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Reference: Aged Care Amendment (Residential Care) Bill 2007

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SENATE STANDING COMMITTEE ON

COMMUNITY AFFAIRS

Tuesday, 1 May 2007

Members: Senator Humphries *(Chair)*, Senator Moore *(Deputy Chair)*, Senators Adams, Allison, Carol Brown, Fierravanti-Wells, Patterson and Polley

Participating members: Senators Barnett, Bartlett, Bernardi, Mark Bishop, Boswell, Bob Brown, George Campbell, Carr, Chapman, Crossin, Eggleston, Chris Evans, Faulkner, Ferguson, Fielding, Forshaw, Heffernan, Hogg, Hurley, Hutchins, Joyce, Kemp, Kirk, Lightfoot, Ludwig, Lundy, Marshall, McEwen, McGauran, McLucas, Milne, Nash, Nettle, O'Brien, Parry, Payne, Robert Ray, Siewert, Stephens, Stott Despoja, Watson, Webber, Wong and Wortley

Senators in attendance: Senators Adams, Humphries, McLucas, Moore

Terms of reference for the inquiry:

Aged Care Amendment (Residential Care) Bill 2007

WITNESSES

Committee met at 9.07 am

GRAY, Mr Richard Nelson Worsley, Director, Aged Care Services, Catholic Health Australia

CHAIR (Senator Humphries)—I declare open this public hearing of the Standing Committee on Community Affairs into the Aged Care Amendment (Residential Care) Bill 2007. Welcome, Mr Gray. Information on parliamentary privilege and the protection of witnesses and evidence has been provided to you. The committee has a submission from Catholic Health Australia, and we would like to question you on that submission. First of all, I invite you to make an opening statement.

Mr Gray—I will make a very brief opening statement. Catholic Health Australia is the largest non-government provider grouping of health, community and aged-care services in Australia, nationally representing Catholic health and aged-care sponsors, systems, facilities and related organisations and services. With over 19,000 Commonwealth approved residential aged-care beds, the Catholic sector plays a significant role in Australia's overall healthcare industry, representing around 13 per cent of the residential care market and employing around 30,000 people. CHA supports the introduction of the aged-care funding instrument and therefore, apart from the matters raised in the submission to this inquiry, supports the bill.

CHAIR—Thank you; that was very succinct. I will kick off by asking you to clarify a couple of matters that you raise in the submission. On the second page you describe the effects of items 1 and 2, subsection 22-2(3) and paragraph 22-6(2)(c). You talk about the distinction between high and low care. Can you explain to the committee the point you are making in those paragraphs?

Mr Gray—The concern that we have is that the level of care of a care recipient should be determined by the aged-care funding instrument rather than the secretary having specific powers to limit the care to a particular level. Under the current residential classification system, there is a method for the secretary to limit the level of care to a low level of care. That is based on the fact that when the aged-care assessment team assesses a resident as needing low-level care and the approved service determines that it is actually high-level care then the low-level care is what pertains to the funding—so it is linked to funding. The difference between the aged-care funding instrument and the existing RCS is that the aged-care funding instrument will assess the care that is needed by the person as opposed to the RCS, which determines the level of care that is provided.

The other point is that this is really about determining what the secretary believes should be the level of care of the resident, which has implications, as we have pointed out, for the specified care and services. We believe that this artificial determination of setting a high-level/low-level care distinction with the aged-care funding instrument is really no longer necessary with respect to the prescribed services, which can be determined by reference to the questions and particular results drawn with respect to the care level of the person under the aged-care funding instrument.

The other point about the high-level/low-level care distinction is that it specifically impacts on the determination as to whether a person pays a bond or does not pay a bond. Again, our argument is that it is only political policy reasons that continue to maintain that artificial

distinction—to avoid people going into a high level of care paying a bond. We believe that that is unnecessary. The other point also is that the high-level/low-level care distinctions do have implications with respect to the allocation of aged-care places. Under some of the changes to be implemented from 20 March next year, the number of places per thousand people aged 70-plus will be 44 places for low care and 44 places for high care. Our argument would be that maintaining an artificial distinction between high-level and low-level care should no longer be necessary in the allocation of places. The allocation of the place should be based on a total number of places per thousand people aged 70-plus, and the determination of who goes into that place and therefore what that place is classified as should simply be based on the level of care needed by the resident going into the place.

CHAIR—Catholic Health Australia was a member of the reference group that looked at the new formula.

Mr Gray—Yes.

CHAIR—In discussions in that reference group was it intended that the power for the secretary to override the formula should be exercised sparingly and in exceptional circumstances, or do you expect that this is the kind of power that would be exercised frequently?

Mr Gray—I do not recall any discussion during the reference group meetings with respect to the secretary having that specific power and how that secretary would use that power. We believe there should be no need for the secretary to have that power. That would be our argument again because our reasoning is that it should be the aged-care funding instrument that determines the level of care that is needed by the person.

CHAIR—Okay. We will certainly take that up with the department. On subsection 42-1(4), you say:

> CHA considers that there are still circumstances where a resident in a low care facility needing temporary high care may not be able to stay in the low care facility, particularly in regional and rural areas.

I am told that this was supported by the ACFI reference group, but there are obviously differences of view among members of the reference group.

Mr Gray—I remember some discussion about this and I remember certainly the department did indicate to the reference group that there were very low levels of people using this particular temporary high-care requirement. That was the basis to justifying why, given the very small number, there was no need to continue it. But our argument would be: if there is such a low number then there is no argument to get rid of the capacity for a facility to move a resident temporarily into a high-care approved place in order for that person to have some temporary high care if the low-level facility that they are currently in is unable to provide the high level of care that that person needs for a short period of time. That would be particularly the case, say, for somebody who has been discharged from hospital, who has been on hospital leave, and has come back to a hostel but really needs a little bit of high care on a short-term basis.

CHAIR—That sounds fair enough. We will also ask the department about that. Finally, I want to confirm that you are arguing for the new regime to commence at a later starting date

of 1 July 2008. Am I right in assuming that the extra $400 million or so that the government has attached to these arrangements would therefore be delayed in coming to the sector if that commencement date were to be pushed back?

Mr Gray—Most of that $400 million is really grandparenting the existing residents when the aged-care funding instrument comes into being. You are right; it would be pushed back. It really is about grandparenting, therefore it is not a lost benefit to the sector because the person will be on their RCS level until the aged-care funding instrument starts. They will remain on that same subsidy level when the aged-care funding instrument starts, unless their dependency level increases to a point where they can move to a higher funding level under the aged-care funding instrument. It will be the same on the anniversary of their assessment. Again, if they do not actually increase dependency then they will stay on their existing RCS subsidy rate until their dependency increases.

Most of that $400 million of extra money is really devoted to that. There is a small amount, I think about $80-odd million, from memory or around that figure, that is to be put as additional money into the supplements. But again, it remains to be seen as to how much of that will actually flow out because we still have not been given the actual dollars to be attached to the weightings under the aged-care funding instrument. At this stage, it is not possible for the industry to model exactly how funds under the aged-care funding instrument will flow to the industry and what impact the aged-care funding instrument will have on the industry. There will be some winners and some losers. Some facilities will possibly gain some income, others will lose income and, until we can make that assessment, we cannot be sure whether the aged-care funding instrument and the supplements are going to deliver the actual funding into the industry.

CHAIR—I take it that the reference to grandparenting is the new, politically correct version of grandfathering—is that right?

Mr Gray—Yes, that would be right—given that most of the residents in residential aged care are females.

CHAIR—Yes, I suppose so.

Senator McLUCAS—Thank you, Mr Gray, for your submission. Going back to the first point Senator Humphries was talking about—the secretary's ability to deem a person as low care—how many people are we talking about who might be caught up in that? Is it a larger number of the 166,000 people we have in aged care?

Mr Gray—I do not know the answer to that question. I think that would probably be a question that the department would be better able to answer. It is probably not a significant number, but it could be that if the aged-care assessment team says that a person is low care and then, when the facility applies the aged-care funding instrument and the facility believes it is high care, if the secretary believes that that person should stay at low-level care for whatever reason, it could be a significant number.

Senator McLUCAS—Do we know yet where the split along the three ACFI streams is going to come in terms of the high-care/low-care split?

Mr Gray—I understand from the preliminary information to do with the amendments to the principles that high care will be medium- or high-level ADL category, a high-level behaviour category or a medium- or high-level complex healthcare category.

Senator McLUCAS—So that has been clarified with the sector?

Mr Gray—That has been clarified with the sector, yes.

Senator McLUCAS—Good. That leads me to the reduction in paperwork objective of the ACFI. Does Catholic Health Australia have a view about whether or how ACFI will in fact reduce paperwork for providers?

Mr Gray—Based on the trial, it should reduce paperwork because we will have a reduced set of questions under the ACFI—down to 12 questions. We would also have set assessment tools that underpin the ACFI. Based on the trial, the average length of time to assess a person was around one hour. That will reduce significantly the amount of time involved in assessment, and it will also reduce the amount of paperwork, because a lot of the paperwork generated in aged-care facilities is around demonstrating the care provided to support the RCS and the classification determined by the facility under the RCS. There will be fewer pieces of paper underpinning the ACFI with respect to validation of the instrument.

Senator McLUCAS—I think Aged Care and Community Services Australia are saying that we should monitor that. Are you of that view as well?

Mr Gray—Yes, I agree; I think we do need to monitor the impact of the ACFI with respect to certain criteria. Will it reduce documentation? How complex is it to administer? Is it achieving what was intended for it?

Senator McLUCAS—I go now to the question of the implementation date. You are recommending that it should be 1 July 2008. In the Department of Health and Ageing submission they link the date to 20 March 2008, because that is the date on which the pension changes occur. Can you see that moving the ACFI implementation date to that date is relevant?

Mr Gray—I cannot really, other than with respect to those persons who pay an income tested fee. That is the only link that I can determine with respect to the ACFI. The ACFI rates change each year on 1 July, and that has an impact on the income tested fee for those residents paying income tested fees simply because the income tested fee reduces the care subsidy by the corresponding amount to the approved provider. But the other problem with the 20 March start date is that it is more appropriate from an operator's point of view to have a change in a funding system start on a specific date that links in with how you do your finances, and then your finances and accounting are all done on a monthly and financial year basis. The introduction date was originally going to be 1 July 2007 anyway, so there was clearly no need to link that introduction date with the pension change. There is still no need to do it, in my view.

Senator McLUCAS—So even if the compromise, potentially, was to move it to 1 April, that would make more sense to a provider?

Mr Gray—It would definitely make more sense.

Senator McLUCAS—Because that is the way you do your accounts?

Mr Gray—Yes.

Senator McLUCAS—Okay. We will talk to the department.

Mr Gray—I notice the legislation does not specify the start date and that is probably for good reasons: in case, for whatever reason, 20 March 2008 just was not an achievable date for Medicare Australia and the department.

Senator McLUCAS—We will talk to the department about that as well. The final question I have is on the comment you have already made about the dollar amount that will be attached to the ACFI categories being unknown. What does that mean for your providers?

Mr Gray—I have had comments from some of my people saying they really want 12 months to be able to know what the funding is likely to be. For example, if the aged-care funding instrument was going to be introduced from 1 July this year, if we knew what the level of funding for it would be then that would be useful for being able to anticipate the level of funding under the funding instrument for when it does commence next year. That would be useful so that providers can get ready for whatever adjustments they need to make. An example is if the aged-care funding instrument with respect to new residents coming in is going to impact adversely simply because there will be insufficient funding to support certain levels of residents into that facility, and that currently is an important catchment for them in terms of new residents, then they will have to think about how they will adjust their resident profile and also their staffing mix to match the expected levels of residents and levels of income that will flow to them under the ACFI.

Senator McLUCAS—It has been put to me that smaller facilities that have large numbers of low-care residents are the group that we can predict already; irrespective of knowing what the dollars attached to the ACFI streams are going to be, they will be worse off. Does Catholic Health Australia have many of those types of facilities?

Mr Gray—Yes we do, and we certainly are concerned at how the ACFI may impact on low-care levels, particularly where the predominance of the people in those facilities is low level. A classic example is Corpus Christi out at Greenvale, an outer suburb of Melbourne. It has 84 beds and caters exclusively for homeless alcoholic men. They are, generally speaking, 5s, 6s and 7s under the RCS. So if the ACFI is going to result in it being uneconomic to provide new residents coming in with the level of care that they need then that is going to impact adversely on that facility. They will be protected in the short term, with the grandparenting, but the impact will be as new residents come in.

Senator McLUCAS—The supplement on challenging behaviours would not be affected in that particular home?

Mr Gray—It is likely that they will attract that supplement but, again, the combination of the ADL and whatever they would receive under that supplement still may not necessarily achieve a good income outcome for them, given that most of their residents are at a low level of care.

Senator McLUCAS—I think it underlines the need for there to be some clarity—

Mr Gray—And monitoring of the impact of the ACFI will be very important.

Senator McLUCAS—It has also been put to me that regional and rural areas have the type of facility that you have just described—not necessarily for homeless people—and that regional and rural areas have a higher number of what are deemed as low-care residents. Is that your assessment as well?

Mr Gray—Yes. In fact, you will probably find that a lot of rural facilities might have a lot of category 8 residents, simply because there are probably people in the community living on their own who do need some supervision and a little bit of support but not enough to justify, under the RCS, attracting a subsidy. So they will tend to get admitted into a facility in a rural community as a community service by that facility, even though there is no income flowing in terms of a care subsidy. That is another area of concern—how will those facilities get on if their income is going to be reduced under the ACFI?

Senator McLUCAS—Have you had any indication from the government about when they will be able to provide the information about what dollar amount will be attached to each category?

Mr Gray—I understand that they are going to provide that information soon, but we have not been given an exact time frame.

Senator McLUCAS—'Soon' has been an interesting term in the relationship between the aged-care sector and this department. We were going to have the response to Hogan soon and we have never actually seen it at all.

Mr Gray—The $1.5 billion package starting 20 March next year was supposed to be the final response to Hogan.

Senator McLUCAS—We know that there was a document that was going to be released as part of the discussion leading up to the final announcement, but that has never been released. We will leave that one, though.

Senator MOORE—Mr Gray, I have a question about process. I get the impression from your submission and your evidence today that you are largely content with the process and the involvement there has been. Would that be fair?

Mr Gray—That is correct.

Senator MOORE—I am interested in the question Senator McLucas was asking about the actual dollar amount. In the meetings I have had with providers in Queensland, that is the biggie. They have been waiting so long. Would it be fair to say that most of the providers in your organisation will be able to calculate fairly accurately, once those numbers are available, exactly what the impact is going to be?

Mr Gray—It may be not that easy because, firstly, you really have to apply the ACFI to your existing residents and then compare what that would deliver in terms of ACFI dollars compared to what the RCS is now delivering. That will be where—

Senator MOORE—That will be the time-consuming element.

Mr Gray—Yes.

Senator MOORE—I have read your submission, of course, and I have read the department's one. The justification for the implementation date does seem not to be clear. It is

wordy without being clear. Is that the major concern that providers have about the actual implementation date—the absolute clarity of working out what the immediate impact is going to be on the future of the facilities?

Mr Gray—No. The starting date is more about fitting in with a natural financial cycle—

Senator MOORE—The flow, the cycle—yes.

Mr Gray—and clearly it is difficult to form a budget for the next financial year when all you can do is predict your RCS income up to 20 March and for new residents after that you cannot determine what income—

Senator MOORE—You cannot predict—

Mr Gray—That is right. That is again why it would be better to have a 1 July start date: simply because it is the start of a new financial year and it would enable a service to, based on their turnover, predict the income for new residents coming into that facility. Again, they might have to make adjustments, both in terms of staffing levels and resident mix to be able to maintain a staffing level—if they cannot maintain the resident mix they might have to change their staffing level. They might have to increase their staffing level; they might have to reduce it to fit in with the income.

Senator MOORE—Yes, because that would be determined by the new program.

Mr Gray—The aged-care funding instrument will certainly have an impact in those areas and therefore facilities need time to be able to assess that impact and make adjustments.

Senator MOORE—I know that you would have raised these issues in discussions with the department and that the department have acknowledged in their submission that there has been discussion. From your Catholic Health Australia aged-care perspective, what did the department tell you when, as you explained to us, you said why you as a provider were concerned about this process? What did they tell you?

Mr Gray—I have not raised questions with them about the 20 March 2008 start date, but I have certainly indicated to them that a 1 July or a first of the month start date was preferred.

Senator MOORE—So you have had no further information about why it was that date?

Mr Gray—No.

Senator MOORE—Naturally, we will ask the department. I am always keen to find out what has already been discussed.

Senator ADAMS—Mr Gray, thank you very much for your submission. I would like to ask you about accommodation bonds. With the new classification, will there be more or fewer accommodation bonds paid? How do you see that situation?

Mr Gray—I believe the likely result of the proposed high-/low-care level split under the ACFI will result in fewer residents being entitled to pay a bond. That is because of the potentially reduced numbers of low-level care people being able to be assessed under the ACFI as low-level care.

Senator ADAMS—I come from a rural area in Western Australia, and this is a real problem for our particular town mainly because a lot of the aged-care residents are

concessional residents anyway. It is getting to the stage where the lodge is really on its last legs as it is costing so much. I am wondering whether in this respect we may be able to get more accommodation bonds paid, but it does not seem like it.

Mr Gray—It would have been more appropriate, in my view, to have limited the high-care level to the actual high-care levels under the instrument, under the ADL, the behaviour supplement and the complex healthcare supplement. That would have made more sense. Sure, it would have increased the potential numbers of people able to pay a bond, but the reality is that people in high care are being denied a choice of paying a lump sum. There is only one choice: they pay an accommodation charge if they are assessed as being able to do that. But at least in low-level care consumers do have a choice of, in effect, paying on a daily basis with a periodic payment or paying a lump sum.

Senator ADAMS—I think it is really starting to bite in rural areas. I know that with us they are not going to be taking in high care. They have got two high-care places but they cannot keep that up because of the staffing. So those people really have to move to a hospital or elsewhere wherever they can find a place, which is not easy.

Mr Gray—You are right.

CHAIR—Mr Gray, thank you very much for the evidence that you have given today. We thank Catholic Health Australia for its submission.

[9.38 am]

MUNDY, Mr Gregory Philip, Chief Executive Officer, Aged and Community Services Australia

CHAIR—Welcome. Mr Mundy, you are an old hand at these appearances so I do not need to tell you about parliamentary privilege and the protection of witnesses. We do have the submission from Aged and Community Services Australia. It is a comprehensive one. Thank you very much for that. We have questions but first of all we invite you to make an opening statement.

Mr Mundy—Thank you, Chair. We are cautiously supportive of the introduction of the new funding system. We certainly see a need to replace a system that has been in place for 10 years. In fact, there are very few things that can last for a 10-year cycle without the need for renewal, updating and so on. I think the funding system is one of those. In our submission we have highlighted some of the different factors that different people have had in mind in arguing the need for reform of the system. We have sat there right through the entire process since 2001 and have had a number of different people expressing different views as to what needed to be changed. In our view there is no doubt that the system does stand in need of reform because there are significant flaws, at least in practice, with the current RCS system.

An overall concern, a major worry, about the ACFI system is that it might—perhaps not deliberately but inadvertently—have the effect of retargeting the provision of aged-care services. I note that the committee's questions to the previous witness focused on that point too. It is of concern to us that we may be seeing a shift in the targeting of residential aged care more towards high care and away from low care. That would have a number of implications which would be of concern to us. I do not think I can say definitively that that will occur, but certainly the feeling of our members who took part in the trial of the ACFI is that there will be more people coming out as high care than under the old system. That would have a number of consequences, both in meeting the need, as Senator Adams indicated, in rural areas in particular and also because there are lots of other policy issues that happen to be tied to that high-low distinction. We might have some inadvertent consequences arising from that.

We acknowledge that there are number of measures in the ACFI and included in this bill that are intended to streamline the paperwork, which was one of the major reasons for conducting the review. We certainly follow the logic of and support those measures. The changes to the information principles are explicitly designed to prohibit the production of certain types of information, which is another way of trying to reduce the amount of documentation people feel that they have to provide. We are, however, a little bit cautious because of our experience of the history of the RCS. The RCS was not designed to be a paper intensive system either; it just turned out that way when actual human beings got hold of it and started using it. Its excessive production of paperwork was not a designed consequence; it just happened to be that way. We are a bit cautious because the history of the previous system is that the paperwork spiralled due to unforeseen dynamics within that system.

As our submission makes clear, we do have some concern about some of the details of the ACFI and the implementation. I have listed those in the submission. I guess our overall

conclusion is that we are broadly supportive of the introduction of the ACFI but it is a very big and complicated system, and changing something as big and complicated as the whole funding system for residential aged care is hard to assess all at once and all in a piece. For that reason we have argued that one of the things we should do is make provision for a fairly robust review 12 months down the track. There was in fact a fairly robust review of the RCS about a year after its introduction, and a number of changes were made. I think we are foreshadowing signalling the things that, if they pan out as they were designed, will be absolutely fine, but it would probably be unrealistic to expect that to occur in 100 per cent of the cases.

I would like to make two last points by way of introductory comments. There has been quite a lot of modelling done of the financial impact of the ACFI, both by the consultants that did the original design work, Applied Aged Care Solutions, and more recently by Access Economics. The modelling has not been redone, to my knowledge, to incorporate the effects of the securing the future package that was announced in February, which does put some additional money into the system. That would seem to me to be a useful thing to do.

We do have some concern that the location of the high-low boundary, if we have to have one, is designed to be absolutely neutral in policy terms—to be at exactly the same point as it is under the RCS system. That was based on data that was obtained during the trial, and real data is always different from trial data. It may well be that in practice it does not fall exactly where people thought it was going to fall, because when people are doing real ACFIs on real residents, we would not expect them to match the trial data 100 per cent. So it is possible that that dividing line between high and low care might move not by design but by the difference between the trial and operating in practice. So the policy could shift unconsciously, not as a result of a deliberate decision.

Again, I think that is something to monitor to make sure that that does not occur and that, if it does, corrective action can be taken. It is relatively easy in the ACFI to move the boundary should there be a need to do it, because it has more funding points than the old RCS; it is more finely gradated. If it needs to move back a couple of points that would be easier to do in the ACFI than under the RCS. I am not saying it will be necessary to do that; I am saying we should make sure that there are not inadvertent targeting shifts and that we can make adjustments if there are. That is all I wanted to say by way of introductory comments.

CHAIR—Just to clarify, I see in your submission that you are talking about there being more funding points than in the old system. I do not quite understand how this works. There were eight classifications before collapsed into three but you say there are more funding points in the new system. How does that work?

Mr Mundy—Yes, there are, Senator. There are three primary divisions—high, medium, and low—but any resident can also access either or both of two supplements each of which has high, medium and low, and that actually generates a large number of funding points. I think it is 48. The department can give you the figure, but it is a large number of funding points. Maybe it is in the department's submission. So it is actually a more finely gradated system than the RCS that it replaces.

CHAIR—It would be the case, wouldn't it, that most residents would not be eligible for either of those supplements and so most people would be in one of those three broad categories?

Mr Mundy—The modelling done by Access Economics estimates the number of people who would get each of the supplements, and I think the data from that modelling is summarised in the Department of Health and Ageing submission to the committee. Certainly it is a question that they could answer. I think that quite a few people would qualify for the supplement and quite a few people would qualify for the complex nursing supplement. The residential aged care population is very heavily skewed towards the very top end of the distribution and I think it is right that the Access Economics modelling indicated that by the time you get to RCS 2, coming downwards, you have got 78 per cent, or some very high figure like that, of the entire population. So there are a lot of people right at the top.

We think it is right that more resources are put into the funding system to cater for people with very high care needs. Those people are in the system right now. They have been there for some time and they are bumping up against an artificial ceiling after the RCS, so we think that it is right that the ceiling is lifted because the people in residential aged care are frailer now than they used to be. But we do not favour just filling that gap by redistributing the money from the base upwards. The securing the future package acknowledges that, in that it puts in some additional funding to pay for the extra supplements, but as a percentage of the total it is actually quite small. Fifty million dollars as a percentage of $5 billion is 0.1 per cent. It is not a big increase and we are concerned for that reason that there will be some retargeting of the residential care program upwards. That might not be a terrible thing but we ought to look at the consequences very carefully to make sure that other things are done to compensate for that shift as it occurs over time. It will not happen on day one; it will happen as a new population of residents comes into the system, and that is another reason to monitor the social impact of the ACFI and its implications for other parts of the care system. If you change the targeting of the Australian government's major effort in aged care, you ought to look very carefully at the flow-on effects of that for other parts of the care system. Care in the community, the use of hospitals—everything is connected to everything else, particularly with frail older people that never just have one thing wrong with them. There are always layers of things that need to be addressed.

Senator McLUCAS—Thank you, Mr Mundy, for your submission. I first go to the question of the implementation date, and I think you heard Mr Gray's submission. I do not think that you go to that question specifically in your submission, but do you have a comment about the point that Mr Gray has made?

Mr Mundy—I cannot think of a good reason why you would implement it on the 20th of the month either. I understand why things linked to the pension are done on the 20th of the month because otherwise you would have to recalculate them instantly if they were done on the 18th or 19th. But there are not that many links between the pension rate and the subsidy system for residential aged care. Mr Gray has correctly identified one that is but it is a minority one. I have certainly heard providers argue for a first of the month start date as being better. The first of the quarter has an additional advantage to it, and I suppose that the cleanest one of all would be the first day of a new financial year. But I think that any one of those

options is probably more logical from a financial management point of view than the 20th. I cannot even be sure which day of the week the 20th is in 2008, but it will be the day that the pension is done. It is actually set, so it could be a Sunday for all I know.

Senator McLUCAS—It means that you would have to do your books twice in the month of March next year?

Mr Mundy—Yes, it does mean that if you get any new residents between the 20th and the 31st. If you do not then nothing changes. The existing residents will remain on their existing subsidy.

Senator McLUCAS—They are grandparented, yes.

Mr Mundy—It will be if you get any new residents or you have residents whose classification expired during that 11-day period. I guess the chances are that there will be some, but there will not be a lot. It would be tidier to do it from the beginning of a month, the beginning of a quarter or the beginning of a financial year. There is no question about that.

Senator McLUCAS—You make a comment in your submission about the phasing-in of supplements and how that will work. You recommend that additional resourcing to meet higher care needs should be available from inception. Can you practically explain how the phasing proposal is proposed and what it means in a facility?

Mr Mundy—The securing the future package was where the phasing-in proposals were announced. The upper level of funding under the ACFI is intended to rise from the current $123 approximately up to about $160. But, under the securing the future proposals, that increase gets phased in in $10 instalments over a four-year period. I can understand why you would do that—because it saves money, reduces the forward estimates and all of those sorts of things—but, from our point of view, we have people with very high care needs in the system now and we do not support phasing in the money to pay for their care when they are already with us. We see it simply as a savings measure. I understand why people want savings measures. But our job is not to save the government money; our job is to care for the older people in residential care. We would like the money now because we have the people now.

Senator McLUCAS—Given your earlier discussion about the fact that most people in residential care are of high need, it could have quite a considerable impact on care delivery.

Mr Mundy—I have heard estimates that the difference between the securing the future proposal to phase in and paying the subsidy up-front would be $600 million or $700 million. That sounds like a lot of money until we go back and compare it with the base residential aged care program, which is over $5.3 billion I think. It is actually not a big fraction of $5.3 billion. We have had the ceiling in place for the RCS for 10 years. Let us say that for the last four years we have had residents increasingly bumping up against that ceiling. There are going to be a lot of people there whose care needs are not adequately subsidised currently.

Interestingly, all of the consultants that looked at the RCS system—Aged Care Evaluation and Management Advisors did the 2001 review—identified that there are many people in the system whose care needs are not fully funded. The Applied Aged Care Solutions report in 2004 came to the same conclusion, as did Warren Hogan's analysis of that data. So it has been fairly well documented. It is in fact accepted by government that there are people in the

system currently whose care needs are not covered by the RCS subsidy. Our argument would be that, if the people are already in the system right now, what is the rationale for phasing in the subsidy to meet the care needs?

Senator McLUCAS—We all know that the highest cost in aged care is staffing and that those funds would be put to increase staffing to provide the level of care that is required. With a phased-in system, how does an aged-care provider then increase staffing on a monthly basis?

Mr Mundy—With difficulty, I would argue. There are, of course, two ways in which you can spend money on staffing. You can have more staffing hours or you can pay more for each hour that you purchase. I am sure I would be confident that some mix of both of those would in fact occur. People do not really change their rosters for minute changes in care levels but they will do it progressively over time if there is a trend or a measurable increase in care needs.

It is interesting to note that the available data on where the money goes in aged care confirms the fact that increases in federal government subsidies have by and large flowed into care staffing costs over the last decade. In fact, the proportion of aged-care funding that is now spent on care staffing costs has gone up. After being a fairly level figure for most of the second half of the nineties, in the last two years it has actually risen quite significantly. That indicates that the money is being spent on staffing, which is appropriate—that is what it is for. It is there to provide care.

Senator McLUCAS—I suppose I am going to the management point of incremental increases. I do not know how a manager then says, 'Righto, we have an extra $10 for that resident, so we will have another 20 minutes from that nurse.'

Mr Mundy—It is an arbitrary overlay over the care needs. It does not make sense from the point of view of managing the care of the individual person because it is an arbitrary staging of the increase in the first place. If a person has the care need now and you allocate it at, say, the full $35, you would say, 'Okay, that's an extra so many hours of care that we can provide to that person.' I suppose you would have to do the calculation: if they need an extra 20 hours; they can have five this year, an extra five next year—if they are still with us—and so on. I think the likelihood is that people at that end of the care spectrum will not be around at the end of the four-year forward estimates period.

Senator McLUCAS—I understand. The other objective of the introduction of ACFI was a reduction in paperwork—and you say you are hopeful that will happen—and that is good. Picking up from the chair's point earlier: whilst we have three levels of classification now, as opposed to eight, I have seen a table that has about 60 boxes.

Mr Mundy—Yes, it is a lot.

Senator McLUCAS—It is a lot of boxes. When I saw that box, I was tentative and questioned whether or not it was going to be a simpler system. When questions are asked by someone coming into a facility, how do you end up being classified in each of those boxes? Is it a very simple system whereby getting six out of 10 for a question will lead you into that box?

Mr Mundy—If you add all the scores together it will put you in a particular funding box. If I were an aged-care provider, I would have a computer program to do that and would not do it in my head. You will have a score on each of the bands in terms of the activities of daily living and you will have a score on each of two supplements. The three things added together will constitute the funding level that you will receive. I think there will be quite an active market in the production of software tools so that people can, firstly, do the calculations and, secondly, keep abreast of the funding they are getting for residents and so on. It looks more complicated—and that is a negative feature—but it is also smoother. There are not big jumps between levels. One of the identified flaws in the RCS is that it is not a linear scale—that there are points on a scale where you can make huge financial gains, and vice versa, where you have to have a huge increase in care needs to get an extra dollar.

The ACFI, because it has been designed for a clean sheet of paper, is a much smoother relationship between the points that you score from the assessment instrument and the dollars and cents. Having more points makes it easier to make it a smoother transition. It also means that the consequences of adjustments post-hoc to the funding levels are less consequential. Professor Hogan was of the view that the fewer levels you have the fewer changes there will be, but of course the corollary of that is the more significant they will be as well. From our point of view, it is probably a more conservative and safer option to have more funding points so that theoretically there is a greater chance of the funding levels being varied, but the consequences of those variations are much less. If you only had a three-band system with no other things the consequences of moving from one, to two to three would be significant and potentially catastrophic—not in the big groups that are spread over 30 or 40 facilities but particularly in the small rural ones that Senator Adams referred to earlier, where the margins are quite tight and significant fluctuations in funding are things you cannot really accommodate.

Senator McLUCAS—We will not be having validation, as we used to do under the RCS. How can a person move through the gradations of care over time? I understand there is to be a 12-month deemed time when a person can stay on a level.

Mr Mundy—They can stay on indefinitely—

Senator McLUCAS—Yes.

Mr Mundy—which I think is much better than the system that operates in the RCS, where everyone has to be reassessed after 12 months. As the department's submission makes clear, some 60,000 of those reappraisals result in no change. So there is an instant saving in the paperwork, because nothing happened, but more importantly those annual reappraisals created a disincentive for rehabilitation, because you actually work hard and improve someone's functioning and then the government takes the money away. Some people will do that regardless of that incentive structure, but it is not the way to encourage people to provide care that maximises people's independence. Those automatic reappraisals have been eliminated and we certainly applaud that. I think that is a big step forward in terms of setting a better incentive structure into the heart of the payment system. There are some caveats to that, and we have argued against those in our submission. We would rather have the system without those significant caveats, and they should in our view be looked at after 12 months to see whether they can in fact be done away with. I understand that they are there to allay the

concerns of other parties, such as Treasury and the department of finance, and I do understand how those pressures operate, but those interests are not our interests.

Our interests are providing the care of residents, and we would like those things looked at, if not on day one, which is probably impractical, certainly after the first 12 months. But if people's care needs change significantly, providers can do a reassessment and submit an additional claim. There is a threshold for making such claims—their care needs have to rise by a $30 increment, I think. That in itself is not a new provision. That is taking an old RCS provision forward into the ACFI, but it has long been a bone of some contention with the industry: if someone's care needs have gone up by a little bit, why should you have to wait until they have gone up by a whole lot before the subsidy increases? There is no logic to that other than the fact that it saves the government money and slows down the cash flow, and that is a legitimate consideration for governments to have but it is not one that we have got any reason to prosecute. Our interest is to provide the care, not to save the government money.

Senator McLUCAS—And that then goes to the comment you make about the reviewing of certain classes. Is that validation in another form?

Mr Mundy—Sorry, where is that?

Senator McLUCAS—On page 5 of your submission, the last paragraph. Is that validation in another form? Could you explain that to me? I will ask the question again.

Mr Mundy—The ordinary standard resident, if you like, no longer has to have an annual reappraisal, but if a resident comes into aged care from hospital or if a resident has their classification upgraded during the preceding period then they have to have another assessment six months later. It is just a check that the more volatile clients are not receiving too much funding, if you like, for the care that they receive. That is probably a compromise position between having everyone reappraised in 12 months and having no-one ever reappraised. We think the need for those six-monthly reappraisals should not be set in concrete. It should be itself reviewed. I have suggested a sunset provision here to make sure that there is a review and it may well be the case that there is no need to review the classification of people admitted from hospital after six months. If the aged care home has worked hard to improve the level of functioning of that person and made them more independent, should they be effectively penalised for doing so or should they be rewarded?

One of the tasks of a funding system is to set the incentive structure for good care. It would seem to me that by limiting those classifications to six months, you are not choosing the strongest incentive that is available to provide good rehabilitative, restorative care. You come back to a second choice option, if you like. We would certainly prefer that the maximum amount of incentive be provided in this system for improving people's level of functioning. It does occasionally happen that people are discharged from residential care and they go home again, and that is a day that I think everyone should celebrate.

Senator McLUCAS— The final question is about when we will find out what the dollars are that are going to be attached to each of the funding streams. What is your advice from government about when that might be?

Mr Mundy—I think I had actually been advised—and I should say informally—that April is when that would be. I think that was yesterday. I would support Mr Gray's comments that it

is imminent that we would get indicative funding under the ACFI. It cannot be definitive, because we do not have indexation figures for 2007-08 or any of those sorts of things, but we do understand that the indicative funding levels will be released quite shortly so that aged-care providers can start to have a look at the impact of the ACFI on their actual operations as distinct from the trial.

I also agree with Mr Gray's comment that the other step in doing that—that is, working out what ACFI level your residents would be on—adds a significant complication to that, because no-one has actually ever done a live ACFI assessment. There will also be a degree of imprecision in estimation from that source. But we certainly welcome the release of draft figures so that people can start to put their budgets together. People often do budgets in aged care on a three-year cycle. The firmer the data they can put into the out years the better their financial modelling will be.

Senator McLUCAS—I recall there was going to be a training program that was operational when ACFI was to be introduced in July this year. Is that happening?

Mr Mundy—The training program has been redesigned and redeveloped. I am happy that good use has been made of the additional time for implementation to revisit the training question to schedule it differently. I do not think the volume of training changes, but it is certainly done over a better time frame that I think will produce much better outcomes than we would have had from 1 July this year. In fact, we have argued quite strongly that, if 1 July this year was attempted, it would result in a mess. We were quite happy that it was put back to 20 March, so we celebrated the delay rather than discussed the precise date. We have already talked about that point.

Senator McLUCAS—Do you see any disbenefit in moving implementation to 1 July next year?

Mr Mundy—No.

Senator ADAMS—On the penalties for the late submission, I see that you are asking that that be abolished. Could you explain a little bit more about that.

Mr Mundy—The penalty for a late submission was introduced by the department to keep providers in line. It punishes them if they do not get their paperwork in on time. Effectively, it is a type of fine. There is already a disincentive for not putting in your paperwork: you do not get paid. I think I described it as an arbitrary exercise of administrative power. It is just a slap on the wrist and a fine. I can understand why it suits the department to have that incentive to get people to put their paperwork claims in. It has always been an irritant. I do not think it is a necessary part of a good relationship between the industry and the department. People are already penalised if they do not put their claims in because they do not get the money. I think it is an unnecessary belt and braces type of thing that could easily be done away with.

CHAIR—Perhaps it is because I have not yet had any coffee this morning, but I am certainly having difficulty understanding the recommendation you made on page 5. Can you just run me through it again.

Mr Mundy—This is about not having the six-month reassessment. We think there is a good case to improve the incentive structure still further by not excepting from that provision

the people who have been in hospital or have had a significant reappraisal. We are saying, 'Let that run for 12 months but make it—

CHAIR—So when they come out of hospital, the existing appraisal runs for 12 months. Is that what you are saying?

Mr Mundy—No. When they come out of hospital they will be given a new ACFI assessment but, unlike other ACFI assessments, the currency of those assessments will be only six months. So if they go into hospital or have extended hospital leave then they will have to have another assessment six months later. We are saying: 'Let's try that for 12 months, but ask the government, ask the department, to justify the need for those six-monthly appraisals after we have had a full 12-month cycle of operation,' with a view to removing that exception to the otherwise enduring classification that ACFI provides. Is that still convoluted?

CHAIR—I think so. You recommended a time limit of 24 months—the sunset provision—on the restriction. What do you mean by that?

Mr Mundy—I think there is a strong case that the six-month provision will not be in the best interests of the care of residents and that we should eliminate that restriction if it is at all possible. We should see what the impact of it is in practice with a view to—

CHAIR—After 24 months?

Mr Mundy—Yes.

CHAIR—You make two recommendations about additional resourcing: one is not to have the grandparenting arrangement and the other is to bring the necessary funding forward at the beginning of the process.

Mr Mundy—It is not that we would argue against the grandparenting but that we would argue against the phasing in or the staging of the higher funding for higher levels. We would prefer to have that all at once, at the beginning.

CHAIR—Do you have an estimate of what it would cost to achieve that objective?

Mr Mundy—Our estimate of not reducing the funding for lower levels and applying the new funding to higher care needs, so that in perpetuity no-one would receive less funding under the ACFI rather than just in a grandparenting sense, is about $250 million a year in very round figures. There are different permutations and combinations of that that can reduce that total but that would be the maximum cost in our view.

CHAIR—Is that per annum?

Mr Mundy—Yes, per annum. Again, on a base of $5.3 billion, $250 million sounds like a lot but it is actually not a big percentage.

CHAIR—That is clear to me. Thank you very much for your evidence today, Mr Mundy and for the submission that ACSA has provided to the committee.

Proceedings suspended from 10.11 am to 10.34 am

KEARNEY, Ms Gerardine, Assistant Federal Secretary, Australian Nursing Federation

CHAIR—I am very pleased to welcome Ms Kearney. I invite you state the capacity in which you appear.

Ms Kearney—I am here representing Jill Iliffe, the national secretary. She sends her apologies.

CHAIR—Certainly. We have a submission from the Australian Nursing Federation which covers a number of points fairly comprehensively. We are happy to examine the submission, but first of all I invite you to make an opening statement.

Ms Kearney—Thank you very much. I will take it as read, so I will be very brief. There are just a couple of things from the submission that I have been asked to emphasise. First of all, I would like to say that we wholeheartedly support the instrument—the ACFI. We think it is a great advancement, particularly for our members who have reported to us that they spend a great deal more time documenting than actually providing care for their patients or support for other staff, who need a more qualified staff member at times. We feel that it will require less documentation and we are pleased that it is focused on care that is needed rather than care that is provided, which we think the old tool was particularly focused on.

However, there are a couple of concerns that we would like to raise. We would like to express our concern about external assessments, which seem to have slipped off the radar. We think it is very important for patients going to residential care to have an external initial assessment, for the reasons that we outlined in the submission. We would also like to highlight our concerns about the definitions of high and low care. We would like you to understand how closely they are linked to the provision of quality care, because once the patient is classified it actually determines what care they will receive from what staff, and what skills and qualifications they actually have. Also, we believe that they are very closely linked at the moment to the provision of accommodation bonds, which is something that we have concerns about. Again, that is outlined in the submission quite clearly.

So what the ANF would ask for is that high- and medium-care be defined as ‘not low care’, that those two classifications exclude patients from being subjected to accommodation bonds and that they are seen as being quite high levels of care that require high levels of skills and qualified staff.

We made some comments in the submission regarding training in the ACFI. We would like to emphasise that, with the high turnover of staff in aged care and with the large number of part-time staff, we think it is essential that adequate training is provided to staff in using the new instrument, and also an explanation of the reasons behind the change. We feel that there could be some cultural resistance in the facilities, and it might help that if there is some explanation of the philosophy behind the reasons for the change.

Another thing that I would like to emphasise from our submission, which Jill asked me to raise with you—not lessening any of the other concerns raised—is the repeal of section 42.14. We are concerned that there are facilities around at the moment that simply are not able to provide ageing in place. We are particularly concerned for facilities in the rural sector, and

smaller facilities in the metropolitan sector. We are worried that if they lose their subsidies while their residents are forced to go elsewhere for that temporary high care the residents might actually lose their beds, because the facilities cannot afford to keep their beds for them if they do not receive that subsidy. You actually point out in the papers that because this happens infrequently it is unnecessary; we would like to say that, if it is infrequent, it would be okay to leave it there and it would not really be of any serious consequence.

Lastly, we certainly look forward to being involved with any further procedures, particularly into the amendments to the quality care principles. I will leave my opening comments at that and I am happy to talk to the submission as best I can.

CHAIR—That is great. Thank you very much indeed for that, Ms Kearney. The Nursing Federation has been part of the reference group on the development of this legislation, I understand.

Ms Kearney—Jill Iliffe has represented the Australian Nursing Federation right from the very beginning, and she asked me to convey her congratulations to the department on the level of consultation and the process that has occurred.

CHAIR—That is good. Can I get you to explain how you feel that the system creates a refocus on care required rather than care provided? What exactly is it about the changes in the system that engineer that kind of refocusing?

Ms Kearney—With the old system we were being told by our members that they were constantly having to tick boxes of things that were done to the patient—yes, they were showered today; they had meals fed to them today; they had PEG feeds given four times today—and it was constantly being recorded. They had to provide all that information, whereas with the new funding they have to say, 'Yes, they needed to be PEG-fed' and that is really how it goes. So it is the care that is needed that is documented in the ACFI rather than the care that was provided. That is my understanding.

CHAIR—That is clear, thank you. You say that there is a decision either not to provide external assessment or to delay external assessment.

Ms Kearney—That is our understanding.

CHAIR—So you understand no decision has yet been made about whether or not external assessment will be part of the new system?

Ms Kearney—Our understanding is that there is certainly a move away from that, that the department is tending towards allowing the facilities to make their own assessment internally. Our concern about that is that, again, the nursing staff will be required to do that and it will take them away from any patient-centred care or provision. The only documentation that would be considered necessary is where a reappraisal needed to be done. We think it would be a great disappointment if reappraisal were taken away—that the external assessment was already done and the patient comes in with their funding level set and, bang, the nursing staff can get on with providing care and not have to worry about the assessment.

CHAIR—So would the Nursing Federation say, in an ideal situation, that all the assessments should be done externally or only some of them?

Ms Kearney—In an ideal situation, we would like to see the ACATs perform the assessment before the patient is admitted to the residential facility.

CHAIR—Okay, and while they are in those facilities, would reviews be done externally or internally?

Ms Kearney—I think we would be happy for full reviews to be done internally.

CHAIR—You talk about the risk of aged-care providers seeking to influence the classification of high or low care in order to push people down to low care so as to collect accommodation bonds. With the new system, how do you think that might be achieved? What kinds of devices might unscrupulous providers use to do that?

Ms Kearney—Our concern is not so much that they might be tempted—that is one concern—to classify a patient as low care; our concern is that, if a patient is considered to be medium care, which is the old RCS 3 to 4, that that patient is considered in the quality care principles to be a low care resident, so that low and medium would both be considered low. Our premise is that, if you are classified as a medium and high, you are actually considered not high. Those two classifications are considered to be at the high end of care. It is not so much that providers would manipulate assessments to put everybody in the low section, but that they would capture both low- and medium-care people in that low-care classification.

CHAIR—You are saying the classification system should be reorganised so that people with medium-level needs are classified as high need and therefore are not supposed to pay accommodation bonds?

Ms Kearney—Correct.

CHAIR—You call for training in the ACFI—that is appropriate, I think. There is a reference in the government submission to there being additional funding to support industry training in the use of ACFI but there is no amount indicated. We have heard already today about some efforts being made to train. Do you have any idea what sort of training might be made available under the new arrangements?

Ms Kearney—Do you mean funding for training?

CHAIR—Yes.

Ms Kearney—I am really sorry, I could not make a guess at what would be needed. I could get back to you on that. The providers might have a policy.

CHAIR—I understand only recently some information has been provided about how much funding for training is going to be rolled out. You might like to consider, if there is any information at hand about that, whether that is going to be adequate from your point of view to properly provide for the training of people at the coalface, as it were.

Ms Kearney—I am sorry I am not appraised of that.

CHAIR—Sure. Lastly, in paragraph 6 of your submission you comment:

The ANF is concerned that the Australian Government is attempting to introduce the ACFI from an existing inadequate funding pool and that the funding allocated under the grandparenting arrangements will be insufficient to ensure stability within the industry as the industry moves from the RCS to the ACFI.

What exactly do you mean by that? Can you quantify what you think is the shortfall that is evident from this process?

Ms Kearney—My understanding is that it has been accepted that there will be a slight reclassification of patients going from the number that we have now to the 3 and that, in the wash, some residents might ultimately receive less funding than they do now. That has been accepted, so grandparenting arrangements have been put in. But we are still a little bit concerned that there has not been enough investigation done to see the exact impact of that arrangement on some of the facilities and we would like to see a bit more research done, particularly for the rural facilities that have little recourse and might be affected more seriously than some others. We are really just asking that a closer look be taken at that situation.

CHAIR—Thank you for that.

Senator McLUCAS—Thank you, Ms Kearney, for your submission. I want go back to the external assessment issue. You have basically answered the questions I had about why you want that to occur. In a practical sense, the reality is that a lot of people go through an ACAT assessment and then it is some time between that initial ACAT assessment to their admission into residential aged care. Would it require a subsequent assessment using the ACFI so that assessment would be done of care needed at the point of entry into residential aged care?

Ms Kearney—We do not envisage that there would be a great deal of change from the ACAT initial assessment to the time of admission, but—and I think we said this in our submission—there may be only a small amount of documentation needed to reassess part of the ACFI that would change the ultimate outcome. That could be done internally. We would be quite happy for that to be done internally if there was an obvious difference once the patient came into the facility from the assessment that was made externally. I have not been intimately involved with all of the trialling, but my understanding is that the external assessments matched pretty closely the admission assessments during the validation process.

Senator McLUCAS—Thank you. I have a question about training. We heard earlier that the training rollout has been revised and delayed. Can you tell us what you know about how the training is going to roll out?

Ms Kearney—Unfortunately, I am not fully apprised on the training. Our concern, as Jill has put in the submission, is that it extend over at least a four-year period to cover rollover of staff and part-time staff. I am sorry, but I am really not fully apprised of the training.

Senator McLUCAS—We can ask the department their views about how long it is going to take to roll out as well. Finally, you made the comment that you oppose section 42-1(4) being repealed. You made the point that it is not going to affect many people, so why change it? Do you have any notion of how many people we are talking about?

Ms Kearney—I do not have any notion, no. It is just that we know that there are facilities out there at the moment that still do not have the ability to age in place and that it would certainly affect them and we have been speaking with some of our members who have concerns about that, I cannot tell you the exact numbers, no. I am sorry.

Senator McLUCAS—That is okay. It is the department's language that it does not affect many people, so why change it. The other point you make in 7.4 is that the items allow the minister to determine a different subsidy level when people are receiving extended care in hospital. The RCS denotes people by two categories. Do you know what is proposed? Has the department advised you on what is proposed?

Ms Kearney—No. The point of our submission is that it is very unclear what the new arrangements would be and we ask that that is made very clear so that we know where we stand, or that providers know where they stand, and what the outcome will be.

Senator McLUCAS—Have you talked with the department about that at all?

Ms Kearney—I am not sure if that has been raised.

Senator McLUCAS—We can raise that on your behalf anyway. Other submissions talk about the broader impact of securing the future and what that might mean, particularly for—to use the old language—hostel type facilities and rural and remote facilities. Does the ANF have a view about what securing the future might mean for those types of facilities?

Ms Kearney—A lot of our concerns are for those facilities and certainly for our members that work in those facilities. That is why we have focused quite a few of our concerns with our submission on those areas, particularly in relation to ageing in place. With anything that we do from now on with the funding for the aged-care facilities we actually do stop and separately take into account what it means for those smaller facilities and make absolutely sure that we are not undermining their existence and the care that they can provide. The last thing we want is to be in a situation where we do not have enough staff, we do not have a good skill mix and we do not have the qualified staff there to provide good care for the residents in those facilities. Really all we ask this inquiry is that, in anything that is done, there is extra special focus on what will happen, on what the impact is on those small facilities.

CHAIR—Thank you very much indeed for that evidence, Ms Kearney, and please thank Jill Iliffe for the submission. We appreciate the effort that has gone into that.

[10.52 am]

BROADHEAD, Mr Peter, Assistant Secretary, Policy and Evaluation Branch, Ageing and Aged Care Division, Department of Health and Ageing

McNEILL, Ms Anne, Director, Funding Model Implementation Team, Policy and Evaluation Branch, Ageing and Aged Care Division, Department of Health and Ageing

STUART, Mr Andrew, First Assistant Secretary, Ageing and Aged Care Division, Department of Health and Ageing

TRACEY-PATTE, Mr Keith, Director, Funding Model Implementation Team, Policy and Evaluation Branch, Ageing and Aged Care Division, Department of Health and Ageing

CHAIR—Welcome. Do you have any comments to make on the capacity in which you appear?

Mr Broadhead—The officers responsible for the process of development of this particular aged care funding instrument are within my branch.

Mr Tracey-Patte—I am one of the two directors of the funding model implementation team which is tasked with managing the overall implementation of the aged care funding instrument.

CHAIR—Thank you. Information on parliamentary privilege and the protection of witnesses has been provided to you. I think some of you, at least, have appeared before these committees before. You will not be asked, as departmental officers, to give opinions on matters of policy, although this does not preclude questions asking for explanations of policy or factual questions about when and how policies were adopted. We have a submission from the department—thank you for that. Before we ask you questions, would you like to make an opening statement about the matters before the committee?

Mr Broadhead—The purpose of the bill is to introduce a new classification as the basis for paying care subsidies in aged-care facilities. The current instrument is called the resident classification scale—the RCS is how it generally gets referred to. The RCS is based upon care plans. The original intention of this was that it would be a by-product of processes that already took place in the organisation and delivery of care and therefore it would not be a burden. But in practice that is not the way things have turned out. It has become a driver of documentation—largely, I would say, due to fears on the part of homes about their fate when validation takes place; that is, when their classifications are reviewed to see whether or not they match the needs of the resident or the care plan provided to the resident. So there has been a lot of defensive documentation going on. This has given rise to an overburden of documentation within the industry which is distracting from the provision of care.

The answer to this seemed to be a review of the RCS in 2002, which the then minister commissioned. That recommended a new funding model and a reduced question set for the classification. There was also a recommendation in 2004 when Professor Hogan did his review of pricing arrangements in aged care, which suggested a collapsing of the number of categories in the funding instrument from eight to three. He also recommended the

introduction of three new supplements. In the government's response they accepted that there should be two new supplements: one for people exhibiting complex or challenging behaviour, which can be a predictor of the need for intensity of care, and the other for people needing complex health care support, particularly people who are in need of palliative care.

A reference group was set up in August 2004. I think you have heard today from a number of the members of that reference group. A national trial was established to look at how we might change the way in which the classification was done. Dr Richard Rosewarne from Applied Aged Care Solutions essentially led that study. In 2005, 23 per cent of aged-care facilities participated in a national trial, and 5½ thousand residents were classified using a new instrument, the aged-care funding instrument. The outcome of that was a report from them to the government, the result of which is the instrument we now propose to use.

I suspect that the major difference between the resident classification scale and the ACFI, or the aged-care funding instrument, is that the ACFI attempts to assess care needs. It is not based on care planned. It has a fairly strictly defined documentation set to try to limit the tendency for more and more documentation to be brought to the business. It has a reduced number of questions: 12, plus two diagnostic fields. So less information needs to be gathered in order to produce a classification of a resident. Almost 2,000 validations were performed as well, and there was 95 per cent agreement between the results of validation and the assessments done within the homes. That is comforting. At the moment we can have disagreements between validators and time assessments. In some instances, it is almost approaching half, so 95 per cent is a very encouraging result.

The promise of the ACFI is that it will better identify the care needs of residents. It will allow payment that is more aligned with the care needs of residents. I think you heard Greg Mundy suggest that the current one has some fairly lumpy bits in it and that small changes in care needs can lead to large changes in payment. The ACFI does not suffer from that; it is essentially linear. It will have a reduced requirement for documentation strictly defined. We have an ACFI documentation pack, which people will complete when doing assessments. It is essentially the documentation that is required. We expect to have much less disagreement and therefore less incentive towards defensive documentation as a result.

As part of the introduction the government has also introduced some additional funding. So there will be higher levels of payment at the top of the ACFI, phased in over time, as you would be aware. In total, if everybody were to be on the ACFI instantaneously, the government would be spending approximately $50 million more per year on care than it would under the RCS—as best we can predict. Because it is being phased in over time, the additional resources are $96 million over the first four years as people move from the RCS to the ACFI.

The bill covers a range of other issues which are related to this change in the classification, including, as you have heard, things to do with classification expiry. In particular, currently the RCS classification expires after 12 months. This means that everybody has to be reappraised every year, and about 60,000 of those reappraisals result in no change—roughly one-third of those. So, as part of the changes, it is proposed that the classification be indefinite—that it goes on until there is seen to be a need to reclassify somebody. This should eliminate the number of assessments done that result in no change.

On transfer from one place to another, one currently has to again reassess somebody. That is to be removed so that a home may accept the existing classification. It is their option. If they believe that the person's classification does not reflect their care needs then they can assess the person, as they do now; but, if they believe it does, there is no compulsion to reassess. This should again significantly reduce the burden of classification on the sector and result in less paperwork for the sake of paperwork.

On training, we have a contract with the Western Institute of TAFE—technical and further education—in New South Wales. They won through open tender a contract for the provision of training nationally. We have since revised that contract, given the additional time now available to the introduction. The value of the contract is approximately $4 million. It will provide training in two rounds essentially. The plan is that the first round will be to managers in October-November this year so that the people managing facilities will have the opportunity to acquaint themselves with the features of the new system. The training of people who will be involved in assessment will happen closer to the time of the introduction, largely because what you learn does not stick forever unless you get to practise it. Training close to the time that people will begin practising is seen as a good thing and also because there are levels of staff turnover. It would be a pity to train someone who then moves on and then find that untrained people are attempting the assessments.

Overall, we expect 3,000 people in the management phase to access training and then 7,000 assessors to access the training. This is in the context of about 3,000 facilities that provide care. There is essentially one management person per facility in the first round of training. In the second round, facilities with fewer than 80 places will have the opportunity for two people to be trained; facilities with between 80 and 120 places will be able to have three people trained; and facilities with more than 120 places will be able to have four people trained. It will be conducted nationally. Also, the materials generated out of that will be made available for people to use in continuing training.

I think that is probably all I wish to say in my introductory statement. I am happy to take questions of course.

CHAIR—We might deal with some of the issues thematically rather than by senator, if that is all right. Senator McLucas, do you want to kick off with your first area of concern?

Senator McLUCAS—Thank you, Chair. Let us go first to the question of implementation. You may have heard Mr Gray's evidence—I know that Ms McNeill did—in which he said that he could not find a reason why 20 March next year would be useful. Mr Mundy, in response to my question on this issue, said that there would be no disbenefit in extending the implementation date to 1 July. The point made by the Catholic Health Australia submission and by Mr Mundy in his evidence was that the linking of the changed pension arrangements with the implementation of the ACFI date was somewhat meaningless and that it would be better to put it to a financial year basis as a first preference and, as a second preference, to at least the first of a month for ease of implementation. Do you have a view on why that could not be moved?

Mr Broadhead—It is feasible to move implementation date. I suppose the question is why one would. It was earlier planned that the ACFI be introduced from 1 July this year. It was

consequent upon submissions from the sector, including the peaks and from a number of providers, that it was moved back, and that was largely to do with the capacity of their software suppliers to develop systems that incorporated the ACFI. We believe that the revised date of 20 March 2008 will enable those developers to make the necessary changes. So we believe that the impediment to doing it earlier will no longer be there by 20 March.

It is correct that 20 March relates to the date on which pensions are indexed—and that might seem to be an odd date. It is because the rescheduling occurred as part of a larger package, which includes a number of changes to funding arrangements. It was thought sensible to bring those in on the same day that some of the parameters that affect payments were going to change anyway. It provides a period of six months stability in the funding arrangements post that indexation point.

With the question of the timing, I think it would be best if the ACFI were done sooner rather than later. I think that is the general view. I suspect that even those who talked earlier today would hold that view to some degree, which is that the ACFI is a better instrument. It will resolve documentation problems to a significant degree for the sector. For people with higher care needs, it will result in higher levels of payment than are currently available. In order to get the benefits as early as possible, there is a variety of reasons why you would not want to delay it. I think the implementation date is really a balancing act between being prepared to do it in a smooth and orderly fashion and doing it as soon as possible to bring the benefits of it to the sector and to the people receiving care. Apparently, in the government's view, 20 March is the balancing point.

Senator McLUCAS—Do you understand the point made by submittees though that the first day of a month is a simpler way of introducing such an instrument that affects budgeting and financial management in the way that it does?

Mr Stuart—I would make a couple of points in relation to that. One is that, for both the department and aged-care providers, lining up with the other changes means one set of system changes and one implementation date, which is of some benefit. Another point I would make is that, with this measure, not a lot happens on implementation day.

Senator McLUCAS—I think that is the point they are making.

Mr Stuart—It is the date after which new residents arriving will be assessed by a new instrument, but it is not some kind of a sea change; it does not impact existing residents until their previous RCS classification expires. Really, it is only a quite small trickle of incoming new residents that will be assessed under the aged-care funding instrument. So I am not sure that I completely understand the benefit of a change to the first of a month versus the 20th of a month.

CHAIR—The providers who have to deliver these changes seem to be united in the view that that would give them an appropriate lead time to prepare. They would normally be the ones seeking additional resourcing and benefits to flow more quickly, but they say that they would prefer a later date. That would be a compelling reason, would it not, to defer the matter until that later date?

Mr Stuart—The date chosen was more than a year after the announcement date of 8 February and itself was a further delay to implementation. We are very confident that we will

get through the finalisation, the training and the work with the industry by that date. It is not a date that makes the department think we have a significant challenge in meeting the time line.

Senator McLUCAS—I think it is more of a financial management question rather than a question of 'Will we be able to get the training done in time?' I do not think the submittees are making any sort of comment about not being ready by then; I think it is about being able to do your books more effectively.

Mr Broadhead—As my colleague Mr Stuart mentions, if you have a 60-bed home, essentially fewer than 10 new residents, on average, will be classified under the ACFI in the first three months. The average length of stay is roughly three years, so roughly a third of people would turn over in a year; in a quarter of a year, you would have a quarter of a third of people, so it is not as though there is an intensive burst of activity. In addition, the outcomes will not affect the revenue of a home except at the margin. By far, the bulk of residents in any home will still be on the RCS by the end of that financial year. So, in a sense, it gives homes a taste of the changes and it gives the capacity to start working with them but in a time frame that means for that financial year it will have, at most, a marginal impact on their overall revenues. I think that is a good balance.

Senator McLUCAS—We have heard from witnesses this morning about the element which talks about the secretary deeming at the low level of care, section 22-2(3) and 22-6(2)(c). Could you explain that for the committee please?

Mr Broadhead—My understanding and I may yet refer to my colleague Keith Tracey-Patte is that at the moment if you have an ACAT assessment only for low care then you cannot be classified as high care subsequent to entry to a facility. That is the case as we speak. In order to be classified as high care you would need to be visited by an ACAT and assessed as to whether your needs included high care or should be extended to high care. That is the existing arrangement, as I understand it. This is not something where the secretary herself intervenes in a classification; it is a delegated power to decide what level of care somebody is eligible for. If they come with only eligibility for low care then it raises a question if they are classified for high care and there is a need to revisit their eligibility before they can be classified for high care.

Senator McLUCAS—How many people is that expected to affect?

Mr Tracey-Patte—As at 31 December 2006 there were 17,643 residents who had been classified by the ACAT as a low-care resident whose subsequent RCS appraisal was for a high level of care.

Mr Broadhead—Is that for the first six months of the financial year?

Mr Tracey-Patte—That is within the existing population as at 31 December. That is how many residents at that time had an initial ACAT approval of low but who were subsequently classified as high. So that decision could have been made at any time prior to that.

Senator McLUCAS—So essentially what is happening in this legislation is that we are duplicating the current situation?

Mr Tracey-Patte—That is correct.

Senator McLUCAS—Catholic Health Australia is suggesting that is not required. Is the reason for those 17½ thousand people essentially changing their classification on entry because of a time delay between the ACAT assessment and entry into residential care? Is that why that happens?

Mr Tracey-Patte—That is certainly one of the reasons that it can happen. It may simply be that the ACAT makes a decision using a slightly different set of criteria to those the home will use to make their decision about the RCS classification. The ACAT looks at the person's care needs at the time they are assessing them during that particular interview and they may talk to other people who have been caring for the person. That is a very different process to when a home has had somebody in their care for a week. They start to go through and then they go through the 20 questions. There may be an element of the time delay but it is also a different decision.

Senator McLUCAS—Because of the instrument being different from ACAT to RCS now ACFI.

Mr Tracey-Patte—Yes.

Mr Broadhead—There is also Keith's point that a home has usually had somebody in for some days and so their opportunity to observe and understand a person's care needs is different from an ACAT which may do it in hospital or on a visiting basis in a person's home.

Senator McLUCAS—I am trying to understand the policy intent of that section.

Mr Broadhead—The policy intent is to provide a brake on the classification of people who, in the view of ACATs, were eligible for low care only being classified for high care. It is essentially a control. It is assumed that although there is some discrepancy between ACAT assessments and assessments by facilities that where an ACAT did not assess a person as eligible for high care there ought to be a re-examination rather than simply accepting the home's appraisal. In other words, there ought to be an occasion for a review, if you like, if there is a discrepancy between the two. It is a brake on the possible overclassification of people on entry.

Senator McLUCAS—I might have this wrong, but let me put it this way and you can tell me if I am wrong. The ACAT has assessed the person as a low-care recipient and they have been admitted to the facility on the basis—that is, they can be charged a bond. Subsequent to that, the facility believes that they actually need a higher level of care and therefore a bond cannot be applied. So the secretary is making a determination that they are low care so that the financial arrangement that the facility has engaged in can be respected.

Mr Tracey-Patte—No. The initial approval by the ACAT at a low level of care means that a bond can be asked of the resident even if they are subsequently classified at a high level of care according to the RCS. That does not change or negate the accommodation bond issue.

Senator McLUCAS—That is fine.

CHAIR—Under the present arrangements, is it the secretary who exercises the discretion at the moment?

Mr Tracey-Patte—The secretary in this particular situation has delegated her authority to the ACAT to make the decision about whether or not the person is approved as high or low level of care.

CHAIR—Sure. I appreciate that it is not done personally by the secretary. How often these days is the secretary's discretion being exercised in respect of residents in this form?

Mr Tracey-Patte—I am not sure that I understand your question. We have 17,643 current residents who were approved at a lower level and who were subsequently classified as being at a high level. Once the resident reaches the aged-care home, the aged-care home has an option to ask the ACAT to come back and reconsider the approval. That would be a subset of that 17,000, but I do not have an exact number for how frequently that occurs.

CHAIR—This request has been made by the provider?

Mr Tracey-Patte—That is correct.

CHAIR—You talked before about the secretary's discretion. You said that the provisions in this bill are a replication of what is in the existing legislation. Is that correct?

Ms McNeill—It is not a discretion of the secretary. If you are talking about the classification of a person who comes in with a limitation to low, the secretary must classify that person within a low classification. So the person is in effect always classified as RCS 5, which is the highest of the low classifications.

CHAIR—So it is a default position more than anything else in the absence of an ACAT assessment that gives them a higher—

Ms McNeill—In the absence of an ACAT reassessment the service may ask for ACAT to come and reassess the resident. When the ACAT does that and reassesses the person as requiring high care then they can access high classifications.

CHAIR—Both the ANF and Catholic Health Australia have said that that capacity to limit the level of care to a lower level is not necessary and that the formula—the ACFI—should determine their level of care. I think I have described what they are saying in their submissions. Are you saying that we should retain a default position when a resident initially comes into the system but that that should be capable of being dislodged by a later assessment by an ACAT?

Mr Broadhead—That is in effect the way it is at the moment. To step back a little bit, aged care assessment teams are essentially the gatekeepers of entry to aged care and they assess people as to whether or not they need aged care or are eligible for it in strict terms. As part of that they assess whether they are eligible for low care, high care or community care. Whatever their judgement may be, that is the person's assessment. When that person turns up—if they do, and they may not turn up immediately for a variety of reasons—to access care there will be a proportion—not a large proportion, in my view—of cases where the ticket they have, as it were, from the ACAT does not agree with the provider's assessment of their care needs.

The recourse is to go back to the ACAT and ask: have you got this right? They will reassess the person, and if they say, 'Yes, it's true that this person actually does have high-care needs' then they can be classified for high care in the facility. In the absence of that eligibility, they cannot be. It is a basic control on the system about who is eligible for care and what level of

care they are eligible for. It is imperfect. There are times when there are disagreements between the various assessments. There are opportunities to rectify that. It is not always the case that somebody who the provider thinks is eligible for high care—where the ACAT has given only a low-care assessment—ends up being eligible for high care, but I suspect that in most instances it would end up with the person being assessed for high care. I do not have those figures at hand though. If you would like, we could provide you with a breakdown.

CHAIR—When section 22 refers to the secretary limiting the level of care of a resident to a particular level—

Mr Broadhead—That is the ACAT eligibility assessment.

CHAIR—So what you are saying is that the decision by the secretary or her delegate is really being made by the ACAT?

Mr Broadhead—Yes. It is about the level of care the person is eligible for, which may be restricted to low care, for example.

CHAIR—That is reasonable because it is a decision by an ACAT.

Senator McLUCAS—That leads to the recommendation from the ANF about external assessment. The recommendation was to have the ACAT do the ACFI. No-one in the world would know what we are talking about: the ACAT do the ACFI! It sounds ridiculous.

Mr Broadhead—The aged-care assessment team do the aged-care funding instrument assessment.

Senator McLUCAS—Their recommendation is that the ACAT do the ACFI. Was that contemplated so that you basically have one assessment and it is done according to what everybody thinks are the ways that we assess care needs, and then off we go? Mr Tracey-Patte, there is some delay between the ACAT assessment and entry, for a whole range of reasons, so we cannot just say, 'You'll get your ACFI assessment today and you'll go into residential care tomorrow.' That does not happen. Did you contemplate having the ACAT doing the ACFI? Why was that discounted, as not appropriate?

Mr Broadhead—We did. In fact, the national trial had ACATs involved in doing assessments. The problem that we had with the results of the national trial was that, although a number of people were assessed in the community, only 27 actually went into care during the period of the trial. So we had insufficient data, quite literally, to understand the extent to which the external assessments tallied with people's assessments on entry. Of course, the critical factor here in designing prior external assessments is how good it is—how well does it correspond to the assessments one would make on entry, or shortly after entry, as we currently do? If one could design a system that to a high degree came up with an assessment that was similar to the assessment or the same as the assessment made under the current arrangements then you would say that at least technically it is feasible, and possibly for other reasons desirable, to move to external assessment. But the national trial did not yield enough instances where people had been previously assessed and subsequently entered care for us to form any judgements about that.

That said, we—that is, the officials involved in this—are still interested in trying to develop an understanding of how well external assessment would work and whether it is indeed an

option that should be put to government in advice. We have taken the view, however, that in the circumstances, with the number of changes going on, that this is something that should be on our list of things to do but is not something that should be done right now. With the changes that are happening, the view would be taken that there needs to be a period of adjustment for the industry to absorb the new arrangements—to bed down the use of the ACFI and various other things that are going on. In the meantime, we need to do some work on the conceptual side of how it might work, and that might lead to some further work in cooperation with the industry around the possibilities for external assessment.

ACATs are an obvious choice. There were other assessors involved in the national trial as well—for example, we had the Royal District Nursing Service involved in assessments in Victoria. So ACATs are not the only option. There are some issues around whether or not ACATs want to be involved. We had some resistance in New South Wales, for example, to ACATs having any role in the national trial, so it is not necessarily readily accepted in some quarters that this is a role that ACATs should be performing or could perform. There is a range of issues to be explored here. But, yes, we do think that external assessment is worth a good, hard look. Yes, we think it is worth some developmental assessments, but we think there is a timing issue about when we pursue it.

Mr Stuart—Just to embellish that, ACATs come with a perspective that they are there to direct care. While the ACFI is much more about care than its predecessor, I think we still have a bit of a way to go to persuade ACATs that the new funding instrument is about care rather than about money, which is not an immediately appealing task for ACATs. So there is a policy issue there. There is also an issue of the kind of journey of clients through ACAT assessment, which can happen several times for an individual client, and with year to year delays as people try to delay their entry into residential care. So there is a question of how many times an ACAT would do an ACFI assessment for an individual. I think there is also some merit in the industry gaining some trust in the objectivity of this measure by implementing it, and then, if there is a clear understanding that this is an objective instrument, that may open possibilities in the future. So I think it is something to think about and to learn from.

Senator McLUCAS—The other element is that ACATs do not only do assessments for residential care; they do assessments for community care as well. And whether or not you can extrapolate this care need assessment tool to community care—I do not know the answer to that.

Mr Broadhead—You've been listening to our discussions! That is exactly the kind of discussion we have been having. For example, the ACFI uses 'activities of daily living' as a key component. In community care, instrumental activities of daily living—in other words, not things that require care within a given setting but things like shopping and so on—can be key predictors of people's capacity to remain in the community. There is not that component in the ACFI as it stands, but of course, as you say, ACATs do assessments for community care. So, yes, there is a bunch of issues in there that we have to better tease out and explore that are of exactly the kind that you have raised.

Senator McLUCAS—I am happy with that.

CHAIR—On this question of classification, you may have seen the recommendation that is made by ACSA on page 5 of their submission about the validity of the classification decisions within six months of a resident's entry. Have you seen that recommendation and do you have a view about it?

Mr Broadhead—Yes. In general, the idea of having a six-month assessment period in relation to some residents is for residents whose care needs are thought to be likely to change. The key example of this would be where a resident has entered from hospital and may still have some care needs that relate to whatever they went into hospital for. If you do an assessment shortly after they arrive from hospital there will be a range of care needs that are correctly identified for a period of time, but some time down the track—in two or three or four months—their care needs may well have changed because the aftermath of the hospital episode is behind them, and therefore there ought to be a trigger to reassess. That is the basis of having it at six months. It is a protection against the possibility that people will be assessed at a point where their care needs are not typical of what their care needs will be into the future.

CHAIR—So you do not see any merit in the suggestion that ACSA has made?

Mr Broadhead—No. I have to say we are in constant dialogue with the industry around a range of these sorts of issues, about their merits or otherwise. I expect that if it were apparent that people who were assessed after hospitalisation and then reassessed six months later and there was no change in the classification for the majority of them then we would be entirely open to a discussion about what that meant and whether or not it would be sensible, therefore, to revise the arrangements. But we already have requirements for reassessment, and in our view the reason why we have advised government and government has accepted the need to continue this is that people's needs do change. Again, it is a balance between trying to reduce the assessment burden, through things like not having the classification expire and not requiring it on transfer, and ensuring that the classification really does reflect the person's needs. At this point we think this is required to ensure that latter requirement.

CHAIR—I take it that leads to the intention to monitor how these arrangements work out under the new regime and, if there is some evidence that the burden on providers is still significant or there is some capacity to get better outcomes for residents, there would be some reconsideration of these arrangements.

Mr Stuart—That is certainly going to be possible to monitor. The ACFI is a far more objective instrument and will say more meaningful things about the care needs of clients. Certainly, it will be possible for the department to monitor whether the six-month review point is turning up reductions in resident classification. As Peter has been outlining, we have gone through really quite a substantial reduction in reclassification requirements in this package. Basically, from looking at existing experience with the RCS, where a lot of reclassifications were resulting in a return of either the same or a higher subsidy amount, we think that if there is likely to be a higher subsidy amount then providers will be motived to reclassify, and they can do so. But we do not see any need to impose a reclassification requirement every year anymore when in the past we have seen a lot of classifications remain at the same level.

Senator McLUCAS—How regularly can a provider reapply for reclassification?

Mr Broadhead—In theory they can do it serially.

Senator McLUCAS—Every day if they want to?

Mr Stuart—It is not quite as simple as that. Correct me if I am wrong, Keith, but at the point when an existing classification expires the provider can choose to reclassify—

Senator McLUCAS—At the end of the 12-month period?

Mr Stuart—They do not have to but they may choose to do so. But at other times reclassification can be sought on the basis that there is a significant jump in the resident care need.

Senator McLUCAS—Yes, but that is motivated by the care provider? They make the decision. Something has happened, a person has had a fall or—

Mr Broadhead—The current system essentially says that, within the 12-month period that the classification is current, you may still reclassify a resident if you believe there is a significant change. In the current system the significant change is a change that will result in a shift of two categories.

Senator McLUCAS—Thirty dollars?

Mr Broadhead—This is the two category shift. After the 12 months has expired, in fact on expiry, you must reassess the person. At that time they can shift a category. Obviously their care needs may have changed in a minor way, but if it does not result in a category shift then they are still funded under the same category as they were previously. In principle, you could reassess somebody on 12 months and then six months later, due to some decline in their circumstances, you could reassess them and bump them two categories, and I am sure that actually happens in practice.

The new system essentially says there is no compulsory reassessment after 12 months, but again if you wished to reclassify somebody within 12 months of their last classification or reclassification then it would need to be a significant change. So there is a brake, if you like, on classifying everybody periodically just to see if you can get a bit of a change out of it. It requires a significant change again. Because we now have a basic category and two new supplements, the rules around what is a significant change are somewhat different and the legislation deals with that, but again the principle is that it would need to be a significant change within the 12 months. After the 12 months, a single-category shift either in the basic category or in either of the supplements is possible. Have I made that as clear as mud?

Senator McLUCAS—No, I understand what you are saying. As to the issue you were discussing with Senator Humphries—I am loath to use the word 'validation', but I think it sort of is a validation—they are simply people who have entered resi care from hospitals, and you could likely predict that their care needs may decline as they improve?

Mr Broadhead—Yes. Essentially, the requirement for reappraisal within six months applies to people whose care needs are thought highly likely not to be stable. The classic example is somebody coming out of hospital: they may often have a period of recovery and they may well be assessed prior to completion of their recovery, for good reason. The question

is then: do you go back and reassess them or do you require them to be reassessed? The answer at the moment is, yes, you do require them to be reassessed. Six months is a long enough period to be certain that their care requirements have stabilised, at least due to whatever episode it was that occasioned their hospitalisation, and so it gives you a bit of a check and a balance on whether or not the classification that is being paid for is indeed the right classification for that person.

Senator McLUCAS—I understand that; thanks. I think the ACSA submission raised the question of the phasing in of supplements. Mr Mundy said that the phasing in of supplements will delay funding coming on stream as people take time to pick up the amount of money that they should be receiving according to their assessment. What is the quantum that will be saved—I think 'saved' is probably the right word—by phasing in the supplements rather than bringing in the supplement payment on the first day?

Mr Stuart—Can I put a bit of context around that.

Senator McLUCAS—Thank you, Mr Stuart.

Mr Stuart—We are neither phasing in the supplements nor phasing in the aged care funding instrument. Both will apply from the first day, but only for new residents and then for residents that are due reclassification. If the suggestion is being made that we should start paying the supplements for existing residents immediately, then that could be quite a different kind of a system. We would then have a system in which you needed to subject every existing resident to the aged care funding instrument on or before the implementation date and we would have a frenzy of classification going on in aged-care homes around the implementation date. So we are not setting out to save any money. What we are doing is setting out to grandparent existing residents and phase in sensibly the new arrangements.

Mr Broadhead—However, you may be referring to the fact that the maximum payment available is being phased up. At the moment, for example, the maximum care subsidy is $122.77, I think, for an RCS1, which is the top classification. That does not include enteral feeding or oxygen supplements, but that is essentially the top payment. The top payment under the ACFI will be $10 more than it would have been under the RCS in the first year of the ACFI and then will be raised to $20 more. For many people this will make no difference to the outcome, because it is only a ceiling, if you like, on the top-level payment. So if you are in the mid range then it will make no difference to the level of payment made. The government chose to phase in the top level payment I think because of the level of resourcing required to introduce the ACFI overall, and this provides a mechanism to make sure that, even from day one, people who are assessed as requiring it will get a higher level of payment, but over time that higher level will rise even further. The ultimate amount will be over $160 per day for somebody who is classified at the highest level using the ACFI, but it will take four years for the top level payment to reach that amount.

Senator McLUCAS—I would call that phasing in.

Mr Stuart—Yes, I agree that that is a phasing in. It is not the supplements; it is the maximum payments.

Senator McLUCAS—If it is not on the supplement, I understand the error I made. Because the number of people using ACFI and being funded by ACFI will grow from zero at

the implementation date to a number over four years—and nobody knows what that will be exactly but you would imagine by the end of four years it will be everybody.

Mr Broadhead—No, it will not be everybody.

Senator McLUCAS—No, it will not be everybody, but let us say it would be a good two-thirds.

Mr Broadhead—A majority.

Mr Stuart—It will be more than two-thirds; it will be the greater majority. But there is always a small tail. We still have residents in care from before the 1997 reforms. It is a small number, but there are some.

Senator McLUCAS—You should know the names of those people, who are obviously doing very well.

Mr Stuart—They are still on grandparented arrangements.

Senator McLUCAS—If you were to not phase in the incremental $10 a year payment but, rather, paid the full payment according to the funding instrument from day one, what would be the difference in the total amount of money for those two ways of implementation?

Mr Broadhead—As I understand it, what you are essentially asking is that, given all the other arrangements about how it is to be introduced, if there were not a ceiling on the maximum payment what do we anticipate would be the order of expenditure as compared with the order of expenditure under the arrangements as they currently stand? The answer is that it will be a cost of $393 million over four years. From memory, and with your permission I will confirm this with an answer on notice, it is of the order of $680 million without that ceiling. So it will have a substantial impact on the four-year cost.

Senator McLUCAS—So it is about $300 million over four years?

Mr Broadhead—Yes. As I said, I would like to go back and make sure I have the right figure and I will confirm it to you.

Senator McLUCAS—In the first year it would not be very much, but in the fourth year it would be quite a bit of that $350-odd million.

Mr Broadhead—It is a complex interaction because you have very few people because of the time it takes for new residents to arrive and for old residents to be reclassified. In the first year it will not have a huge impact in terms of outlays. As the volume of people builds it will have a larger impact, but then the ceiling is rising. So the curve of the difference is not a simple line.

Senator McLUCAS—But at the end of the fourth year everybody who is eligible will get the appropriate level. So if you come in during year 3 you will come in at the third incremental rise; is that right?

Mr Broadhead—Let's say, for argument sake, that in the third year it will be $153. So if you are a person who has been assessed at the very top level you might otherwise have received $160 per day but, due to the ceiling, you will receive $153 per day to support your care. The following year you would receive $160-odd, or whatever the figure turns out to be,

a day for your care. So, as the ceiling rises, people classified under that will also have their care payments increased—if they are up against that ceiling.

Senator McLUCAS—And is this only for the top-level care? Is it phased through everyone else as well?

Mr Broadhead—No. It is only a ceiling, and that is why I am using that term. It does not affect people below. People whose outcome would put them on a payment level that is even 20c less than the ceiling will be unaffected. It is only where you would end up above it. As I say, from day one, people who are assessed with top-level care needs will receive more payment per day but it will take time to phase up.

Senator McLUCAS—Mr Broadhead, if you would provide that difference between the two implementation models we have just talked about I would appreciate it.

CHAIR—Senator McLucas, while you think of your next question I wish to clarify the situation. Does that mean that under this new system every resident with the highest care needs will be receiving more for their care needs than was the case before?

Mr Broadhead—Yes. At the moment the maximum that you can receive—as I said, excluding oxygen and enteral feeding, which only applies to some people—is $122.77. Under the new system the top-level payment will ultimately be above $160 but in the short run it will be phased up, so it will be $10 more than was possible under the RCS in the first year, it will be $20 more than was possible under the RCS in the second year and so on. As soon as people reach that level of classification in the system there will be people paid at a higher level than is feasible under the current arrangements.

CHAIR—As estimated, that is an increase in real terms in the spending on their care?

Mr Broadhead—Yes, that is an increase in real terms. It is over and above indexation. Indeed, the ceiling is pegged, as I recall, to the indexed level of the RCS payment. Say it was $122.77 today. If it were indexed to, shall we say, $124 or $125, then the ceiling would be $125 plus $10 in the first year, which equals $135, plus $20 and so on. It is not only rising due to the amount of the limit going from $10 to $20 to $30; it is also rising because the underlying thing to which it is hooked—that is, the maximum RCS payment—will still be indexed.

Mr Stuart—The overall policy construction here is that moving from one funding system to another funding system is always complex and there is always a complex pattern of potential gainers and losers. The government has chosen to grandparent all existing residents so that the income that providers are earning in respect of existing residents cannot go down, so providers are enabled to gain but not enabled to lose. Consequently, there is a significant cost to government during the first four years of the introduction of the new funding instrument. This is simply a device that says we will not allow providers to make a loss on any resident and therefore we are going to limit the gains for a period in an offsetting fashion.

CHAIR—ACSA made the point though that residents entering the system after that four-year transition who had the same level of need as that of certain residents before may be on a lower level of payment than was the case before; some people may move downwards in effect

in equivalent positions or equivalent levels of need. Is that (a) possible and (b) likely to be the case very often?

Mr Broadhead—If I have understood it, and I am not sure that I have, if I am classified in a year at the top level of payment—therefore I am being paid the amount that the ceiling determined in that year—and then subsequently the amount goes up, because the ceiling has now risen in the following year by $10, my care payment also goes up. Nobody will be left on what the ceiling payment was because that was what applied when they arrived, so they will not be left on that level while the level of payment has now risen to a higher level. Have I understood the question properly?

CHAIR—I am not sure that is quite the point that ACSA were making. I think they were saying that there is to be a new classification system, so that it is possible that some individuals with a certain level of care need—let us say below the top level of care need—may actually end up being on lower payments as a result of this new classification system because they fall into a different classification.

Mr Broadhead—That is the issue dealt with by grandparenting.

CHAIR—But that only applies to those who are in the system now. Those who are entering the system after this arrangement are not affected by the grandparenting arrangements.

Mr Broadhead—Correct.

CHAIR—So a certain resident with a level of need who is in the system now would have their arrangements grandparented but a resident coming in at the same level of need after this arrangement has been put in place might be on a lower level of payment?

Mr Broadhead—That is correct. That is an outcome. Taking the lumpiness, as Greg mentioned, out of the RCS and moving to a more linear scale does mean that, for some types of people or for some people with levels of care need, they would receive less subsidy for their care under the ACFI than they would under the RCS. That is why grandparenting is there: to ensure that existing residents do not receive less than they do now. But it is true that, as a new resident, I might receive less funding under the ACFI than I would have had I entered under the RCS a week earlier if I happened to be at the cut point. If you introduce a new system of classification you get different results. If you only got the same results why would you introduce it?

CHAIR—With more money going in, presumably there are more winners than losers under this arrangement. Is that a fair comment?

Mr Broadhead—Yes.

Senator McLUCAS—It is within the same pool?

Mr Broadhead—It is not within the same pool. That was originally a design requirement. Let me expand further on that. When it was first contemplated after Professor Hogan's review that it would collapse a number of categories and introduce two new supplements, at that time the government also introduced the conditional adjustment payment. The view at the time was, 'Yes, we're introducing a new basis for distributing the subsidy, but we're introducing it at the same time that we are also increasing the level of available resources for care by the

introduction of the conditional adjustment payment,' which is an additional payment that originally was 1.75 per cent of basic subsidy, then 3.5 per cent. This year it is 5.25 per cent of basic subsidy and next year it will be seven per cent. At the time, the view of the government was, 'We're increasing the level of care subsidy by that means at the same time as we agree to the introduction of a new method of distributing the care subsidy between residents.' So the design parameter was then shortened. The short description of it was to do it within existing resources. That included the additional $877 million that was going to be provided over four years through the conditional adjustment payment.

Since that decision, the government has subsequently decided to increase the level of resources over and above the increase it has provided through the conditional adjustment payment. That was the $50 million I referred to earlier. If everybody was on the ACFI rather than the RCS then, overall, the government would be spending an additional $50 million a year in care subsidies over and above what it would otherwise spend. That is exclusive of the effects of the conditional adjustment payment. The government has decided to put in additional resources for the introduction of this instrument. As a result, there are more winners than losers under the ACFI, but it still remains the case that there will be people who, had they been classified under the RCS, would have received a higher level of subsidy than they will under the ACFI. There will not actually be anybody in that situation because of the grandparenting. But, theoretically, somebody who, had they entered here would have received this; now they have entered there, they will get that. Most subsidies will go up, but some will go down.

Mr Stuart—It is important to say that the goal of any funding instrument is to ensure that providers receive an income stream which does not discriminate on the basis of care need. We want all types of resident care to be attractive to aged-care providers. Having said that, though, in the end, the instrument delivers an income stream to an aged-care provider. We do not expect them to hypothecate on an individual by individual resident basis the care that they give to the resident. It is logically possible for someone entering after the reforms to receive a little less in care funding than those who entered just before the reforms. While others are being rewarded substantially more, we do not think that in any sense goes towards damaging the prospects of their receiving appropriate care.

Mr Broadhead—Overall, the level of resourcing will increase substantially. The $393.1 million over four years is real money over and above what would have been spent on care subsidies in that four-year period. However it is arrived at, partly by grandparenting, partly by increased resources et cetera, it is real, additional money over and above what would otherwise have been spent. You can say that just shy of $400 million more, over the next four years, will be spent in care subsidies than would have been spent. Dare I suggest that that is a reasonable lift.

Senator ADAMS—Just on the allocation of high- and low-care places, can you explain how that will work as far as your advertising is concerned. I will come back to rural issues, because I can foresee that we have a few problems arising there. Starting with your advertisement, how many places are available? Can you just describe how we differentiate between them?

Mr Stuart—We are continuing to differentiate between high- and low-care places at the point of allocation, and on much the same basis as before—although there was an announcement as part of this particular package that there would be more high-care places released in future, to rebalance the ratio to some extent towards high care; towards 44 low and 44 high. I think I will stop there and let you elucidate. I think there is more that you want to know, but I am not sure I am getting at it.

Senator ADAMS—Yes, there is. It is a question I asked earlier on, regarding where I come from. In my home town we had some high-care places, but because of the problems of attracting the staff to look after those people we are now going back to a low-care situation. But we have got a terrific lot of concessional residents there, and everyone is getting a little bit worried because I think the shire run the 22-bed facility, and with their depreciation they are running at a $400,000 loss. So we as a community are having real problems. This is a community service, and unfortunately it has not been making a profit. It is far too small for any private organisation to come in and take it over. It looks as if it may close its doors, and the community is going to be left high and dry. So there is a lot of confusion around this new classification, as to how they can survive. Will it improve? There are very few people now paying accommodation bonds. That was what I was going to ask: where that cuts off. We start with the low care, but if they then move into that medium range, where does the situation go, practically?

Mr Stuart—Okay, I think I understand. So it is more about the income levels that attach to low care and high care that you are asking about?

Senator ADAMS—Well, it is to a point. It is just the fact that high care has to be abandoned because of the skill set of the staff. They were all doing very well with low care, but to actually employ those extra staff with the problem of the budget they have made a decision to drop that out completely. The other thing is: how do we keep the doors open? It is just really difficult.

Mr Stuart—That is probably a problem specific to certain aged-care facilities.

Senator ADAMS—That is right. There are a number of others going to end up the same way, I think. So is this going to help or isn't it? I cannot see how we are going to advance under this classification.

Mr Stuart—Obviously we cannot speak exactly for the circumstances of an individual aged-care home without having done some research on that. There are two or three things I would just point to, however. One is that in this package the government has taken concerted steps to increase the return to aged-care homes for high-care residents, with quite a considerable increase in resourcing into high care. The second is that, as part of this package and as part of enabling aged-care providers to consider how they fare under it, the government is also making available a pool of financial advisers who will be able to work with individual providers to help them to better understand the incentives that are available under this package. Thirdly, as part of this package there is a redefinition of the concessional resident and an increase in funding for the government for concessional residents, which a number of providers have not fully grasped yet. We will be going about from state to state later this month and early in June to explain these changes in detail, and at that time we will also put

out a very detailed fact sheet for aged-care providers, which should help them to understand the incentives under the new arrangements in greater detail.

Senator ADAMS—That might help a little.

Mr Stuart—I hope so, and I am certainly willing also to have a look at the circumstances of an individual provider if you would like to organise that.

Senator ADAMS—That would be great.

Senator McLUCAS—That leads us to the question that was raised earlier about modelling. There had been a modelling exercise for the ACFI that was subsequently undertaken by Access Economics. It was put to us that that modelling has not been redone subsequent to the bringing in of the securing the future changes. I think that is the case, if I understand that correctly. Has it?

Mr Broadhead—Yes.

Senator McLUCAS—Can we have a copy of it, please?

Mr Broadhead—I do not know what the status of the report is. But I believe we plan to release it. It has only recently been completed in a form that would be intelligible to anybody except possibly Keith, who is on my left here. Yes, there was modelling done and indeed Access Economics presented their findings to, for example, the board of ACAA. The initial assessment did not take account of some of the aspects that were subsequently decided as part of the securing the future package, in particular the additional funding. It has since been rerun to incorporate that and we propose to make the report available, so we would be happy to provide it when we do. I would expect that to be in the next week or two.

Senator McLUCAS—Would that then assist the facilities that Senator Adams is referring to? The concern that I am receiving from the sector is this: whilst you can talk in telephone numbers, and these numbers sound extraordinarily large, what does it mean for my 40-bed facility in a rural area when most of us are low care? That is what we need to know.

Mr Broadhead—It will and it won't. In the end, how this will affect a particular home will depend on the mix of residents that they have, the mix of new residents that they have coming in and so on under the ACFI and how they are classified. The Access Economics model looks at the overall situation but it does not have the capacity to predict the outcome for an individual home because at that level there is not enough stability in the numbers to do it. So you cannot say with any degree of certainty that it will have exactly this effect on a particular home. That will depend on who comes through the door; indeed, that is the case now. You cannot predict precisely whether your next resident will be an RCS3 or an RCS2 or whatever until you do the assessment. So it is not a feature of the ACFI; rather, it is just a feature of the system that it depends who you take in as residents and who your existing residents are. I believe it will provide some information that will enable people to form views about the overall effects and the likely impacts but it will not tell you exactly what will happen to your home because that is not feasible.

That said, as my colleague has raised, where—in the course of moving to the ACFI and classifying new people and indeed under the other arrangements that are coming in as part of the securing the future package—homes find that they are struggling with this there will be

independent advice available, funded by the government, to support them to work through those issues to make sure that this is not simply a misunderstanding of how it applies or some other issue that could be managed by the home if they better understood what was going on.

Senator McLUCAS—As for when the department was modelling the securing the future changes, I understand that it has to be done at a very high level. But how it impacts on the various types of aged-care facilities in Australia must have been modelled, I hope.

Mr Broadhead—We did attempt to look to see if there were any patterns. Without trying to predict the outcome for a particular home, one can look at the analysis and say: 'Overall, does there appear to be a differential impact on rural homes versus urban homes? Does there appear to be a differential impact on this versus that?' The answer is that although we went looking for it we could not find it. So, in other words, we have not been able to identify that there is a systematic advantage or disadvantage to homes because they are small or large, because they are rural or urban and so on.

Senator McLUCAS—Because they are high care or low care?

Mr Broadhead—No. There is a bit of a common understanding out there that the ACFI results in a transfer of resources from low to high. In practice, that could not be the case to any great degree because 50 per cent of residents under the RCS are in the top two categories—1 and 2. Those are also the categories that draw the highest per diem payment. From memory, I think about 80 per cent of the resources are in the top two categories. So there is not enough money, as it were, in the bottom categories in terms of the volume of people and the payments made, to shift large amounts out of the bottom to the top. So the redistributive effect of the ACFI is more complicated than that, and it is to some degree a shift within high care. For example, one of the bumps that Greg Mundy referred to would be category 3 residents. You can go from a category 5 or 4 to a category 3 with a relatively small shift in care needs but a relatively large shift in payment.

So, if you try to compare them side by side, some of the ways in which the ACFI is different from the RCS are actually in the middle categories rather the bottom categories. I am trying to speak in general terms to illustrate that it is not a simple shift from here to there and the impact really does depend on the profile of residents that a home has and how they would fall under the ACFI. There is a long time for the transition. It is not like homes. We do not have that frenzy of classification in the lead-up, where everybody goes from RCS to ACFI. Even after four years, there will still be people being paid under the RCS. So there is a long transition period that allows homes time to adjust to the new regime, to understand how it operates in respect of both the cost of their operations and their resident mix. It is not an instant impact.

Senator McLUCAS—Mr Gray talked this morning about an 85-bed facility in Victoria where people are classified as low that serves, essentially, homeless alcoholic men. I think you could assume that, given those people's classification is low—by and large nearly all of them are low—that home will do worse under ACFI than it would under RCS. Is that correct?

Mr Broadhead—I would be very wary of making that assumption. I will make a couple of points. For example, the ACFI is a multidimensional instrument. It not only looks at the activity of daily living, it looks at healthcare needs and it looks at behavioural challenge, for

example. It is quite possible that somebody who at the moment is classified as low might score more than people might expect, particularly under behavioural challenge.

Senator McLUCAS—Challenging behaviours.

Mr Broadhead—So it is not simple. They are not two linear scales side by side and you just map people from here to there. On average, people in category 8 in the RCS, who receive no payment under the RCS, will receive a few dollars under the ACFI. So there are people who currently get paid nothing in care subsidy who will receive some care subsidy under the ACFI. So it is not a simple translation. It is not a simple, 'If you're low under the RCS you'll get less, and if you're high under the RCS you'll get more.' It is a more complicated translation than that. That is why I think the fact that it is coming in over time and there will be a process of moving from the old to the new over some years is actually a good thing, because I think it is easy for people to assume that it is a simple case of: 'If you're low you'll go down, and if you're high you'll go up.' That is not necessarily the case.

Senator McLUCAS—So when will the department advise providers of the dollar amounts that will be attached to each stream?

Mr Broadhead—Again, we plan to release indicative prices. They will be indicative only. This is subject to the agreement of the government, but I imagine it will be forthcoming. I say that they will only be indicative because, as was mentioned earlier—by Greg Mundy, I think—we do not know exactly what they will be. They will be determined by ministerial determination prior to the introduction. But, for the sake of allowing people to better understand, we will be releasing indicative prices. We will put out this kind of information as part of the information that we put out to support what we are calling the roadshow—that is the series of workshops around the country to assist people to better understand elements of the securing the future package.

Senator McLUCAS—Will that be soon?

Mr Broadhead—Yes, our flights are booked.

Senator McLUCAS—When? Let us have the date.

Mr Broadhead—I could not tell you off the top of my head.

Mr Stuart—We are just finalising a draft schedule for a period during the second half of May and into the early part of June. We expect to be in upward of a dozen centres around Australia, but the exact number escapes me.

Mr Broadhead—I cannot tell you when I am going to be in Traralgon, Ballarat, Coffs Harbour or—

Mr Stuart—Capital cities and large regional centres.

Mr Broadhead—Bundaberg. We are going to get around a bit.

Senator McLUCAS—Make sure that you come to Cairns. Item 27, which refers to section 42-1(4), talks about people who have to move from—in the old language—a hostel to a high-care facility for a temporary period. Concern has been expressed on two fronts: firstly, that person might lose their place if they then want to return to their original facility; and, secondly, you cannot double fund a person for higher need, short-term temporary—it has to

be high-care—aged care. We have been told that it does not affect many people; therefore, why are you doing it? How many people are we talking about; and what is the cost of continuing it?

Mr Stuart—We have read with interest the comments that have been made in the submissions. We thought we had got through this issue; we had discussed it broadly and come to an agreed view on it, which is reflected in the draft legislation. You can argue the low numbers in one of two ways. Firstly, it is only a low number of people, so why change it; and, secondly, quite honestly, if it were affecting a large number of people, you would be arguing the opposite. However, the number is so low that we really question the benefits of retaining the existing administrative arrangements, both for the department and for the industry. I will ask Peter to speak to that.

Mr Broadhead—I would say two things. We did a review of this in 2006—not a capital 'R' review—where we looked at the incidence of this in the 2004-05 financial year. We found that in facilities in six out of the eight states and territories it was not used at all in that year. In one of the two states where it was used, it was used once.

Senator McLUCAS—Are we talking about Queensland and Western Australia?

Mr Broadhead—No. It was used in New South Wales and, as it happened, once in South Australia. Fewer than 20 residents were involved.

Senator McLUCAS—So it was used for 19 in New South Wales and for one in South Australia.

Mr Broadhead—I think it was for 17 in one, so it would be 18 in total. When we looked at the individual cases, we discovered that in a number of instances it probably was not applicable. So it was used very rarely and possibly when it should not have applied, even in instances where it was technically applicable. For example, a single provider had two facilities, which were co-located, for which they had separate IDs. They were transferring somebody within their own arrangement. Technically, they were eligible—

Senator McLUCAS—That would be called double dipping, I think.

Mr Broadhead—to be paid for both places while they had the person in the high-care facility and not the low-care facility. I would also strengthen what Andrew said earlier. We had a working group of the industry reference group in 2004. A number of people who sat before this committee earlier today participated in that group and they reported back to the main reference group supporting the abolition of this. However, time passes and things change.

Senator McLUCAS—They may have changed their mind in the intervening period.

Mr Broadhead—We are a little dismayed to discover the same people putting forward a different view now. That is probably all I should say on the subject.

Senator McLUCAS—I think your points are fairly well made. We are talking about fewer than 20 people in Australia, unless it has changed significantly in the intervening years.

Mr Broadhead—Prior to coming to this, we had another look. In the first six months of the current financial year, the number was four. We have not gone to see whether in fact those were instances that really should be there or not.

Mr Stuart—I think it is important to note that it is not only an issue of double payment from government; it is also an issue of double charging of users as well.

Mr Broadhead—They can be charged fees for both places.

Senator McLUCAS—Does that happen?

CHAIR—Will they be? Is it automatic or is it a discretion on the provider's part?

Mr Broadhead—Fees are discretionary on the provider's part in general so, yes, it is discretionary. We have not examined the instances to find out whether in fact that is taking place.

Mr Stuart—I am not sure that that data would be available to us.

CHAIR—Are there instances, though, where such a provision for double payment is appropriate and fair in all of the circumstances?

Mr Broadhead—I would not want to rule out the possibility that there would be instances where it could be useful—in other words, hypothetically, that there would be somebody whose situation was such that the thing might be useful. I suppose the question is whether there is no other means of meeting that person's care needs—I am not clear that that is the case—and whether one keeps alive provisions in legislation that cater to very rare circumstances where there might be another recourse.

Mr Stuart—For example, ageing in place has grown across the sector to such an extent now that most aged-care homes that are classified as low care contain a number of high-care classified residents and they need to be able to accommodate their care. I think that goes partly towards explaining why the numbers utilising this particular function are so low.

Mr Broadhead—The other thing that has changed in recent times is the provision of transition care. Going back to the discussion we had about six-month review of classification, people returning from hospital may require a period of more intensive care post hospitalisation. The government has introduced in recent times the Transition Care Program, which now makes an expected average of about eight weeks of care available for up to 13,000 people. It is fully functioning in 2,000 places around the country. So there are new forms of care available even outside of aged-care facilities which are targeting the kinds of people to whom this provision might have been more applicable in the past.

Senator McLUCAS—I cannot imagine, though, that a person would transition from residential care to transition care. It would go the other way.

Mr Broadhead—No, this is where somebody is coming from hospital and might require a period of higher care than usual, which is what this provision originally was about. It was about somebody who needed to be moved to somewhere else in order to receive a higher level of care for a temporary period. An example where that might be the case is where somebody had higher care needs on exiting from hospital. There are now forms of care available—like transition care, which provides a higher form of care for a considerable period of time in some

instances prior to them returning to their usual facility—which were not previously available. There are a range of changes happening which are undercutting the use of and need for this provision. I suspect that is why very few people use it.

Senator McLUCAS—If a facility—and I am thinking of a very small rural facility of 25 places—felt that they required some consideration of a circumstance, could they go somewhere or ring up the department and say, 'We are pretty special here—can you have a look at our situation?' Is there a discretion that the secretary can apply?

Mr Broadhead—Not to my knowledge. My guess, again, is that amongst the options available there is an issue about the extent to which somebody's care needs have been resolved prior to exiting the hospital. There might be an issue about whether somebody is returned to a low-care facility as soon as they otherwise would be. Particularly in rural facilities, often in smaller rural towns, what we are looking at is not actually a stand-alone facility but a multipurpose service. So it is really about shifting people between categories, if you like, within the same facility. The other option is that you can bring in care on a temporary basis to the low-care facility, whether it is in the form of an agency nurse or somebody of that nature. That is a feasible outcome or option as well. I feel I am discussing hypothetical examples here because there are so few instances of it in practice. One could sit here and think about ways in which it might happen, but in practice it does not happen so much.

Senator McLUCAS—That satisfied me; thank you.

CHAIR—We are running a bit over time. Are there any other issues that you want to cover?

Senator McLUCAS—That is all I had on my list, Chair.

CHAIR—Senator Moore, do you have any other issues?

Senator MOORE—No.

CHAIR—Senator Adams?

Senator ADAMS—Just this last one: the penalty for late submissions of applications was considered to be not really required?

Mr Broadhead—Most applications are not late. The issue here is that—and I will get my colleague to speak in more detail if required—the classification is retroactive. In other words, if a classification is late, it can apply to the period prior to when the classification comes in. So there is the risk here in the classification that—because, on average, people's needs increase rather than decrease—by delaying a classification you might achieve a higher level of classification than you otherwise would. So this is again one of those checks and balances where there is seen to be merit in having an incentive for people to not delay classification.

The penalty that is proposed under the new arrangements is in fact on average lower than the penalty that applies currently. The old penalty was a flat rate penalty, from recollection, which resulted in some instances, where people were on a lower care subsidy, in no care subsidy whatsoever being payable for the late application; whereas this one is proportional. So we think that this is a better approach but that it still achieves that issue of making sure that people are not taking advantage, I suppose, of late submissions to gain higher

classifications—there is a countervailing incentive operating. Does that answer the question, or would you prefer—

CHAIR—No, I think—

Mr Tracey-Patte—The existing penalties are $20 per day in low care and $35 per day in high care. The proposed late penalty under the aged-care funding instrument will be $25 for all classifications.

Mr Broadhead—The period after which it applies?

Mr Tracey-Patte—The three months—at the moment, when a classification expires, a reappraisal is to be submitted in the period one month before and one month after the date that the classification expires. A late application can be received at any time after the end of that month after the expiry date. In the situation where the application is late, we pay the rate that would be payable to the classification, less the penalty rate, back to the date of the expiry. As Mr Broadhead indicated, the risk that we are endeavouring to manage there is that, if a person continues to deteriorate in condition, there may be an incentive to submit a very late application and receive a much higher rate of subsidy backdated to the period of the expiry.

CHAIR—Okay. I am happy with that.

Senator McLUCAS—On the question of a review, it has been put to us that ACFI should be reviewed after 12 months. What is the department proposing? I am clearly getting the indication that you are going to review it all the time, but, in terms of the formal review, what is the department proposing? My other question is: is 12 months long enough to make a proper assessment about how it is rolling out?

Mr Broadhead—I would suggest that, no, 12 months is not, because of the time taken for new people to arrive and old people to be reclassified. You would be only reclassifying the last of your existing residents at the end of 12 months, and perhaps a third of your people would be new residents who had come in. So I would have thought that a longer period of time would be required to be sure that the thing had settled.

That said, of course, we will be monitoring how this thing happens in practice from day one and keeping an eye, as it were, on whether it is tracking according to expectations. We will be in discussions with industry groups, I am sure, about that through that period. So, in a sense, we will be monitoring and looking at how it is travelling in the first 12 months, not waiting until some period after. I will probably get a kick under the table for this, but I would be very surprised if, for example, the ANAO did not take an interest in our implementation of this some time after.

Senator McLUCAS—That is a wonderful recommendation.

Mr Broadhead—Do not give them a copy of the *Hansard*! But I would be very surprised if they did not. At the moment we have got a range of proposed audits in front of us for the coming year. They routinely trawl through our programs and look at what happened and what was intended. Even were we not as attentive to what is going on as we will be, we are still going to be subject, I think, to review.

Mr Stuart—There are a number of natural pieces of data that will come in front of us on a very regular basis. We monitor our expenditure very closely. If our expenditure is not in line

with expectations, we ask searching questions about why that might be so. In fact, we are required to answer regular questions from central agencies' finance sections that govern that in relation to our estimates. As well as that, we have already highlighted that there will be a panel of advisers that will be able to assist individual aged-care homes. I managed such a panel in relation to the previous lot of reforms in 1997 and it was an instructive and useful process. While we will not of course be obtaining information about individual aged-care homes, that panel will be able to give us feedback about what it is that they are finding in the general, and I think we will be very interested in that as well. I do agree with Peter that a year is too short for formal review, but after a year there will be very considerable indications in public data and we will also be working closely with the provider peaks.

Senator McLUCAS—Mr Stuart, I recognise what you are saying and I do not dispute that it is valuable, but a formal review does give you an opportunity to take a step back from that day-to-day monitoring and say, 'What is happening?' I recognise that you are going to look at expenditure, and that is important, but I think we also have to look at the care that is being delivered, making sure that the ACFI as a care analysis instrument is actually turning into the quality of care outcomes that we all share as a goal. My concern was that 12 months was probably a little short as well, but is 18 months realistic in terms of the number of people who will have gone through the system, the number of people who have been trained to do the work et cetera? I am trying to find a realistic time that our committee might want to recommend as a formal review.

Mr Stuart—I do not think we should—

Senator McLUCAS—You do not want to comment—that is fine.

CHAIR—As there are no further questions, I thank the department very much for the evidence it has provided today and for the submission it has lodged with the committee. That concludes our hearing on the Aged Care Amendment (Residential Care) Bill. We are due to report on this bill in about a fortnight's time, but we may be able to get a draft together fairly quickly and circulate that to senators.

Senator McLUCAS—And additional comments and dissenting reports—the response to this will be a very thick document.

CHAIR—Machines are whirring away preparing that already, I am sure. Thank you very much to all concerned with today's hearing.

Committee adjourned at 12.29 pm