MPIR extends from what is used by the ATO. It is a standard interest rate that changes every quarter. It is something that you would understand government would want to use in terms of that consistent measure or translation point from an interest perspective. So that makes sense. It is just that, when you apply it in two ways to the current reform agenda in this area, what is changing is that, as I said in my submission, 90 per cent of residents currently pay a bond. It creates a platform of certainty for the banks in terms of their lending profiles and policies. We have spent a lot of time trying to understand where the banks were coming from and what their process was in terms of supporting debt funding for providers in terms of their capital expenditure. It would seem that, if there was uncertainty that entered the market from a greater number of residents moving to the daily accommodation payment, this would lessen the pool in terms of bond moneys that banks currently would use as a platform, if you like, for assessing loan-to-value ratios etcetera.

6.46 Following the KPMG advice, Minister Butler has written to the Committee and advised that the review provisions in the bills will be amended to include further review processes on the appropriateness of continuing to anchor the equivalence formula in the RAD, taking into account the impact on consumers, providers and investment in the sector.

6.47 Despite this last ditch effort at patching up, the complex issues raised by the RAD and DAP and the MPIR and WACC are not resolved.

Recommendation

Given the financial concerns raised, the lack of appropriate modelling in so many areas and the overall uncertainty within the sector created by these proposed changes, Coalition Senators recommend that all changes to accommodation payments should be reconsidered pending further detailed modelling and the outcome of the review processes imbedded in the bills.

Chapter 7

Pricing Commissioner

7.1 The Coalition is concerned at the lack of distinction between the roles of the proposed Pricing Commissioner and the existing Aged Care Funding Authority (ACFA)

7.2 While an independent pricing framework is supported by the Coalition, there appears to be insufficient distinction between the two proposed roles which will only add to the compliance burden for providers and potential confusion for consumers.

7.3 Aegis Aged Care Group the largest residential aged care Provider in Western Australia argues that:

> No caps should have to be approved by the Pricing Commissioner. The prices charged should be transparent and published on the Provider's website and the Government's My Aged Care website.[1]

7.4 Masonic Care Alliance is worried about the independence of the Aged Care Pricing Commissioner:

> The MCA believes that this is a vital role within the new aged care structure and should be independent and not be able to delegate its responsibility to the Department.[2]

7.5 Mr Ray Glickman from ACSWA is concerned about the additional regulation facing the sector:

> I think that we could talk about the pricing commissioner in relation to additional regulation. I have heard it described as 'a solution looking for a problem', and certainly, I think that in Western Australia that that is true. We have had a bond market, if you like, that has worked well in Western Australia and I am not aware of super bond problems such as this legislation is supposed to correct. I think that it has actually worked pretty well in having balanced and reasonable outcomes in terms of bonds. As someone said before- and I think it was Mr Gillett - there is a whole new bureaucracy being developed about regulating prices and I am not sure whether that is going to be a great benefit to the system.[3]

7.6 Mr Felix Pintado, Board Director, Masonic Care Alliance reinforces the view that the pricing commissioner needs to be independent, but also needs to be a full time role:

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1 Aegis Aged Care Group, *Submission 7,* p. 3.

2 Masonic Care Alliance, *Submission 25*, p. 2.

3 Mr. Ray Glickman, Aged and Community Services WA, *Committee Hansard*, 29April 2013, p.37

> We believe that the pricing commissioner needs to be a full-time position. It needs to be independent of government and not able to delegate to the department its authority. We also believe that the Aged Care Financing Authority is an admin construct at the moment. It should be supported in the statute - in other words, a statutory authority - with an additional provision added that requires the minister to provide a statement of material facts and reasons for decisions where the minister varies from the advice provided by the authority.[4]

Recommendations

- **That further consideration be given to the need for two separate pricing regulatory arrangements – the Pricing Commissioner and ACFA;**
- **That further clarification is required for the roles and responsibilities of the Pricing Commissioner and the Aged Care Funding Authority; and**
- **There be no capacity to delegate the authority of the Pricing Commissioner to the Department of Health and Ageing**

4 Mr Felix Pintado, Board Director, Masonic Care Alliance, *Committee Hansard*, 30 April 2013, p.36

Chapter 8

Rural and Regional

8.1 Many older Australians indicate a desire to age in place. However for older people residing in rural and regional Australia, this is substantially more difficult to achieve, particularly as care level needs increase.

8.2 'Ageing in place' is commonly referred to as residential based care that enables an individual to independently remain in their own home, or to receive progressively increased services. This requires flexibility in delivery and continuity particularly for rural areas, but also access to formal care services within their own communities due to social connections.

8.3 Ageing in local community is important for not only the individual's wellbeing, but also for the stability of community and cohesiveness of family.

8.4 Ease of access is essential for the wellbeing of couples where one with dementia or other illnesses requires separate living arrangements. This can be an additional burden in regional areas due to lack of transport and large distances.

> The proportion of elderly people within the population is increasing. This trend is intensified and more prevalent in rural and regional areas than in urban centers. In 2008 the number of Australians aged 75 years or over within the rural population had been growing at over 3 per cent per year for around a decade.[1]

8.5 Coalition Senators recognise the significant role that aged care facilities play in rural townships. Aged care facilities and services in rural and regional areas enable families to remain close as people age closer to home, family and community. Aged care services are often one of the major employers, thereby contributing to the economic activity of local townships. In regional Australia there are 1225 Residential Aged Care providers, and 1124 (91%) have 60 beds or less.[2] Regional aged care providers also play a significant role in providing a range of services in the one location, as compared to metropolitan facilities able to focus on niche markets.

8.6 Rural and regional service providers made significant representation to the inquiry.

8.7 From submissions received, and evidence presented at hearings, all submitters recognise the need for reform in the Aged care sector, and welcomed the Productivity Commission's report, Caring for Older Australians. Regrettably, only 5-6% of the

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1 Bureau of Rural Sciences, 2008, *Country matters: Interactive social atlas of rural and regional Australia*, Commonwealth of Australia, Canberra, p.3

2 Department of Health and Ageing, Service List Analysis, June 2012.

recommendations proposed by the Productivity Commission have been adopted in the Living Longer Living Better package of bills.

8.8 Coalition Senators are particularly concerned about the impact of this package of bills on rural and regional areas. These Bills do little to recognise the unique issues faced by rural aged care providers. Evidence presented at four public hearings in Perth, Sydney, Melbourne and Canberra, and in over 100 submissions received, highlighted some of the specific challenges faced by rural and regional providers:

- The inadequacy of the existing 'viability supplement' to compensate for the challenges faced by regional providers.
- The inequity of bond calculations given the much lower property values of regional areas compared to metropolitan and coastal locations.
- The removal of retention payments affecting the viability of regional providers.
- The challenge of recruiting and retaining staff in regional locations.
- The burden of accreditation and administration on smaller providers.
- The challenges of rural providers to meet the staff and training requirements of the Workforce supplement.
- The lack of funding for rural providers to invest in capital works, expansion or upgrade of facilities, and recognition of the additional cost of building in rural areas.
- Duplicating service delivery provided by other levels of government.

8.9 There has been increasing concerns raised by rural and regional providers about their future viability and the need to reform Australia's aged care system. The need for reform has been long overdue, markets by their nature, cannot offer certainty and providers who cannot attract enough clients will fail. This can pose risks for the clients of these providers, especially in the case of aged care. There are also risks that providers will not enter a market where demand is limited, such as in rural and remote areas or where there are relatively few clients with particular needs, or a capacity to pay, as rural providers are already closing down.

> There are providers in rural and remote areas of Queensland that have decided to withdraw their services due to viability issues.[3]

8.10 Addressing failures of the aged care market is a further reason for government involvement. There are a number of areas where the market for aged care lacks features of an ideal market. The level of demand for aged care services varies across location and the cost. The expectation in regional area of the reform package following the Productivity Commission's report was high.

3 The Hon Lawrence Springborg MP, Minister for Health, Queensland – *Submission 98,* p. 2.

8.11 Coalition Senators are concerned that the government's piecemeal approach to so called reforms will result in increased complexity and cost without addressing the core issues of both providers and people dealing with ageing in rural Australia.

8.12 There are considerable challenges faced by aged care service providers in rural and remote areas when it comes to implementation, delivery and management of holistic aged care service including[4]:

- The relatively high cost of establishing and delivering services.
- Difficulties in attracting, retaining and professionally developing suitably qualified staff
- The limited availability of medical practitioners and allied health professionals to support the provision of aged care services.
- Low incomes asset value
- Distance
- Logistics of continuous care provisions in rural locations

8.13 With this in mind, the Coalition points to the Productivity Commission Report which gave special consideration to older Australians living in rural and remote locations and concluded:

> Where there are unavoidable and significant variations in occupancy, alternative funding models, such as supplementary block funding and capital grants in addition to mainstream funding, may be required to ensure the ongoing availability of aged care services in these locations.[5]

8.14 It is disappointing that despite the Commission's findings in 2011, the Living Longer Living Better package of Bills that seek to reform the aged care sector, continue to ignore the concerns raised by rural and regional providers.

8.15 Coalition Senators recognise the desirability of certainty for aged care providers in regional areas. This will assist to ensure that the infrastructure that is the lifeblood of these small community towns remains viable, as recommended by the Productivity Commission Report. This perspective was supported by industry:

> There were a couple of things recommended by the Productivity Commission which certainly the National Presbyterian Network and also Aged and Community Services Australia have in the past supported. They include looking at enhancing the capital funding stream; it is very small for the number of facilities in regional areas. You can look at the fact that maybe you need to do some block funding. At the moment, we fund aged care by the number of residents or clients in aged care packages. If you do not have any old people, you do not get any money. Maybe you need a

4 Productivity Commission Report, *Caring for Older Australians 2011,* p. 265.

5 Productivity Commission Report, *Caring for Older Australians 2011,* p. 265.

> level of guaranteed funding so that there is an infrastructure that stays in those small community towns[6].

8.16 The following points highlight some of the concerns raised by rural and regional providers in evidence provided to the Committee during the inquiry.

Inadequacy of the existing viability supplement

8.17 Coalition Senators recognise that aged care reforms cannot apply a 'one size fits all' approach as providers in rural and regional locations face different challenges to metropolitan areas. These concerns were identified in the Productivity Commission's report, recognising the relatively high cost of establishing and operating an aged care service compared to similar services in metropolitan and other regional locations. In addition, older Australians living in rural and remote communities may not have high levels of income and assets from which aged care providers can draw additional payments, such as significant accommodation bonds or extra service fees.[7]

8.18 Coalition Senators are aware that the Government's package of bills to reform the aged care sector fail to address this issue of ongoing viability of regional providers, and the specific challenges that they face.

8.19 When asked how the Living Longer Living Better legislation will improve access to residential aged care for people living in regional, rural and remote areas, the answer provided by the Department of Health and Ageing's Question and Answer Fact Sheets state:

> Under aged care reform, resources will be targeted to the areas of aged care most in need. In general it is more expensive to build and deliver aged care services in non-urban areas, compared to urban areas. A viability supplement will continue to be made available to eligible providers operating in regional, rural and remote areas. This will ensure services are available for all older Australians regardless of where they live. [8]

8.20 The government's response was put to rural and regional providers and their response was dismissive. The quote below from Narrogin Cottage Homes best encapsulates their comments:

> I love that comment: 'This will ensure'. It is an incredibly laughable statement. I am very surprised that they used those words, because that is saying that it meets a need. It does not. The viability supplement was put in place many years ago. It was quite a complex … The methodology itself is so old and out-of-date. It has not been looked at for some considerable

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6 Mr Paul Michael Sadler, Chief Executive Officer, Presbyterian Aged Care New South Wales and Australian Capital Territory, National Presbyterian Aged Care Network – *Hansard Tuesday 30 April 2013*, p. 43.

7 Productivity Commission Report *Caring for Older Australians 2011, p.* 266.

8 DoHA, *Questions and Answers Regarding the Legislative Changes*, p. 11, http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/ageing-legislative-questions-and-answers-toc (Accessed 21 May 2013)

> period of time. So, when you make a statement that it will ensure that these services are available, it is not making them available. It certainly assists, but it is not a true reflection of cost of care. .. I am not saying the viability supplement should be scrapped; I am just saying that, if we do have to keep it, it needs to correctly reflect services in the region that the viability supplement is being applied to.[9]

8.21 Clearly the existing measures are not working whilst the government's failure to address the underlying issues of the viability of service providers in rural areas.

Inequity of the bond calculation

8.22 A further challenge faced by rural and regional providers through this legislation is the strengthened dependence on bonds. Coalition Senators recognise that aged care providers depend on the investment earnings of Bond money to run their facilities. However, this 'one size fits all' approach by the Government fails to recognise the significant inequity in property prices. One submitter said;

> In most country towns people's properties are not worth as much as they are in coastal areas and in metropolitan areas. That means the refundable accommodation deposit—in the new language—that they will potentially pay will be lower. Under the current arrangements, we accept in our rural services a substantial number of part bond payers who are not paying the full amount of the bonds.[10]

8.23 Another issue for rural and regional communities is in the case of a family farm, where the asset is inherited by the next generation leaving the aged "owner" without the capacity to meet bond requirements. Coalition Senators are keen to see greater flexibility in service delivery ensuring that regional Australians are not disadvantaged by their geography as they age.

8.24 In giving clients greater flexibility to move into an aged care facility and decide within 28 days if they want to remain, the delay in Bond payments creates uncertainty for the provider and the relationship with their financial institutions. The question remains that if someone wants to move in and fails to pay, how can they be forced out, and where will they go?

Removal of retention payments

8.25 In many rural areas providers accept part bond payers, who are not paying the full amount of bonds because their property's value is low– and therefore the aged care facilities rely on retention payments. Under these bills, retention payments have been replaced by refundable accommodation deposit – but the amount will potentially be a lot lower. Increasing the total price to raise sufficient interest is not viable in

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9 Mrs Julie Annette Christensen, Chief Executive Officer, Narrogin Cottage Homes, Hansard Monday, 29 April 2013, p. 45.

10 Mr Paul Michael Sadler, Chief Executive Officer, Presbyterian Aged Care New South Wales and Australian Capital Territory, National Presbyterian Aged Care Network – *Hansard Tuesday 30 April 2013*, p. 42.

rural communities, where people simply do not have the money, either from the value of their property or other assets.

> The challenge for us under the government's new arrangements is: with the retention amount removed from the equation there is then the question of how do you make that up? The government appears to be saying that the mechanism you use is to increase the total headline price to raise sufficient interest in order to cover the lost income. There is a real question of whether that will be viable in rural communities because people may simply not have the money, even off the value of their property let alone other assets they might own.[11]

8.26 Coalition Senators recognise the risk of unintended consequences from 'one size fits all' policy initiatives.

Challenge of recruiting and retaining staff in regional locations

8.27 Coalition Senators recognise the challenge that rural and remote communities face in recruiting and retaining aged care staff. In some rural areas there are limited training opportunities where skill development relies on the expansion of accredited courses, vocational training opportunities and availability of advanced nursing courses. Whereas nursing staff in metropolitan areas can easily access courses to develop their professional skills or participate in advanced clinical courses under the watchful eye of trained professionals, these opportunities are limited in regional and rural areas. Distance can inhibit training opportunities for regional and rural service providers, and further research needs to be undertaken to harness technological advances to expand training opportunities in regional locations.

8.28 At the heart of the challenge facing many regional providers is the cost of wages and labour, expressed by Anita Ghose, Director of Life Services with Baptistcare;

> I think one of the main issues that we face in rural and regional areas is around our workforce. And the challenge we have is dual: we need to provide a quality service—our clients, our residents, demand and expect that—but we also need to provide quality staff who are trained and supported in that environment. We have a unique demographic in Western Australia, which I think has been lost in the national debate, which is around the challenges of the tyranny of distance but also what has happened in terms of the cost of living and the issues around our mining and resources sector, which in some cases is being used as the explanation for every problem in the west. But I have to say unequivocally that the issue around the cost of wages and the cost of labour in regional and rural areas is decimating the viability of regional providers. For Baptistcare, as Dr Morris mentioned, we have 60 per cent of our services in regional areas. Our challenge is to not only find good staff but to keep them. Unfortunately we have had to resort to bringing in expertise from overseas using the 457 visa

11 Mr Paul Michael Sadler, Chief Executive Officer, Presbyterian Aged Care New South Wales and Australian Capital Territory, National Presbyterian Aged Care Network – *Hansard Tuesday 30 April 2013*, p. 42.

> process. We have brought in nurses and qualified practitioners from Ireland, the UK et cetera. The challenge in retaining those individuals..We have firsthand experience of using recruitment agencies, at great cost to the organisation. Our cost structures have increased in our recruitment processes and bringing these individuals in from overseas. In one instance, one of them lasted one week in a country town—and that was Albany. They do not last that long because of the issues they face around being in regional areas. The challenge for regional providers is that they are the rich fabric of our demographic in Western Australia and we need to prioritise and support. I do not think the workforce supplement does that at all. I think what it does is erode the viability of those providers and disadvantage them.[12]

8.29 A similar view was expressed by Mr Paul Michael Sadler, Chief Executive Officer, Presbyterian Aged Care New South Wales and Australian Capital Territory, National Presbyterian Aged Care Network;

> The other area that needs looking at is clearly the workforce costs in some of these small communities in order to access things like registered nurses and so forth. Particularly when you get to the really remote areas, and Aboriginal services, they are huge and that need to be recognised.[13]

8.30 Skill shortages in regional areas occur for a number of reasons and not only in aged care. Coalition Senators acknowledge that technology can deliver innovative ways to access training and placement opportunities – which are not addressed in these bills.

The burden of accreditation and administration on smaller providers

8.31 The accreditation process is yet another element that presents significant challenges for rural and regional providers. Additional administrative burdens are continually added that have a significant cost to small rural service providers unable to defray the costs over multiple sites like larger providers.

8.32 The need to tailor the challenges of the accreditation process are outlined in the following submission by LHI Retirement Services:

> It is proposed that a provider can be suspended from undertaking ACFI appraisals if there have been two incorrect appraisals submitted. An educative approach would be preferable to assist staff to undertake ACFI appraisals rather than the proposed punitive approach. The educative rather than punitive approach will assist smaller country rural and remote facilities

12 Anita Ghose, Director of Life Services with Baptistcare, *Committee Hansard 29 April*, p. 14-15.

13 Mr Paul Michael Sadler, Chief Executive Officer, Presbyterian Aged Care New South Wales and Australian Capital Territory, National Presbyterian Aged Care Network – *Hansard Tuesday 30 April 2013*, p. 43.

> to use the ACFI process appropriately and accurately, and reduce the number of facilities that will otherwise have to cease operating.[14]

8.33 Balancing regulatory burden is important in a sector concerned with frail older Australians. However, its impact should be minimised on front line service delivery and economic viability for providers.

Inability of regional providers to meet the workforce supplement requirements

8.34 Regional providers have highlighted that retaining registered nurses in remote areas leads to a higher workforce cost, which needs to be taken into consideration when looking at the real cost of delivering aged care services in regional areas. When added to the already thin margins of regional providers, the onerous workforce supplement requirements could result in significant job losses in areas where employment opportunities are limited.

8.35 During the inquiry, industry raised concerns that rural providers may struggle to fund the additional costs of meeting the requirements of the supplement;

> ACSWA rural and remote providers, and small providers are particularly impacted by the proposed Workforce Supplement. Members have provided examples of the cost impost with respect to legal advice on the terms and conditions of an enterprise agreement, travel and accommodation surcharges to access relevant training, or to bring trainers or specialists to their sites. This has particular relevance for providers in areas of WA that have to compete with the mining resources sector to secure accommodation and airfares for staff or presenters that significantly contribute to additional expenses.
>
> Speculation about the additional costs to providers to fund the Supplement requirements suggest that mitigation factors such as a reduction in staffing numbers will be the most likely result, as providers have no other option than to cut their costs and many are already under financial duress. Providers have limited opportunities to increase their income to cover the additional costs incurred by the Workforce Supplement as they are constrained by a tightly regulated environment and there are no additional income streams available to recoup the additional expenses to achieve the requirements of the Workforce Supplement. ACSWA has received feedback that most small and rural and regional providers will not be able to afford to take up the Supplement. In one instance a 31-bed residential care provider has estimated that to receive $17,000 from the supplement, it will cost them an extra $30,000 to meet the requirements.[15]

8.36 Submissions received requested greater flexibility be given to smaller regional providers in satisfying the requirements to access funding;

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14 LHI Retirement Services, *Submission 8* – same information also present in 4 other submission from Lutheran Homes

15 Aged & Community Services - Western Australia, *Submission 77*, p. 3.

> The workforce supplement will have significant impacts on the sustainability of providers and the level of care delivered to the frailest and most vulnerable members of our community….the capacity of small, independent, rural and remote aged care providers to satisfy the requirements to access this funding must be identified, acknowledged and addressed. For example, rather than have an arbitrary delineation of 50 beds as a determining condition there should be greater flexibility taking into consideration factors such as the provider's rural, regional and remote situation. The size of a facility should not necessarily be the sole determining factor as other factors such as remote location influence wage matters. Neither rural, regional and remote providers nor standalone providers should be financially compromised in the implementation of the workforce supplement.[16]

8.37 The government's blunt response fails to acknowledge the unique workforce issues across regional Australia. Thin margins, lack of skilled workforce, low number of training options and high recruitment costs of rural and regional service providers already impact on their economic viability. The government's changes could see a reduction in employment levels in aged care services across the regions - a negative result for workers and the community.

Investment in capital works and facility upgrades

8.38 Providers have expressed concern at the continued restrictions on the use of bond money, which restricts the ability of smaller regional providers to expand their services, and broaden their income base by widening the range of aged care support services provided. Where metropolitan services can develop niche services, rural aged care facilities fulfil a very different role, providing in many cases a one stop shop for aged care services.

8.39 Providers have been critical of the lack of adequate capital funding needed to upgrade their facilities;

> Half of our members would be rural organisations. Until recently I was a member of the board of Mary MacKillop, which is also providing care in rural areas. They are a group that looks after the people nobody else wants. They will tell you it is dire straits in country areas with facilities. They have not been able to upgrade. Often the family farm is inherited, so there is not the capital. I think it is very un-Australian for us to continually focus on user pays and ignore the fact that people in country areas are doing it so tough that we cannot within our system, whatever it is, find a solution to their particular problems. It is only going to get worse for them. Most of them do not have a competitor down the road; they are often the sole provider for a very large area. I am sure there will be a need for the government to come up with some better ideas.[17]

16 Ms Alexandra Zammit, Chief Executive Officer, Thomas Holt – *Submission 74*, pp 5-6.

17 Mr Tim Gray, Chief Executive Officer, LHI – *Committee Hansard, 30 April 2013*, p. 42.

8.40 LHI have expressed a need for capital certainty if they are to remain viable, as highlighted in a submission from LHI;

> Refundable Accommodation Deposit (formerly Accommodation Bonds) are the most important capital base for the future viability and development of aged care facilities. The proposed periodic payments system must not undermine the capital base of organisations and threaten future aged care developments, particularly in the smaller rural and remote section of the industry. A significant growth factor for residential care services is expected to continue into the future and the capital base must be secure to ensure replacement and additional developments are viable for the care of the elderly.[18]

8.41 Many regional providers of residential aged care are not-for-profit community facilities utilising fundraising efforts from small communities in order to meet increasing costs. As evidenced in the inquiry, the government's failure to acknowledge the lack of desire for investment in regional areas, due to low demand, indicates their disconnection from the realities of operating aged care in the regions.

Summary

8.42 Coalition Senators recognise that any reform of the aged care sector needs to take into account the unique aspects of ageing in rural and regional communities. From the evidence received, it is clear that a flexible approach is required in rural and remote communities. The Living Longer Living Better package of 5 bills inadequately addresses the specific needs in rural and regional area allowing for continuity of care, within their community, recognising the financial reality of lower incomes and asset levels, the higher importance of access to home care and the acknowledged greater service delivery costs in those areas.

8.43 Providers have suggested that flexible funding and delivery models are required to address the specific concerns of rural and remote communities. Evidence gathered during the inquiry supports reforms of the aged care sector that will ensure the maintenance and development of facilities, high standards of service delivery, adequate training, and coordinated delivery of aged care services in rural and remote areas.

8.44 The Government has failed to take account of these realities due to the lack of modelling to inform their response which does little to address the problem, as the key recommendations within the Productivity Commission report are ignored.

8.45 The Government has also failed to recognise that in many rural areas there is not the demand, or at the very least, the stability of demand to ensure a competitive process in aged care service provision. This is a significant issue ignored in these bills.

18 LHI Retirement Services, *Submission 8* – same information also present in 4 other submission from Lutheran Homes

Recommendations

That the Government reconsider the changes to address the unique challenge of aged care service provision in regional, rural and remote Australia as identified by the Productivity Commission enquiry "*Caring for Older Australians*".

That the Government take into account the need for flexible funding and flexible provision models, that consider the many issues raised throughout the inquiry, such as:

- **building stock;**
- **standards of delivery;**
- **staff development;**
- **delivery of HACC services;**
- **service sustainability and support; and**
- **flexible methods of service provision.**

Senator Sue Boyce **Senator Concetta Fierravanti-Wells**

Senator Bridget McKenzie **Senator Dean Smith**

AUSTRALIAN GREENS ADDITIONAL COMMENTS

Introduction

1.1 The Australian Greens are strongly supportive of responsible and much needed reform within the aged care sector. Reforms have been spoken about for many years, and all the while, pressure on older Australians and the staff who delivery services to them has increased.

1.2 In a country such as ours, it is shameful to think that older Australians are being denied access to appropriate and adequate care, especially in regional and remote areas.

1.3 As our population continues to age, the challenges faced by the sector will increase and must be met through comprehensive reform.

1.4 Many organisations have taken time to participate in the committee process, despite the short time lines, and the Australian Greens thank all those people and organisations who participated in the inquiry for preparing submissions, appearing at the hearings and providing the additional materials and advice as the committee requested it.

1.5 The Australian Greens have consulted widely with the sector and have identified a series of outstanding issues that still need to be resolved in order to be confident that the legislation, when implemented, will ensure the objectives underpinning Bill are realised and do not unduly disadvantage any particular group of consumers or providers.

1.6 However, on the whole, the Australian Greens believe that, the Living Longer, Living Better legislation will be an important step forward in ensuring quality care is accessible for all older Australians.

1.7 The Australian Greens also note there has been some significant anxiety about the passage of the legislation. Some of that anxiety was avoidable, had the principles behind the Bill been released at the same time as the legislation itself. The Australian Greens want to reiterate the remarks in the majority report, that introducing significant legislation without at least the draft delegated legislation makes it difficult to assess and is a poor process which needs to be avoided in future reform packages.

1.8 The Australian Greens are committed to continuing to work on aged care reform that builds on the architecture set out by this legislation and can ensure the delivery of better outcomes for older Australians and the aged care sector alike.

Productivity Commission Report

1.9 The Australian Greens believe that all people should have access to high quality aged care that allows them to live their lives with dignity, regardless of their capacity to pay and that funding is available to support vulnerable people who are unable to meet the costs on their own. However, the Australian Greens recognise that

in order to ensure this access and quality of care in the face of increasing demand, aged care services needs to be financially viable and capable of achieving growth.

1.10 The Productivity Commission (PC) reviewed the delivery of aged care services in Australia and highlighted a range of areas within the aged sector that are in need of attention and through its recommendations set the scene for significant reform. This legislation, which provides the architecture for a broader reform package, builds on both the Productivity Commission inquiry and the National Aged Care Alliance Blueprint[1]; still many submitters noted in their evidence that this legislative package has only partially adopted the PC report's recommendations. These submitters emphasised their preference to adopt the PC recommendations more fully and there was a particularly focus on the entitlement model for service delivery proposed by the PC. The Australian Greens are supportive of the idea of consumer directed care and giving individuals capacity to exercise choice and control over the services that they receive but also recognise that this is only financially sustainable in the long term if combined with a much stronger emphasis on co-contributions to care from those who can afford it. Through this legislation, the Government has taken some steps towards introducing broader means testing as well as care contributions for all forms of care, including high care, but clearly wasn't prepared to implement the Productivity Commission recommendations fully. The Government indicated at the time it did not believe that the Australian community would support the measures, which in turn has limited the scope of the reforms. In particular, the Government did not explore fully the appetite of the Australian people for a Pensioner Aged Care Home Credit scheme and associated Australian Pensioners Savings Account, which would have allowed individuals to access the equity in their homes.

Co-Contributions

1.11 The Australian Greens are broadly supportive of the introduction of a payment framework which facilitates co-contributions but also provides important protections such as the annual and lifetime caps, along with greater flexibility and time-frames for consumers to choose how they pay though a mixture of lump sum and regular payments. However, the Australian Greens have some significant concerns about the operation of the co-contribution tests, particularly in home care, that have not been adequately addressed by the majority committee report.

Home Care

1.12 The Greens believe that delivering care in the individual's home contributes to positive ageing and ensures that ageing Australians stay connected to the broader community. It is good to see that there are significantly more places available in home care already and these places were taken up through the last ACAR funding round, demonstrating that service providers are preparing to deliver more home packages. However, the evidence presented by Uniting at paragraphs 3.45 to 3.47 of the majority committee report clearly demonstrates the pressure that part pensioners will experience under the pricing structures proposed by these reforms. The Australian

1 National Aged Care Alliance, *Blueprint for Aged Care Reform*, February 2012

Greens are disappointed that DoHA's response to Uniting Care's concerns has been to calculate the cost impact on the consumer using a measure of the average basic fee that providers currently collect rather than the maximum basic fee, given the expectation that service providers will begin to move to delivering home care as individualised packages of funding, without block funding in most cases, and so will no longer be able to price smooth across consumers. The graph at paragraph 3.46 of the majority report clearly demonstrates that these fees rise too quickly as a portion of income for part pensioners up to $33,700.

1.13 The Australian Greens agree with Uniting Care's assessment that part pensioners who face a range of other cost of living pressures will not be able to afford care and share the concern that some people will self-ration out of care. The Australian Greens do not share the majority view on this matter at paragraph 3.60 of the majority committee report.

1.14 Uniting Care propose smoothing the cost to part pensioners by changing how the taper rates operate. The Australian Greens recognise that this will have a cost to Government. However, if part-pensioners self-select out of care, they are likely to have a significant impact on the public health system in the future which will have its own associated costs.

Recommendation 1: The Australian Greens recommend that home care taper rates be revised.

1.15 Council of Social Services of New South Wales identified a potential impact on demand for Home and Community Care Services (HACC) if the cost of home care is not addressed.[2] HACC also delivers important community services, but through a model that is based on block funding services and it appears that the Government has given little consideration to how the program will interact with HACC. HACC services did not feature prominently in the evidence that the committee received but the Australian Greens are aware that the move towards CDC and the introduction of a very low level care package in Home Care will interact with the block funded HACC services. The Australian Greens agree with the majority committee report's assessment that the effects on HACC will need to be reviewed but believe that this monitoring should be ongoing and that the delivery of care and support through the NDIS, HACC and these new Home Care packages should be the subject of a broader inquiry in the near future.

Recommendation 2: That the impact of consumer directed Home Care packages be monitored with a view to the impact that it has on the delivery of broader community care programs such as HACC

Recommendation 3: That there is a broader review of how community care is delivered in Australia through both individualised packages in aged care and disability and the intersection with other community care programs such as HACC.

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2 Council of Social Services of New South Wales, *Submission 96,* p.10

Residential Aged Care

1.16 As this legislation represents significant reform, both consumers and providers will experience significant changes and inevitably there will be some trade-offs as a result. For example, consumers will have access to greater choice and control over how they pay for care, but are now expected to contribute to the cost of that care if they can afford to. The asset rich, income poor consumers who have largely avoided paying for high care places will now contribute the same as someone with the same overall means but a different mix of assets and income. The distinctions between high and low care, and the associated restrictions on who could be asked to pay for care, will disappear which will ensure that there are more consumers contributing to the cost of their accommodation and care but providers have to contend with a longer decision making period of 28 days and increased control for consumers to choose if they pay daily or lump sum contributions.

1.17 The Australian Greens recognise the need for trade-offs, if they improve the sector overall and increase access and consumers and providers are all treated fairly and equally, while still delivering the key outcomes of consumer control, access for those of limited means and sector viability. However, we also recognise the concern that industry has about the impact of the legislation on the business model currently used by many providers and their ability to navigate effectively through the reforms. The KPMG modelling outlined in Chapter 4 of the majority report was unfortunately not finalised until after the committee hearings were concluded. This report indicates that on aggregate there will be a greater inflow of capital overall, however for at least some providers there is a genuine risk that there will be unmanageable impacts on both the cash-flow required to operate the existing services and access to the capital inputs needed to build for the future.

1.18 Most significantly for consumers and providers alike is the shift in their understanding of how the lump sum bonds are negotiated by establishing a clearer link between the cost of delivering accommodation and the lump sums that individuals deposit with providers for the duration of their time in that care facility. These deposits were previously named an accommodation bond and now called a refundable accommodation deposit. Consumers may also choose to pay for their care on a daily basis, using a daily accommodation payment. Establishing a strong link between the daily accommodation payment (DAP) and the residential accommodation deposit (RAD) is important for consumers and facilitates fair, transparent pricing. However, this is clearly the most contentious part of the legislation, and as noted Chapter 4 of the majority committee report, residential providers have a number of concerns that largely focus on whether the legislation will result in a significant shift by consumers from RADs. This is an important consideration because in the current system, large lump sum accommodation bonds have played an important role in driving investment and have been used by some providers as short term capital to facilitate growth in the number of places that are available to consumers and ongoing refurbishment of facilities, but the size of these accommodation bonds have not always been appropriate for the individual consumer.

1.19 These reforms put restrictions on the size of bonds but increase the total pool of people who can pay their accommodation fee through a lump sum payment, as part

of lifting the distinction between high care and low care.[3] With this reform, those consumers who may have waited too long to enter care because of the perceived barrier that large low care bonds have represented will have more options available to them, including daily accommodation payments, as well as being able to form combinations of daily payments and a lump sum. However, providers have to face a situation of less certainty about how consumers will choose to pay their contributions, and their evidence to the committee demonstrated that this does have implications for their business planning.[4] Other submitters expressed concern that, given the industry's heavy reliance on the capital that upfront bond payments provide, that a move by consumers away from lump sums will require them to find new ways to attract bank loans to build new facilities and service their debt.[5]

1.20 Consumer representative body, COTA, noted that, "COTA does not think there will be a big shift away from RADs in the short term. If [there is], that will be an expression of consumer preference, which is the purpose of the reform."[6] However, the evidence that the committee heard raised some serious questions about whether the legislation has indeed ensured equivalence between the DAP and the RAD payment. For many submitters an ideal policy outcome was expressed as one where there was neutrality of choice between payment types and consumers were not necessarily led towards one over the other; however they argued that in the current reform package this principle is not necessarily achieved because of the decision to maintain the existing arrangements for the primary residence in the asset test.[7]

1.21 Consumers who hold onto the primary residence will be treated differently to those who do not in the asset test. The Department of Health and Ageing were explicit in their evidence that the house is treated as a special asset.[8] As a result of this different treatment, the Australian Greens share the view of many submitters that this will impact on how consumers may perceive their options. While the primary residence is given protected status it is difficult to address this situation, however, providing special treatment for the primary residence compared to the realised asset in cash is also not a new concept, it has been a foundational decision in many other policy frameworks, including the aged pension test.

1.22 The Australian Greens are reluctant to address the issue of equivalence between the treatment of the lump sum (and the suggestion that it unintentionally preferences the daily payment over the deposit) simply by allowing lump sum payments for care to also receive protection from asset testing. The Australian Greens believe that giving bonds the same treatment would unwind most of the progress that has been made in ensuring that assets are means tested and that consumers contribute

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3 DoHA, answer to written question on notice, (received 14 May 2013), Attachment 4, p. 3.

4 See for example, Catholic Health Australia, *Submission 55*, p.12.

5 See for example, ANZ, *Submission 94*, p.2.

6 COTA, *Submission 87*, p.15.

7 See for example, Leading Edge Services, *Submission 58*.

8 Ms Balmanno, Department of Health and Ageing, *Proof Committee Hansard*, 1 May 2013, p.77.

to the cost of their care, which would in turn undermine the financial viability of the sector into the future.

1.23 Another suggestion was to treat the rental income of a retained residence the same under the DAP as under the RAD. The Australian Greens have considered this, but recognise that to do so would significantly impact on the architecture of the bill and its intersection with the means testing that occurs under the aged pension, and may have significant unintended consequences for the calculation of the pension, which is another critical component that underpins how older Australians access care and support. The impact of the means testing arrangements is included in the review and the Australian Greens believe that the interaction of these means tests with the tests for the aged pension should also be reviewed at the same time.

1.24 As discussed in the majority report, the modelling from KPMG demonstrates that even with this difference in treatment of the assets, most rational, wealth maximising consumers will still be better off choosing a RAD over a DAP, given their financial circumstances.[9] The KPMG report does help resolve some of our concerns by helping to quantify the possible effects of the reform on capital available to aged care providers, but we acknowledge that this modelling cannot account for the emotional and personal factors, such as simplifying personal affairs or attachment to their former home that may also influence the individual's decision making. We recognise that for many providers, as this modelling may not have resolved all of their concerns about what real consumers may actually choose to do, there will still be a great deal of uncertainty for them to contend with in, as an industry that is in transition.

1.25 While the KPMG Report demonstrates that the aggregate effect would be to generate a significant increase in new lump sums that help underwrite the capital expansion of the industry, the impact on some individual providers may not be so positive. For example, Catholic Health Australia raised concerns that some of their services that are currently set up to provide low care only would find it more difficult to shift their business model.[10] Similarly rural and regional providers raised concerns that they cannot attract bonds at the moment, which has resulted in limited opportunities for growth.[11] Neither group of provider seem very confident of their ability to attract new bonds from patients who would have formerly been classified as high care. Therefore, these providers believe that the access to capital to refurbish and expand their services is likely to continue to be a significant problem, even though the ability to attract customers who want to pay with a combination of a bond and a daily payment will also open up new sources of capital for some of these providers.

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9 KPMG, *Scenario analysis of selected LLLB financial arrangements – Interim report*, prepared for Aged Care Financing Authority, May 2013.

10 Catholic Health Australia, *Supplementary submission 55*.

11 See for example Mrs Christensen, Narrogin Cottage Homes, *Proof Committee Hansard*, 29 April 2013, p. 44-45.

1.26 This uncertainty for providers has also been linked to both the use of a Maximum Permissible Interest Rate to link the DAP and RAD and the 28 day period that consumers have to decision about how to pay their care costs.

1.27 The Australian Greens acknowledge the evidence in the majority committee report which demonstrates that residents are not required to wait 28 days to make a decision about how they will pay for care and agree with COTA that for those entering care in a crisis situation, 28 days is an important safeguard that will allow the individual time to seek financial advice about what will be best for them.[12] We also note that under current arrangements, consumers still have six months after entering care within which to pay an agreed upon lump sum bond.

1.28 However, the Australian Greens are aware that price setting between the DAP and RAD via the mechanism of the Maximum Permissible Interest Rate (MPIR) also has implications for a provider who may simultaneously be negotiating a consumer into a new place while ensuring that they have sufficient cash flow to release the RAD of the previous occupant. Submitters raised some important points about how the pricing setting by estimating a RAD from an DAP using the current MPIR would mean that that even if the new entrant wants to pay a RAD, the calculated value of that RAD could change significantly due to shifts in interest rates. Many service providers asked for this setting to be reversed so that RAD total will stay constant and it is the associated DAP that will fluctuate with interest rate changes. In additional evidence provided to the committee, the Aged Care Financing Authority (ACFA) also recommended reversing the price setting mechanism and the Government has indicated that it will implement AFCA's recommendation.[13] The Australian Greens support adopting this for the first three years as a stabilising measure for providers, but also agree that it should be included in the review process.

1.29 The shift in the industry financing structure will be a gradual one, as existing arrangements will be grandfathered under transitional arrangements. However, the Australian Greens recognise short term liquidity problems will need to be addressed immediately, not just during the review process.

1.30 The Australian Greens recommend that there should be careful monitoring prior to the review period and where problems with individual providers (or particular types of services, such as those mentioned above) are identified, there needs to be a series of transitional arrangement in place to facilitate their transition to a sustainable financial model. The NACA Blue Print asked for refinancing facility for otherwise solvent providers who may face liquidity problems as a result of the greater consumer flexibility to choose between bonds and periodic payments, as well as capped matching grants for smaller providers to seek business advice on their future in the reformed system.[14]

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12 COTA, *Submission 87*, p.15.

13 Correspondence between Ms Lynda O'Grady, ACFA and the Hon. Mark Butler MP, 17 May 2013 http://www.livinglongerlivingbetter.gov.au/internet/living/publishing.nsf/Content/Aged-Care-Reform-Implementation-Council-Communique-advice-to-minister

14 National Aged Care Alliance, *Blueprint for Aged Care Reform*, February 2012.

1.31 Some aspects of this monitoring should be conducted independently from the Department of Health and Ageing and ACFA should be recognised in legislation as an independent body, with a similar composition of industry skills and experience to its current membership, that can undertake this monitoring work with a view to ensuring the financial viability of the sector, and provide timely analysis and make recommendations to Government about how and when to implement transitional arrangements that can address liquidity and capital problems as they arise. These transitional arrangements could include business advice, loan guarantee and bridging finance as part of a commitment to support industry adjustment.

1.32 This monitoring will also serve the purpose of quickly alerting the Government to wide-scale failures, in growth and liquidity, should any arise.

Recommendation 4: The Government should commit to transitional arrangements that include business advice, loan guarantee and bridging finance as part of a commitment to support industry adjustment.

Recommendation 5: ACFA should be recognised in legislation as an independent body with a similar composition of industry skills and experience to its current membership that can undertake this monitoring work separate to the Department of Health and Ageing

Recommendation 6: ACFA should provide timely analysis and make recommendations to Government about how and when to implement transitional arrangements that can address liquidity and capital problems as they arise.

Rural and Regional service providers

1.33 The Australian Greens recognise that this reform has not resolved some of the ongoing problems in service delivery for rural and remote communities. This reform should deliver better outcomes for Australians living in regional areas by better ensuring that they can also access quality care. The Department of Health and Ageing have argued that the ability of service providers to collect more fees and for consumers to combine their payments in the form of lower RADs topped up by DAPs may help ensure more growth in regional areas and therefore more options for consumers to enter care.[15] However, as discussed in the previous section, the exact impacts of the new arrangements cannot be known at this stage and therefore transition packages should be available to regional and remote providers who require them.

1.34 Providers also identified attracting and retaining staffing as a significant challenge in rural and remote communities.[16] The workforce supplement was not considered appropriate to overcome these challenges by many of the regional submitters. As well as making sure that the workforce supplement is delivered to regional and remote employees, further improvements to the scope of viability supplements on offer may also be required.

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15 DoHA, answer to written question on notice, (received 14 May 2013), Attachment 8, p. 2.

16 See for example, Ms Anita Ghose, Baptistcare, *Proof Committee Hansard*, 29 April 2013, p. 15-16.

1.35 In addition to providing more support and funding, the classification tool that is used to determine the eligibility of a service provider for targeted assistance also requires review. For example a service provider in Narrogin, WA, is unable to access the viability support but is clearly delivering services in a challenging rural environment.[17] This is an issue that has been picked up by this committee during other inquiries into service delivery outside metro areas and the instrument should be revised by Government with a view to resolve the broader issues as well.

Recommendation 7: The Government should ensure that the workforce supplement also results in improved wages for regional and remote employees.

Recommendation 8: Further improvements to the scope of viability supplements on offer should be undertaken by the Government.

Recommendation 9: The classification tool that is used to determine eligibility as a regional or remote service provide should be reviewed.

Supported residents

1.36 The Australian Greens fully support efforts to ensure that there are adequate places for supported residents as part of a commitment to ensuring high quality care for all Australians. This is not a component of the legislation, however some submitters raised questions about how the quotas would be applied[18] and the Australian Greens share the concerns expressed that it may not be possible to realise the targets in all regions. We acknowledge that ACFA will be reviewing this issue, which is another clear demonstration of the need for a body such as ACFA to undertake this detailed analysis and provide recommendations to Government. The Australian Greens urge the Government to ensure that this review is completed in a timely fashion and acted upon before the implementation date of 1 July 2014; however the Australian Greens would not support any recommendation that effectively restricts access for supported residents.

Special Categories of Need and associated supplements

Dementia and Mental Health

1.37 The Australian Greens welcome the recommendation in the majority report to broaden the dementia supplement out into a behavioural supplement that has the ability to capture other mental health issues but we remain concerned that this may be an inadequate solution for tackling complex mental health needs. The needs of veterans were explicitly recognised through a veterans supplement, and the Australian Greens believe that this should be seen as best practise for addressing particular at risk groups. The effectiveness of this supplement to meet the care needs of all individuals with a mental health need should be considered during the review process, and additional supplements considered at that time.

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17 Mrs Christensen, Narrogin Cottage Homes, *Proof Committee Hansard*, 29 April 2013, p. 45.

18 See for example, Mr Prior, Hall and Prior Aged Care Organisation, *Proof Committee Hansard*, 29 April 2013, p. 5.

Recommendation 10: That the review of the legislation also considers the adequacy of this supplement to meet the mental health needs of older Australians and considers creating a separate supplement for mental health.

Homelessness

1.38 The committee heard from the Wintringham service about the challenges of delivering aged care to the homeless.

1.39 Mr Adam Bandt, Greens MP for Melbourne, reflected on the importance and unique work that is being undertaken by this service, noting in his second reading speech that:

> Unlike those of us who have family members who will care for us and may go and make the inquiries on our behalf about what would be an appropriate aged-care service, if you are homeless you probably do not have someone to do that for you. It may actually take the service itself conducting outreach, going to where you are—and you might be sleeping rough; you might be in a shelter—and saying to you, 'We can look after you.' … The Wintringham service has gone out of their way to be an aged-care provider for people who have been homeless or are at risk of homelessness. They have devised a system that provides quite a high level of care to the people who end up living there. They have been able to make the service operate within the existing funding systems and set themselves up as an aged-care provider for homeless people and when you walk into one of their places, it is not is what one might call a 'normal' aged-care environment with a smattering of homeless people; almost everyone who is in there has been homeless or at risk of homelessness.[19]

1.40 People who have been homeless for a long period and find themselves getting aged-care services are going to have issues, by and large, that the rest of the people who find themselves in aged care will not necessarily have. Being homeless ages you prematurely, so by the time that you find yourself entering aged care you have a large number of health issues that others do not necessarily have and may require intensive support and care. And, of course, there may be special consideration given to how residents behave and interaction with others. For people who have been homeless for a long period of time then you have learnt to survive and get by, and that does not necessarily involve interacting with others in the way that people who have lived in stable housing all their lives would. Providers may be putting people together who may not have had stable accommodation arrangements for most of their lives.

1.41 Clearly individuals who have experienced homelessness are highly likely to need specialised support to address complex mental health and behavioural needs. While the Wintringham facility has managed to cobble together mainstream funding, it is clear that there is increasing pressure on their services under the new ACFI arrangements. Evidence presented to the committee demonstrated that the service had lost about $20 a day per resident and given that these services are not likely to be collecting any fees from their residents, their long term viability is now in question.

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19 Mr Adam Bandt MP, *House of Representatives Hansard*, 27 May 2013, p.84

1.42 As flagged by Adam Bandt during the second reading debate in the House of Representatives, the Australian Greens have actively pursued a homelessness supplement and are glad to see that this has been adopted into the majority committee report.

Recommendation 11: That the Government include a separate homelessness supplement in the legislation to ensure that services like Wintringham are financially viable.

LGBTI

1.43 The Australian Greens do not believe that exemptions should be granted to faith based organisations to discriminate on the basis of sexuality, but in the absence of this broader reform, the Australian Greens strongly agree with the view of GRAI, who argued that exemptions under the Sex Discrimination Act should not be granted to faith based providers of aged care who receive Commonwealth funding. Just before the tabling of this report the Government introduced a Bill which may achieve this outcome. The Australian Greens welcome this initiative, support it in principle and will review the detail carefully.

1.44 However, the reform still needs to address discrimination on the basis of sexuality in all training and planning aspects of aged care reform. The Government should also take further steps to ensure specific strategies, designed in partnership with the LGBTI community, are put in place to encourage providers to improve their cultural awareness and actively reassure LGBTI individuals that they will be safe and welcome in their facilities, and encourage the advocacy of groups like GRAI and LGBTI Health Alliance.

1.45 Given the significant issues associated with discrimination for this cohort of ageing Australians, the Australian Greens also strongly believe that there should be some further work undertaken with the Commissioner to better facilitate the reporting of discrimination, and ensure that complaints are responded to effectively.

Recommendation 12: The Government should ensure that the anti-discrimination legislation is progressed with this package of Bills.

Recommendation 13: The Government should ensure that the Commissioner prioritises the development of strategies that will help ensure that LGBTI discrimination is identified and reported and that complaints are responded to quickly and effectively.

Recommendation 14: The Government should support the LGBTI community to participate in the design and implementation of the reforms and encourage the advocacy of groups like GRAI and LGBTI Health Alliance.

Workforce Supplement

1.46 The Australian Greens want to see funding for wage increases delivered through the reform package. We note that the development of a wages bridging supplement was part of the NACA Blueprint for reform and had broad in-principle

support across the sector.[20] Therefore, the Australian Greens support the inclusion of the workforce supplement in the legislation, noting that the Government can continue to work on the design and the implementation of the subsidy with all stakeholders. We want to be assured that the approach that is taken is one that maximises how much funding flows to workers but we also note the supplementary evidence provided by Hall and Prior which clearly demonstrates that there will be on-costs for the providers and acknowledge that this needs to be addressed.[21]

Recommendation 15: Retain the workforce supplement in the legislation.

Recommendation 16: That Government continue to work with all stakeholders to ensure that the workforce supplement is able to directly improve wages while not unduly disadvantaging any providers and considers offsetting the increase in on-costs to providers to ensure that the supplement is widely taken up.

Ageing with a disability

1.47 The Australian Greens are concerned that people who acquire a disability after 65 may not receive adequate or appropriate care. During the consideration of the National Disability Insurance Scheme legislation, the Australian Green proposed lifting the 65 year upper age limit on the NDIS, to ensure that people who develop a requirement for disability care and support later in life are cared for by the system that best meets their care needs and provides access to appropriate aids and equipment. As this recommendation was not adopted, the Greens believe that ageing with a disability must be considered in the scheduled future reviews of both disability and the aged care reform. As highlighted in the home care section above, there is also a growing need to conduct a broader review of how these significant age and disability reforms have impacted on the delivery of community care services across state and federal jurisdictions and the interaction between block funded services like HACC and these new consumer-directed funding packages.

Recommendation 17: Government should consider the capacity of aged care services to deliver care and support to individuals who acquire a disability over the age of 65 in future reviews but that these services should also be considered within the context of review of the National Disability Insurance Scheme.

Quality Assurance Agency

1.48 The NACA Blueprint proposed the establishment of an independent Australian Aged Care Commission (AACC) that would inter alia include a complaints system. An independent complaints system was also recommended by the Walton Report.[22]

1.49 The Australian Greens acknowledge and support the recommendations about quality and complaints made in chapter eight of the majority report, but continue to be

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20 National Aged Care Alliance, *Blueprint for Aged Care Reform*, February 2012.

21 Hall and Prior, Submission 110, p.1.

22 COTA, *Submission 87*, p.54.

concerned that because this legislation has not established the AACC, there is still a lack of independence in the complaints processes.

1.50 COTA proposes to take a step towards addressing this by:

> As a minimum first step that a clause be added to the Bill that amends clause 95A-1 (2) (a) of the Aged Care Act 1997 to substitute the words " and make recommendations to the Secretary arising from the examination;" by the words "and make enforceable determinations arising from the examination;".[23]

Recommendation 18: Amend the legislation to ensure the Commissioner has powers to make enforceable determinations.

Senator Rachel Siewert
Australian Greens

23 COTA, *Submission 87*, p.54.

APPENDIX 1

Submissions and Additional Information received by the Committee

Submissions

1	Name Withheld
2	Kalyna Care
3	Queensland Nurses' Union
4	Royal Australian and New Zealand College of Psychiatrists
5	Office of the Aged Care Commissioner
6	Grant Thornton Australia
7	Aegis Aged Care Group
8	LHI Retirement Services
9	Riverview Lutheran Rest Home Inc
10	Rose Lodge
11	Wintringham
12	Cobden District Health Services Inc
13	Tandara Lodge Community Care Inc; Emmerton Park Inc; Melaleuca Home for the Aged Inc; and Mt St Vincent Nursing Home and Therapy Centre Inc
14	Lutheran Aged Care Residential Network
15	Parkwood Aged Care Services
16	Australian Blindness Forum
17	Name Withheld
18	Shepparton Villages
19	Java Dale Pty Ltd
20	Association of Independent Retirees Ltd

21 Menarock Aged Care Services

22 Retirement Aged Care Management Pty Ltd

23 Vasey RSL Care Ltd

24 Name Withheld

25 Masonic Care Alliance

26 Australian Association of Social Workers

27 MND Australia

28 Barwo Homestead

29 Consumers Health Forum of Australia

30 Cookcare Group

31 Attendant Care Industry Association

32 Hill View Aged Care Pty Ltd

33 AMP

34 Combined Pensioners and Superannuants Assn of NSW Inc.

35 Yackandandah Bush Nursing Hospital/Yackandandah Health

36 Confidential

37 Presbyterian Aged Care NSW and ACT

38 Cooinda Village

39 Southern Cross Care (Vic)

40 Queensland Law Society

41 ECH Inc; Eldercare; and Resthaven

42 KinCare

43 Australian Nursing Federation

44 IRT

45 Advocare Incorporated

46 Aged Care Guild

47 The Royal Society for the Blind

48 Carers Victoria

49 Australian Medical Association

50 Medical Technology Association of Australia

51 Centre for Research on Ageing, Health and Wellbeing

52 Australian Guardianship and Administration Council (AGAC)

53 Amberlea Residences Pty Ltd

54 Macular Disease Foundation Australia

55 Catholic Health Australia

56 Australian Unity

57 Alliance Care Services Pty Ltd

58 Leading Age Services Australia

59 UnitingCare Australia

60 Fairway Hostel

61 Futures Alliance

62 Nazareth Care

63 Domain Principal Group

64 Havilah Hostel Inc

65 Ms Georgina Pinkas

66 Embracia Communities Pty Ltd

67 Aged and Community Services Australia

68 National Seniors Australia

69 Council of Social Service of NSW

70 St Paul's Lutheran Homes Hahndorf

71 Department of Veterans' Affairs

72 Alzheimer's Australia

73 HammondCare

74 Thomas Holt

75 Anglicare Australia

76 Capecare

77 Aged and Community Services Western Australia

78 St Ann's Homes Inc

79 St Andrew's Aged Care

80 Freemasons' Homes of Southern Tasmania Inc

81 Vision Australia

82 Narrogin Cottage Homes Inc

83 Health Services Union

84 United Voice

85 Prime Minister's Council on Homelessness

86 Aged Care Gurus

87 COTA Australia

88 National LGBTI Health Alliance

89 Australian Psychological Society Ltd

90 Australian Association of Gerontology

91 Mr John Gerrard

92 Department of Health and Ageing

93 Palliative Care Australia

94 ANZ

95 Advantaged Care

96 Royal Australian College of General Practitioners

97 National Stroke Foundation

98 Queensland Government

99 National Association of Community Legal Centres Inc

100 National Rural Health Alliance

101 Department of Health, Victorian Government

102 Confidential

103 Taverners Group

104 Lutheran Community Care Qld

105 Australian Federation of Disability Organisations

106 National People with Disabilities and Carer Council

107 Dr Kathryn Antioch

108 Young People In Nursing Homes National Alliance

109 Health Services Commissioner

110 Hall & Prior

111 Australian & New Zealand Society for Geriatric Medicine

112 The Aged-care Rights Service Inc (TARS)

Additional Information

1 Executive summary of the Needs Study, from Shire of Merredin, received 19 April 2013

2 Letter from the Hon Mark Butler MP, tabled by Senator Rachel Siewert, at Perth public hearing 29 April 2013

3 Brief for Committee, tabled by Hall and Prior Aged Care Organisation, at Perth public hearing 29 April 2013

4 Graph, tabled by Aged and Community Services Association WA, at Perth public hearing 29 April 2013

5 Opening Statement, tabled by UnitingCare Australia, at Sydney public hearing 30 April 2013

6 Home care fees graph, tabled by UnitingCare, at Sydney public hearing 30 April 2013

7 Financial information, tabled by Shepparton Retirement Villages, at Melbourne public hearing 1 May 2013

8 Presentation, tabled by Aged Care Guild, at Melbourne public hearing 1 May 2013

9 Cost comparison information, tabled by Kalyna Care, at Melbourne public hearing 1 May 2013

10 Letter to Aged Care Reform Implementation Council, tabled by Kalyna Care, at Melbourne public hearing 1 May 2013

11 Presentation, tabled by South West Aged Care Alliance, at Melbourne public hearing 1 May 2013

12 Position Paper on Ageing in Australia, from Australian Association of Social Workers, received 1 May 2013

13 Agreement coverage of residential aged care facilities operated by Catholic Church providers, tabled by Australian Nurses Federation, at Canberra public hearing 2 May 2013

14 Speaking notes, tabled by Australian Association of Social Workers, at Canberra public hearing 2 May 2013

15 Articles dated 26 April 2013 from The Australian, tabled by Senator Concetta Fierravanti-Wells, at Canberra public hearing 2 May 2013

16 Dementia and Veterans Supplements consultation paper cover, tabled by Department of Health and Ageing, at Canberra public hearing 2 May 2013

17 Dementia and Veterans' Supplements in Aged Care Consultation Paper, tabled by Department of Health and Ageing, at Canberra public hearing 2 May 2013

18 Home Care Packages Program Guidelines Consultation Draft, tabled by Department of Health and Ageing, at Canberra public hearing 2 May 2013

19 Consultation process information, tabled by Department of Health and Ageing, at Canberra public hearing 2 May 2013

20 United Voice flyer, tabled by Senator Concetta Fierravanti-Wells, at Canberra public hearing 2 May 2013

21 Communique of National Aged Care Alliance's quality indicators advisory group meeting, from Attendant Care Industry Association, received 3 May 2013

22 KPMG report: Scenario analysis of selected LLLB financial arrangements, from Department of Health and Ageing, received 23 May 2013

Correspondence

1 Correspondence received from National Aged Care Alliance, 11 May 2013

2 Correction from Department of Health and Ageing to evidence given at Canberra public hearing 2 May 2013

3 Correspondence from 22 consumer groups of older Australians, 21 May 2013

Answers to Questions on Notice

1 Answers to Questions on Notice received from Carers Victoria, 2 May 2013

2 Answers to Questions on Notice received from Australian Nursing Federation, 6 May 2013

3 Answers to Questions on Notice received from Combined Pensioners and Superannuants Association of NSW Inc, 7 May 2013

4 Answers to Questions on Notice received from Royal Freemasons, 7 May 2013

5 Answers to Questions on Notice received from GLBTI Retirement Association Inc, 7 May 2013

6 Answers to Questions on Notice received from Association of Independent Retirees Ltd, 8 May 2013

7 Answers to Questions on Notice received from Alzheimer's Australia, 8 May 2013

8 Answers to Questions on Notice received from Australian Nursing Federation, 8 May 2013

9 Answers to Questions on Notice received from Aegis Aged Care Group, 8 May 2013

10 Answers to Questions on Notice received from ECH Inc, 9 May 2013

11 Answers to Questions on Notice received from Aged Care Guild, 9 May 2013

12 Answers to Questions on Notice received from Wintringham, 9 May 2013

13 Answers to Questions on Notice received from National Seniors Australia, 10 May 2013

14 Answers to Questions on Notice received from Australian Guardianship and Administration Council, 10 May 2013

15 Answers to Questions on Notice received from from Leading Age Services Australia, 10 May 2013

16 Answers to Questions on Notice received from Baptistcare, 10 May 2013

17 Answers to Questions on Notice received from National Rural Health Alliance Inc, 10 May 2013

18 Answers to Questions on Notice received from Health Services Union, 10 May 2013

19 Answers to Questions on Notice received from Hall and Prior, 10 May 2013

20 Answers to Questions on Notice received from United Voice, 13 May 2013

21 Answers to Questions on Notice received from Royal Australian College of General Practitioners, 13 May 2013

22 Answers to Questions on Notice received from Australian Unity, 13 May 2013

23 Answers to Questions on Notice received from Prime Minister's Council on Homelessness, 13 May 2013

24 Answers to Questions on Notice received from Ability Options, 13 May 2013

25 Answers to Questions on Notice received from Department of Health and Ageing, 14 May 2013

26 Answers to Questions on Notice received from Department of Health and Ageing, 23 May 2013

27 Answer to a Question on Notice received from Anglicare Australia, 28 May 2013

28 Answers to Questions on Notice received from Craigcare, 23 May 2013

29 Answers to Questions on Notice received from Department of Health and Ageing, 30 May 2013

APPENDIX 2

Public Hearings

Monday, 29 April 2013

Legislative Assembly Committee Office, Perth

Witnesses

Narrogin Cottage Homes
CHRISTENSEN, Mrs Julie Annette, Chief Executive Officer

Gay Retirement Association Inc.
COMFORT, Dr Jude, Chair
LOWE, Ms June, Deputy Chair

DE ROSARIO, Ms Rosemary, Private capacity

Aged and Community Services Association, Western Australia
KOBELKE, Mr Stephen, Chief Executive Officer
GLICKMAN, Mr Raymond, Chair
MORRIS, Dr Lucy, Deputy Chair
FENWICK, Mr David, Treasurer

Baptistcare
GHOSE, Ms Anita, Director, Life Services

Baptist Care Australia
MORRIS, Dr Lucy, Chief Executive Officer, Baptistcare

Craigcare Group Pty Ltd
GILLETT, Mr John Vincent, Chief Executive Officer

Resthaven Inc.
HEARN, Mr Richard, Chief Executive Officer

JORGENSEN, Ms Kathy, Private capacity

ECH Inc.
KEMP, Mr David, Chief Executive's Adviser

Hall and Prior Aged Care Organisation
PRIOR, Mr Graeme, Chief Executive Officer

United Voice
SHAY, Ms Kelly, Assistant Secretary, Western Australia Branch

Aegis Aged Care Group
TAYLOR, Mr Geoff, Director

Tuesday, 30 April 2013

Portside Centre, Sydney

Witnesses

KinCare
HOWIE, Mr Jason, Chief Executive Officer
ADAMI, Ms Therese, Chief Operating Officer

Lutheran Aged Care Residential Network
ADAMS, Mr Keith, Chairperson

Wesley Mission, Brisbane
BATKIN, Mr Jeff, General Manager

Attendant Care Industry Association
BENNETT, Ms Danielle, President
MERRAN, Ms Barbara, Board Director

Fullarton Lutheran Homes Inc.
COOPER, Mr Ashley, Managing Director

Combined Pensioners and Superannuants Association of New South Wales Inc.
CROWE, Ms Charmaine, Senior Policy Adviser

Australian Guardianship and Administration Council
DODDS, Ms Imelda, Acting Chair

Council of Social Service of New South Wales
GILLETT, Mrs Sue, Senior Policy Officer
KUMAR, Ms Rashmi, Senior Policy Officer

LHI Retirement Services
GRAY, Mr Tim, Chief Executive Officer

UnitingCare Ageing, New South Wales and Australian Capital Territory
TEULEN, Mr Steven, Director
GROVER, Mr Chris, Director of Finance and Strategic Development

UnitingCare Australia
HATFIELD DODDS, Ms Lynn, National Director
HELD, Ms Ronda, Interim Director, Services Development

Health Services Union
McLEAY, Mr Mark, Senior National Industrial Officer
HAYES, Mr Gerard, Secretary, New South Wales Branch
TWYFORD, Ms Lindy, Branch Councillor

Aged-Care Rights Service Inc.
JOYCE, Ms Patricia Mary, Manager, Advocacy

Aged and Community Services Australia
KELLY, Adjunct Professor John, Chief Executive Officer

Masonic Care Alliance
MacDONALD, Ms Marie-Louise, Board Director
PINTADO, Mr Felix Joseph, Board Director

Queensland Nurses' Union
O'CONNOR, Ms Bernadette, Team Leader, Aged Care Organisers
SHEPHERD, Mr Jamie, Professional Officer
TODHUNTER, Dr Elizabeth Anne, Research and Policy Officer

National Presbyterian Aged Care Network
SADLER, Mr Paul Michael, Chief Executive Officer, Presbyterian Aged Care New South Wales and Australian Capital Territory

New South Wales Trustee and Guardian
WOODS, Ms Annette, Assistant Director, Financial Planning

Wednesday, 1 May 2013

Ether Conference Centre, Melbourne

Witnesses

Shepparton Retirement Villages Inc
BERTRAM, Mr Kevin, Chief Executive Officer

Parkwood Aged Care Services Pty Ltd
CLARK, Mr Darrell, General Manager
KULESZA, Mr Aleks, Managing Director

Cobden District Health Services, South West Aged Care Alliance
CREELY, Mrs Jeannine, Chief Executive Officer

Sunnyside Lutheran Retirement Village, South West Aged Care Alliance
GRIMMETT, Mr David, Chief Executive Officer

Edgarley Home Inc, South West Alliance
TOOPE, Mr Steven, Chief Executive Officer

Wintringham
LIPMANN, Mr Bryan, Chief Executive Officer
DESCHEPPER, Mr Michael, Chief Financial Officer

Royal Australian and New Zealand College of Psychiatrists
ELLISON, Dr Anne, General Manager, Practice, Policy & Projects
McKAY, Dr Roderick, Chair, Faculty of Psychiatry of Old Age

The Futures Alliance
HAYHOE, Ms Nicola, Executive Leader, Research and Policy, Ability Options Limited
MILLS, Ms Annie, Research Officer, Ability Options Limited

Prime Minister's Council on Homelessness
HORTON, Ms Netty, Member

National LGBTI Health Alliance
TALBOT, Mr Warren, General Manager
IRLAM, Mr Corey, Convenor, Ageing and Aged Care Working Group

Aged Care Guild
JOHNSTON, Mr Ross, Chairman
SUDHOLZ, Mr Mark Andrew, Director

Office of the Aged Care Commissioner
LAMB, Ms Rae, Aged Care Commissioner
RALSTON, Ms Penelope, Director
PETRE, Ms Catherine, Investigations Manager

Australian Unity, Retirement Living
McMILLAN, Mr Derek Allan, Chief Executive Officer
LUNN, Mr Stephen, Senior Manager Public Policy

Carers Victoria
MULDOWNEY, Ms Anne, Policy Adviser

Kalyna Care
SHELDON-STEMM, Mr Mark, General Manager

Yackandandah Bush Nursing Hospital
SMITH, Mr Chris, General Manager

Royal Australian College of General Practitioners
WENCK, Dr Beres, Chair, College National Standing Committee: GP Advocacy and Support

Thursday, 2 May 2013

Parliament House, Canberra

Witnesses

Vision Australia
AH TONG, Mr Brandon, Policy and Public Affairs Advisor
BLEECHMORE, Mr Marcus James, Government Relations Advisor

Department of Health and Ageing
HUXTABLE, Ms Rosemary, Deputy Secretary
SMITH, Ms Carolyn, First Assistant Secretary
BALMANNO, Ms Rachel, Assistant Secretary
MURRAY, Mr Nigel, Assistant Secretary
TRACEY-PATTE, Mr Keith, Assistant Secretary

Australian Nursing Federation
CHAPERON, Ms Yvonne, Assistant Federal Secretary
BLAKE, Mr Nick, Senior Federal Industrial Officer

National Seniors Australia
CARVOSSO, Mr David, Chairman, National Seniors Board
SKINNER, Ms Marie, Senior Policy Adviser

Anglicare Australia
CHAMBERS, Ms Kasy, Executive Director
PINKAS, Ms Georgina May, Aged Care Reform Coordinator

Macular Disease Foundation Australia

CUMMINS, Mr Rob, Research and Policy Manager
CHOO, Mr Mark, Policy and Research Officer

United Voice

CROSBY, Mr Michael, National President
PORTER, Mr Sam, National Industry Coordinator, Aged Care

Association of Independent Retirees

CURLEY, Mr Robert, Federal Director, Policy Development and Advocacy, and New South Wales President

Australia and New Zealand Banking Group Ltd

GATES, Mr Richard, Head of Healthcare Banking, Corporate Banking
GRAYSON, Mr Richard, Director, Healthcare, Corporate Banking

National Rural Health Alliance

GREGORY, Mr Gordon, Executive Director
HOPKINS, Ms Helen, Policy Advisor

Catholic Health Australia

MERSIADES, Mr Nicolas, Director, Aged Care

Alzheimer's Australia

REES, Mr Glenn, Chief Executive Officer

Leading Age Services Australia

RILEY, Mr Marcus Vincent, Deputy Chairman
RICHARDS, Ms Kay Lorraine, National Policy Manager

COTA Australia

YATES, Mr Ian, Chief Executive
SPARROW, Ms Patricia, Director, Aged Care Reform

Australian Association of Social Workers

SUDBURY, Ms Basia, Professional Officer, Social Policy and Mental Health
STOJANOVIC, Ms Tamara, Member, National Social Policy Committee

APPENDIX 3

Department of Health and Ageing – Consultation process information

CONSULTATION UNDERTAKEN BY THE DEPARTMENT OF HEALTH AND AGEING ON *LIVING LONGER LIVING BETTER* REFORMS

- 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.
- 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 3 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 legislation changes.

Summary NACA advisory groups

- Currently 12 advisory groups (including 6 sub-groups), auspiced by NACA, have been set up with a focus on different parts of the reforms. Their membership is composed of

representatives from NACA organisations and other non-NACA organisations such as National Seniors Australia.

- The Department has officers who attend these meetings.
- Since July 2012 there have been 42 meetings of these various groups.
- These groups are the:
    - **Ageing Expert Advisory Group**
    - **Home Care Packages Working Group**
    - **Gateway Advisory Group**
    - **Commonwealth Home Support Program Advisory Group**
        - HACC service Group 2 Sub-group
        - Respite Sub-Group
        - Home maintenance and Modifications sub-Group
        - Meals Review Sub-Group
        - Community Transport Review Sub-Group
    - **Quality Indicators Advisory Group,** and the
    - **Specified Care and Services Reference Group**
        - The combined Additional services and clinical Care Sub-Group provides advice to this Reference group.

Summary of Non NACA advisory groups

- In addition to the NACA groups the Minister and the Department have also set up and/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 of Health and Ageing on issues relating to the implementation and monitoring of programs, and dementia-related issues.
- **Aged Care Funding Instrument Monitoring Group** has been formed to monitor 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** – this 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.
- The **National Aboriginal and Torres Strait Islander Aged Care Reference Group** – provides advice to the Department on matters relating to the reforms that affect ATSI people.
- **Lesbian, Gay, Bisexual, Transgender, and Intersex Advisory Group** - In July 2012, the Department engaged the National LGBTI Alliance to work with the Department to develop the Strategy, including coordinating a comprehensive consultation process to inform the direction of Strategy. A total of **15 consultation sessions** were held across all states and territories. Consultations took place with relevant stakeholders including individuals, community groups and peak organisations. All consultations were attended by DoHA staff. Additionally, a draft of the strategy was made available on the Department's website for a six week period to encourage submissions from interested parties.
- **Culturally and Linguistically Diverse Advisory Group** - development of the Strategy commenced in July 2012 with the Department engaging the Federation of Ethnic Communities' Council of Australia (FECCA) to undertake a series of targeted consultations during September and October. A total of **13 consultation sessions** were held across all states and territories. Consultations took place with relevant stakeholders including individuals, community groups and peak organisations. All consultations were attended by DoHA staff. Additionally, a draft of the strategy was made available on the Department's website for a six week period to encourage submissions from interested parties.

Legislative Changes - Consultation

- 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 legislation 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 understanding of the proposed changes.
- During late November and December, the Department also held briefing sessions in Melbourne, Sydney and Canberra on the proposed changes.
- Stakeholders and the general community 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.
- Submissions received via the consultation on the overview of the proposed legislative changes were used to inform drafting of the Bills.

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:
    - Accommodation Pricing Guidelines (9 April - 1 May 2013);
    - Home Care Packages Program Guidelines - Consultation Draft (29 April - 17 May 2013);
    - Dementia and Veterans' Supplement Guidelines (1 May – 22 May 2013); and
    - Workforce Supplement Guidelines (2 May - 23 May 2013).

Aged Care Bills - Industry Briefings – Autumn 2013

- In late February 2013 the Department announced that it would be holding industry/sector 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 included:

    - 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 23 April 2013

- For those who were unable to attend the industry 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.

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.

Living Longer Living Better **Stakeholder Consultation/Advisory Groups**

A number of advisory groups have been established in order to support, advise, monitor and evaluate the *Living Longer Living Better* aged care reforms. An overview of these groups is attached. The membership of each group and the dates on which they have met are also attached.

Summary of National Aged Care Alliance Consultation/Advisory Groups

The **National Aged Care Alliance** (NACA) is a representative body of peak national organisations in aged care, including consumer groups, providers, unions and health professionals. NACA is comprised of 36 member organisations, including:

- Aged and Community Services Australia
- Alzheimer's Australia
- Anglicare Australia
- Association of Independent Retirees Limited
- Attendant Care Industry Association
- Australian Association of Gerontology
- Australian College of Nursing
- Australian General Practice Network
- Australian Healthcare and Hospital Association
- Australian Nursing Federation
- Australian Physiotherapy Association
- Australian & New Zealand Society for Geriatric Medicine
- Baptist Care Australia
- Carers' Australia
- Catholic Health Australia
- COTA Australia
- Divisional Therapy Australia
- Exercise and Sports Science Australia
- Federation of Ethnic Communities Councils of Australia
- Health Services Union
- Leading Aged Services Australia Ltd
- Legacy Australia
- Lutheran Aged Care Australia
- Macular Disease Foundation
- National LGBTI Health Alliance
- National Presbyterian Aged Care Network
- National Stroke Foundation
- Occupational Therapy Australia
- Palliative Care Australia
- Pharmacy Guild of Australia
- Public Sector Residential Aged Care
- Returned & Services League of Australia
- Royal College of Nursing Australia
- Royal Society for the Blind
- Salvation Army
- United Voice
- UnitingCare Australia

NACA meets quarterly and the Department is invited to attend part of each meeting to answer questions and discuss aged care reform. Currently, 12 advisory groups (including 6 sub-groups), auspiced by NACA, have been established, with a focus on different parts of the reforms. Since July 2012, there have been 42 meetings of these groups.

The **Ageing Expert Advisory Group** (AEAG) provides specialist advice from the aged care sector's perspective to the Minister, the Department and the ACRIC on elements of the aged care reforms.

The Department funds the Council on the Ageing (COTA) Australia, on behalf of NACA, to provide secretariat support and services to the AEAG and other specialist advisory groups. Currently, five specialist advisory groups have been established including:

- the **Home Care Packages Working Group**;
- the **Gateway Advisory Group**;
- the **Quality Indicators Advisory Group**;
- the **Specified Care and Services Reference Group** (the combined Additional Services and Clinical Care Sub-Group provides technical advice to this Reference Group); and
- the **Commonwealth Home Support Program Advisory Group** (this Group is informed by a number of sub-groups, including: 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).

Additional advisory groups will be established as required.

Summary of non-NACA Consultation/Advisory Groups

The **Aged Care Reform Implementation Council** (ACRIC) is responsible for monitoring, evaluating and providing independent advice to the Minister for Mental Health and Ageing on the progress of the reforms.

Membership of the Council was chosen on the basis of individuals' independence from the aged care sector, and their diverse range of specialist knowledge and expertise across the public and private sectors including legal, union and government.

The **Aged Care Financing Authority** (ACFA) provides the Minister with independent advice on aged care pricing and financing and helps ensure care recipients receive value for money.

The **Strategic Workforce Advisory Group** (SWAG) assisted in developing the Aged Care Workforce Compact to improve the capacity of the aged care sector to attract and retain staff.

The **Minister's Dementia Advisory Group** (MDAG) provides advice to the Minister and to the Department of Health and Ageing on issues relating to the implementation and monitoring of programs, and dementia-related issues.

The **Aged Care Funding Instrument** (ACFI) **Monitoring Group** has been formed to monitor the impact of the recent ACFI changes, and reports directly to the Department. The **ACFI Technical Reference Group** reports to the ACFI Monitoring Group on technical issues. The **Dementia and Veterans Supplement Working Group** provides advice to the Department on eligibility criteria for new supplements for the care of people with dementia, other behavioural conditions and veterans.

A number of Advisory Groups have been established to provide advice and guidance to help inform the way Government responds to the needs of older people from diverse backgrounds

and to better support the aged care sector to deliver care that is sensitive to their care needs. These report to the Department and currently include:

- The **National Aboriginal and Torres Strait Islander Aged Care Reference Group** (NATSI-ACRG);
- The **Culturally and Linguistically Diverse** (CALD) **Advisory Group**; and
- The **Lesbian, Gay, Bisexual, Transgender, and Intersex** (LGBTI) **Advisory Group**.

Existing inter-governmental forums are being used to support discussions between the Commonwealth and States and Territories regarding the reforms.

Aged and Community Care Officials (ACCO) 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 ACCO.

The **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 ACCO and the NACA Gateway Advisory Group, and reports directly to the Department.

Non-NACA Advisory Groups have met a total of 49 times.

Non-NACA Advisory Group Members

Aged Care Reform Implementation Council		
Position	**Name**	**Independent Member - Current Position**
Chair	Prof Peter Shergold AC	Chancellor, University of Western Sydney
Member	The Hon. Susan Ryan AO	Age Discrimination Commissioner
Member	Prof Ann Harding	Director, National Centre for Social and Economic Modelling
Member	Prof Henry Brodaty AO	Director, NSW Dementia Collaborative Research Centre
RESIGNED	Mr Jeff Lawrence	Deputy President, Australian Fair Work Commission
Member	Mr Rauf Soulio	Judge, South Australian Courts; Chair, Multicultural Council
Ex-officio	Ms Lynda O'Grady	Chair, ACFA

Aged Care Financing Authority		
Position	**Name**	**Independent Member - Current Position**
Chair	Ms Lynda O'Grady	Independent Director, National Electronic Health Transition Authority
Deputy Chair	Prof Graeme Hugo	Director, Australian Population and Migration Research Centre
Member	Mr Ian Yates	Chief Executive, COTA Australia
Member	Mr Nick Mersiades	Senior Advisor Aged Care, Catholic Health Australia; ACSA
RESIGNED	Ms Susan Lines	Assistant National Secretary for United Voice
Member	Mr Paul Gregersen	CEO, BUPA Care Services; Board, Leading Aged Services Victoria
Member	Ms Sally Evans	Head of Aged Care, AMP Capital
Member	Mr Graham Hodges	Sector Financing
DoHA Rep	Ms Carolyn Smith	Department of Health and Ageing
Treasury Rep	Ms Joanne Evans	Treasury

Strategic Workforce Advisory Group *now disbanded*		
Position	**Position**	**Organisation**
Chair	Commissioner Anne Gooley	Fair Work Australia
Member	Mr Darren Mathewson	Aged & Community Care Services Australia
Member	Mr Gary Barnier	Aged Care Guild
Member	Ms Susan Lines	United Voice

Member	Mr Martin Laverty	Catholic Health Australia
Member	Mr Chris Brown	Health Services Union of Australia
Member	Mr Charles Wurf	Leading Age Services Australia
Member	Ms Lin Hatfield-Dodds	Uniting Care Australia
Member	Ms Lee Thomas	Australian Nursing Federation
Member	Ms Rosemary Huxtable	Department of Health & Ageing
Member	Mr John Kovacic	Department of Education, Employment & Workplace Relations

Minister's Dementia Advisory Group		
Position	**Position**	**Organisation**
Chair	Assoc Prof Susan Koch	Research Fellow, Royal District Nursing Service
Co-chair	Ms Sue Pieters-Hawke	Author
Member	Prof Jennifer Abbey	Director QLD Dementia Collaborative Research Centre
Member	Dr Kerry Arabena	Director National Congress of Australia's First Peoples Ltd.
Member	Prof Henry Brodaty AO	Director, NSW Dementia Collaborative Research Centre
Member	Ms Ara Cresswell	Chief Executive Officer, Carers Australia
Member	Ms Sharon Davis	Manager, Uniting Church Australia Frontier Services
Member	Dr Stephen Judd	Chief Executive, HammondCare Group
Member	Ms Jaklina Michael	Cultural Liaison Coordinator, Royal District Nursing Service VIC
Member	Prof Rhonda Nay	Chair, Interdisciplinary Age Care, La Trobe Unversity
Member	Prof Dimity Pond	Head, Discipline General Practice, University Newcastle
Member	Dr Glenn Rees	National Executive Director, Alzheimer's Australia
Member	Dr Ron Sinclair	Chairperson, Consumer Dementia Research Network of Alzheimer's Aus
Member	Ms Wendy Venn	Aged Care Nurse Practitioner, Aged Care and Rehabilitation Service
Member	Assoc Prof Mark Yates	Clinical Director, Aged Care and Rehabilitation Medicine

Aged Care Funding Instrument Monitoring Group		
Position	**Name**	**Organisation**
Chair	Ms Rosemary Huxtable	DoHA
Member	Prof John Kelly	Aged & Community Services Australia
Member	Mr Ian Yates	COTA Australia
Member	Mr Nick Mersiades	Catholic Health Australia
Member	Dr Glenn Rees	Alzheimer’s Australia
Member	Prof Tracey McDonald	School of Nursing, Midwifery and Paramedicine
Member	Mr Richard Gates	Australia and New Zealand Banking Group (Finance)

Member	Dr Jeffrey Rowland	Australia and New Zealand Society for Geriatric Medicine
Member	Ms Lee Thomas	Australian Nursing Federation
Member	Mr Ross Johnston	Aged Care Guild, CEO of Regis
Member	Mr Patrick Reid	Leading Aged Services Australia
Member	Mr Chris Grover	Uniting Care Australia

ACFI Technical Reference Group		
Position	**Name**	**Organisation**
Member	Dr Jeffrey Rowland	Australian & New Zealand Society for Geriatric Medicine
Member	Prof Tracey McDonald	Australian Catholic University, Faculty of Health Sciences
Member	Ms Loula Koutrodimos	Leading Age Services Australia
Member	Ms Kate Nott	Catholic Health Australia
Member	Ms Karina Peace	Aged Care Guild
Member	Mr Peter McHale	Catholic Homes Incorporated
Member	Dr Edward Strivens	Cairns and Hinterland Health Service District
Member	Prof Jennifer Abbey	Director QLD Dementia Collaborative Research Centre
Member	Ms Jan Erven	Allied Health Professionals Australia
Member	Mr Rik Dawson	Australian Physiotherapy Association
Member	Mr Keith Tracey-Patte	Department of Health and Ageing
Member	Mr Damian Coburn	Department of Health and Ageing
Member	Dr Rodney Jilek	Department of Health and Ageing
Member	Dr Susan Hunt	Department of Health and Ageing
Member	Mr Robert Hurman	Department of Health and Ageing
Member	Ms Kathryn Foley	Department of Health and Ageing
Member	Ms Vicky Boyd	Department of Health and Ageing

Dementia and Veterans' Supplement Working Group		
Position	**Name**	**Organisation**
Member	Dr Glenn Rees	Alzheimer's Australia
Member	Ms Wendy Venn	Aged Care Nurse Practitioner
Member	Ms Angela Raguz	Service Provider (HammondCare)
Member	A./ Prof Michael Woodward	Gerontologist, Aged and Residential Care Services Austin Health
Member	Ms Niki Van Dimen	Veterans Consumer Representative
Member	Ms Wendy Bateman	National Aged Care Alliance
Member	Ms Paula Trood	National Aged Care Alliance

Member	Mr Keith Tracey-Patte	Department of Health and Ageing
Member	Ms Judy Daniel	Department of Veterans' Affairs

National Aboriginal and Torres Strait Islander Aged Care Reference Group		
Position	**Name**	**Organisation**
Chair	Mr Graham Aitken	Executive Director, Aboriginal Elders and Community Care Services Inc
Deputy Chair	Ms Cath McGee	Department for Communities and Social Inclusion, ACCO
Member	Ms Kelly Chatfield	Department of Family and Community Services NSW
Member	Ms Nicole Winters	Gilgai Aboriginal Centre
Member	Mr Gary Wingrove	Aboriginal HACC Development Officer
Member	Ms Lena Morris	Executive Manager, Aged Care and Disability Services
Member	Mr Solomon Nona	HACC Indigenous Service Development Officer, Chermside Community Centre
Member	Ms James Canuto	Yarrabah Combined Aged Care Service
Member	Ms Priscilla McFadzean	HACC Indigenous Policy Officer, Cairns
Member	Ms Jennifer Mairu	Torres Strait Islander & NPA Health Services District
Member	Mr David Crompton	Kulgardi
Member	Ms Jeanette James	Departmentof Health and Human Services TAS
Member	Ms Rachel Coad	Women's Karadi Aboriginal Corporation
Member	Mr Michael Bell	Ngunnawal Community Centre
Member	Ms Belinda Mayo	Department of Health and Ageing NT
Member	Ms Louise O'Neill	Department of Health and Ageing

Culturally and Linguistically Diverse Steering Committee *now disbanded*		
Position	**Name**	**Organisation**
Co-chair	Mr Pino Migliorino	Federation of Ethnic Communities Councils of Australia
Co-chair	Mr Russell De Burgh	Department of Health and Ageing
Member	Ms Petra Neeleman	Dutch Care
Member	Ms Ljubica Petrov	Centre for Cultural Diversity in Ageing VIC
Member	Dr Jeffrey Rowland	Australian & New Zealand Society for Geriatric Medicine
Member	Mr Nick Mersiades	Catholic Health Australia
Member	Mr Andrea Comastri	Co.As.It NSW
Member	Ms Ada Cheng	Australian Nursing Home Foundation
Member	Ms Rosa Colanero	SA Multicultural Aged Care
Member	Mr Ian Yates	COTA Australia
Member	Ms Elaine Goddard	Community Care, UnitingCare Ageing

Observer	Mr Bruce Shaw	Federation of Ethnic Communities Councils of Australia
Observer	Ms Melanie Tulloch	Federation of Ethnic Communities Councils of Australia

Lesbian Gay Bisexual Transgender and Intersex Steering Committee *now disbanded*		
Position	**Name**	**Organisation**
Co-chair	Dr Catherine Barrett	Aus Research Centre for Sex Health and Society, Gay & Lebian Health
Member	Mr Corey Irlam	National LGBTI Health Alliance
Member	Dr Daniel Parker	WA Department of Health
Member	Ms Jessica Williams	Anita Villa Residential Aged Care Facility
Member	Ms Pat Sparrow	COTA Australia
Member	Ms Annette Hogan	Leading Aged Services Australia
Member	Ms Kellie Shields	Aged and Community Services Australia
Member	Ms Carrie Hayter	Australian Association of Gerontology
Member	Dr Jude Comfort	WA Centre for Health Promotion Research, Curtin University
Observer	Mr Steven Kennedy	National LGBTI Health Alliance

Aged and Community Care Officials	
Member	**Jurisdiction**
Chair: Carolyn Smith	Department of Health & Ageing
Craig Harris	Department of Health & Ageing
Rachel Balmanno	Department of Health & Ageing
Dr Christine McPaul	Department of Veterans' Affairs
Debra Burnett	ACT Government - Health Directorate
Therese Gehrig	ACT Government - Health Directorate
Catherine Katz	NSW Ministry of Health
Chris Chippendale	Department of Family and Community Services, Ageing, Disability & Home Care
Robyn Westerman	Department of Health NT
Samantha Livesley	Department of Health NT
Graham Kraak	Queensland Health
Majella Ryan	Department of Communities QLD
Barbara Renton	Department for Health & Ageing SA
Cath McGee	Department for Families and Communities SA
Lynette Pugh	Department for Communities and Social Inclusion SA
Pip Leedham	Department of Health & Human Services TAS
Erica Heeley	Department of Health & Human Services TAS
Jane Herington	Department of Health VIC
Jeannine Jacobson	Department of Health VIC

Rob Willday	WA Department of Health
Paula Gevers	WA Department of Health

Gateway Consultation Forum	
Name	**Organisation**
Craig Harris, Chair	Access Reform Branch, Department of Health and Ageing
Carolyn Brown	Gateway Programme Office, Department of Health and Ageing
Catherine Katz	Government Relations Branch, NSW Ministry of Health
Barbara Anderson	Aged Care Unit, NSW Ministry of Health
Steven Gal	Community Building and Reporting, NSW Department of Family and Community Services, Ageing, Disability & Home Care
Janice Diamond	Aged Care Unit, Aged and Disability Program, Department of Health NT
Paula Gevers	Aged and Continuing Care Directorate, Department of Health WA
Debra Burnett	Aged and Community Care Policy, Health Directorate ACT
Jeannine Jacobson	Ageing and Aged Care, Department of Health VIC
Michelle McLeod	Community Care Transitions, Tasmania Department of Health and Human Services
Alice McDonald	Aged Care Assessment Program, Policy and Strategy, Office for the Ageing South Australia Health
Lynette Pugh	Domiciary Care and Access 2 Home Care, SA Department for Families and Communities
Graham Kraak	Older People's Health Extended Care, Queensland Health
Ervin Grecl	Community and Aged Care Policy, Department of Veterans Affairs
Mr Ian Yates	Council on the Ageing (COTA), Aged Care Gateway Advisory Group
Peta Braendler	Aged Care Services Australia (ACSA) , Aged Care Gateway Advisory Group
Jan Erven	Occupational Therapy Australia, Aged Care Gateway Advisory Group

NACA-auspiced Advisory Group Members

Ageing Expert Advisory Group		
Position	**Name**	**Organisation**
Chair	Ms Lee Thomas	Australian Nursing Federation
Member	Mr Ian Yates	COTA Australia
Member	Ms Lin Hatfield Dodds	UnitingCare Australia
Member	Mr Tim Jacobsen	Health Services Union
Member	Prof Julie Byles	Australian Association of Gerontology
Member	Dr Glenn Rees	Alzheimer's Australia
Member	Mr Richard Gray	Catholic Health Australia
Member	Prof John Kelly	Aged and Community Services Australia
Member	Mr Patrick Reid	Leading Aged Services Australia
Member	Mr Sam Porter	United Voice
Member	Mr Bruce Shaw	Federation of Ethnic Communities Councils of Australia
Member	Ms Marie Skinner	National Seniors Australia
Member	Mr Robert Curley	Australian Independent Retirees
Member	Mr Gary Barnier	Aged Care Guild
Member	Mr Graham Aitken	NATSI ACRG Chair
Member	Dr Catherine Barrett	LGBTI Health Alliance
Secretariat	Ms Pat Sparrow	COTA Australia

Specified Care and Services Reference Group	
COTA Australia	Ms Pat Sparrow, Chair
National Seniors Australia	
Australian Nursing Federation	
Australian and New Zealand Society of Geriatric Medicine	
Australian College of Nursing	
Dutch Care	
Occupational Therapy Australia	
Leading Aged Services Australia (LASA)	
UnitingCare Australia	
United Voice	
Department of Veterans' Affairs	
Aged and Community Services Australia (ACSA)	
Alzheimer's Australia	
Australian Medicare Locals Alliance	
Catholic Health Australia	

Carers Australia	
The Aged Care Guild	

Home Care Packages Working Group	
COTA Australia	Ms Pat Sparrow, Chair
Alzheimer's Australia	
United Voice	
ACH Group	
National LGBTI Health Alliance	
Leading Age Services Australia - Victoria	
Uniting Care Ageing NSW & ACT	
Carers Australia	
Aged and Community Services Australia (ACSA)	
Attendant Care Industry Association	
Australian Nursing Federation	
CO.AS.IT	
Australian Association of Gerontology Inc	
St Laurence Community Services	
National Seniors Australia	
Blue Care (representing UnitingCare Australia)	

Gateway Advisory Group	
COTA Australia	Mr Ian Yates, Chair
National Seniors Australia	
Alzheimer's Australia	
Australian and New Zealand Society of Geriatric Medicine	
Australian College of Nursing	
Occupational Therapy Australia	
Carers Australia	
Anglicare Australia	
Catholic Health Australia	
Aged and Community Services Australia (ACSA)	
Diversional Therapy	
Leading Aged Services Australia (LASA)	
UnitingCare Australia	
Federation of Ethnic Communities' Council of Australia (FECCA)	
Australian Medical Association	
Frontier Services (representing National Rural Health Alliance)	

Quality Indicators Advisory Group	
Alzheimers Australia	Mr Glenn Rees, Chair
Aged and Community Services Australia (ACSA)	
ANF	
Anglicare Australia	
Australian Physiotherapy Association	
Australian Association of Gerontology	
Catholic Health Australia	
Carers Australia	
COTA Australia	
Federation of Ethnic Communities' Council of Australia (FECCA)	
Leading Aged Services Australia (LASA)	
LGBTI – La Trobe University	
Palliative Care Australia	

Commonwealth Home Support Advisory Group	
National Presbyterian Aged Care Network	Mr Paul Sadler, Chair
Leading Aged Services Australia (LASA)	
LGBTI Health Alliance	
Health Services Union	
Federation of Ethnic Communities' Council of Australia (FECCA)	
COTA Australia	
Catholic Health Australia	
Carers Australia	
Alzheimer's Australia	
National Seniors Australia	
Occupational Therapy Australia	
Uniting Care Australia	
Aged and Community Care Officials Rep - Dept of Health Vic	
Municipal Association of Victoria	
NSW Home Modifications and Maintenance State Council	
Department of Family and Community Services Ageing	
HACC Indigenous Policy Officer, Cairns (NATSI-ACRG Member)	
QLD Meals on Wheels	
Aged and Community Services Australia (ACSA)	
Australian Community Transport Association	

Advisory Group meeting dates (up to June 2013)

Advisory Groups	Meeting Dates
Aged Care Reform Implementation Council	7 August 2012 19 October 2012 03 December 2012 15 February 2013 6 May 2013
Aged Care Financing Instrument Monitoring Group	7 August 2012 21 August 2012 12 September 2012 21 September 2012 (Teleconference) 22 October 2012 23 November 2012 10 December 2012 05 February 2013 19 February 2013 (Teleconference) 27 March 2013 26 April 2013 21 June 2013
Strategic Workforce Advisory Group ***(now dissolved)***	18 June 2012 6 July 2012 24 July 2012 8 August 2012 27 August 2012 11 September 2012 25 September 2012

	Group disbanded
National Aged Care Alliance	30 and 31 August 2012 27 and 28 November 2012 11 and 12 February 2013 27 and 28 May 2013
Ageing Expert Advisory Group	12 November 2012 04 February 2013 4 March 2013 (Teleconference) 4 April 2013 17 May 2013
Home Care Packages Working Group	09 August 2012 (Teleconference) 15 August 2012 28 August 2012 (Teleconference) 07 December 2012 (Teleconference) 21 and 22 January 2013 28 March 2013 6 May 2013 (Teleconference)
Specified Care and Services Reference Group	29 August 2012 17 September 2012 (Teleconference) 26 November 2012 28 February 2013 28 February 2013 25 March 2013 22 April 2013 24 May 2013 19 June 2013
Combined Clinical Care and	12 November 2012

Additional Services Sub-group	10 December 2012 (Videoconference) 06 February 2013 (Videoconference) 21 February 2013 (Teleconference) 7 March 2013 5 April 2013 17 April 2013
Gateway Advisory Group	29 August 2012 15 October 2012 09 November 2012 12 December 2012 (Teleconference) 10 January 2013 (sub-Group meeting) 31 January 2013 (sub-Group teleconference) 05 February 2013 5 March 2013 10 April 2013 8 May 2013 6 June 2013
Commonwealth Home Support Program Advisory Group	19 December 2012 (Teleconference) 19 February 2013 29 April 2013 (Teleconference) 13 and 14 June 2013
Quality Indicators Advisory Group	15 March 2013 11 and 12 April 2013 31 May 2013
Gateway Consultation Forum	30 January 2013 (Videoconference) 20 February 2013

	22 March 2013 29 April 2013 20 May 2013 21 June 2013
CALD Steering Committee *(now dissolved)*	22 August 2012 4 October 2012 30 November 2012
LGBTI Steering Committee *(now dissolved)*	2 August 2012 24 September 2012 3 December 2012
National Aboriginal and Torres Strait Islander Aged Care Reference Group (NATSI-ACRG)	7 and 8 November 2012 20 and 21 March 2013

LLLB Consultation Calendar

	AUGUST, 2012			SEPTEMBER			OCTOBER			NOVEMBER			DECEMBER	
S				1									1	
S				2									2	
M				3			1						3	ACRIC 12pm - 4.00pm Dementia Supp telecon PM LGBTI meeting
T				4			2						4	
W	1			5			3						5	
T	2			6			4	CALD 10am - 3pm Scarborough		1			6	
F	3			7			5			2			7	Home Care/CDC teleconference
S	4			8			6			3			8	
S	5			9			7			4			9	
M	6	2012 *LLLB* National Conference, Adelaide		10			8			5	Dementia Supp telecon PM		10	Additional Services Videocon 9:30-12:30 ACFI
T	7	2013 *LLLB* National Conference, Adelaide	ACFI Monitoring Group ACRIC Meeting, 07/08	11	SWAG Canberra	ACFI	9			6			11	
W	8	SWAG		12	ACFA MDAG Canberra		10			7	NATSI Shepparton		12	Gateway teleconference IDWG Meeting
T	9	Home Care/CDC telecon		13			11			8	NATSI Shepparton		13	
F	10			14			12			9	Gateway meeting Sydney		14	ACFI TRG 1.30-4pm
S	11			15			13			10			15	
S	12			16			14			11			16	
M	13			17	Speci Care AG Telecon 10am-1pm		15	Gateway Workshop		12	ACFA meeting Clinical Care 10-1 Addtl Services 2-5pm Speci Care 10-4pm	AEAG Telecon	17	Clinical Care Videocon 10am-1pm
T	14			18			16			13			18	
W	15	Home Care/CDC AG		19			17			14	ACCO Telecon 1-5pm		19	
T	16			20			18	ACFI TRG 1-4pm 19/10 ↓		15			20	
F	17			21	ACFI		19	ACRIC 10am - 4pm Scarborough		16	ACFI TRG 1.30-4pm		21	
S	18			22			20			17			22	
S	19			23			21			18			23	
M	20			24	ACFI TRG Canberra	LGBTI Canberra	22	ACFA	ACFI	19			24	
T	21	ACFA	ACFI	25	SWAG Sydney		23			20			25	
W	22	CALD, Canberra		26			24			21			26	
T	23			27			25			22			27	
F	24			28			26			23	ACFA	ACFI	28	
S	25			29			27			24			29	
S	26			30			28			25			30	
M	27	SWAG Melbourne					29			26	Speci Care AG Canberra 10am		31	
T	28	Home Care/CDC - teleconference					30			27	NACA Canberra			
W	29	Gateway Advisory Group (AM) Speci Care AG (PM)					31	MDAG, 9am - 4pm		28	NACA Canberra			
T	30	NACA Adelaide								29				
F	31	NACA Adelaide								30	CALD meeting			
S										31				
S														

Legend

SWAG (Strategic Workforce Advisory Group)	ACRIC (Aged Care Reform Implementation Council)
ACFA (Aged Care Financing Authority)	ACFI (Aged Care Funding Instrument) Monitoring Group

MDAG (Minister's Dementia Advisory Group)	ACRIC (Aged Care Reform Implementation Council)
LGBTI (Lesbian, Gay, Bisexual, Transgender Advisory Committee)	ACFI (Aged Care Funding Instrument) Monitoring Group

AEAG (Ageing Expert Advisory Group)	Home Care/Consumer Directed Care Advisory Group
Speci Care (Specified Care and Services Advisory Group)	Quality Indicators Advisory Group

MDAG (Minister's Dementia Advisory Group)	Gateway Advisory Group
LGBTI (Lesbian, Gay, Bisexual, Transgender Advisory Committee)	ACFI TRG (ACFI Technical Reference Group)

ACCO (Aged and Community Care Officials)	NATSI (National Aboriginal and Torres Strait Islander Reference Group)
CALD (Culturally and Linguistically Diverse Advisory Group)	Dementia and Veteran's Supplement Working Group

LLLB Consultation Calendar

	JANUARY, 2013			FEBRUARY			MARCH			APRIL			MAY			JUNE		
S/S																1/2		
M										1						3		
T	1									2						4		
W	2									3		Legi Industry briefing, Hobart	1	HSP - Service group 5 WG t/c, 2-4pm		5		
T	3									4	AEAG meeting, Canberra 10am-2pm		2	HSP - Transport WG t/c, 10-12		6	Gateway AG meeting 10am - 4pm	
F	4			1			1			5	Combined Sub-Group meeting		3			7		
S/S	4/5			2/3			2/3			6/7			4/5			8/9		
M	7			4	AEAG meeting, 1-2pm Canberra		4	AEAG teleconf 10-11am		8	Legi Industry briefing, Melb		6	ACRIC 10am - 4pm Canberra	Home Care Packages telecon 2pm - 3.30pm	10		
T	8			5	Gateway meeting 10am - 4pm	ACFA Meeting	5	ACFA Meeting	Gateway AG meeting 10am - 4pm	9	Legi Industry briefing, Melb		7	ACFA Meeting		11		
W	9			6	Combined sub-group videconf 10am - 1pm		6			10	Gateway AG meeting 10am - 4pm	Legi Industry briefing, Adelaide	8	Gateway AG meeting 10am - 4pm		12		
T	10			7			7		Combined sub-group meeting 10am - 1pm	11	Quality Indicators AG meeting #2	Legi Industry briefing, Perth	9			13		CHSP Advisory Group meeting 10am - 4pm, 13-14 June
F	11			8	ACFI MG meeting		8			12	Quality Indicators AG meeting #2		10			14		
S/S	12/13			9/10			9/10			13/14			11/12			15/16		
M	14			11	NACA Canberra		11			15			13			17	HSP - Service Group 2 WG meeting, Melb	
T	15			12	NACA Canberra		12			16			14	Budget	HSP - Service Group 2 WG t/c, 1-3pm	18		
W	16			13			13	MDAG meeting		17	ACFA Meeting	Combined Sub-Group meeting	15			19	Speci Care 10am - 4pm	
T	17			14			14			18	Dementia and Vet's WG meeting	Legi Industry briefing, Syd	16			20	Home Care Packages telecon 2pm - 3.30pm	
F	18			15	ACRIC 10am - 4pm Sydney		15	Quality Indicators AG meeting #1		19		HSP - Service Group 2 WG meeting	17	AEAG meeting, Canberra 10am-2pm		21	Gateway CF	ACFI MG meeting, 10.30am - 1pm
S/S	19/20			16/17			16/17			20/21			18/19			22/23		
M	21	Home Care Packages meeting Canberra		18			18			22	Speci Care 10am - 4pm		20	Gateway CF		24	HSP - Transport WG meeting	
T	22	Home Care Packages meeting Canberra		19	Home Support AG 10am - 4pm		19	Legi Industry briefing Canberra		23	NACA OOS Legi Briefing, Canberra		21			25	HSP - Respite WG t/c, 12-2pm	
W	23			20	Gateway CF		20	NATSI-ACRG meeting Scarb Hse	Legi Industry briefing, Sydney	24		MDAG meeting	22		IDWG meeting	26	MDAG meeting (tent)	HSP - Service Group 5 WG meeting
T	24			21	Combined sub-Group t/c		21	NATSI-ACRG meeting Scarb Hse		25			23	ACCO Meeting, Melbourne	ACFA Meeting, Syd HSP - Meals WG t/c, 2-4pm	27	HSP - Service Group 2 WG t/c, 10-12	
F	25			22			22		Gateway CF	26	ACFI MG meeting, 10.30am - 1pm		24	Speci Care 10am - 4pm	Reform Programme Board meeting	28		
S/S	26/27			23/24			23/24			27/28			25/26			29/30		
M	28			25			25	Speci Care 10am - 4pm		29	Gateway CF	HSP - Meals Services WG meeting, Bris	27	NACA Melbourne				
T	29			26			26	Legi Industry briefing, Darwin (VC)		30	Home Support telecon 3.15pm - 4.30pm		28	NACA Melbourne				
W	30	Gateway CF videocon		27			27	ACFI MG meeting, 10.30am - 1pm	Legi Industry briefing, Brisbane		HSP - Respite WG t/c, 2-		29					
T	31	IDWG Meeting		28	Speci Care 10am - 4pm		28	Home Care Packages telecon 10.30 - 12.30					30					
F							29						31	Quality Indicators AG meeting #3				
S/S							30/31											

Legend

ACRIC (Aged Care Reform Implementation Council)	MDAG (Minister's Dementia Advisory Group)
ACFA (Aged Care Financing Authority)	ACFI (Aged Care Funding Instrument) Monitoring Group

AEAG (Ageing Expert Advisory Group)	Speci Care (Specified Care and Services Reference Group)
NACA (National Aged Care Alliance)	Combined Additional Services and Clinical Care Sub-Group

Quality Indicators Advisory Group	Dementia and Veteran's Supplement Working Group
Gateway Advisory Group	Gateway Consultation Forum

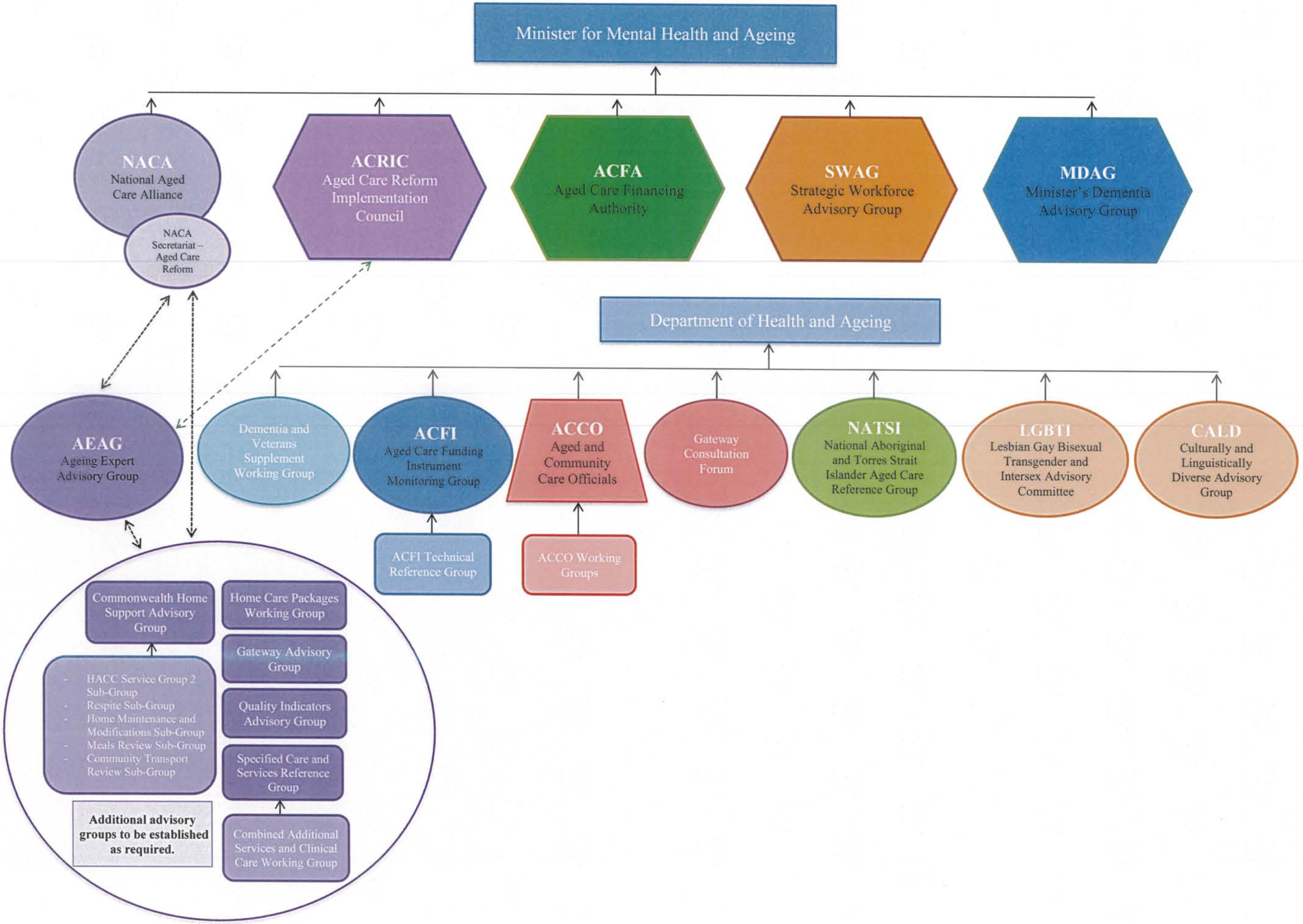
IDWG (Inter-Departmental Working Group)	ACCO (Aged and Community Care Officials)
Home Care Packages Working Group	NATSI (National Aboriginal and Torres Strait Islander Reference Group)

Commonwealth Home Support Program (CHSP) Advisory Group and sub-groups	ACFI TRG (ACFI Technical Reference Group)
LGBTI (Lesbian, Gay, Bisexual, Transgender Advisory Committee)	CALD (Culturally and Linguistically Diverse Advisory Group)

SWAG (Strategic Workforce Advisory Group)

Correct as of 2 May 2013

Living Longer Living Better Stakeholder Consultative/Advisory Groups



APPENDIX 4

Department of Health and Ageing - Availability of Delegated Legislation

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.