Submission in Response to Royal Commission Consultation Paper 1:

Aged Care Program Redesign

INTRODUCTION

As Australia's largest non-government provider grouping of health and aged care services, providing care to all those who seek it in fulfilment of the Catholic Church's mission, Catholic service providers have a vital interest in ensuring the sustainable provision of aged care services that meet community expectations for quality of care and safety and quality of life.

Accordingly, Catholic Health Australia has a vital interest in the work of the Royal Commission into Aged Care Quality and Safety.

This submission responds to the Royal Commission's invitation to provide comment on the Consultation Paper *Aged Care Program Redesign: Services for the Future*, which canvasses a fundamental redesign of the current aged care funding arrangements, consistent with the Royal Commission's undertaking that "our Final Report will deliver comprehensive recommendations for substantial reform of the aged care system ……. not mere patching up".

The Consultation Paper proposes a set of Principles to guide the design of a new aged care service system which has the objective of "putting people at the centre".

The proposed redesign is based on the creation of three separate funding streams for aged care services that are agnostic of setting: domestic assistance, social supports and minor home modification and assistive technology (an entry-level support stream); personal care, nursing care and allied health services (care stream); and reablement and respite services and more expensive home modifications and assistive technology (investment stream).

These separate funding streams would span all aged care and thereby be available for all eligible older people irrespective of their accommodation arrangements, whether home-based or any form of congregate living setting.

In contrast, the current funding arrangements are based on the separation of residential care and home-based care, with the latter further separated into the Commonwealth Home Support Program (CHSP) and the home care package program - roughly separated based on intensity of care and support needs and service use, with CHSP clients using relatively fewer services than package holders.

The Consultation Paper also addresses how information requirements of older people and needs assessment, including assistance with system navigation, would be best catered for under the proposed program redesign; how health services would be accessed under such a design; and questions how the current quality regulatory framework may need to be adapted.

Finally, the Consultation Paper notes the Interim Report's conclusion that the current aged care system is "unacceptable" and that closing the gaps will increase expenditure in aged care "considerably", both now and in the future.

PRINCIPLES

The Principles proposed in the Consultation Paper for the redesign of Australia's aged care system includes those that have been articulated previously from time to time when aged care reform has been contemplated or introduced. These Principles would be familiar to, and supported by, most stakeholders, including Catholic Health Australia.

However, there are other dimensions worth exploring, and other principles also come into play.

Spirituality

As well as respect and support for the rights, choices and dignity of people, the Principles must include specific reference to respect and support for the spiritual needs of older people. Spirituality speaks to each person's need for meaning, purpose and connectedness with self, others, creativity, nature and 'Something Bigger'. This includes, but is not limited to, religious expression.

Funding and financing

It is noteworthy that while the Principles refer to affordability and sustainability for the community (ie. taxpayers and government) and individuals, there is no recognition that sustainability also depends on the financial viability of service providers within the system – unless it is contemplated that all aged care will be provided by government entities. Non-government service provider entities have to be financially viable and 'bankable' in order to support service quality, service continuity and to attract financing for service expansion to meet increasing demand, and to meet prudential and governance standards.

This is not a trivial point given the critical opinions offered at Royal Commission Hearings about the surpluses/profits generated by non-government entities, and the implied criticism directed at service providers for their attention to financial viability considerations, noting that they are fundamentally 'price takers', not 'price setters'.

On the question of sustainability, a starting point for taking the public debate forward would be to have a costing of the individual measures being considered by the Royal Commission to fund the existing gaps in the system so that the scale of cost increases is known and can be taken into account. It is pertinent to recall in this regard the conclusion of the *Legislated Review of Aged Care 2017* that there is currently no reliable method to estimate future demand for aged care services to inform the overall cost and sustainability of program redesigns.

Affordability

Catholic Health Australia agrees that aged care services should be affordable for individuals, implying a regime that incorporates both subsidised access to services and user contributions. However, there is no objective measure of affordability. Because determining affordability ultimately involves balancing policy judgements and Federal Budget priorities, intermingled with electoral considerations, it would be useful for the Royal Commission to propose principles to guide the application of user contribution policies, along the lines of those presented in the Productivity Commission's 2011 Report *Caring for Older Australians*.

Efficiency and effectiveness

Efficiency and effectiveness is an important principle in service provision, including how system design and regulation may both inhibit or facilitate efficiency, effectiveness and productivity. This aspect of program design is especially important when a system remains substantially taxpayer funded.

Choices

The Principles indicate that the design of the system should respect and support "choices" of older people, but it is unclear how this Principle is to be interpreted and applied.

It could mean choice of a range of services specified by government and whose quality is substantially influenced by government-set prices, or choices made possible by a system with flexibility to respond to individual and family preferences, including to purchase additional services beyond those that can be provided within prices set by government. An overriding principle of "putting people at the centre" of the system would suggest the latter approach, irrespective of setting.

It is unclear to what extent the Principles envisage a mainly universal standard of aged care services, or whether they contemplate a system design that includes flexibility to respond to the lifestyle choices of older people and their families, beyond standards of clinical care and safety, and effective protections for older people with limited means.

Given the long term nature of aged care compared with hospital-based care, and recognising that ageing does not mean that lifestyle choices and considerations cease to be relevant, the Principles should explicitly address whether the funding and regulation Principle assumes all older Australians will receive the same basic standard of living, or whether older people would have the option to benefit from planned older age, rather than settling for services and a lifestyle that can be provided at the prices set by the government having regard to its fiscal position.

There are also levels of 'person-centred care' and choice. They range from goal-based approaches to assessment, planning and service delivery where the person actively participates in the planning process, including a focus on independence, wellness and other goals that are meaningful to the person, but whose adoption depends on the goodwill and culture of the provider and its staff and regulation, through to individual budgets and control over the use of the budget and opportunities for people to supplement their care and services with additional services from their own resources.

Competing principles

Finally, there is an issue concerning the extent to which the proposed aspirational Principles have or can be fully applied, noting the tensions that arise because of competing Principles. For example, the tension between an affordable and sustainable aged care system and providing equity of access regardless of location. The inevitable requirement to balance competing Principles (not to mention other national priorities) needs to be acknowledged as policy does not have the luxury of being developed in a vacuum.

INFORMATION, ASSESSMENT AND SYSTEM NAVIGATION

As recognised in the Consultation Paper, an aged care system whose underpinnings includes respect for individual choices must in turn be underpinned by an informed community and individuals. This requires a system that is transparent, easy to understand, easy to navigate and easy to make comparisons, with its simplicity and comprehensiveness increasing along with the level of individual choice and control that is envisaged.

Informed individuals and communities are essential to the efficient and responsive provision of goods and services in any sector of the economy, as are regulations to protect the community.

Information

For decades, the aged care system expected people needing care and their families, in effect, to use their own initiative to gain information about the system, especially information about comparative service quality. This included word-of-mouth, supplemented by government pamphlets and booklets providing high level information about the system, and sometimes help from Aged Care Assessment Teams (ACATs), once their existence came to individuals' attention – generally in the context of a hospital episode. Information and guidance in the CHSP/HACC domain essentially fell to providers.

This approach had its origins in an aged care system characterised by very high occupancy rates in residential care, low overall service provision ratios, (undisclosed) waiting lists and, for a long time, no or limited availability of home care options. In practice, there was limited scope for older people to exercise choice over service type or service provider. Many saw aged care as essentially a government service, so there was little to be gained in directing resources to improve comparative information.

With the introduction of accreditation, information was published about each residential facility's accreditation status and compliance record. Online service finders were also developed which provided basic information about services, but next to nothing about comparative quality. To the extent that compliance reporting was required, it was primarily intended to support quality regulation by the regulator, rather than to provide comparative quality information for consumers.

To a large degree, this situation still lingers today, though nascent moves to improve the quality of information have been gradually emerging. These nascent moves have emerged in parallel with changes aimed at increasing choice, such as choice over a daily payment or a refundable accommodation deposit in residential care, and introducing individual budgets and choice of provider for home care package holders.

While there has been some improvement in the quality of information, such as publication of prices, there is also scope for considerable improvement. The foreshadowed introduction of performance rating is essential for improving comparative information for aged care users, but its benefit will be diminished if demand exceeds supply and supply does not align with community preferences. A considerable investment will be required to ensure that performance rating is informative for the community, fair and that the information is current.

System Navigation and Finder Services

Producing timely, reliable and comprehensive comparative service information which is easily understood by older people and their families is critical, but not sufficient of itself to ensure individuals access services appropriate to their needs and preferences. Such information is of limited value if it is not effectively communicated to older people and their families, or if the person needing care does not have the capacity to benefit from the information.

While there have been some steps taken to improve service information, with an eye to its fiscal position, the primary means relied upon by government to date to communicate this information has been to make information available online through the My Aged Care website. Successive iterations of My Aged Care have improved functionality and the quality of information, but there is still considerable scope for improvement, especially with regard to comparative quality.

Catholic Health Australia agrees with the view in the Consultation Paper that an online information service is insufficient. This recognises the fact that some sections of the community may need more assistance and guidance with exercising choice about accessing aged care services which meet their needs.

If money is no object, the most effective way to connect older people to aged care services is to create a regional network of 'contact/information/case management/assessment centres' that the community can access directly, complemented by timely, easily understood and accurate online information for those who are comfortable accessing this medium for all or some of their information requirements. Accurate online information is also required to assist staff offering face-to-face support in the 'contact/information/case management/assessment centres'.

To date, unlike the NDIS's Local Area Coordinator (LAC) network, successive governments have been reluctant to make the significant investment that would be required to create a network of access centres for aged care. That said, Catholic Health Australia recognises the operational shortcomings associated with the current LAC arrangements identified in the recent Review of the National Disability Insurance Scheme Act, especially in relation to assessment and care planning. Whatever is put in place for aged care should have regard to this Review's findings.

The aged care centres should be dedicated to aged care (including family carers of older people), free to access, and independent of service providers.

The aged care centres would perform a range of face-to-face information, guidance and support functions, including how to access services and arrange assessments, through to providing case management and information on individuals' status within the system at any point in each individual's ageing experience, including waiting list information if the program redesign sees a continuing need for service rationing.

An important influence on the role of the centres will be whether individuals assessed for the 'care' stream will be classified according to an assessment of their care needs/frailty and assigned to a funding level or package, or have an individual 'care' budget and associated care plan determined based on the NDIS's 'reasonable and necessary' criterion. Given the subjectivity of this criterion and the potential for disputation/review requests, Catholic Health Australia considers that assigning people to needs classification levels would be a more efficient administrative arrangement, noting also that home-based care does not provide 24/7 care. This approach would also allow more flexibility in how care planning is undertaken.

Resourcing of the centres would not be based on the assumption that all older people will need the same level of support and case management (including care planning). Instead, the system needs to be capable of being tailored to cater for the spectrum of competencies and preferences so that older people have a choice as to the level of engagement and case management they prefer. This would range from choosing to have their ongoing aged care needs, care plan and individual budget managed by a case manager located in the centre, electing to have their care coordinated by a preferred service provider (including care planning), coordinating their care themselves, or using their budget to engage a private care coordinator.

Case management could also extend to connecting vulnerable individuals with services outside the aged care system, where appropriate.

However, the potential positive outcomes that would be supported through the availability of more timely and better information and system navigation would not be fully realised if the supply of services continues to be rationed, older people do not have the option (home care package holders aside) to direct their subsidy to their preferred care provider, and good services have long waiting lists. Many older people and their families are capable of exercising choice, but the current system does not reward good providers or provide a business incentive or regulatory flexibility for providers to expand their services outside the regulated system, which in turn shields poor performers.

Assessment

Assessment to determine eligibility for government subsidised aged care services and each person's subsidy entitlement must be undertaken professionally and independently, including independent of service provision and independent of whatever system navigation arrangements are put in place. There are few other areas where individuals collectively have the delegated authority to commit the government to such large ongoing Budget outlays as occurs in aged care. Performance management and consistency in assessment will be critical to the effective and efficient administration of the assessment function and to system sustainability. Given the ever increasing Commonwealth expenditure on aged care, it would be a false economy to under invest in assessment.

Assessment should be undertaken independently by a single multidisciplinary workforce which could be co-located with the 'contact/information/case coordination/assessment centres', acknowledging though that assessment of carer and the older person's needs would often be undertaken in the older person's place of residence. Assessors would assess older people for ongoing subsidy under the 'care' stream, as well as assess older people under the 'investment' stream for restorative care, respite care and more expensive home modifications and assistive technology.

FUNDING STREAMS SPANNING ALL AGED CARE

Catholic Health Australia understands that a key objective of creating separate funding streams that span all aged care irrespective of setting is to help simplify and integrate the system, and to allow greater flexibility and innovation in accommodation and models of care, including "a transition in residential care over time to a less institutional and more home-like physical environment which provides high end dementia and end of life care".

In general, and putting aside for now funding, financing and sustainability considerations, Catholic Health Australia supports the proposed concept of three funding streams across all aged care, but considers that aspects of the proposed redesign need to be explored further, with clarification or adaptation as necessary.

These include the following:

1) It is unclear what the proposed setting-agnostic design envisages regarding the future of residential aged care services caring for older people on a 24/7 basis, and whether the redesign envisages a continuing role for means tested accommodation supplements for low means residents in certain settings.

   Catholic Health Australia's view is that a continuing role for 24/7 residential aged care services should be explicitly provided in any new funding arrangements. As well as catering for older people with high care needs, such as high end dementia and end of life care, there will also be a sizeable proportion of older people living in inadequate accommodation and without the means to access age appropriate privately-provided housing without accommodation support, or who do not have the informal carer support to manage on their own.

   There is also scope in a system where people have real choice of setting for residential aged care providers to compete with home care providers by offering residents a superior quality of life through socialisation, companionship, security, age appropriate accommodation and better amenity, and more easily accessed wellness activities, including 24/7 access to nursing staff. Evidence of this trend is already emerging, partly prompted by increased competition from home-based care options. In a competitive service environment where the strongest relationship is with the older person and their family, rather

than government, there will be greater incentives for providers to pursue innovation in accommodation and models of care in pursuit of improved quality of life for residents.

Our members also highlight their experience that 24/7 residential aged care is a viable and beneficial option for older people in the early stages of ageing, and not only for end stage care.

The above approach would not preclude both the 'entry-level support' and 'personal care, nursing care and allied health' funding streams being applied in residential aged care, with some modifications to the latter – addressed in the Attachment to this submission.

2) The Principles refer to respect and support for choices for older people, but it is unclear whether the program design envisages a continuation of the current rationing of services, or a move to a needs based supply of services with real choice of service provider(s), as applies for the NDIS. A program design that includes individual budgets based on assessed needs increases the importance of supply meeting demand because the opportunity available under pooled/block funded arrangements to cross subsidise and deploy resources as needed is effectively removed.

3) It is unclear whether the personal and nursing care stream would be pooled in a 24/7 residential setting or managed and accounted for separately.

4) Including respite under the 'investment stream', along with reablement funding, raises issues.

   Reablement services are short term interventions, even if they can be accessed more than once if there is scope for positive outcomes. Respite, however, to achieve its objective of supporting informal carers and thereby help avoid the need for residential care (as well as supporting community preferences to live at home for as long as possible), should be available on an ongoing basis, although accessed periodically.

   Moreover, the need for carer respite is more likely to parallel an older person's need for personal care and nursing care. Accordingly, this suggests that respite should be funded as an ongoing individual budget. A case can also be made in a demand-driven system that respite funding could be included in the 'personal care and nursing care' stream.

   An ongoing individual budget however raises the practical problem of assessing what form of respite is to be funded in each case, noting that the unit cost of different respite types varies considerably, as do current price controls and subsidies for different respite types. Different respite types also often each fulfil different objectives.

   There is also a question mark over whether the 'investment' stream should be a separate stream in residential care, or whether it is included in the 'personal care, nursing care and allied health' stream. The primary focus in residential aged care will be ongoing maintenance of mobility and strength, which is intrinsic to wellness, rather than short term restorative care. There is also questionable relevance of respite for carers when those needing care are permanent residents of residential aged care services.

5) It is unclear whether each older person's subsidy entitlement under the 'personal and nursing care and allied health' stream would be unique based on a care plan, as in theory happens in the NDIS, or whether a needs-based/frailty classification system will be developed which is agnostic of setting and which would assign older people to funding levels. There would then be flexibility in care plan preparation, ranging from a 'centre' case manager or preferred provider, through to contracted private

care coordinator or self-management. One option is to adapt and align the AN-ACC classification system being developed for residential care to older people receiving care in other settings.

6) The design does not explicitly address the regulation of fees for additional services, and whether setting would have implications for regulation in this area. The proposed redesign presents the opportunity to introduce greater regulatory certainty in this area based on increasing the scope for service providers to respond to local community preferences.

7) The current CHSP has an important role in supporting the development of 'social capital' in local communities by funding organisations to operate social inclusion services for older people. The program design ideally should make provision for continued government support for such services, but these services should be subject to greater quality and performance monitoring.

A Variation on the Proposed Redesign

Drawing heavily on the proposed program redesign in the Consultation Paper, addressing the issues identified in the dot points above, and putting funding, financing and sustainability aside, Catholic Health Australia has developed an expanded redesign for a future aged care system which is presented below for the Commission's consideration. The primary adaptation is to make explicit provision for residential care essentially within the proposed three separate funding stream structure.

The modified three funding stream structure is described at Attachment A.

IN-REACH PRIMARY AND SPECIALIST HEALTH ADVICE AND SERVICES

Access by older people receiving aged care and support under a dedicated aged care system to Medicare hospital and community health services is a relevant consideration under any program design when the aged care system operates within an overall health and hospitals sector characterised by overlapping Commonwealth/State service delivery and funding responsibilities, supplemented by private service provision.

Older people receiving aged care and support, regardless of whether they live in a 24/7 aged care home or in their own home, or in any other form of congregate living arrangements, have the same right to Medicare services as any other member of the community. The aged care and support system is not funded to provide the full range of Medicare services, nor would it be an efficient use of resources to plan for this to be the case.

The fact is that the Commonwealth/State divide in the provision and budgeting for Medicare services means that access to Medicare services, especially for residents of aged care homes, is problematic and inconsistent. There are examples of effective cooperative approaches at the local level in some locations, but this tends to be the exception rather than the rule. Also, as older people are given more opportunity to remain living in the community while receiving aged care and support, the capacity of the Medicare system to cater for this population will need to improve.

However, given the poor track record of Commonwealth/State cooperation, and while the bifurcated health system continues to exist in Australia, Catholic Health Australia considers that the Commonwealth should explore separate and dedicated funding arrangements, which it controls, to service residents of aged care homes. A recently introduced example of this approach is the provision of mental health services for residents of aged care homes through Commonwealth funding of Primary Health Networks.

The Commonwealth already separately funds the provision of certain services, such as GP and Nurse Practitioner services, specialist dementia services and mental health services. As well as improving the availability and reach of these services, similar arrangements are needed for other health services such as specialist palliative care and dental care. A model of primary care that uses blended payment arrangements and multidisciplinary teams that is suitable for the care of older people with multiple chronic conditions, and which could be further developed and expanded, is the Commonwealth's Health Care Homes program. The model could be expanded to apply irrespective of accommodation setting.

The proposal that the 'entry-level support' stream will operate across all settings will assist lower means residents of aged care homes with meeting transport costs should they require specialist or other medical services.

DIVERSITY AND ACCESS IN RURAL AND REMOTE AREAS

Catholic Health Australia agrees that a combination of approaches is needed to encourage the availability of aged care services that meet the diverse needs of certain groups and individuals, including:

- recurrent and capital funding to meet the differential costs of service provision where they exist,
- services that address communication and other barriers, including information and guidance on accessing services that meet individual needs, such as appropriately staffed 'contact/information/case management/assessment centres' and interpreter services,
- programs that enhance the understanding of the role of cultural issues associated with particular groups, and
- flexibility and incentives in a more competitive service model for providers to develop services that cater for particular groups (rather than the current flawed process of conditional allocation of rationed licences where monitoring of compliance is impractical).

Ensuring access to aged care services in rural and remote locations, and thin markets generally, requires modification of the architecture of aged care services designed for the more populated areas of Australia. Modifications include:

- recurrent and capital funding that recognises the additional cost of service delivery in rural and remote locations, including the lack of scale in such locations,
- service models that seek to ameliorate the impact of the lack of scale, such as block funding and pooled funding, including Multi-Purpose Services, and
- specific measures to train a local workforce as well as attract and retain clinicians, such as remoteness loadings and staff housing, which are extensively used to support other primary care services in rural and remote locations.

It has to be noted, however, that few of the above measures, if any, are new to the aged care debate, and the current system already includes modifications to the mainstream system to cater for rural and remote requirements. The question is their comprehensiveness and effectiveness, and the need for adequate funding.

FINANCING ARRANGEMENTS

Aged care funding and financing issues are addressed in the Aged Care Funding Authority's recent reports, including in its submission to the Royal Commission and its report on attributes for sustainable aged care.

Funding and financing issues, including the fairness of older peoples' contributions, have also been addressed in reviews such as the Productivity Commission Report *Caring for Older Australians* and the *Legislated Review of Aged Care 2017,* and Aged Care Financing Authority's submission to the *Legislated Review.*

The fundamental issue, which the Consultation Paper acknowledges, is that additional revenue sources will be required to fund the additional expenditure that will be required to improve the quality of aged care services, both now and into the future, which the Interim Report has already indicated as being unacceptable. An essential starting point for taking the public debate forward would therefore be to have a costing of potential reform measures so that the scale of cost increases is known and can be judged against the potential benefits. That said, as noted earlier in this paper, the absence of a methodology and data to reliably estimate future demand will constrain assessment of the sustainability of alternative designs.

The options for sourcing additional revenue, either implemented individually or in combination, that have been previously identified (formally and informally) include: increased and fairer contributions by older people that balance capacity to pay; Budget funding within ongoing tax revenues and in competition with other national priorities; dedicated funding through an increase in the Medicare Levy, as was done for the NDIS; or, in the longer run, a regime of compulsory saving for aged care needs. It is likely that increased taxes will not have community support, and that some combination of increased Budget funding and fairer contributions by older people, and reforms that can be accommodated within future Budgets, offer the best prospect.

Of course, the program redesign and the other foreshadowed reforms to improve the quality of aged care services will be academic if new revenue sources acceptable to the community cannot be found, or the reforms are not tailored to available revenue.

QUALITY REGULATION

The new Aged Care Quality Standards have been designed to apply across all aged care settings, including home-based care.

A priority going forward is to ensure that the new Standards are effectively applied and administered and that the foreshadowed improvements to the quality regulatory framework, such as the Serious Incident Response Scheme, performance rating, Clinical Indicators, Consumer Experience Surveys, regulation of inappropriate use of physical and chemical restraints and medication reviews, are developed and effectively implemented.

To the extent that the quality regulations are used for services in non-residential aged care settings, the principle that should apply is that the level of regulation, including in relation to approved provider and compliance reporting arrangements, should be proportionate to the level of risk associated with the service. Catholic Health Australia understands that the NDIS and the new Aged Care Standards both have regard to this principle. The quality regulatory framework for non-24/7 care settings will also need to take into account that the care provider is not being funded to deliver fulltime care and support.

The provision of personal care, nursing care and allied health services that are agnostic of setting, and the potential for innovation in congregate accommodation for older people, raises questions about the appropriateness of building design. Residential aged care homes are currently required to comply with the Building Code of Australia standards for Class 9C Buildings which are designed for people with varying degrees of incapacity, including needing assistance to evacuate the building in an emergency.

The applicability of the current Building Code of Australia standards to innovative accommodation for older people, including a variety of congregate living settings, will require review.

TRANSITION AND IMPLEMENTATION

Catholic Health Australia concurs with the Consultation Paper's statement that any major redesign of the aged care system will involve complex and interdependent change affecting older people, providers, the aged care workforce, different levels of government and the broader community, and that implementation of reform has to be carefully managed. However, financiers and investors must be added to the list as well.

Catholic Health Australia would also contend that the risks entailed in major reform should be weighed against the potential benefits of pursuing that reform. There may be cases where the risks and costs of particular reforms outweigh potential benefits.

Noting that there is currently no reliable way to estimate future demand for aged care services to inform the overall cost and sustainability of program redesigns, future program design and transitional arrangements will need to be adaptable to emerging demand, cost and sustainability data, including making provision for a phased removal of supply controls.

Catholic Health Australia notes that the Royal Commission will be carefully considering implementation and transition issues in the months ahead.

Catholic Health Australia
24 January 2020

CATHOLIC HEALTH
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ATTACHMENT

Design Features Under Proposed Setting Agnostic Funding Streams	Comments Relating to Residential Aged Care
Entry-level support service stream	
<u>Entry-level support service stream (domestic assistance, social support, transport, minor home mods and assistive technology)</u> • Independent eligibility assessment by 'contact/information/case management/assessment' centre. • Individual budget, debit card and choice of service provider(s). No funds pooling. Limitations on service types that can be purchased with debit card. Capacity to purchase additional services privately. • Standard individual budget (subsidy) amount. Only age pensioners eligible, but subsidy amount scaled for part pensioners. • Setting agnostic and ongoing, subject to 'investment/restorative care' outcomes. • Uncapped supply – demand driven • Choice regarding degree of self-management, ranging from management by case manager in 'contact/information/case management/assessment centres' through to self-management. Case management option (including care planning) for vulnerable people. Would also assess for services outside the aged care system. • No set prices for individual services as there is already a private market – price controls do not apply for non-pensioners and the wider community – but may have market informed price caps to assist case managers	• Older people would have choice to access preferred purpose-built (9C) and accredited residential care service with 24/7 nursing care on site, where means tested accommodation supplements would apply. • A basic daily fee would continue for living expenses. • Funds on the 'entry-level support' stream debit card may be used to purchase additional services from the approved provider or externally eg transport, social support • Self-funded retirees would similarly have the option of fees for additional services, with minimal or no cross subsidisation of lower means residents. Each residential provider would have flexibility to tailor their service offering according to local preferences. • Residential providers may target high needs residents (palliative care and severe dementia), but also compete with home care providers by offering superior quality of life (socialisation and companionship, security, better amenity, ongoing wellness programs, 24/7 care).

• Scope to continue to block fund service providers such as Meals on Wheels, but fee regimes would apply. • Financial support program for community organisations providing senior's related social capital/social inclusion activities.	
Investment stream	
<u>Respite and restorative care (allied health and therapy), including STRC and Transition Care, and more expensive home modifications and assistive technology.</u> • Restorative and respite care and home modification/assistive technology needs individually and independently assessed by 'contact/information/case management/assessment centres' - respite assessment to focus on needs of informal carer • Restorative care is short-term, with more immediate goals; carer respite needs are ongoing and increase as personal and nursing care needs of person being cared for increase. • Assessment centre controls restorative care, home modifications/assistive technology budget and purchases services/or directs people to contracted restorative care services (STRCs) and suppliers. • Needs based budget for 'investment' stream, but no fees applicable for restorative care as an incentive to participate. • Means testing would apply to home modification/assistive technology and respite. • Individual budgets for respite care, with choice regarding degree of self-management, including management of individual budget by 'contact/case management/assessment centre', by preferred provider or self-manage. • There is a case for including respite in a demand-driven system design in the 'personal care and nursing care' stream given the relationship between carer respite needs and increased personal and nursing care needs of the older person.	• A separate' investment' stream would not apply in residential care – carer respite no longer applicable for permanent residents and ongoing allied health and therapy for maintaining mobility and strength can be integrated with the 'care' stream subsidy. • While residents could choose to use the debit card to purchase additional wellness and social inclusion services (from residential provider or externally), the expectation would be that personal and nursing care funding for residential services would include wellness and restorative care services, and be subject to annual independent and transparent costing studies that would include wellness services, consistent with the new Quality Standards.

Personal care, Nursing Care and Allied Health Stream	
<u>Personal care, nursing care and allied health</u> • Individual independently assessed budget by single assessment workforce operating from 'contact/information/case management/assessment centres', linked to needs-based classification levels; same debit card as for 'entry level support' services applies. • Needs classification system for determining subsidy entitlement, which would align with AN-ACC in residential care. • Subsidy entitlement based on efficient cost of care delivery in defined 24/7 'residential care' setting. • Service prices set in competitive market, but published for ease of comparison. • Ongoing allied health and therapy services included ie. for mobility and strength maintenance etc • Choice regarding degree of self-management, including management of individual budget and care planning by 'contact/information/case management/assessment centres', by preferred provider or self-manage. • Individual budget subject to 'investment stream' outcomes • Uncapped supply – demand driven • Same means test across all settings, including hardship provisions	• Current basic care subsidy in residential care applies, which would include the investment stream services • AN-ACC used to classify residents • Cost of care in residential care informed by annual independent and transparent cost of care studies. • External assessment of individual care subsidy entitlement (new model to replace ACFI) as part of 'contact/information/case management/assessment' centre • Providers would have the option to 'pool' assessed care subsidies/individual budgets or offer invoicing by usage, along with invoiced fees for additional services. • Existing care supplements dealt with as proposed for new funding model to replace ACFI

Daily Living Expenses	
• Privately funded (age pension, income, superannuation, savings) in non-residential aged care settings.	• The basic daily fee for living expenses (85% of the single age pension) would continue, with capacity for residents/families to purchase additional services for a fee, either privately or using the 'entry-level support' stream debit card.
Accommodation Subsidy (Means Tested)	
• Accommodation supplement does not apply in settings other than in purpose-built defined residential aged care settings; alternative settings may include public housing and affordable community housing for older people.	• Definition required to establish which settings would qualify for receipt of accommodation supplements for means tested residents – eg. purpose-built Building Code of Australia 9C aged care homes. • Capacity for 'residential care' to compete with home-based care eg offering socialisation, companionship, security, wellness services, 24/7 care, with flexibility to pursue innovation in accommodation and care models.
Regional Contact/information/case management/assessment centres	
• Capacity for 'contact/information/case management/assessment centres' to offer face-to-face guidance and assistance, including system navigation assistance, arranging eligibility and needs assessment and case management assistance with care planning and management of individual budget, depending on each older person's/family capacity to manage on their own or care planning by preferred provider. • System navigation and any case management is independent of service providers and assessment for subsidy entitlement. • Assessment for subsidy entitlement independent of both service providers and navigation/case management function, but latter could be co-located for the convenience of older people and their families. • Centres would focus on the needs of both the older person and their family carer.	• Assessment based on AN-ACC • Care planning done by provider

• Choice regarding level of self-management. Care planning by the centre for those who choose this option, otherwise self-management or care planning by preferred provider. • Case management would also assess for, and link, vulnerable older people to services outside the aged care system, as appropriate. • Multi-disciplinary assessment teams • Older people could refer back to 'centre' for guidance and support at any time as needs and circumstances change. • OPAN would continue to operate across all aged care settings.	