INITIAL ANALYSIS OF THE AUSTRALIAN GOVERNMENT'S AGED CARE REFORM PACKAGE IN RESPONSE TO THE PRODUCTIVITY COMMISSION REPORT *CARING FOR OLDER AUSTRALIANS*

SUMMARY

The Government's response to the PC Report involves a package of reform measures with an estimated cost of $3.7b[1] over five years. As elaborated on below, much of this spend is covered by the redirection and reprioritisation of funds that were already in the Budget forward estimates, increases in user pays and savings through providing more care through home care. In the absence of Budget cuts, funds in the forward estimates would have flowed to the sector for service delivery and service improvement. New Budget funding contributes only $577m to the cost of the package, 72% of it in the period 2015-17.

The package has many elements, as outlined in the body of this paper, so it is difficult to summarize. But in brief, the package:

- increases user contributions but excludes the family home from the means test for home care ;
- increases the supply of age care services but stops short of entitlement based on assessed needs;
- increases the opportunity for people to receive care at home through more Home Care Packages;
- continues the balance of care ratios, Age Care Approval Round (ACAR) processes and licences;
- embeds consumer directed care (CDC) principles in all home care packages, with the intention of trialling CDC in residential care;
- creates a Home Support Program by combining HACC and existing Commonwealth community programs such as respite and day therapy programs, with the intention of putting a greater emphasis on prevention and reablement and a consistent fees policy after 2015;
- improves access to services by the creation of a Gateway;
- introduces choice of fully refundable lump sum payments or rent for all residents;
- increases the accommodation payment for supported residents in new or redeveloped homes to $50/day (2012 prices);
- recalibrates scores and/or payment levels within the ADL and Complex Health Care domains of the ACFI to reduce the rate of growth in care subsidies;
- redirects $1.6b of the ACFI 'blow out', with $1.2b of it to be used to improve terms and conditions for the aged care workforce under a (to be negotiated) Workforce Compact;
- creates an independent pricing authority to make recommendations to Government on subsidies and payments and to approve prices for accommodation and optional extra services;
- includes a number of measures to improve care for people with dementia, increase support for carers and improve palliative care;
- includes a number of measures to improve services for people from diverse and marginalised backgrounds, including rural and remote communities;
- creates a new statutory authority (the Aged Care Quality Agency) which will accredit and monitor residential and home care providers, while retaining DoHA's role with the Complaints Scheme and compliance and sanctions;

[1] References to costs in this document are over five years, unless otherwise stated.

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- establishes a Data Clearing House in the AIHW to support research and policy development; and
- creates an Implementation Reform Council to guide the implementation and further development of the reforms.

The various elements of the package will be phased in over a ten year period (by 2022), with many measures starting or ramping up significantly after 2014 and 2015.

The funding sources for the measures are as follows:

	$m
Redirected ACFI 'blow out' funding ……..	1,592
New Budget funding……..	577
Increased user contributions……..	561
Savings from the transfer of resi places to home care packages……..	454
Redirection of funding for the Long Stay Older Patients Initiative……	187
Transfer of resi and home care funding to fund dementia initiatives……	153
Reallocating existing call centre/front end funding to the Gateway……..	123
Transferring resi places to create 200 new flexible Indigenous places……	44

The main source of the redirected funding is the larger than budgeted for expenditure on residential care subsidies under the ACFI. When DVA funded age care homes are included, the 'blow out' over the four year forward estimate period 2011-15 was $2.3b. The updated forward estimates for the four year period 2012-16 included an estimate for the 'blow out'. The Minister achieved Cabinet agreement to redirect $1.6b of the 'blow out' to fund elements of the reform package. The balance of the 'blow out' remains in the Budget forward estimates for ACFI ie 100% of the 'blow out' has been retained, and none has been returned to Consolidated Revenue.

The bulk of the redirected $1.6b is to be used to cover the cost of the package's most costly component ie the $1.2b allocated for addressing workforce pressures by improving terms and conditions of employment of the workforce over the next five years through a Workforce Compact. The payment will take the form of a Conditional Adjustment Payment. The balance of the retained ACFI funds ($0.4b) went into the pool to help fund the other measures in the package, including an increase in the accommodation supplement for new or significantly refurbished homes ($489m) and for continuing the increased viability supplement ($108m).

In the absence of Budget cuts, the $1.2b would have flowed to providers who would have had flexibility as to how it was used eg higher wages, additional staff, repairing balance sheets etc. Under the Compact, and subject to enterprise agreements that are struck, it is expected that most of the funding will be directed to increased wages, though there is reference to also supporting wider workforce development through an Aged Care Workforce Strategy developed under the Compact. While the increased wages will be funded during the five year period of the Compact, the recalibrated ACFI will deliver less funding than it otherwise would have. It will therefore be critical that the 3.5% CAP on top of ACFI continues beyond the life of the Compact. It will also critical that the Aged Care Financing Authority, when recommending subsidies and payments, is required to take into account the need to pay competitive wages.

In short, a large part of the retained ACFI 'blow out' funds will be used to fund the Compact which is designed to achieve improved terms and conditions of employment for the existing workforce, including to help bridge the wage gap with health sector nurses and the higher wages that will gradually apply under the SACS Award. The Minister has referred to the Compact as 'bridging' funding for improved terms and conditions pending the ACFA processes.

The main departures from the Productivity Commission's recommendations are as follows:

- The Government has rejected entitlement based on assessed care needs. While increasing the overall provision ratio, the Government has retained rationing and balance of care ratios and the associated regulations such as the licensing of places and the ACAR, and has increased price regulation. Consumer choice of provider and whether care is received at home or in an aged care home will continue to be constrained, but less so as supply increases and unmet need is reduced.

- While there is a commitment to establish a Gateway, its scope is unclear, including whether it will be as broad as that envisaged by the Commission and NACA. Only $75m of new funding has been allocated and significant emphasis has been placed on a web site development.

- Care subsidies and fees across residential and home care will not be aligned. The ACFI will continue to apply only to residential care (though further work to develop a comprehensive ACFI for residential and home care is foreshadowed).

- The renamed HACC program (Home Support Program) will remain block funded and will incorporate existing Commonwealth community care programs such as the National Respite for Carers Program and Day Therapy Centres. Review and development work will be undertaken in the period prior to July 2015 on issues such as including a preventative care and reablement emphasis and developing a consistent fees policy.

- A comprehensive wealth test will not apply in home care ie the family home has been excluded.

- Means testing arrangements for care in residential care and home care are not aligned. An income test will apply in home care whereas a combined income and assets test will apply in residential care. Means testing arrangements have not been simplified.

- The Government has rejected a Government-backed Home Equity Scheme and the Pensioners Savings Account on the basis that it does not want to create 'Australia's biggest bank' and their need is reduced because care at home will only be income tested. The Government instead has put its faith in the private equity release market for which it has recently legislated to strengthen consumer protections. If people do not make greater use of private equity release schemes, an implication of the increased user contribution regime is that more will be likely to have to sell the family home to meet their payments.

- There is no refinancing facility for bond-dependent providers to cope with any significant consumer switch to rent, especially in the absence of a low cost (CPI) home equity release scheme.

- The Commission's recommendation for a single regulatory agency separate from DoHA (an Australian Aged Care Commission) was rejected. Instead a new statutory authority, the Aged Care Quality Agency, will be created to accredit and monitor both residential and community age care providers. It will subsume the Aged Care Standards and Accreditation Agency. The Complaints Scheme and regulation around compliance and sanctions will remain with DoHA.

Other noteworthy points:

- Commercial reverse mortgage or equity release schemes will charge commercial rates of interest which may reduce the incentive to pay by lump sum compared with the low cost (CPI) Home Equity Scheme proposed by the Productivity Commission. Provider target rates of return are still likely to exceed the cost of equity release schemes, which should still make lump sum payments financially more attractive than rent for the 'rational person', but significantly less so than the lower cost Home Equity Scheme (with the spread falling to around 3%).

- It is unclear how independent the ACFA will be from DoHA and how transparent it's processes will be. Arrangements for the ACFA, including costing principles that it may be required to follow, will be critical for the viability of the sector. This relates to both its recommendations to Government about subsidies and payments and its role in regulating prices for accommodation and optional extra services. In the development of this measure, the Implementation Council will need to ensure that onerous and restrictive red tape is avoided and that commercial costing methodologies apply.

  There is also a concern that a $50/day (in 2012 dollars) accommodation supplement together with price regulation by the ACFA will constrain the potential for cross subsidisation, and may result in inadequate revenue to sustain new developments built to contemporary standards. A flat $50/day supplement also does not recognise regional cost differences, and is intended to support 'a basic standard of accommodation'. It will be important that in approving accommodation prices for non-supported residents, the ACFA takes into account regional differences, and has regard to the preferences of the local market concerning standards of amenity so that the prices reflect the underlying value of accommodation which meets those standards. Cross subsidisation, albeit on a lesser scale, seems inevitable.

- The implications for providers who already pay above average wages of the Workforce Compact and associated enterprise bargaining arrangements will have to be carefully considered. Equity issues will need to be dealt with. The balance of effort under the Compact between improved terms and conditions of employment and wider workforce development measures will also need to be carefully considered during the negotiation of the Compact.

- The Implementation Reform Council will have a crucial role in developing the detail around the measures in the package. As well as the points noted above, other points that will need to be carefully considered by the Council include the criteria for 'significantly refurbished' to qualify for the increased accommodation supplement, the development of the quality indicators, the scope of the Gateway and the rebalancing of the balance of care ratios.

- It is noteworthy that in the supporting document *Living Longer. Living Better. Aged Care Reform Package. April 2012,* the Government states that consideration will be given after year five of the package (2016-17) to further reforms along the lines of the recommendations of the Commission and NACA in relation to an entitlement based system linked to assessed need, removing controls on the number and mix of places and greater integration of community and residential care.

  Also, in its document which responds to each of the Productivity Commission's recommendations, the Government states that there will be a significant review of the reforms after five years, and the one of the roles of the Aged Care Implementation Council will be to oversee the implementation of the 10 year plan.

  It is disappointing that the Government did not at least give in principle agreement to an objective of entitlement based on need and the removal of supply restrictions, but these statements suggest that there is an intention to build on the reforms in the current package, which in turn have built of the reforms of past years. Future Governments need to be aware that the sector will not waver from this objective.

THE MAJOR REFORM MEASURES

MEASURE	TIMING	COST $M	COMMENT
ENTITLEMENT, ACCESS, CHOICE AND CONTROL			
Increase in the provision ratio The package provides for a gradual increase in the overall provision ratio over ten years from 113 to 125 places per 1000 people aged 70 and over, resulting in approximately 400,000 places by 2020-21. The Home Care Package ratio will increase to 45 by 2021-22 and the residential ratio will decline to 80.	Implemented by 2020-21		The Government did not accept the PC and NACA recommendations that age care should transition to a needs based entitlement system like Medicare, including individual choice of provider and where the entitlement is used. Instead the package provides for an increase in the overall provision ratio and a shift in the balance of care ratios in favour of Home Care Packages (HCPs) in response to perceived consumer preference (see further below), and a continuation of the current ACAR and system of 'place' licences. The residential ratio is expected to reduce to 85 by 2016-17 and 80 by 2021-22, but total residential places are expected to increase from 191,500 currently to 257,000 by 2021-22. The significant increase in HCPs does not start until 2014-15. Documentation issued as part of the package indicates that after 2016, as the supply of places increases and unmet need is reduced, 'consideration would be given to removing controls on the number and mix of places, in conjunction with a fully integrated funding and classification system for community and residential care'. The continuation of ratios and provision caps means that all of the regulation required to administer a rationed system will be maintained and enhanced in relation to price controls through the operation of a new Aged Care Financing Authority (see below).
There will be a review of the current planning regions to integrate the current ACAR and HACC regions.	2012-13		

Gateway A Gateway system will be created to be the principal entry point for aged care services and to provide clear and reliable information (including prices), based on a *My Aged Care* website, a national call centre and a national assessment framework. The Gateway will not involve investment in new local infrastructure to establish a physical network, 'the need for which will be carefully monitored over time'.	Phased in over several years, with the first release of the website in early 2013.	198	The package only allocates $75m of new funding for the Gateway. Builds on work already underway to improve the 'front end' as part of the Commonwealth takeover of ACATS. Unclear whether the scope will be as comprehensive as envisaged by NACA and the PC. Likely that the Gateway will be based on the current ACAT system and CARELINK/NRCP Centres. The Government's response envisages that in time the ACFI will be revised to make it more easily applied by independent assessors, with the function moving to the Gateway. It is not clear whether this applies to initial or assessment at threshold points only, but this change is seen as a building block for an entitlement system. Extending the arrangement beyond initial and threshold points would be highly impractical. The Implementation Council will need to be closely involved in the development and implementation of this measure to ensure that the objectives of the PC and NACA recommendations are achieved.
Consumer Directed Care (CDC) Building on the CDC trials, CDC principles will be embedded in all new Home Care Packages (the new name for community care packages) from July 2013, with a view to 'possibly' requiring CDC to be available in all community care places from July 2015. A pilot program will be conducted to test whether CDC could be applicable in residential care.	Ongoing 2012-14	65	This measure represents further development in the light of the current CDC pilots and their evaluation.
Improving choice in purchase of extra amenities in residential care There will be two levels of additional charges for amenities and hotel services above the basic specified care and services, and the discontinuation of the current 25% 'clawback' which applies to extra services – *optional extra services* such as food and entertainment services and *dedicated extra services* which apply in a wing or entire service (effectively the current Extra Service).	July 2014		This measure responds to the discontinuation of the primary distinguishing factor for Extra Service ie the ability to seek lump sum deposits for high care residents, which created a mechanism to allow people to choose and pay for additional services and amenities. It seems that this measure does not apply to additional care services, such as additional physiotherapy.

There will continue to be a cap on Dedicated Extra Service places and prices will be 'considered' by the Aged Care Financing Authority. The cost to the Budget of removing the 'claw back' is $65.4m. <u>*Supported Resident Ratio Obligation*</u> The Aged Care Funding Authority will review the current measures to protect access for supported residents, including the supported resident ratios that apply in each region and the current 'penalties' that apply to providers that fall below the 40% threshold.			The continuation of rationing drives the need for price regulation. In the longer term, it is proposed to apply similar arrangements to Home Care Packages, noting however that it is not unusual at present for community care recipients to pay for extra services ie this practice may be regulated in future. The Government's response supported in principle the Commission's recommendations to modify these arrangements which would have made them fairer and more effective. With the continuation of rationing, the sector will need to take a close interest in the review that is to be undertaken.
STAYING AT HOME <u>*Home Support Program*</u> A new Home Care Support Program will be developed by the integration of HACC, Day Therapy Centres, and the National Respite for Carers Program and ACHA. The new Program would have an emphasis on prevention and reablement in the medium term. When the HACC takeover was negotiated, the Commonwealth gave a commitment to HACC providers and relevant States that it would not make any significant changes to HACC until July 2015. <u>*More Home Care Packages*</u> The provision ratio for Home Care Packages (HCPs) will increase gradually from 25 to 45 by 2020-21, or from 59,900 HCPs currently to about 140,000.	Changes will be gradually rolled out from 1 July 2015. Increase starts with the next ACAR.	75 880	A logical extension of the Commonwealth takeover of HACC, though the implications for services in Victoria and WA are unclear. Will remain a block funded program for the foreseeable future. The period prior to July 2015 will be used to review the current HACC service types, including with a view to maximizing preventative and restorative care options; develop processes to benchmark service provision and derive unit costs as a basis for encouraging greater competition in future; and to develop uniform arrangements for charging fees. HACC recipients who currently receive funding comparable to packages will in future receive HCPs. The proportion of Home Care Packages will increase from 22% currently to 36% by 2020-21.

Around 4,900 new HCPs and 7,500 resi places will be advertised in the 2012-13 ACAR. There will be four levels of HCPs, Levels A,B,C and D, with the highest level (Level D) being the current EACH. Level A will be a new (and lowest) level and the current CACP will be Level B. EACHD will be replaced by a new Dementia Behaviour Supplement (10% of the value of the package). The annual values of the levels will be around $45,000 for Level D, $30,000 for Level C, $15,000 for Level B and $7,500 for Level A.	New Level A and C piloted 2013-15		The Implementation Council will need to closely monitor the re-balancing of the provision ratios to ensure that they are in line with consumer preferences and that they are phased to reduce the risk of instability in the system. The substantial increase in Home Care Packages does not occur until 2015-16 when 18, 212 packages will be advertised (compared with an annual average of 4,500 packages prior to then). The creation of the new levels fall of an entitlement system which spans care in resi and home care. The new levels are nevertheless an improvement, especially if they are viewed as a transition measure.
<u>*Support for carers*</u> The National Respite for Carers Program, which will be integrated into the new HSP, will be expanded to support an additional 5,000 persons per year.	Carer measures phased in from 2012-13.	37	The measures provide for streamlining the different respite programs from July 2014, standardising assessment and exploring flexible ways of delivering respite care to give people more choice and control.
The National Carer Counselling program will be expanded to provide support for an additional 1,500 carers per year.		5	
A new network of Carer Support Centres will be established to broker emergency respite and provide information, education and counselling and referral services.		11	
RESIDENTIAL CARE <u>*Accommodation payments*</u> The maximum level of the accommodation supplement will increase from $32.58 per day currently to $52.84 per day from July 2014, but will only apply to homes 'built or significantly refurbished' after 20 April 2012.	1 July 2014	487	The criteria for determining 'significantly refurbished' will need to be developed and carefully considered. Under existing policy, the supplement is indexed to CPI. The Government did not support the payment of different rates in

			different regions 'at this time' because it would result in higher subsidies going to wealthy areas where there is greater scope for providers to ask higher prices. We need to ensure that this perspective is carried through to ACFA's approach when approving prices for non-supported residents, especially as the $50/day accommodation supplement only provides a basic standard of accommodation.
Removal of low/high distinction The low/high distinction will be removed and residents will have the choice of paying for their accommodation through a fully refundable lump sum payment, rent or a combination of both.	1 July 2014		This measure extends a uniform accommodation payment regime across low and high residential care, including extending lump sum payments to non-extra service high care. The treatment of the family home for means testing purposes will remain as it currently applies ie the home remains exempt if it is occupied by a spouse or other protected person. It also means that bonds in mainstream high care will not apply until after the next election, which leaves it open for the Opposition to campaign against this measure in its election platform (though they have not shown any inclination to do so to date). As the increased capital funding by extending the new arrangements is not guaranteed to flow until 2014, there is some risk of under subscription again for residential places in the next ACAR. The package seeks to address this by allocating a high proportion of places to community care (in line with a major objective of the reforms) and maintaining the residential places at about the same level as that for places allocated in the 2011 ACAR (and again depend on the greater flexibility in ESS to deliver sufficient quality applications). For most people, a lump sum or rent will still have to be drawn from the value of the family home, either as a result of sale or through a commercial equity release scheme. The Government has recently legislated to increase consumer protections to guard against negative equity.

			A review of Specified Care and Services will be undertaken by the Aged Care Financing Authority so that a single set of requirements will apply across all residential care from 1 July 2014.
Providers will need to seek the approval of a new Aged Care Financing Authority for the level of the accommodation payment that they charge. Providers will not be allowed to choose between residents on the basis of how that person intends to pay for their accommodation, and residents will not need to decide how they intend to pay for their accommodation until they have entered care and are protected by the security of tenure arrangements. There will also be a 'cooling off' period to allow people time to decide.	1 July 2014		The Authority will reside within DoHA. Pricing controls are the result of the continuation of rationing. The Implementation Council will need to be heavily involved in developing the detail of the regulatory role and operating procedures for this agency as it will have significant implications for the viability of the sector and regulatory costs. The duration of the 'cooling off' period is still to be decided. Cash flow implications will need to be addressed.
<u>*Requirement to insure lump sum deposits*</u> Providers will be required to insure any lump sum payments that they receive after 1 July 2014.	1 July 2014		This measure is a variation on that which was recommended by the Productivity Commission, which recommended that the Commonwealth should directly charge a fee. Providers will be expected to pass on the cost to residents.
<u>*Regional, rural and remote services*</u> Additional viability funding will be provided to providers operating in remote locations or who provide services to Indigenous Australians and older people who are at risk of homelessness. The two existing capital grant programs will be combined and given greater flexibility to target priority areas, including rural and remote areas and disadvantaged groups. The combined program will have $51m (indexed) to allocate annually.	1 July 2012	108	This measure provides funding for the continuation of the 40% increase in the viability supplement which was first introduced in the 2009-10 Budget, but whose funding authority expires at the end of 2011-12. There is no provision for ZRILs beyond the $150 m that remains to be allocated. The Government's response also indicates that the ACFA will take into account the higher cost of delivering services in rural and remote areas and for Indigenous communities, including the level of viability supplements.

MEANS TESTING *Home Care Packages* A new income tested fee will apply to Home Care Package recipients on top of the current maximum basic fee of 17.5% of the pension. Depending on income, the annual income tested fee would average $2,200 for a part pensioner and $8,800 for a self-funded retiree. Pensioners would continue to be liable to pay the current maximum basic fee (currently $3,163 pa). Existing Home Care Package recipients will not be subject to the new arrangements while their current 'episode of care' continues.	1 July 2014	-183	As currently is the case for residential care, Centrelink will administer the means test (DVA administering the test for veterans). The average basic fee currently levied by providers is less than 17.5% (about $1,800). The Commonwealth will achieve the saving by reducing future payments to providers by the income tested fee, similar to the arrangement that applies in residential care. The Commonwealth will assume that all providers are collecting both the income tested fee and the full basic fee, even though some have not been collecting the latter in full or, in some cases, not at all. Co-contributions for care in the home will not be subject to the comprehensive wealth test (which includes the family home) that was recommended by the PC. The means testing arrangements that will apply for care delivered in the home and in an aged care home will not be the same. This measure will reduce the Government's share of Home Care Package costs from 84% to 76%.
Residential care Means testing arrangements in residential care will be revised to combine current income and assets tests to address the anomaly that results in asset-rich/income-poor paying for all of their accommodation and nothing for care, and income-rich/asset-poor residents paying for their care but not their accommodation. The means test will operate so as determine eligibility for any accommodation supplement in the first instance, and then proceed to assess the impact of care fees.	1 July 2014	-378	With the removal of the low/high distinction, the combined means test will apply to all new residents. This change will reduce the Government's share of residential care costs from 65% to 61%. Respite care in an aged care home will continue to be exempt from means testing.

For single residents with assessable assets below $44,000 (2014 prices) ie **income rich and asset poor**, the income threshold at which the resident would not qualify for any accommodation subsidy is $63,905. The income threshold at which the resident would be required to pay $25,000 in care fees (the annual CAP and assuming their cost of care reached this level) is $113,905. For single residents with assessable income below $25,440 ie **income poor and asset rich**, the value of assessable assets at which the resident would not qualify for any accommodation subsidy is $153,905 (noting that the first $153,900 of the family home is not exempt CHECK). The value of the assessable assets at which the resident would be required to pay $25,000in care fees (the annual cap and again assuming their care costs reached this figure) is $1.5m. <u>*Lifetime cap on care costs*</u> A lifetime cap of $60,000 (indexed) on care fees will be introduced to protect all care recipients who receive care for a longer than average period of time. Annual caps (indexed) for care costs will also apply - $25,000 in residential care and $5,000 and $10,000 respectively for part pensioners and self-funded retirees receiving Home Care Packages.	1 July 2014		The life time cap applies to care costs incurred in both community and residential care. The measure insures people against the risk of high aged care costs, which is unpredictable for individuals, and was a key recommendation of the PC to introduce a form of 'risk pooling' in lieu of introducing social insurance. By reducing individual risk, this measure should provide a stimulus for private insurance to develop products which cover aged care costs.
WORKFORCE <u>*Workforce Compact*</u> A Workforce Compact between providers and unions, endorsed by the Government, will be developed by an independently chaired Advisory Group to ensure that funding for workforce reforms leads to improvements in terms and conditions for the aged care workforce. The Chair of the Advisory Group will be appointed by Minister Shorten.	2013- 2017	1,200	Funding for the Workforce Compact will be obtained by redirecting $1.2b of the retained ACFI 'blow out' ($1.6b) on the condition it feeds into improved wages and other workforce improvements. The 3.5% increase in the CAP under the Compact will also be payable to providers of Home Care Packages, and corresponding funding will flow to Home Support program providers through variations to

The funding will be paid by way of a gradual increase in the Conditional Adjustment Payment (CAP) over four years to 3.5%, subject to providers having enterprise bargaining agreements in place 'which deliver higher wages targeted to areas of greatest workforce pressure.' The Compact will also provide for the development of an aged care workforce strategy, including to address the VET training issues identified by the Productivity Commission and to review the targeting of existing workforce development and training programs.			funding agreements. Based on the current split of resi and community care funding, about 80% of the funds is likely to go to residential care providers. The Minister has referred to this measure as providing 'bridging funding' to increase aged care workforce wages. During this 'bridging' period, the Aged Care Financing Authority will commence operations and this should see the end of prices being based on COPO indexation. We need to ensure that the Authority will be required to take into account the need to pay competitive wages, having regard to nurses wages in the health sector and movements in the SACS Award as well as the higher wages struck under the Compact. The sector will need to be closely involved in the negotiation of the Compact and the workforce strategy, including the implications for existing EBAs and for providers who are already paying above average wages.
OLDER AUSTRALIANS FROM DIVERSE BACKGROUNDS *Aged care services specific to needs of people from diverse backgrounds* Additional funding so that care providers, through staff training and access to expert assistance, can improve skills and knowledge to meet the needs of diverse populations. *National Aboriginal and Torres Strait Flexible Aged Care Program* An additional 200 flexible age care places will be made available over the next five years, mainly in rural and remote areas. *Veterans with eligible mental health problems* Additional funding to provide better services for veterans with an accepted mental condition receiving home care or residential care. *Sexual diversity* Funding will be provided to support training to help ensure that sexual diversity does not act as a barrier to accessing services.	2012-17 2012-17 2013-17 2012- 17	24.4 43.1 114.8 2.5	This funding will provide for a 33% increase in flexible places.

Older homeless The Assistance with Care and Housing for the Aged (ACHA) program will be expanded to better link older people at risk of homelessness or who are homeless to suitable accommodation and services.	2012-17	7.3	
SUBSIDIES, FEES AND PAYMENTS *Aged Care Financing Authority* A new Aged Care Financing Authority (ACFA) will be created to make independent recommendations to Government on aged care subsidies and payments and to regulate (approve) accommodation prices and fees for additional services. ACFA will 'represent taxpayers, aged care providers, consumers and aged care workers' and consistent of a committee of independent experts from industry and consumer groups as well as Government.	Established during 2012-13	About $5m per annum	It does not appear that the ACFA will be a separate statutory authority, but rather some sort of administrative entity within DoHA. The Implementation Council will need to be satisfied that the set up for ACFA will ensure its independence and transparency. The Council will also need to ensure that its price regulation role does not result in onerous and restrictive red tape and that, in considering the underlying value of accommodation, it also has regard to community preferences for amenity standards and commercial costing principles. Agreeing methodologies for determining prices, including broadly establishing 'equivalence' between a lump sum payment and rent, and for determining costs of care delivery will also be issues that will need to be addressed. Overall, the independence and transparency of the ACFA and its methodology for determining subsidy levels and administrative approach to approving prices will be central to the ongoing viability of the sector and the quality of services. As funding has been provided in 2012-13 to establish ACFA, it should be in a position to report on costs relatively soon; this suggest that the current reliance on COPO should not be needed for much longer, although some form of indexation arrangement will be needed between periodic cost of care reviews. COPO is expected to apply in 2012-13. As noted in earlier analysis, the sector will need to step up its capacity

			to engage authoritatively with costing and pricing issues. It is unclear whether residents will be allowed to pay a larger lump sum that that approved by the ACFA if this were financially favourable to the individual eg age pension implications.
DEMENTIA *A New Very High Level in ACFI Behaviour Domain for dementia* A new Very High Level of funding will be included in the Behaviour Domain to better recognize the additional costs of caring for residents with severe behavioural and psychological symptoms.	2013-14	41	The cost of this measure will be partly offset by a reduction of 30 cents per day in the High Level in the Behaviour Domain from 1 July 2013, a saving of $35. 6m over five years.
Dementia Supplement in Home Care Packages A new Dementia Supplement of 10% of the level of the basic subsidy for the care recipient will be introduced – about $4,800 pa at the highest level of basic subsidy.	1 July 2013	123.3	The cost of this measure will be partly offset by a reduction of 2% in the existing basic subsidy levels for Home Packages ($99.5m over five years) to reflect the lower average cost of caring for people without dementia compared with the current average which includes caring people with dementia. Total new money for the above two measures is $29m over five years.
Dementia Behaviour Management Advisory Services (DBMAS) and early diagnosis Additional funding will be provided to expand the scope of DBMAS to include support for people with dementia in primary care and hospitals to enable health professionals to manage people presenting with behavioural and psychological symptoms. Funding will also be provided to support GPs to make more timely diagnosis of dementia to allow the opportunity for earlier medical and social interventions.	2012-13	41.3	The early diagnosis funding will be administered as grants, and will not be reflected in any changes in MBS consultation items.

Improving acute care services for people with dementia Funding will be provided for the development and dissemination of nationally agreed principles and protocols for the management of people with dementia admitted to acute care settings.	Development commences in 2012-13	39.2	This program will have about $9m a year for its activities. It is unclear who will be funded to administer the program.
Younger onset dementia Funding will be provided to establish key workers in each State and Territory to act as a single point of contact to assist young people with dementia and their carers to access care and support services. The measure will also fund the development and dissemination of best practice guidelines and other support resources. The Commonwealth will also take a proposal to COAG for dementia to be a national health priority.	2012-13	23.6	This measure does not increase services for people with younger onset dementia, and raises the question of State Government responsibilities to provide services for this group. A similar comment may be made in relation to the measure to improve acute care services for people with dementia.
CONSUMER SUPPORT *Advocacy* Additional funding will be provided to expand the National Aged Care Advocacy Program, with a particular emphasis on rural and regional areas. *Community Visitors Scheme* Additional funding will be provided to extend the Community Visitors Scheme to home care services.	These measures ramp up from 2012-13	30.8	The funding split between these two measures was not provided.

PALLIATIVE CARE *Palliative care advisory services* Funding ($19.8m) will be provided to develop and operate specialist palliative care and advance care planning advisory services for age care providers and GPs caring for older people to build better links between age care and palliative care services. Funding ($1.9m) will be provided to expand the Program of Experience in the Palliative Approach training program aimed at the age care workforce.	Ramps up from 2013-14	21.7	Unclear whether there will be a role for Medicare Locals in implementing this measure.
QUALITY OF CARE *Aged Care Quality Agency* The Aged Care Standards and Accreditation Agency will become a statutory authority (rather than the current company structure) and be renamed the Aged Care Quality Agency to reflect its extended role to include residential and home care. *Age Care Commissioner* The Age Care Commissioner will be given greater power to ensure the independence of the Aged Care Complaints Scheme. *Quality indicators and ratings* Funding provided to develop aged care quality indicators and a rating system which will be published on the *My Aged Care* web site.	1 July 2014 1 July 2014 for residential and 1 July 2016 for home care	166	The Aged Care Complaints Scheme will remain with the Department, along with compliance and sanctions regulation. The Commissioner will be able to direct the Complaints Scheme to undertake a new complaints resolution process and to take into account any matter identified by the Commissioner, and then to provide a draft of the decision to the Commissioner. The Commissioner will have the power to make a report to the Minister on the draft decision. The relevance and appropriateness of the quality indicators and the ratings system will require careful scrutiny.

RESEARCH AND BETTER PRACTICE *Aged Care Data Clearing House* Funding will be provided to establish a Data Clearing House within the AIHW to improve the availability of data for policy makers, researchers and consumers. This measure will also support the expansion of the ABS's Survey of Disability, Ageing and Carers and to increase its frequency, so that it is conducted every three years. *Promoting better practice* Funding will be provided for projects which have a focus on prevention of hospitalisation for older Australians and improved access to complex health care for aged care recipients eg. partnerships with public and private health providers and insurers for the delivery of short term, more intensive health care services and improved access to palliative and psychogeriatric care for aged care recipients,	2012-13 Ramps up from 2012-13	9.1 58.5	A very important measure to improve evidence-based service delivery and to complement the work of the ACFA.
AGED CARE FUNDING INSTRUMENT (ACFI) The scores and/or payment levels within the ADL and Complex Health Care Domains of ACFI will be modified to bring growth due to increased frailty back to historic levels. The Department estimates that these changes will decrease the 2012-17 forward estimates for ACFI by $1.6b, rising from a reduction of $50m in 2012-13 to $480m in 2016-17. Greater power will be sought to enable the assessment right to be removed from providers who are found to have deliberately claimed an inappropriate amount several times.	1 July 2012 for some, 1 July 2013 for the rest	-1,600	As noted earlier, $1.2b will be redirected under the Workforce Compact to allow improved terms and conditions for the aged care workforce, and $0.4b will be used to offset the cost of the other reforms, including $487m for increased accommodation supplement for new services and $108m to continue the increased viability supplement. None of the 'blow out' will be returned to Consolidated Revenue.

Further work will be undertaken on the ACFI to: o enable it in future to be applied by independent assessors, and o to enable it to be applied across both residential and home care settings			The funding under the Workforce Compact will be paid to residential and home care providers through increases in the Conditional Adjustment Payment over the period 2013-17, rising from 1% of the basic subsidy in 2013-14 to 3.5% in 2016-17. The 'blow out' of $1.9b in the period 2011-15 referred to in earlier reports only included DoHA-funded aged care services. The $2.3b figure includes DVA-funded aged care services which also use the ACFI.
IMPLEMENTATION *Aged Care Reform Implementation Reform Council* An Aged Care Reform Implementation Council, reporting to the Minister for Mental and Ageing, will be established for the implementation and further development of the reforms. The Council will be chaired by an eminent person and its membership will include industry, consumer and workforce stakeholders, and experts on age care and ageing. The Council will be supported by a dedicated Transition Office in DoHA. One of the tasks of the Implementation Council will be to oversee the implementation of the 10 year plan for reform, including the 'significant' review of the reforms post 2016.	1 July 2012	15.2	$12.3m of the funds provided will be spent in the first two years. Membership of the Council will be critical to its effectiveness. The creation of an ongoing mechanism to oversee and drive the implementation of reform over a ten year period, including a significant review of the reforms after year 5, is encouraging.

SOURCE AND APPLICATION OF FUNDS

- New funding for the reforms total $577m over five years, with $416m (or 72%) to be spent in the last two years of the forward estimates (2015-17). New money in 2012-13 is only $55m, falling to $27m in 2013-14.

- The total cost of the package is $3,700m over five years, with funds applied as follows:

	$m
• Improved workforce terms and conditions……..	1,189
• Increased community care (home care packages)……..	955
• Increased resi care (mainly accommodation supplement)……..	660
• Dementia care……..	268
• Gateway……..	198
• Services for older Australians from diverse backgrounds……	192
• Research and better practice……	68
• Support for carers……	55
• Advocacy and Community Visitors Scheme……..	31
• Aged Care Funding Authority……	26
• Palliative care……..	22
• Australian Aged Care Quality Council and quality indicators……	17
• Aged Care Reform Implementation Council……..	15

- The source of funds for the package is as follows:

	$m
• Redirected ACFI funding……	1,592
• New Budget funding……..	577
• Increased user contributions……..	561
• Transfer of places from resi to home care packages……	454
• Winding back Longer Stay Older Patients Initiative……	188
• Offsets linked to changed dementia funding under ACFI and home care….	153
• Redirecting existing funding to improve the ‘front end’……	123
• Transfer of resi places to create 200 new Indigenous flexible places……	44