Department of Health

Response to Notice to Give NTG-0755

10 July 2020

1 This is a response to the Notice to Give Information No NTG-0755 dated 6 July 2020, which has been issued by the Royal Commission into Aged Care Quality and Safety (**Royal Commission**) to the Department of Health (**Department**).

2 This information is produced to the Royal Commission on the basis that it will be tendered and received in evidence by the Royal Commission pursuant to Notice No NTG-0755 and on the basis the information be treated as evidence pursuant to section 6DD of the *Royal Commissions Act 1902* (Cth).

THE FUTURE OF AGED CARE

3 By the Notice, the Royal Commission seeks information regarding the financial state of the aged care sector, including as to the costs of delivering aged care services, and what the ideal model for aged care funding should look like.

4 In recent years, there have been significant reforms to move the aged care system towards a more consumer focused system. This is exemplified by the introduction of Aged Care Quality Standards (**Quality Standards**), the single Charter of Aged Care Rights, the introduction of Consumer Directed Care in home care, the *Increasing Choice in Home Care* reforms, and the *More Choices for Longer Life – Improving the Quality, Safety and Accessibility of Aged Care Services* budget measure. While these reforms have sought to refocus the aged care system from providers to consumers, the Department recognises that fundamental reform to the existing funding system is required.

5 The aged care system should be designed around the needs and preferences of those who require care, to ensure the system can provide a continuum of care that meets the needs of individual consumers, including as those needs change. It should give consumers choice and control, to the extent practical, to enable them to choose the setting where they receive support, their provider, the type of support, and the way it is provided. Further, it must be responsive to changes over time in the expectations of consumers and the broader community as to the appropriate standard of care.

6 A system that is built around the needs of consumers would preserve the independence of older Australians, support them to live in the community and in their own home for as long as possible, and provide a framework of support to their families and carers. The system should be evidence based, with a strong focus on capacity building supports, reablement and principles of restorative care, so as to maximise a person's independence and enhance their wellbeing and quality of life and minimise disruptions as a person's acuity increases.

7 In this regard, it is important to encourage innovation and diversity in service delivery, as this increases the choices available to consumers. Allowing consumers to choose their provider, the type of support they want, and where to direct government funds will help drive changes in the aged care

sector by making providers more responsive to consumer preferences. Encouraging greater transparency of provider outcomes will also help consumers and their families and carers to make informed choices about care, and over time, will incentivise high performance.

8 Promoting innovation means striking the right balance between regulating providers and empowering them to innovate and provide best practice care. Regulation is critical to protecting the wellbeing and dignity of older people receiving aged care services by ensuring high quality aged care, as well as detecting and addressing failures of care. A regulatory framework, however, that places too much emphasis on prescriptive inputs has the potential to remove agency from providers who are accountable for providing high quality services, and stifle innovation.

9 In designing the future of the aged care system, consideration must also be had to the fact that it is part of the broader health and social assistance service delivery system. Improved alignment of supports, regulation and funding across sectors will ensure better outcomes for consumers and avoid market distortions. Aged care outcomes will be dependent on the provision of other supports and effective co-ordination and integration of services, particularly with the health care system.[1] There are opportunities to align elements of the regulatory framework between sectors, particularly aged care, disability and veterans' services. Consideration should also be given to funding across systems, as differential pricing would see labour and services gravitate to, or favour, care sectors with higher pricing, undermining the capacity of the sector to meet the standards of care expected. Reducing regulatory barriers between care sectors will encourage providers to offer services across these also reducing the incidence of thin markets.

FUNDING AND FINANCING AGED CARE

10 The Department acknowledges that the level of future investment in aged care will need to increase to meet demand for services, including providing, and enabling investment to, more graduated support for people to remain living at home. The Department also recognises that there is a range of financial pressures and challenges confronting the aged care sector. These include structural issues relating to indexation arrangements and the Aged Care Funding Instrument (**ACFI**) funding model (as discussed in response to questions 18, 19 and 20, and at paragraphs 16, and 18 to 20 below); and the cost of hotel services in residential care.

11 The evidence available indicates financial performance across the residential aged care sector has deteriorated in recent years, with funding increases not covering changes in input costs. This has been highlighted by the Aged Care Financing Authority (**ACFA**) (including in its submission to the Royal Commission dated April 2019 (**ACFA Submission**) and its recent annual reports on funding and financing the aged care sector) and is reflected in the statement of Mr Grant Corderoy (**Corderoy Statement**).

[1] The Department's views on the interfaces between the aged care and health care systems are explored further in the statement of Glenys Beauchamp dated 15 November 2019 and re-signed on 9 December 2019, and the Commonwealth's submissions in response to Counsel Assisting's propositions in relation to the Canberra hearing dated 7 February 2020.

Funding reform

12 Future funding reform requires a long term whole-of-system approach that looks at what changes are needed to produce a stable, equitable and sustainable system to support consumers to receive the care they need, in the way they desire. While funding is an important factor, it is only one of many that could affect the extent to which aged care services are accessible by consumers, and the quality of those services.

13 Funding is one lever to improve outcomes for our ageing population but needs to work in conjunction with providers driving quality outcomes. There must be a shift to a consumer focused system where competition, choice, information, transparency, productivity, innovation in care delivery and appropriate regulation all play their part.

Levels of funding

14 The Department acknowledges that limitations of funding lead to restrictions being placed on access to aged care services, which constrains consumer choice. This is particularly so in relation to care provided in the home, as evidenced by the wait times for higher levels of home care.

15 Further, the level of funding available for in-home care may be arbitrarily limiting consumers who wish to be cared for in their own homes. While there are likely to be some limits on what type and level of care could reasonably be supported in a person's home, there are potentially more people who can have their assessed needs cost-effectively supported at home.

16 The Department also recognises that, overall, the level of indexation has not been sufficient to cover the increasing cost of service delivery inputs over time. As noted above, the evidence available indicates financial performance across the residential aged care sector has deteriorated in recent years. Additionally, there has been a decline in hours of care provided to recipients of home care packages over time.[2]

17 As raised in the ACFA Submission, there are structural issues with both the indexation methodology used for aged care and with the ACFI)[3] In particular, low indexation arguably encourages providers to make higher than appropriate funding claims under the ACFI model (outlined at paragraphs 18 to 20 below). This may have contributed to residential aged care providers increasing the value of their claims, leading to significant and unsustainable increases in claims affecting overall expenditure at times (explained further in the response to questions 18, 19 and 20 below).

Aged Care Funding Instrument

18 The Department considers that ACFI is no longer an appropriate mechanism for determining the funding that providers need to meet the care of individual residents. This is on the basis that it does not focus adequately on providers' actual costs to deliver care or a residents' care needs. The

[2] The Department notes the 2020 analysis by StewartBrown of the Home Care Provider Survey (the **StewartBrown Report**) indicates that there also remains significant levels of unspent funds in the home care packages program, which also suggests that home care package budgets are not being managed in a manner that is most beneficial for consumers. A copy of the final report was produced to the Royal Commission in response to NTG/NTP-0752 [CTH.1000.0004.1009].

[3] See pages 18-20 of the ACFA Submission.

Department also recognises that ACFI:

(a) has resulted in a history of unpredictable and unstable funding outcomes for providers and Government;

(b) can encourage outdated modes of care as the ACFI assessment process focuses on tasks rather than care needs;

(c) can lead to inequitable funding outcomes as ACFI assessments are completed by providers, rather than independent assessors. Accordingly, a provider who is well equipped to complete their ACFI assessments may be better able to maximise the funding available; and

(d) is inefficient and costly to administer. There is a high level of administrative work associated with completing ACFI claims, which leads to aged care staff (most commonly nurses) being diverted from the delivery of care.

19 This view is supported by the work of the Australian Health Services Research Institute (**AHSRI**).[4]

20 In addition, the Department considers that ACFI does not sufficiently encourage providers to improve outcomes for people living in residential aged care, and that in some cases, it may have a negative impact on providers that improve outcomes for their residents. Even when accurately completed, the ACFI fundamentally assesses a combination of a resident's incapacity, and actual care services received. The greater a resident's recorded incapacity and support requirements (as claimed by the provider), the more subsidy is provided to the provider. As such:

(a) providers are discouraged from fully meeting care needs and improving health outcomes for care recipients, in case later reassessment or an ACFI review by the Department leads to lower domain levels and reduced subsidies; and

(b) providers are encouraged to overstate actual levels of incapacity and support requirements and thereby 'upscale' ACFI scores. For example, providers may be encouraged to provide particular services, whether these are needed or not, in order to attract associated subsidies. This is neither in the best interests of residents, nor is it cost-efficient.

REFORMING THE AGED CARE FUNDING SYSTEM

Approach to future funding reform

21 The Department believes that developing a system that is more oriented to the consumer and encourages innovation through choice and control, and which addresses the identified funding pressures, will require fundamental reform.

[4] See Australian Health Services Research Institute, 'Alternative Aged Care Assessment, Classification System and Funding Models Final Report: Volume 1: The Report' (February 2017), pages 15-17.

22 The Department considers that the principles identified in the ACFA Submission (**ACFA Principles**) are an appropriate framework to help guide future reform of the aged care funding system:

(a) confidence and trust;

(b) stable, predictable, efficient, equitable and effective arrangements for allocating government funding, based on the needs of consumers and transparent evidence based studies to determine the cost of care;

(c) appropriate overall government funding to support the delivery of quality care, but not support inefficient or poorly managed providers or provide higher than necessary funding;

(d) funding that is flexible and adaptable to changing demographics, demands, and innovations in the way services are delivered;

(e) equitable contribution to costs by consumers;

(f) effective prudential oversight to support a more efficient and resilient aged care sector; and

(g) sound management and governance arrangements, to reflect that providers need to consider their internal operations to facilitate effective and efficient service delivery.[5]

23 The ACFA Principles are set out in further detail in ACFA's 2019 Annual Report on the Funding and Financing of the Aged Care Industry (**ACFA 2019 Report**),[6] a copy of which is at **Exhibit NTG-0755-1** [**CTH.1000.0004.8151**].

24 Consistent with the Commonwealth's previous submissions on aged care program re-design, the Department considers that the best way to address the identified issues, implement reform consistent with ACFA principles, and put consumers at the centre of the system will be to develop a needs-based system that supports consumer choice and provides a continuum of care that fully meets the broad spectrum of assessed aged care needs, from lower level needs to the significant care needs of those who are currently supported in residential care.

Introduction of new funding models

25 Transitioning to a needs-based system will require the development of a set of funding classifications and associated assessment instruments to ensure that funding tracks assessed needs. This may be addressed through the possible introduction of the Australian National Aged Care Classification (**AN-ACC**) model for residential care, and a new Assessment, Classification and Funding (**ACF**) model for a unified home care program. The AN-ACC model and a potential ACF model are described further at paragraphs 30 to 39 below.

26 If the AN-ACC model and an ACF model for the unified home care program are implemented, there would be a similar approach to funding classification and assessment across all of aged care that could be presented in a consistent manner to consumers to enable them to make informed choices. The introduction of new funding models in residential aged care and in-home care should also

[5] ACFA Submission, page 3.
[6] ACFA, Annual Report on the Funding and Financing of the Aged Care Industry (July 2019), pages xiii to xiv.

involve a consistent methodology for indexation. The current routine indexation arrangements are set out in response to questions 18, 19 and 20.

Consumer contributions

27 Means testing arrangements and consumer contributions to care differ across the existing aged care programs. Any reforms to create a continuum of care will therefore have implications for these arrangements. The expectations of aged care consumers and the broader Australian community as to who should fund care and services to the expected standards, including how much they are prepared to fund directly themselves or as taxpayers, are also critical. The Department considers there are opportunities for older Australians who can afford to make a financial contribution to contribute more towards the cost of their aged care. This principle is in line with recent ACFA findings and the Legislated Review of Aged Care 2017.[7]

28 Further, community standards and values should be reflected in the approach to means testing in aged care, and be aligned as closely as possible with the means testing approaches used in other government programs which older Australians are familiar with, such as the aged pension. The Department acknowledges that further work would have to be completed to assess a range of issues before a position could be reached on any reforms to consumer contributions. Relevant issues that would have to be examined include: equity of means testing arrangements; demographic changes and the propensity of older Australians to contribute; along with the impact on Commonwealth financial sustainability in the context of the ageing population.

29 Consideration should also be given to the extent to which individuals should be encouraged to make provision for their aged care needs earlier in their lives.

AN-ACC MODEL FOR RESIDENTIAL CARE

30 The proposed AN-ACC model for residential aged care has been developed through extensive work since 2016 to investigate options for residential aged care funding reform.[8] It comprises a funding model, case-mix classification and assessment model.

[7] See, for example, ACFA, 'Attributes for Sustainable Aged Care: A Funding and Financing Perspective' (October 2019), and recommendation 16 of the Legislated Review of Aged Care 2017.

[8] For further information on the AN-ACC model, see the letter to the Royal Commission dated 15 November 2019 [**RCD.0012.0037.0001**], Submissions of the Commonwealth on Melbourne Hearing 3: Aged Care Workforce dated 15 November 2019 [**RCD.0012.0033.0002**]; and paragraphs 105 to 113 of the Department's response to NTG-0736 dated 24 March 2020 (**NTG-0736 Response**).

31 The Department considers that the AN-ACC model would align care needs and cost drivers in residential aged care to better facilitate the provision of services and funds to where they are needed. It is a streamlined model that is administratively simple. The Department expects that implementation of the AN-ACC model would address the issues with the ACFI identified earlier, support delivery of better quality care for older Australians, and improve funding certainty for Government, providers and investors. In particular, under AN-ACC:

(a) Providers would no longer make their own assessments of residents for funding purposes. Instead, this will be undertaken by independent assessors which would deliver a more reliable and stable funding assessment.

(b) The existing methodology of indexing subsidies at a prescribed rate of WCI9 (as discussed below in response to questions 18, 19 and 20) could be replaced by a methodology involving an independent individual or body undertaking regular analysis of cost changes and drivers with these studies to inform the annual changes in subsidy rates from Government.

(c) The ACFI assessment tool would be replaced with the AN-ACC case-mix assessment tool and separate funding for fixed and variable costs. The new tool would no longer encourage particular types of care delivery for funding purposes, supporting an improved focus on care over funding and also a fairer allocation of funding between providers.

THE ACF MODEL FOR UNIFIED HOME CARE

32 The ACF model is currently being developed for a unified home care program, which will combine the existing home care packages program with the Commonwealth Home Support Programme (**CHSP**) to offer flexible, needs-based in-home care. Details of the proposed ACF model are set out in a report by HealthConsult concerning the first stage of the project to develop the unified home care program (**HealthConsult Report**), a copy of which is at **Exhibit NTG-0755-2** [**CTH.1000.0004.8045**].

33 The preferred ACF model for the unified home care program identified in the HealthConsult Report is a mixed service event and episode funding model which uses a fit-for-purpose mixed service event and episode level classification system (the **mixed model**).

34 Under the mixed model, the episode level funding model would be used to fund consumers and carers that undergo assessment and are assigned an episode class, whilst the service event level funding model would be used to fund low risk and / or low resource use consumers who access services outside of the classification system via screening or triage, at the service event level only. As such, it is a flexible and tailored solution that aims to ensure funding is proportionate and appropriate to the wide spectrum of in-home care needs, which range from low-level episodic care to complex care requiring significant coordination.

35 In practice, this means that clients requiring minimum basic services would be able to access this support without an extensive aged care assessment. All other clients (and their carers) would be assessed in their homes by an aged care assessment service. The outcome of the assessment would be to assign the client to a service/funding class that meets their assessed needs. The client will then be able to access a targeted bundle of services, which includes support for their carer. The

service types and funding levels for each class would be determined based on further research and analysis.

36 The HealthConsult Report is currently being considered by the Department, with implementation of the ACF Model ultimately subject to a decision of Government.

Implementation of the ACF model

37 Should Government choose to proceed with the mixed model, further consideration would be required to develop, test and cost the model to support its implementation and gather accurate, evidence-based information to ensure that providers are adequately covered for the costs of providing high quality care and services under the unified home care program. This consideration would require expert advice and data collection to inform the case-mix and service bundling, and to support analysis of costs under the mixed model. The costs analysis could involve examination of:

(a) the factors affecting the costs of providing care and services, including differing contexts, different service characteristics (such as after-hours services), locations, and different consumer cohorts;

(b) the average costs of different service types, actual costs, or efficient costs; and / or

(c) fixed and variable costs.

38 The results of the costs analysis could be used together with a classification system to assign a Relative Value Unit for different classes of consumers. This would determine the subsidy amount to align costs / funding and services with need, and could be adjusted over time as required. This approach would be similar to that which was taken to develop the AN-ACC in residential aged care.

39 Further consideration will also be needed to determine the funding mechanism for service providers. Providers are currently funded through grants under the CHSP and via consumer directed packages under home care packages. It is expected that a combination of funding mechanisms may be needed. It will also be important to explore how provision of funding directly to consumers would give them greater choice and control as well as forcing providers to innovate and be more efficient.

Question 3

Are aged care providers adequately funded to provide quality care? In answering this question, please refer and respond to the statement of Mr Grant Corderoy to the Royal Commission into Aged Care Quality and Safety dated 20 April 2020 (Annexure A to this notice) and the matters raised at: pp 3-5.

40 As outlined in paragraphs 12 to 13 above, while funding is an important factor, it is only one of many that affect the extent to which aged care services are accessible by consumers, and the quality of those services. As noted by ACFA in their annual reports, there are broad variances in quality of care and financial performance across aged care providers under the current funding arrangements[9]

[9] ACFA. Report on the Funding and Financing of the Aged Care Industry (July 2020) (**ACFA 2020 Report**) page 120; ACFA 2019 Report, pages 79 and 121. A copy of the ACFA 2020 Report is at **Exhibit NTG-0755-3** [**CTH.1000.0004.9017**].

which highlights how a blanket conclusion about the adequacy of funding can be simplistic.

41 The Department is of the view that while there is clear opportunity to improve the funding, financing and performance of the aged care system, there are providers of aged care services currently able to provide high quality care across residential care and in-home care, and providers are able to meet their obligations under the Quality Standards.

42 The Department acknowledges that there are a range of financial pressures confronting the aged care sector, particularly in residential aged care, as outlined above, and in response to question 4 below. The evidence indicates that financial performance across the residential aged care sector has deteriorated in the most recent years with funding increases not covering changes in input costs as highlighted in the Corderoy Statement. Additionally, there has been a decline in hours of care provided to recipients of home care packages over time.

43 For these reasons, additional funding would help support improvements to aged care service delivery, which would also be supported by reforms to the funding system as identified at paragraphs 21 to 29 above. There are also important roles to be played by aged care providers in improving consumer focused care delivery and operating efficiently and effectively and lifting quality to those of the best operators.

Question 4

Identify and explain the key financial challenges that aged care providers experience under the current aged care system. Without limitation of the matters you wish to address, your statement should cover:

a. the factors that exacerbate the key challenges;

b. how the challenges can be addressed, ameliorated or mitigated against;

c. the impact of caps on what can be charged for daily living costs and care including the role of potential approvals of fees for extra services and fees for additional services;

d. the impact of the regulation of payments and deposits for accommodation in residential aged care services, including the role of potential approval of Refundable Accommodation Deposits (RADs) and Daily Accommodation Payments (DAPs) above the maximum levels determined by the Minister, via application for approval to the Aged Care Pricing Commissioner;

e. funding of providers' administration costs and other corporate overheads;

f. any evidence for your response.

RESIDENTIAL AGED CARE

44 The Department considers that there are number of financial challenges faced by the aged care sector such as:

(a) **Structural issues relating to indexation arrangements and the ACFI funding model**: As stated at paragraph 16 above, structural issues relating to indexation arrangements and the

ACFI model have led to indexation not moving appropriately with cost growth and an unstable, inefficient and inequitable funding system that can also incentivise less than optimal care outcomes. This is evidenced by the below table which highlights that ACFI subsidy growth has historically been driven by increases in the level of ACFI claims, rather than indexation.

Year	CPI (change between March quarters)	WPI (Health Care and Social Assistance)	Age Care Award 2010	ACFI subsidy rates (indexation)	Average ACFI payment per resident	ACFI claims growth above indexation	Home care subsidy rates
2008-09	2.4%	4.1%	-	1.7%	7.4%	5.6%	
2009-10	2.9%	3.8%	-	1.7%	7.7%	5.9%	1.9%
2010-11	3.3%	3.3%	3.4%	1.8%	10.0%	8.1%	1.8%
2011-12	1.6%	3.0%	2.9%	1.9%	9.3%	7.3%	1.9%
2012-13	2.5%	3.3%	2.6%	0.0%	3.7%	3.7%	1.6%
2013-14	2.9%	2.9%	3.0%	1.7%	4.6%	2.8%	0.2%
2014-15	1.3%	2.6%	2.5%	4.3%	9.8%	5.2%	4.3%
2015-16	1.3%	2.6%	2.4%	1.3%	6.9%	5.5%	1.3%
2016-17	2.1%	2.3%	3.3%	1.5%	3.7%	2.1%	1.5%
2017-18	1.9%	2.7%	3.5%	0.0%	0.1%	0.1%	1.4%
2018-19	1.3%	3.0%	3.0%	1.2%	2.2%	1.0%	1.4%
Average annual change	2.1%	3.1%	3.3%	1.6%	5.9%	4.3%	1.6%
Cumulative change	26.4%	39.3%	30.0%	18.5%	87.6%	58.4%	18.6%

(b) **The Basic Daily Fee**: The Basic Daily Fee of approximately $53 per resident per day is directed to everyday living services and is commonly associated with payment for hotel services in residential aged care. StewartBrown have identified that the funding for the Basic Daily Fee is not meeting the costs of providing those services, as everyday living costs equate to approximately $75 per day (if an allocation of administrative overheads of approximately $13 per day is included), resulting in a shortfall of approximately $22 per day or $8,000 per resident per year.[10]

(c) **Variance in financial performance across the sector:** There is a wide variance in financial performance across the aged care sector. In their reports, ACFA have identified that while some factors (such as remoteness of service) can affect this, there is also scope for many providers to improve their own financial management.[11] Measures taken to date in response to these concerns include increases to the Viability Supplement which supports eligible providers

[10] ACFA is currently undertaking work on the role of the Basic Daily Fee. This project will provide greater analysis and understanding of the issues around the Basic Daily Fee, including what role it should have in the future.

[11] ACFA 2019 Report, pages xiv and 122; ACFA 2020 Report, pages 69, 85 to 86.

in rural and remote areas with the cost of providing care,[12] and the introduction of the Business Improvement Fund and the Business Advisory Service.[13]

In addition, the Department has commissioned a review of financial viability to inform its understanding of the financial positions of providers and how they can be better supported.[14] The first phase of this work has been completed and has identified the providers that may be at highest risk of experiencing financial viability issues. The second phase of this project has commenced and involves engaging with providers that have been identified as being at risk of experiencing financial challenges. The objective of this engagement is to seek further information on their financial position, including the underlying drivers, to determine whether options exist to improve business operations as well as to inform future policy reforms. The Department is engaging with providers on a risk priority basis.

(d) **The impact of caps:** As outlined above, the cap on the Basic Daily Fee is resulting in revenue for hotel services not meeting costs for those services. However, while the caps on income tested fees in home care and means testing fees in residential care limit the amount of consumer contributions, they do not directly impact total funding levels (as means tested fees charged reduce the government subsidy with no overall impact on the aggregated amount of consumer contributions and government funding). The impact on consumer contribution caps therefore primarily affect the source of provider funding, rather than funding amounts.

(e) **The trend away from refundable accommodation deposits (RADs) to Daily Accommodation Payments (DAPs):** ACFA has reported that there has been a growing trend from payment of RADs to DAPs.[15] This may cause cashflow uncertainty, and financing or liquidity challenges, as DAPs constitute revenue, whereas RADs are interest free loans from residents that have been an important source of funding for capital investment. The extent to which this is an issue will vary from provider to provider. Some providers have a business model which has been more reliant on RADs as a form of capital and so will be challenged to redesign their business model from any significant shift to DAPs. For other providers this would be less or not an issue at all.

HOME CARE

45 The Department considers that while the profit margins in the home care sector have tightened in 2017-18 and 2018-19, the EBITDA and net profitability of the sector have in aggregate been healthy in recent years. While 69% of home care providers reported a profit in 2018-19, there was some variation in profitability across the sector. In particular, for-profit providers in the bottom quartile have

[12] Further information regarding the Viability Supplement is contained in the Statement of Jaye Alexander Smith dated 10 May 2019 at paragraphs 202 to 215.

[13] Further information regarding the Business Improvement Fund and the Business Advisory Service is contained in the Joint Response of the Department and the Aged Care Quality and Safety Commission in response to NTG-0734 and NTG-0735 (**Joint NTG Response**).

[14] Further information regarding this review is contained in the Joint NTG Response at paragraph 35.

[15] See ACFA 2020 Report at pages x and 89 to 90, and the ACFA 2019 Report at pages 90 to 93.

recorded poorer results than not-for-profits and government providers in 2017-18 and 2018-19.[16] The Department notes that recent financial performance in the home care sector has been affected by:

(a) increased competition following the introduction of the *Increasing Choice in Home Care* reforms in February 2017. These reforms have enabled consumers to choose their provider and have led to more providers entering the home care market. Adjusting to this change increased costs for providers, while the significant increase in competition constrained revenue growth. The Department believes the impact of this transition will continue to stabilise as more providers adjust their pricing and service models to compete in the market;

(b) the level of indexation, which appears to have been insufficient to cover the increasing cost of service delivery inputs. This appears to have resulted in a reduction of hours of care in home care packages over time;[17] and

(c) pricing transparency measures which providers report are putting pressure on published service and fee rates.

CHSP

46 CHSP service providers receive grant funding to deliver services in accordance with the outputs specified in funding agreements. Service patterns and relative unit prices in these funding agreements still reflect historical practices inherited from the Home and Community Care Program (which the CHSP replaced). As a result, providers tend to face the following two categories of financial challenges:

(a) funding for services not aligning well to client demand causing supply shortages for some services in some locations, and underspent grants in others; and

(b) unit prices for some providers not aligning with actual costs, leading to under delivery of outputs.

47 In relation to the first issue, the Department has used data analysis in recent years to help target growth funding to services and areas where there are demand pressures. The Department has also taken steps to mitigate this issue through increasing funding flexibility to allow CHSP providers to reallocate up to 50% of their funding between service types to respond to short-term changes in demand. During the COVID-19 pandemic, CHSP providers have also been permitted to reallocate 100% of funding across service types.

48 In relation to the second issue, the Department is currently initiating a project to review unit prices for CHSP services, drawing on the preliminary analysis undertaken by Deloitte Access Economics.

49 These issues will also be addressed more broadly as part of the development of the unified home care program.

[16] See ACFA 2020 Report, Chart 5.6.

[17] The StewartBrown Report analysing the Home Care Provider Survey data over a 10-year period indicates that the average number of hours of care provided to consumer have dropped.

Question 5

Are there features of the aged care system that impact on aged care services being delivered in a cost-efficient manner? Without limitation of the matters you wish to address, your statement should describe

a. the ideal characteristics of efficient delivery of high quality aged care;
b. whether and how the design and operation of the current system aligns or does not align with or incentivise these characteristics;
c. any evidence for your responses.

50 Generally, the Department considers that a consumer focused market-based system and strong competition, including across current programs, supports the cost-efficient delivery and innovation of aged care services. Fundamental reform, building on AN-ACC and the ACF model would support a more efficient system that better aligns subsidies to assessed need and allows consumers greater control and choice.

51 The Department recognises that there is some degree of inefficiency in the aged care system. A number of inefficiencies in residential aged care, home care, and the CHSP are outlined below. While the Department supports initiatives to improve cost efficiency, it notes that it is important to balance market based and competition considerations around efficiency with ensuring there are appropriate protections for vulnerable consumers and an appropriate regulatory system that supports the delivery of quality care to consumers. There may also be greater challenges for delivery in some markets which create unavoidable inefficiencies. For example, some providers in rural and remote areas may not achieve a high degree of cost-efficiency as they face location based challenges and serve small segments of the population.

RESIDENTIAL CARE

52 The residential care system is primarily centred on providing 24/7 care for elderly Australians who are no longer able to be supported in their home. While there are cost efficiencies in providing this care through a residential care environment, allowing greater choice to consumers would force providers to consider whether such offerings might be provided in different formats and in some cases in the consumer's own home.

53 The system should aim to balance relevant considerations by allowing room for innovation and efficient practices at provider level while at the same time ensuring through the quality regulatory system and quality information disclosure that providers deliver on quality care. An overly regulated and administratively burdensome funding system could bring inefficiencies and stifle innovation. There is some evidence that the current approach to regulation has discouraged providers from striving to imagine and deliver high quality, innovative services that respond to the preferences of older Australians. Inefficiencies in the residential aged care system may also arise due to:

(a) the nature of residential aged care and the frailty of residents, which constrains the extent to which consumers may 'vote with their feet' and move facilities;

(b) the limited options for consumers in thin markets; and

(c) features of the ACFI funding system as discussed at paragraphs 18 to 20 above.

54 There are various mechanisms which can help improve cost efficiency. This includes the promotion of consumer choice and competition (which is also supported by creating greater transparency and disclosure of information on how a service performs in terms of quality and other measurements)[18] as well as the possible introduction of the AN-ACC model (to address the issues in the ACFI funding system); balancing the need for oversight over quality of care against the agency and innovation of good providers in care delivery, as stated at paragraph 8 above; harmonisation of care sectors which would reduce the number of thin markets; and ongoing improvements to the financial management of providers.[19]

HOME CARE

55 The ability of consumers to choose and change their provider following the introduction of the National Prioritisation System and supported by pricing transparency measures,[20] are key drivers of competition and cost-efficient service delivery by providers.

56 The four 'flat' funding bands in the home care packages program and the inability of providers to cross-subsidise across packages do create cost inefficiencies. These issues would be addressed in the development of the unified home care program as discussed at paragraphs 32 to 39 above. The creation of greater cost efficiencies will also, in part, be assisted by the ongoing efforts to minimise the amount of unspent funds retained by providers.[21]

CHSP

57 The block funded model of the CHSP, while it does have its advantages, has likely been an impediment to the development of cost-efficiencies, as it is less likely to encourage competition between service providers, can lead to limited cost transparency and potentially less choice for consumers.[22] These issues would be addressed in the development of the unified home care program as discussed at paragraphs 32 to 39 above.

58 Consideration needs to be given to allowing consumers to control their own funding in all parts of the aged care continuum and this might include whether to purchase a bundled service (the current residential care model) or discrete services in their own home.

[18] From 1 July 2020, a differentiated performance rating model will provide information relating to individual provider performance and compliance on the My Aged Care website. Further information is set out in the NTG-0736 Response.

[19] Initiatives to assist providers with improve their financial management and operations include the Business Advisory Services and the Business Improvement Fund, which are outlined in the Joint NTG Response.

[20] Further information regarding the pricing transparency measures for home care providers is provide at paragraph 58 of the NTG-736 Response.

[21] This will be addressed through the Improved Payment Arrangements measure which will change payment arrangements from the full subsidy and supplements in advance to payments in arrears for the services delivered. Implementation will occur in two phases. Under Phase 1, payment will be the full entitlement in arrears; and under Phase 2, will be payment for services delivered with payment still in arrears. On 27 February 2020, a Bill to amend the *Aged Care Act 1997* to implement Phase 1 was introduced to Parliament, however implementation was paused due to the COVID-19 pandemic. Timing of implementation remains a decision for Government.

[22] This was identified in the 'Integrated Care at Home Program' discussion paper, which is available on the Department's website: https://consultations.health.gov.au/aged-care-policy-and-regulation/discussion-paper-future-care-at-home-reform/.

Question 6

Are residential aged care services (that is, the operations of approved providers by which aged care is provided to residents of residential aged care facilities) cross-subsidising the provision of personal and clinical care, or administration and corporate overheads, through funding obtained for accommodation and daily living costs (including food and drink, laundry, cleaning, maintenance and utilities)? If so include in your statement, if possible:

a. any evidence for your response;
b. your views as to the reasons why this is occurring;
c. your views as to whether this presents problems affecting the efficiency, quality or safety of aged care;
d. your views as whether and how this could be avoided under a new system?

In answering this question, please refer and respond to the statement of Mr Grant Corderoy to the Royal Commission into Aged Care Quality and Safety dated 20 April 2020 (Annexure A to this notice) and the matters raised at: pp 12, 18-19.

59 The Department acknowledges that cross-subsidisation can, and does, occur in residential aged care. As noted in the Corderoy Statement, revenues and costs can be broken down into three broad streams:

(a) direct care funding and associated direct care costs;

(b) everyday living funding and associated costs; and

(c) accommodation funding and associated costs.

60 The Department considers that it is primarily everyday living services which are being cross-subsidised by revenue from other sources. As noted in the Corderoy Statement, revenue collected by residential care providers through the Basic Daily Fee may be insufficient to meet the costs of everyday living or hotel services. In contrast, the Corderoy Statement identifies that direct care funding through ACFI exceeds the direct cost of providing care.

61 The features of the funding system which enable cross-subsidisation do not, in isolation, present concerns relating to the delivery of safe, efficient and high quality aged care services. The Quality Standards must be met regardless of how a provider manages their funding. While funding for particular streams is generally analysed against the costs of that stream of activity and the administration costs associated with it, it is important to note that funding is not required to be spent on the particular streams of care, services or accommodation under which it was provided. In the current system it is desirable for residential care providers to have discretion and flexibility as to how to use the total pool of funding from all sources to provide care, services and accommodation in the most efficient way to deliver the best care and services to residents. The Department acknowledges that the option of unbundling services would create transparency for consumers in a new aged care funding system and lead to greater control over the services they receive.

Question 7

At a general level, what are the categories of actual costs of delivering aged care services (both residential and home care services)? In your answer describe:

a. how these costs can be expressed and measured;
b. whether these costs vary by reference to:
    i. the location in which the aged care service is being delivered (i.e. collective living as against living in the community);
    ii. the geographic location of the service (i.e. metropolitan, regional, remote services);
    iii. the population served (for example, people who are financially or socially disadvantaged, people from culturally and linguistically diverse backgrounds, people from Aboriginal and Torres Strait Islander communities etc)
c. If these costs do vary, how do they vary?
d. What can be done to meet these costs?

COSTS OF RESIDENTIAL CARE

62 The categories of costs of providing residential care can be broadly broken down into care, daily living or hotel services, accommodation, and other.

63 The Department understands that care costs can vary by geographic location and scale. This is supported by findings from the Resource Utilisation and Classification Study (**RUCS**), which identified higher costs in MMM-6 and MMM-7 areas for smaller services and those that specialise in particular areas such as homeless and indigenous services,[23] and a study by StewartBrown. The study by StewartBrown found that:

(a) minimal variance exists in hoteling and everyday living expenses across MMM1-5 (supporting the RUCS finding that higher costs are more apparent in MMM6-7 areas);

(b) although Everyday Living costs do not vary materially across MMM bandings, Everyday Living financial results (i.e. revenue minus costs) decline as remoteness increases reflecting variations in revenue streams;

(c) direct care costs vary across MMM 1-5 categories, but this is predominantly linked to care needs rather than being attributable to geography as the factor; and

(d) results for providers are shown to improve as the size of the provider increases, but this is mainly due to differences in revenue base rather than differences in overall costs.[24]

[23] Australian Health Services Research Institute, 'Resource Utilisation and Classification Study: Report 3 – Structural and individual costs of residential aged care services in Australia' (February 2019), page 16.

[24] StewartBrown, *AN-ACC: Analysis of Care, Hoteling and Accommodation Costs*.

COSTS OF HOME CARE

64 The costs of providing home care include:

(a) care costs, including wages and salaries for care staff, subcontracted or brokered customer services, and other care related expenses; and

(b) administration costs, including wages and salaries for administration staff, administration costs and management fees, depreciation and interest costs.[25]

65 The costs of home care are expressed and measured in different ways, depending on the type of service and the business practices of individual providers. It is common for providers to measure and charge costs based on:

(a) time taken for personal care, cleaning, social support services, respite, allied health and nursing (for example, by the hour);

(b) a single one-off payment for services such as aids and equipment, or home modifications, or costs such as Maximum Exit Amounts;[26]

(c) each kilometre of travel, for travel related expenses; and

(d) a percentage of package subsidy or a set rate that varies according to package level (for example, care management and package management).

Variances in home care costs

66 The costs of delivering aged care services vary depending on a broad range of factors, including:

(a) the nature of services being provided (including associated purchase requirements such as capital purchases (for example, furniture, mobility aids and technology), and consumables (such as bandages, incontinence aids, and nutrition supplements));

(b) features of the provider, such as its ownership type (for-profit, not-for-profit, or government-owned), its location by MMM classification, and its size;

(c) the assessed needs and demographics of the population being serviced, such as their average age, gender, and cultural background.[27]

67 Additional Commonwealth funding provided through the Viability Supplement, the Veterans' Supplement, and the Dementia and Cognition Supplement is aimed at addressing these variances in the cost of delivering home care services. These supplements aim to assist approved providers with the cost of meeting specific care needs, including care recipients living in regional, rural and remote locations. Meeting variances in costs will also be assisted through the proposed introduction of a unified home care program, as discussed at paragraphs 32 to 39 above.

[25] A breakdown of home care expenditure is set out in ACFA 2020 Report at Table 5.7.

[26] Maximum Exit Amounts are the amounts that a home care provider can deduct from a person's unspent home care package if they leave home care.

[27] Further information as to home care costs can be found in the StewartBrown Report (see footnote 2 above).

COSTS OF CHSP

68 CHSP cost categories are likely to be similar to the ones for home care described in paragraph 64.

69 In respect of cost variances, preliminary analysis of CHSP data undertaken by Deloitte Access Economics indicates that CHSP provider costs vary across providers for the same service, with no clear rationale for the cost differences. The preliminary analysis suggests that while there are isolated instances where a provider's characteristics may affect its prices, there is no clear and defining characteristic (in the scope of characteristics available for the CHSP study) that systematically affects the price that is charged by service providers. Unexplainable variances in the costs for CHSP may be addressed through the development of the unified home care program as discussed at paragraphs 32 to 39 above.

Question 8

In your view, what principles should underpin a funding model for aged care?

Question 9

Please explain whether the principles identified in your response to question 8 apply in relation to the funding of the following types of supports:

a. basic domestic supports;
b. basic social supports;
c. personal care, and nursing, allied health and other care for more complex needs provided in the home, flexible supported accommodation or other community settings;
d. personal care, and nursing, allied health and other care for more complex needs provided in the setting of residential aged care facilities;
e. respite (addressing day centre respite, in-home day or overnight respite, cottage respite and residential respite, and any other kind of respite known to you);
f. support services for informal carers.

70 As discussed above at paragraphs 22 to 24 above, the Department broadly supports the ACFA Principles as a framework to help guide future reform of the broader funding of the aged care system. These ACFA Principles apply to funding to all types of aged care services and supports, including personal care, nursing, allied health. As outlined in paragraph 24, the Department also considers that the funding model for aged care should be underpinned by a continuum of care. This will ensure that consumers can obtain the graduated care that meets their needs, including as and when those needs change.

71 In respect of respite care, in addition to the ACFA Principles, the Department supports the recommendation of ACFA in its Respite for Aged Care Recipients report published by ACFA on 31 October 2018 (the **ACFA Respite Report**) that funding arrangements should be neutral between

respite residents and permanent residents, and should not disincentivise respite care.[28]

Question 10

Do you prefer a particular model for the funding of aged care services? If so, describe that model and explain why you prefer that model to alternative funding models.

Question 11

With respect to any preferred model described in response to question 10, explain how that model would operate in relation to the following types of supports:

a. basic domestic supports;
b. basic social supports;
c. personal care, and nursing, allied health and other care for more complex needs provided in the home, flexible supported accommodation or other community settings;
d. personal care, and nursing, allied health and other care for more complex needs provided in the setting of residential aged care facilities;
e. respite (addressing day centre respite, in-home day or overnight respite, cottage respite and residential respite, and any other kind of respite known to you);
f. support services for informal carers.

Question 12

With respect to any preferred model described in response to question 10, would you describe the model as an individualised funding model, a case mix funding model or something else? In your answer, address the following with respect to the individualised, case mix funding or other model identified:

a. what are the key features of this model; and
b. what is required for the successful implementation of this model

Question 26

Would the Australian National Aged Care Classification model improve the quality of assessment and reassessment of the needs of people currently living in residential aged care, and if so, how?

72 In considering the merits of funding models for aged care, the Department is guided by the ACFA Principles discussed at paragraph 22 above, as well as what ACFA have identified as desirable features of a new funding tool: administrative simplicity; funding assessments external to the provider; equitable allocation of funds based on the mix of residents and their needs; recognition that many care costs are shared between residents; transparent studies to determine the cost of care; and indexation arrangements that adequately reflect movement in costs.

[28] See ACFA Respite Report, page 37, recommendation 3. Additional information on the ACFA Respite Report findings and respite care generally is set out in the Statement of Nigel Murray dated 22 July 2019 [**WIT.0338.0001.0001**].

73 The Department considers that these features and the ACFA Principles are reflected in the AN-ACC and the ACF model (as discussed below and at paragraphs 30 to 39 above), which are the Department's preferred funding models for residential aged care and in-home services respectively.

AN-ACC MODEL

Assessments under the AN-ACC model

74 The AN-ACC model separates assessment (and reassessment) for funding from assessment for care planning, which will help ensure that care assessments are not influenced by funding considerations.

75 Funding assessments would be undertaken by independent assessors with training in undertaking AN-ACC assessments and qualifications as a registered nurse, occupational therapist or physiotherapist. This would be aimed at improving the reliability (and therefore quality) of assessment data collected for funding purposes, as the independent assessment process would remove the incentives within the current provider assessment ACFI system to complete assessments to maximise funding. This would also enable Government to better estimate expenditure, particularly within a demand driven system.

76 Care planning assessments would be undertaken separately by providers and focused on care only rather than funding outcomes. These would be more comprehensive than funding assessments and align with requirements of the Quality Standards. Separating the two assessment processes would resolve the current issue with ACFI, under which funding assessments can influence care assessments.

Funding under the AN-ACC model

77 As to funding, under the AN-ACC model:

(a) The Government would make an annual determination about the funding (price) of a National Weighted Activity Unit (**NWAU**) of 1.00. This price would be standard across both the fixed and individualised components of the funding model. All prices in any such funding model would then be set relative to this annually determined NWAU price.

(b) Each year, the Department or an independent body would undertake or commission a national residential aged care costing study, with those results to inform the price-per-NWAU agreed by Government for the following year. Under this evidence-based approach, the price set for funding would take into consideration movements in costs.

(c) Periodically, as clinical and other practices in the sector change – as could be expected to occur following the abolition of the ACFI – additional costing studies would be undertaken to ensure that the cost weights attached to each class remain relevant. This would involve repeating the time and motion study originally conducted in the RUCS, and may involve the addition or deletion of classes as necessary to ensure that the AN-ACC model remains clinically relevant over time.

Implementation of the AN-ACC model

78 If the AN-ACC model is implemented, as with any other significant reform, the AN-ACC will need to be implemented and managed carefully in order for the aged care sector to transition smoothly to the new model and for its resultant benefits to flow through the system. Accordingly, a significant program of change management with residential aged care providers will be required to assist them to transition to the new model, including to move away from care planning processes that may focus on funding and towards those that prioritise residents' needs and wishes.

79 The Department's preferred model to transition to the AN-ACC would be one involving a year of 'shadow assessment' during which all residents would be externally assessed under the new AN-ACC while still being funded under ACFI. After the shadow assessment year all residents would then be funded under AN-ACC. As it will distribute funding (in a fairer and more evidence based way than AN-ACC) some providers will likely be concerned that they could receive less funding under AN-ACC than they were able to claim under ACFI. The University of Wollongong recommended Government consider transitional arrangements such as short term 'stop loss' arrangements which could limit any funding reductions for a period of time to address these transitional concerns.

80 Consideration will need to be given to the impact of changes in the aged care system on related systems which employ similar labour, such as the National Disability Insurance Scheme, Veterans Affairs services, and other health and social service systems.

Question 13

How should the level of funding for aged care services be determined? In answering this question, explain whether you consider the following factors should have a role in determining the level of funding:

a. the cost of delivering aged care services; and
b. changing input costs of aged care providers over time.

81 The Department considers that the practical process for determining funding levels across the aged care sector should be evidence-based and involve a cost of care study, such as the one outlined in paragraphs 37 to 38 above, alongside an independent pricing process, such as the one that would be involved in the AN-ACC model as mentioned at paragraph 77. This process would take into account the cost of delivering aged care services and changing input costs of aged providers over time. This approach could be applied for residential and in-home care.

82 In creating a process for determining funding levels under the ACF model, the Department notes that, as outlined in paragraphs 37 to 39 above, further consideration would be required to create such a process. As part of this, consideration may be given as to whether 'funding categories' based on episodes of care should be included in these price setting arrangements. If the ACF model were to use similar price setting arrangements to the AN-ACC model, it may be appropriate for basic services funded via a service event level funding model that are broadly available outside of aged care (such as, for example, domestic assistance and home maintenance) to be set by market rates.

Question 14

As to the cost of capital and required rate of return on capital for residential aged care service providers, providers of Home Care Packages and the Commonwealth Home Support Programme:

a. Should the funding of aged care meet providers' cost of capital?
b. Does the cost of equity capital materially vary depending upon the scale, business model, constitution (for profit, public listed for profit, not for profit) and capital structure of the provider?
c. Should the cost of capital for aged care service providers be estimated from a weighted average cost of capital including both equity and debt capital?
d. If so, what debt to equity ratio should apply and should it be different as between segments of the aged care sector?
e. If a weighted average cost of capital should not be used, what alternative approach should be used?

83 For aged care providers to be able to continue to invest in new and improved facilities and operations, they need to generate a rate of return from their business operations that allows for this. This is often referred to as being able to meet an appropriate weighted average cost of capital (**WACC**) reflecting the cost of both equity and debt finance.

84 The Department considers that while there is a need for providers to achieve a rate of return, it is not practical to specify precise rates that should be used or to prescribe a set rate of WACC as part of its funding considerations, in light of the diversity of the sector, operating models and business structures. This view is supported by the findings of a 2012 report by PwC which found that "*the WACC approach is specific to entities operating on a commercial basis and does not consider the circumstances of not for profit or other types of organisations providing services on a non-commercial basis. The required returns for not for profit organisations cannot be determined through such a methodology*."

85 PwC did provide an indicative range of WACCs that could apply across the sector (based on then market conditions) in their report but noted that WACCs above or below this range may equally be appropriate depending on the circumstances.

86 The Department notes that the Commonwealth currently supports capital grant funding through the Aged Care Approvals Round, including through smaller capital grants for refurbishments and extensions. This support is targeted towards providers in rural, regional and remote areas, providers who provide services in a region that needs extra residential aged care services, and providers that focus on residential aged care for people from special needs groups or concessional, assisted or low-means residents (such as homeless service providers).

CHSP

87 Major capital expenditure is not permitted under the CHSP Grant Opportunity Guidelines. However, some services funded under the CHSP require capital investment to set-up and/or maintain the service, such as Cottage Respite, and to a lesser extent, transport services. Generally, providers of Cottage Respite services rely on funding from state and territory governments and/or private investors to fund capital projects. The Department will consider issues relating to capital expenditure as part of the development of a funding model for a unified in-home care program.

Question 15

Should the Aged Care Planning Ratio or Aged Care Provision Ratio be considered a tool for the allocation for funding, because it limits the distribution of packages? If so, is the Aged Care Planning Ratio or Aged Care Provision Ratio a suitable tool for allocating funding? Please explain why or why not?

88 The Aged Care Planning Ratio / Aged Care Provision Ratio (**Ratio**) is a target for the number of subsidised operational aged care places per 1,000 people aged 70 or over, to ensure that the supply of services increases in accordance with the ageing of the population, and that aged care expenditure can be planned for by the government. The Ratio is not a tool for allocating funding as it does not assist in the assessment of significant cost drivers – such as individual care needs.

Question 16

Is the current funding mechanism Aged Care Funding Instrument (**ACFI**) suitable for determining the funding that providers need to support the care required by different aged care residents?

Question 17

Does ACFI incentivise providers to improve outcomes for people living in residential aged care? Is it the case that ACFI fails to incentivise such improvements because it provides funding based on a person's health deficits.

Question 25

Is ACFI a suitable tool for assessing and reassessing the needs of people in residential aged care? Why or why not?

89 The Department's views on the suitability of the ACFI are set out at paragraphs 18 to 20 above.

Question 18 What are the annual indexation arrangements that have applied to the funding of: a. residential aged care; b. the Home Care Packages Program; and c. the Commonwealth Home Support Programme; in each financial year since 2008/2009?
Question 19 What, precisely, are the components of any indexation formula referred to in response to question 18?
Question 20 How, if at all, do they account for changes in sector wage costs and wage costs in the general economy?

RESIDENTIAL AGED CARE INDEXATION ARRANGEMENTS

90 The rate of residential aged care basic subsidy (and respite care subsidies) is routinely indexed on 1 July each year. The indexation applied is the Wage Cost Index 9 (**WCI-9**).[29] The WCI-9 is a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 75%) and a non-wage cost component (weighted at 25%).[30] For all Wage Cost Indices, the value of the wage cost component is based on the dollar increase in the national minimum wage (as determined annually by the Fair Work Commission) expressed as a percentage of the latest available estimate of average weekly ordinary time earnings published by the Australian Bureau of Statistics (**ABS**) as at November of each year. The value of the non-wage cost component of WCI-9 is based on changes in the Consumer Price Index between the March quarters each year.

91 The indexation applied to accommodation related supplements (and respite care supplements) is the Consumer Price Index (**CPI**). These supplements are indexed twice a year, in line with the aged pension, on 20 March and 20 September. The CPI, as defined by the ABS, is "*a measure of changes, over time, in retail prices of a constant basket of goods and services representative of consumption expenditure by resident households in Australian metropolitan areas.*" The CPI is published quarterly by the ABS.

[29] ACFA 2020 Report, page 46.
[30] ACFA 2020 Report, page 46.

92 The indexation applied to the supplements (other than accommodation related supplements) is either indexed by WCI9 or by CPI on 1 July each year. The standard methodology and frequency for indexation of residential aged care subsidies is set out below.

Frequency: Annually – July

(a) WCI9 method: Permanent subsidy, Respite subsidy, Veterans' supplement, Homeless supplement, Viability supplement, and Dementia and Severe Behaviours supplement.

(b) CPI method: Oxygen supplement and Enteral Feeding supplement.

Frequency: 6 monthly – March / September

(c) CPI method: Accommodation supplement, Respite incentive, Concessional supplement, Transitional Accommodation supplement, and Pensioner supplement.

(d) Other methods: Transitional supplement (equal to Pensioner supplement) and Basic Daily Fee Supplement (1% of the basic aged pension rounded down).

93 Non-routine changes to ACFI subsidy indexation are set out in the response to question 21 below.

HOME CARE INDEXATION ARRANGEMENTS

94 The home care basic care subsidy and the majority of supplements are indexed by WCI-9 once a year on 1 July. The Oxygen Supplement and Enteral Feeding Supplement are indexed in accordance with the CPI once a year on 1 July. The standard methodology and frequency for indexation for home care subsidies and supplements is set out below.

Frequency: Annually – July

(a) WCI9 method: Viability supplement and Basic subsidy.

(b) CPI method: Oxygen supplement and Enteral Feeding supplement.

Frequency: When basic subsidy changes

(c) Other methods: Dementia and Cognition supplement, and Veterans' supplement (11.5% of the Basic subsidy).

CHSP INDEXATION ARRANGEMENTS

95 Grants under the CHSP are indexed annually at the Wage Cost Indexation 3 (**WCI-3**) rate. The WCI-3 as a composite index constructed by the Department of Finance that comprises a wage cost component (weighted at 60%) and a non-wage cost component (weighted at 40%).[31] The value of the wage cost component is based on the same method described at paragraph 90 above.

96 CHSP providers receive an increase in funding for indexation usually in February each year. From 2020-21, indexation has been built in to the CHSP grant agreements upfront.

[31] ACFA 2020 Report, page 39.

97 The indexation rates for the CHSP since 2015-16 (since the commencement of the CHSP) were 1.5% for each financial year other than 2017/2018 when they were 1.3%. In addition to annual indexation, the CHSP appropriation also grows in real terms by 3.5% per annum, in line with growth of the population aged over 65.

Question 21

Why were indexation arrangements for subsidy rates in residential age care frozen in the 2012-2013 and 2016-2017 financial years?

98 In 2012, the Commonwealth Government paused indexation for twelve months and made changes to the ACFI tool to address concerns of over claiming and to bring growth more in line with estimated sustainable funding levels.

99 In 2014-15 and 2015-16, ACFI claiming growth was again higher than expected and approximately two percentage points higher than estimated. In particular, there was higher than anticipated claiming under the CHC domain in 2015-16. To address the higher than expected claiming under the ACFI, the Commonwealth Government implemented a 50% pause in indexation of the CHC domain on 1 July 2016, effectively halving the indexation increase to CHC funding for 2016-17. This was followed by a 12-month ACFI indexation pause on 1 July 2017, and a 50% pause in indexation of the CHC domain on 1 July 2018.

Question 22

Has the cost of providing aged care increased since financial year 2008/2009? Please detail your understanding of how aged care costs have changed in each financial year since 2008/2009.

100 The costs of providing aged care have increased overall since 2008-09. As noted by ACFA, residential care expenses totalled $19.0 billion in 2018-19, an increase in 8% from $17.6 billion in 2017-18,[32] and representing an increase of 88% since 2008-09. Furthermore, home care packages program expenses totalled $2.43 billion in 2018-19, an increase of 22% from $1.99 billion in 2017-18,[33] and representing an increase of 135% since 2013-14.[34] A significant factor in the increase in aggregate expenses reflects increases in volumes of consumers receiving care over time. This is particularly apparent with the large increase in the total number of home care packages in recent years.

[32] ACFA 2020 Report, pages xii, 58 and 75.

[33] ACFA 2020 Report, pages 42 and 48.

[34] The Department is unable to compare the increase in expenses before 2013-14 as this was the first year in which providers submitted financial performance reports to the Department using a new HCP Financial Report.

101 The Department analysis indicates that the increasing costs of providing aged care have arisen for a variety of reasons, including that:

(a) staff costs have risen over time, with wage increases higher in the aged care sector than elsewhere in the economy.[35]

(b) costs of care have risen and will continue to rise on account of the increasing complexity of chronic health conditions in ageing populations.[36]

(c) at an aggregate level, more people are receiving care;

(d) regulatory costs have increased following the introduction of the Quality Standards and enhancement of the compliance activities of the Aged Care Quality and Safety Commission;[37] and

(e) home care providers have experienced increased costs as they adjusted to the 2017 *Increasing Choice in Home Care* reforms. This is expected to be a transitional impact.

COSTS OF PROVIDING RESIDENTIAL CARE

102 Table 1 below shows that, for the period 2007-08 to 2018-19 total expenses on a per resident per day basis have increased.

Table 1: Revenue and expenses per resident per day

Year	Revenue	Expenses	Difference
2018-19	$283.54	$279.65	$3.89
2017-18	$272.16	$265.62	$6.54
2016-17	$269.58	$254.29	$15.29
2015-16	$263.92	$247.58	$16.34
2014-15	$249.35	$235.05	$14.30
2013-14	$237.00	$225.52	$11.48
2012-13	$224.88	$215.32	$9.56
2011-12	$215.08	$203.14	$11.94
2010-11	$199.13	$190.43	$8.70
2009-10	$183.90	$178.84	$5.06
2008-09	$172.71	$172.52	$0.19
2007-08	$162.10	$159.63	$2.47

[35] ACFA Submission, page 24.
[36] ACFA 2020 Report, page 12. See also the Corderoy Statement at page 4.
[37] ACFA 2020 Report, page 85.

Question 23

Do you think that the increases over the past 10 financial years have been adequate to support the provision of high quality aged care, including residential care, home care and care provided in the community?

103 For the reasons outlined in the ACFA Submission, in the Corderoy Statement, and at paragraphs 16 and 45(b) above, the Department recognises that the level of indexation has not been sufficient to cover the increasing cost of service delivery inputs. If this is not addressed then, over time, it will result in pressure being put on service delivery.

Question 24

Why was the ACFI scoring matrix for the complex health care domain changed in 2016-17? In your answer, identify:

a. Whether the change was due to a concern by the Commonwealth that ACFI expenditure had increased in a way that could not be explained by a corresponding increase in the frailty of residents, and if so
b. Any evidence to support that concern.

104 The changes made to the ACFI scoring matrix for the CHC domain in 2016-17 were driven by the Commonwealth's concerns regarding the significant and unanticipated increases in ACFI expenditure (as outlined in response to question 21) which could not be explained by a corresponding increase in the frailty of residents.

105 The 2017 review of the ACFI by Applied Aged Care Solutions (**2017 ACFI Review**) found that there was a noticeable increase in funding claims over a relatively short period of time and in only the CHC area of the ACFI.[38] In particular, it found that claims in the CHC domain pain management items were subject to significant growth, with pain management items comprising 11.3% of the average daily subsidy by 30 June 2016, constituting $1,248 million of total ACFI funding allocated by the Department.

106 Natural growths in frailty would be expected to occur more gradually over time and be seen across all the ACFI domains. The patterns of claiming indicated the high increase in claim rates was being driven by changes in the claiming behaviour of providers, rather than increasing frailty of residents.

[38] The report on the 2017 ACFI Review is available on the Department's website: https://www.health.gov.au/resources/publications/review-of-the-aged-care-funding-instrument-acfi.

Question 27

What disadvantages, if any, could arise from adopting the Australian National Aged Care Classification model?

107 Concerns and considerations regarding adoption and implementation of the AN-ACC model are outlined at paragraphs 78 to 80 above.

Question 28

Describe the work undertaken on behalf of the Department of Health, to the date of this Notice, in trialling the Australian National Aged Care Classification model, including any preliminary evaluations.

108 The Department has undertaken a nationwide trial to test field performance of the AN-ACC model, as set out in the Response to NTG-0736 dated 24 March 2020 (**NTG-0736 Response**) at paragraphs 105 to 113. The trial was suspended on 27 March 2020 due to the COVID-19 pandemic. As at 27 March 2020, over 7,300 assessments had been completed across more than 120 facilities, a sufficient sample size for evaluating findings. The Department has conducted an internal evaluation of the trial. Based on this evaluation, the Department considers the trial has shown:

(a) the AN-ACC assessment model is fit-for-purpose, appears nationally scalable and costs less on a per-assessment basis than was anticipated when the RUCS was completed;

(b) the AN-ACC assessment tool can be used to sustainably assess 5-6 residents per assessor per day and can, if necessary, be completed adequately even if a face-to-face interview is unable to be completed with a resident; and

(c) appropriately qualified and experienced independent assessors are available to administer the AN-ACC Assessment Tool.

109 In addition, La Trobe University has conducted an evaluation of the training component of the trial. Findings of this evaluation include, amongst other things, that there may be a need for an extension to the face-to-face training provided to include more in-depth training on some of the specific tools used for assessments, as well as additional case studies on how to assess residents with complex dementia and cognitive variables and those from culturally and linguistically diverse backgrounds.

Question 29

Describe any work undertaken or planned by or on behalf of the Department of Health, to the date of this Notice, in response to recommendation 30 of Report 6 of the Resource Utilisation and Classification Study undertaken by the Australian Health Services Research Institute.

110 Recommendation 30 of Report 6 of the RUCS suggests

> *That a study equivalent to RUCS be undertaken in the community aged care sector with a view to expanding AN-ACC so that it includes aged care delivered in all settings.*

111 The Department adopted Recommendation 30 by commissioning the HealthConsult Report outlined at paragraphs 32 to 36 above.

Question 30

Apart from the Resource Utilisation Classification Study, has the Department of Health ever carried out any study to ascertain whether the funding provided through ACFI (or any predecessor funding model since 1997) was adequate to meet the costs of providing high quality care to residents in residential aged care facilities? What were the results of any such studies? Please provide copies of any such studies.

112 While studies have been undertaken to examine options for different funding models and the RUCS examined the relative differences in costs for different case-mixes of residents (see paragraphs 30 to 39, and 74 to 80), these studies did not specifically consider whether funding provided through ACFI or other funding models was adequate to meet the costs of providing high quality care.