Submission to

Senate Community Affairs Legislation Committee Inquiry into the:

Aged Care (Living Longer Living Better) Bill 2013;
Australian Aged Care Quality Agency Bill 2013;
Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013;
Aged Care (Bond Security) Amendment Bill 2013; and
Aged Care (Bond Security) Levy Amendment Bill 2013.

from the Department of Health and Ageing

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Introduction

The Department of Health and Ageing (the Department) makes this submission to the Senate Community Affairs Legislation Committee inquiry into the Aged Care (Living Longer Living Better) Bill 2013, Australian Aged Care Quality Agency Bill 2013, Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013, Aged Care (Bond Security) Amendment Bill 2013 and Aged Care (Bond Security) Levy Amendment Bill 2013.

This submission is in two main parts.

Part 1 provides background to the five Bills including discussing the Productivity Commission's Report on Aged Care *Caring for Older Australians* and the Australian Government's response. Part 1 also describes the extensive consultation undertaken in relation to the *Living Longer Living Better* aged care reform package.

Part 2 provides more specific detail on proposed changes within the five Bills.

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PART 1: Aged Care Reform

Background

Currently, over one million older Australians receive aged care services subsidised by the Australian Government. By 2050, over 3.5 million Australians are expected to use aged care services each year. On 30 June 2012 there were some 252,890 operational aged care places under the *Aged Care Act 1997* (the Act) across Australia[1].

Australia has one of the most advanced aged care systems in the world, yet with Australia's ageing population, significant pressures are being placed on the aged care sector. With an increase in demand for aged care services, older Australians are also seeking greater flexibility in aged care, including independent living arrangements and increased choice. Additionally, there is a greater expectation regarding the quality of care services being provided.

The Australian Government and the aged care sector (made up of government, not-for-profit and for profit service providers and a number of associated supporting businesses) are now facing a significant increase in demand for aged care. This is also coupled with the major issue of a declining proportion of working age people compared with older Australians placing greater financial pressure on the economy. Further information on Australia's aged care system is provided at **Attachment 1.**

Productivity Commission Report: Caring for Older Australians

In April 2010, the Australian Government asked the Productivity Commission (the Commission) to develop detailed options for redesigning Australia's aged care system, to ensure it can meet the challenges facing it in coming decades.

Specifically the Australian Government asked the Commission to:

- Systematically examine the social, clinical and institutional aspects of aged care in Australia, building on the substantial base of existing reviews into this sector.
- Develop regulatory and funding options for residential and community aged care (including services currently delivered under the Home and Community Care program for older people) that:
    - ensure access (in terms of availability and affordability) to an appropriate standard of aged care for all older people in need, with particular attention given to the means of achieving this in specific needs groups including people living in rural and remote locations, Aboriginal and Torres Strait Islander people, culturally and linguistically diverse communities, and veterans;
    - include appropriate planning mechanisms for the provision of aged care services across rural, remote and metropolitan areas and the mix between residential and community care services;
    - support independence, social participation and social inclusion, including examination of policy, services and infrastructure that support older people remaining in their own homes for longer, participating in the community, and which reduce pressure on the aged care system;
    - are based on business models that reflect the forms of care that older people need and want, and that allow providers to generate alternative revenue streams by diversifying their business models;

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[1] 2011-12 Report on the Operation of the Aged Care Act 1997

- are consistent with reforms occurring in other health services and take into account technical and allocations efficiency issues, recognising that aged care is an integral part of the health system;
- are financially sustainable for Government and individuals with appropriate levels of private contributions, with transparent financing for services, that reflect the cost of care and provide sufficient revenue to meet quality standards, provide an appropriately skilled and adequately remunerated workforce, and earn a return that will attract the investment, including capital investment, needed to meet future demand. This should take into consideration the separate costs associated with residential services, which include but are not limited to the costs of accommodation and direct care, and services delivered in community settings;
- consider the regulatory framework, including options to allow service providers greater flexibility to respond to increasing diversity among older people in terms of their care needs, preferences and financial circumstances, whilst ensuring that care is of an appropriate quality and taking into account the information and market asymmetries that may exist between aged care providers and their frail older clients;
- minimise the complexity of the aged care system for clients, their families and providers and provide appropriate financial protections and quality assurance for consumers; and
- allow smooth transitions for consumers between different types and levels of aged care, and between aged, primary, acute, sub-acute, disability services and palliative care services, as need determines.

- Systematically examine the future workforce requirements of the aged care sector, taking into account factors influencing both the supply of, and demand for, the aged care workforce, and develop options to ensure that the sector has access to a sufficient and appropriately trained workforce.
- Recommend a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust.
- Examine whether the regulation of retirement specific living options, including out-of-home services, retirement villages such as independent living units and serviced apartments should be aligned more closely with the rest of the aged care sector, and if so, how this should be achieved.
- Assess the medium and long-term fiscal implications of any change in aged care roles and responsibilities.

In undertaking the inquiry, the Commission received 925 formal submissions and held 13 public hearings nationally[2].

The Commission's Report: *Caring for Older Australians* was released on 8 August 2011.

National Aged Care Alliance Blueprint

The National Aged Care Alliance is a representative body of peak national organisations in aged care, including consumer groups, providers, unions and health professionals, working together to determine a more positive future for aged care in Australia. The National Aged Care Alliance has grown to represent a coalition of organisations interested in working with Government to reform Australia's aged care system.

[2] Caring for Older Australians 2011, Productivity Commission

On 9 February 2012, the National Aged Care Alliance released its Blueprint for Aged Care Reform. The Blueprint was developed from the work of the National Aged Care Alliance Working Group on aged care reform, established by the Minister for Mental Health and Ageing.

The National Aged Care Alliance Working Group, comprised of six subgroups, focused on the following key areas of consideration:

- **Quality of care** – quality and regulatory matters, innovation, consumer choice/control over care and the establishment of an Australian Seniors Gateway Agency.
- **Workforce** – wages, scope of practice, training and career pathways.
- **Wellness approach** – healthy ageing considerations focusing on health promotion, linkages with primary health care both in residential and community care, the role of e-health and dementia/psychogeriatric issues.
- **Financing, care and accommodation** – the implementation of financing reform considered in further detail the assumptions made in the Productivity Commission Report to be further explored, for example the stop-loss proposal.
- **Assessment, choice and consumer-oriented care** – exploration of latent demand for aged care services, choice and supply, when and how individuals enter the aged care system and the fiscal impact of different options for assessment and care delivery.
- **Palliative Care** – exploring how palliative care is administered across Australia with variable funding and differences in support, access to medications and the exploration of business models to enable access to palliative care.

The papers produced by these subgroups formed the basis of the Blueprint for aged care reform. The key underlying principles of the National Aged Care Alliance's Blueprint include:

- Older people are entitled to live active, contributory and fulfilling lives.
- Governments must ensure the full range of public policy and programs are designed to support people to age well.
- Access to services that are affordable, available, client directed and underpinned by a commitment to quality improvement, evaluation and ongoing research.
- Reforms should commence from the 2012-13 Federal Budget.
- Reforms should promote ageing well and independently.
- People should have access and entitlement to flexible services. These services should be affordable, sustainable and equitably funded.
- Aged care should have a quality workforce.
- There should be support for:
    - informal carers and families;
    - people living with dementia; and
    - older people to die with dignity.
- There needs to be an ongoing focus on aged care service and system quality.

Australian Government's Response to the Productivity Commission

The *Living Longer Living Better* aged care reform package was announced on 20 April 2012. It provides $3.7 billion over five years to build a better, fairer and more nationally consistent aged care system. The *Living Longer Living Better* reform package was developed based on the work of the Productivity Commission and National Aged Care Alliance's Blueprint. It represents a 10 year plan, with a major five year review point, to ensure Australia's aged care system meets the changing needs of an ageing population. The reforms being pursued in the first five years deliver important benefits for older people and the aged care sector, while also laying the foundation for longer term, sustainable reform of the system.

The Commission in their report Caring for Older Australians provided a very comprehensive and high quality analysis of the current system and the need for reform. In particular, the Commission argued the aged care system is difficult to navigate; provides limited services and consumer choice; supplies services of variable quality; suffers from workforce shortages that are exacerbated by low wages and some workers having insufficient skills; and is characterised by marked inequities and inconsistencies in the availability of services, pricing arrangements and user co-contributions.

The Commission noted that changing the aged care system would take time and recommended that a staged reform plan would need to be adopted.

The Government's response strongly supported the need for staged implementation. It acknowledged the potential difficulties the sector would face in absorbing and responding to significant structural change in the short to medium term.

Further, the threshold issue of how strong means-testing arrangements for aged care services should be was a key factor in determining the affordability of responding to the Commission's broader suite of proposed reforms. While the proposed reform package moves in the same direction as that proposed by the Commission, it adopts a more graduated approach that seeks to significantly enhance the wellbeing of older Australians and their carers and better position the aged care sector for the possibility of further reforms in the future.

Implementation of the *Living Longer Living Better* Aged Care Reform package

Many elements of the aged care reform package do not require legislative changes to support implementation. Major progress has been made on implementation across the package to date, including:

- The new levels of home care packages have been advertised as part of the 2012 ACAR, and it is expected that they will be available to consumers from July 2013.
- New funding is being provided for a whole range of initiatives and services, including under the Aged Care Service Improvement and Healthy Ageing Grants Fund, the Better Health Care Connections measures, and expansions of both the National Respite for Carers Program and the Assistance with Care and Housing for the Aged program.
- In December 2012, following intensive work with stakeholders, Minister Butler launched the Aged Care Strategy for Lesbian, Gay, Bisexual, Transgender and Intersex Older Australians and the Aged Care Strategy for Culturally and Linguistically Diverse Older Australians. These Strategies will help inform the way Government responds to the needs of these groups, and will better support the aged care sector to deliver care that is sensitive and appropriate.

- The Aged Care Financing Authority was established in August 2012 to provide transparent, independent advice to the Government on pricing and financing issues in aged care. Since establishment, the members of the Authority have undertaken several rounds of consultation to enable them to provide advice to Minister Butler on several key financing issues.
- Healthdirect Australia, formerly the National Health Call Centre Network, has been engaged to develop and deliver the first stages of the new aged care Gateway. A national contact centre and the My Aged Care website will be operational from July 2013.
- In early March 2013 the Minister announced the requirements for the new workforce supplement which will provide up to $1.2 billion to improve pay and conditions for aged care workers employed by eligible providers.

Information on these and other elements of the reforms, including progress and consultation opportunities are published on the *Living Longer Living Better* website: www.livinglongerlivingbetter.gov.au

Consultation

From the outset, it was clear that consultation and engagement with industry, consumers and the broader health and community sectors would be key to developing meaningful and beneficial reforms to the aged care system. Consultation and collaboration has been, and continues to be, an underpinning element of each step in this reform process.

Conversations on Ageing

In developing its response to the Commission's Report: *Caring for Older Australians,* the Australian Government undertook a national conversation with older Australians, their families and carers. The Minister for Mental Health and Ageing, the Hon Mark Butler, visited 31 locations Australia wide to garner community and sector views about the Commission's recommendations, as well as ideas for healthy and active ageing.

The Conversations commenced on 19 August 2011 in Adelaide and concluded in Alice Springs on 1 February 2012. Conversations were held at the following locations:

State	Location
New South Wales	Sydney, Blacktown, Gosford, Port Macquarie, Newcastle, Ballina, Tamworth, Penrith and Wollongong
Victoria	Tottenham, Grovedale (Geelong), Ballarat and Berwick
Queensland	Rockhampton, Mackay, Deception Bay and Acacia Ridge
Western Australia	Victoria Park, Cockburn, Rockingham and Warwick
South Australia	Adelaide, Port Adelaide, Camden Park and Modbury
Tasmania	Hobart, Launceston and Devonport
Northern Territory	Darwin and Alice Springs
Australian Capital Territory	Canberra

The national conversations were attended by more than 4,000 older Australians, their family and carers and provided an opportunity for attendees to share their views directly with the Government.

The discussions were broad ranging with a number of recurring themes raised at each event including:

- palliative care and the right to die with dignity;
- workforce - the need for an increase in nursing staff, quality and training of staff and appropriate remuneration;
- monitoring and enforcement of penalties to help ensure the protection of elderly clients;
- the concept of an Aged Care Commissioner and interest in the scope of the Commissioner's authority;
- fairness of the bonds system;
- the importance of an effective interface between aged care and disability systems;
- support for the proposed Productivity Commission's Gateway concept;
- the use of the family home to pay for care - clarity on the impact of the Productivity Commission proposal;
- dementia rates increasing - need for dementia support and care, including the onset of dementia in younger people;
- cultural issues including language, interpreters, appropriate food and staff; and
- consideration of the care needs of specific groups such as Aboriginal and Torres Strait Islander people, Culturally and Linguistically Diverse (CALD) people and Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI) people.

The Minister continues to consult directly with older people around the country and the aged care sector regarding the changes that have been announced as part of *Living Longer Living Better*.

Alzheimer's Australia Consultation

The Department commissioned Alzheimer's Australia to conduct a series of consumer consultations in response to the Productivity Commission's report Caring for older Australians. Sixteen consultations were held nationwide, as well as an online survey for those unable to attend. Approximately 1000 people attended the consultation and 200 responses were received.

From these consultations Alzheimer's Australia clearly identified key issues for consideration, including early diagnosis, which significantly informed the development of the *Living Longer Living Better* reform package.

Consultation on the implementation of *Living Longer Living Better*

Following the announcement of the reforms, the Government has engaged with a number of advisory groups to support, advise, monitor and evaluate the *Living Longer Living Better* aged care reforms. These groups include:

- The **Aged Care Reform Implementation Council** - an independent body established to monitor, evaluate and report to the Minister on the progress of the reforms.
- The **Aged Care Financing Authority** – provides the Minister with independent advice on aged care pricing and financing and helps ensure care recipients receive value for money. Since being established on 1 August 2012, ACFA has consulted extensively with industry and consumers, and made recommendations to the Minister in relation to accommodation payments, and the definition of significant refurbishment.
- The **Strategic Workforce Advisory Group** - assisted in developing the requirements for the Workforce supplement to improve the capacity of the aged care sector to attract and retain staff.
- The **Minister's Dementia Advisory Group** - provides advice to the Minister and to the

Department of Health and Ageing on issues relating to the implementation and monitoring of programs, and dementia-related issues.

- The **Ageing Expert Advisory Group (under the umbrella of the national Aged Care Alliance)** – provides specialist advice from the perspective of the aged care sector and consumers to the Minister, the Department and the Aged Care Reform Implementation Council on elements of the aged care reforms.
    - Currently, five specialist advisory groups have been established, including the **Home Care Packages Working Group**, the **Gateway Advisory Group**, the **Commonwealth Home Support Program Advisory Group**, the **Quality Indicators Advisory Group,** and the **Specified Care and Services Reference Group** (the Additional Services Sub-Group and the Clinical Care Sub-Group provide technical advice to this Reference Group). Additional advisory groups will be established as required.
- The **Aged Care Funding Instrument Monitoring Group** has been formed to monitor the impact of the recent Aged Care Funding Instrument changes.
- The **Aged Care Funding Instrument Technical Reference Group** reports to the Aged Care Funding Instrument Monitoring Group on technical issues.
- The **Dementia and Veterans' Supplement Working Group** provides advice to the Department on eligibility criteria for new supplements for the care of people with dementia and other behavioral conditions and veterans with specified mental health conditions.
- Other Advisory Groups and Steering Committees - established to provide advice and guidance to help inform the way Government responds to the needs of older people from diverse backgrounds and to better support the aged care sector to deliver care that is sensitive to their care needs. These report to the Department and currently include:
    - The **National Aboriginal and Torres Strait Islander Aged Care Reference Group**;
    - Steering committees on the development of strategies for Culturally and Linguistically Diverse people and those identifying as Lesbian, Gay, Bisexual, Transgender, and Intersex.
- The **Aged and Community Care Officials** – provides a forum for the Commonwealth to engage with state and territory aged care officials to progress multilateral discussions on the existing aged care programs, including transition arrangements in line with the reforms. Cross-jurisdictional issues around aged care reform are addressed predominantly through Aged and Community Care Officials.
- The **Gateway Consultation Forum** – this forum provides a vehicle for the Commonwealth to consult with state/territory government representatives and other key parties on implementation arrangements for the Aged Care Gateway. The Group links with Aged and Community Care Officials and the National Aged Care Alliance Gateway Advisory Group, and reports directly to the Department.

Legislative Changes - Consultation

On 21 November 2012, the Department released a paper providing an overview of the proposed legislation changes. This paper was publicly released on the *Living Longer Living Better* website. A video presentation detailing the proposed legislation changes and providing an executive summary of the overview document was also made available through the *Living Longer Living Better* website, to assist with public understanding of the proposed changes. During late November and December, the Department also held briefing sessions in Melbourne, Sydney and Canberra on the proposed changes.

Stakeholders and the general community were able to provide written comments on the proposed changes during a four week period (21 November 2012 – 21 December 2012) with comments made publicly available on the *Living Longer Living* Better website, unless the author requested otherwise.

The Department received 54 submissions from members of the public, peak bodies and approved providers in response to the published overview of legislative amendments.

The main areas raised by the submissions were:

- the removal of retention amounts;
- accommodation payments;
- bond insurance;
- home care packages; and
- the Aged Care Funding Instrument appraisals.

Submissions received via the consultation on the overview of the proposed legislative changes were used to inform drafting of the Bills and will also inform the development of delegated legislation and program arrangements.

In regard to bond insurance, the Government subsequently decided not to pursue private insurance arrangements for accommodation bonds/payments. Instead the Bills seek to extend the current Government-backed bond guarantee scheme to cover the new types of lump-sum deposits for accommodation being introduced through the reforms.

In some cases, the issues raised reflected a need for greater information regarding the full scope of the proposed changes and their likely effect. For example, providers were concerned about the removal of retention amounts, but did not fully appreciate the other changes being made to the accommodation payment arrangements. Others expressed concern about the lack of detail about the accommodation payment arrangements - further detail released in December 2012 addressed some of the concerns. More information on accommodation payments is included on pages 26 and 27.

Commonwealth Agency Consultation

Extensive consultation with other Commonwealth Agencies has occurred during the drafting of the five Bills. Consequential amendments to other legislation, for example the *Social Security Act 1991* and the *Veterans Entitlement Act 1986* will occur due to amendments to the *Aged Care Act 1997*. Commonwealth Agencies such as the Treasury, the Australian Taxation Office, the Department of Human Services, the Department of Veterans' Affairs and the Department of Families, Housing, Community Services and Indigenous Affairs were consulted by the Department.

As a standard process prior to the Bills being finalised and introduced to Parliament, the Office of Parliamentary Counsel also provided Commonwealth Agencies, with an interest in aged care reform, the Bills for comment.

The Department is in the process of notifying states and territories in regard to the need for consequential amendments to state and territory based legislation.

Aged Care Bills - Industry Briefings – Autumn 2013

Since the announcement of the legislation program, the Department has been engaging with stakeholders on the proposed changes to legislation that give effect to the *Living Longer Living Better* aged care reforms. From the consultations on the overview document, it was clear that industry and broader stakeholder groups were very interested in gaining a more detailed understanding of how the changes to legislation would affect them.

In late February 2013 the Department announced that it would be holding industry briefing sessions across Australia to provide information and explain, in detail, the legislative changes that have been introduced into Parliament. These industry briefings have included:

- Canberra 19 March 2013
- Sydney 20 March (two sessions) and 18 April 2013
- Brisbane 27 March 2013
- Hobart 3 April 2013
- Melbourne 8 and 9 April 2013
- Adelaide 10 April 2013
- Perth 12 April 2013
- Darwin 23 April 2013

More than 2,000 sector stakeholders attended these briefings. Common questions and matters raised at the industry briefings have included:

- identifying a clear delineation between Home Care and the proposed Home Support Program (Home and Community Care)
- operation of caps for home and residential care;
- accommodation payments and bonds in residential aged care;
- operation of Extra Service and Consumer Directed Care; and
- operation of the Dementia, Veterans' and Workforce Supplements.

For those who were unable to attend the industry briefings a copy of the presentation, supporting handouts, a detailed Questions and Answers document and an information video have been made available on the *Living Longer Living Better* website.

Ongoing Consultation

The Department is committed to ongoing consultation and support for the industry and consumers during the implementation of the *Living Longer Living Better* aged care reform package. Many of the groups established to support, advise, monitor and evaluate the 10 year reform plan will continue to provide advice to the Department and the Minister for Mental Health and Ageing throughout the implementation. In addition, ongoing review points and a major legislated five year review have been built into the staged implementation to ensure the needs of consumers and providers continue to be met.

PART 2: Legislation Enabling *Living Longer Living Better*

Significant amendments to the *Aged Care Act 1997 (the Act)* and consequential amendments to other legislation are required to give effect to the *Living Longer Living Better* aged care reform package.

The changes to the Act can broadly be grouped into four categories:

1. Changes relating to home care such as changes to the types of home care available and the way that Government subsidies and fees are calculated.
2. Changes relating to residential care such as changes to the way that Government subsidies and resident fees are calculated, and the options available to care recipients to pay for their accommodation.
3. Changes relating to governance and administration such as the establishment of the new Aged Care Pricing Commissioner and the new Australian Aged Care Quality Agency.
4. Changes that are minor, administrative or consequential. For example, changes that improve the operation of the Act or address anomalies in the legislation.

Consistent with the principles of good regulation, the Government's approach has been to:

1. describe the broad legal and policy framework in the Act;
2. ensure that important safeguards are expressly included in the Act; and
3. enable the Principles and Determinations to deal with matters of detail that are likely to change over time and where flexibility is needed.

As part of the *Living Longer Living Better* package legislative changes have already occurred to give effect to some of the earlier measures. These include:

- changes to the Allocation Principles to allow for the new levels of home care packages advertised as part of the 2012-13 Aged Care Approvals Round; and
- changes to the Allocation Principles to ensure that, when allocating aged care places or making residential care grants, the Department takes into account how the approved provider will meet the needs of lesbian, gay, bisexual, transgender and intersex Australians, in addition to other special needs groups.

On 13 April 2013, the Hon Mark Butler MP, Minister for Mental Health and Ageing, introduced five Bills into Parliament. These Bills include the:

1. Aged Care (Living Longer Living Better) Bill 2013;
2. Australian Aged Care Quality Agency Bill 2013;
3. Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013;
4. Aged Care (Bond Security) Amendment Bill 2013; and
5. Aged Care (Bond Security) Levy Amendment Bill 2013.

The following sections in this submission will outline in detail the five Bills and how these changes will give effect to the *Living Longer Living Better* aged care reform package. The sections are set out in line with the respective legislative amendments as they appear in the legislation and correlated broadly with the three key implementation dates of 1 July 2013, 1 January 2014 and 1 July 2014. In addition to these key implementation dates, the final sections will outline other minor amendments and transitional arrangements.

Five Year Review

The *Living Longer Living Better* aged care reform package includes a 10 year plan for reforming the aged care system. The current legislative changes reflect the decisions that have been taken about what will be pursued in the first five years of this 10 year plan.

To ensure that reform momentum is maintained the Bills include a requirement that the reforms be reviewed in the fifth year of the 10 year plan.

The independent five year review in the Aged Care (Living Longer Living Better) Bill 2013, will commence from 1 July 2016 and will consider at a minimum:

- whether the number and mix of places for residential care and home care should continue to be controlled and if unmet demand for residential and home care places has been reduced;
- scope to move from a supply driven model to one based on consumer entitlement;
- the effectiveness of the new means testing arrangements;
- the new arrangements for regulating prices for aged care accommodation;
- equity of access to aged care services for different population groups;
- workforce strategies;
- arrangements for protecting refundable deposits and accommodation bonds, including readiness to move towards a private insurance model; and
- effectiveness of arrangements for access to aged care services.

The legislation sets out that the independent review will be required to take into consideration the views of stakeholders including consumers and providers across the aged care sector and related sectors.

Changes from 1 July 2013

The changes proposed from 1 July 2013 are outlined in Schedule One of the Aged Care (Living Longer Living Better) Bill 2013. These changes primarily focus on home care and the Community Visitors Scheme.

Home care

A key objective of the *Living Longer Living Better* aged care reforms is to assist people to remain living in their own homes for as long as possible. To introduce more choice for people receiving care at home the Australian Government announced a significant expansion of the home care packages program.

From 1 July 2013 a new type of care, home care, will replace community care (Community Aged Care Packages) and some forms of flexible care delivered in a person's home (Extended Aged Care at Home and Extended Aged Care at Home – Dementia).

The *Living Longer Living Better* package allocated $880.1 million over five years to increase the total number of home care packages. Recognising the substantial unmet demand for home care packages, the number of operational home care packages will increase from around 60,000 to almost 100,000 over the next five years. More than 40,000 additional packages are expected to be available over the five year period, from 2017-18 to 2021-22.

From 1 July 2013 four levels of home care package will be established through amendments to subordinate legislation, to provide a continuum of home care options covering basic home care through to complex home care.

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

From 1 July 2013, all existing packaged care places will transition to home care, as follows:

- Community Aged Care Packages will transition to Level Two home care packages;
- Extended Aged Care at Home (EACH) packages will transition to Level Four home care packages; and
- Extended Aged Care at Home Dementia (EACHD) packages will transition to Level Four home care packages with a dementia supplement.

New places, including the new level one and level three packages, will start to be allocated through the 2012-13 Aged Care Approvals Round that is currently underway.

From 1 July 2013 approved providers will be transitioned under the legislation to be home care providers:

- Existing providers of community care will be automatically approved to provide home care; and
- Existing providers of flexible care will be automatically approved to provide both home care and flexible care.

What each provider actually provides will depend on what places have been allocated to that provider.

The Bills provide that care recipients who have been approved for a Community Aged Care Package will be automatically approved to receive either Level One or Level Two home care packages. Care recipients approved for Extended Aged Care at Home or Extended Aged Care at Home Dementia will be automatically approved to receive any level of package.

Over the first two years of the program, the new home care package arrangements will be closely monitored and evaluated. The evaluation activities will focus on the impact of the new home care arrangements, including the new supplements and consumer directed care arrangements (see below), on:

- consumer experience and outcomes;
- provider operations;
- assessment processes;
- the interface between the Home Care Packages Program and other elements of the aged care system such as the Home and Community Care Program; and
- the effectiveness of the new arrangements in delivering a graduated continuum of care.

Consumer Directed Care

The *Living Longer Living Better* aged care reform package has a strong focus on improving consumer choice and control. Consumer directed care is a way of delivering services that allows consumers and their carers to have greater control over their own lives by allowing them to make choices about the types of care they access and the delivery of those services, including who will deliver the services and when.

From July 2013, all new home care packages, that is packages allocated through the current and future Aged Care Approvals Rounds, must be offered to consumers on a consumer directed care basis. This will be included as a condition of allocation for the places and does not appear in the Bills. The first tranche of 5,835 new home care packages will be allocated to aged care providers through the current Aged Care Approvals Round, which was advertised on 10 November 2012.

In the longer term, the Government has announced that from 1 July 2015 all existing home care packages, including those in operation before 1 July 2013, will need to be offered on a consumer directed care basis.

A consultation draft of the Guidelines for the Home Care Packages Program is being released on 26 April 2013. Comments and feedback from stakeholders on the consultation draft will inform the final Guidelines for the program and the relevant subordinate legislation.

Supplements

As part of the *Living Longer Living Better* aged care reform package three new supplements will be introduced into home care from 1 July 2013.

Approved providers who deliver home care at any level (ie 1,2,3 or 4) will be able to receive a new dementia supplement or veterans' supplement if the care recipient meets certain eligibility requirements. This additional funding will allow home care providers to provide additional and more appropriate care to care recipients with dementia and eligible Veterans.

These supplements will also be available in residential care from 1 July 2013. A consultation draft of the guidelines for the Dementia Supplement and Veterans' Supplement will be available on the *Living Longer Living Better* website in late April 2013. Comments and feedback from stakeholders on the consultation draft will inform the final guidelines for the supplements and relevant subordinate legislation.

From 1 July 2013 the Australian Government will provide additional funding through an Aged Care Workforce Supplement to aged care providers that meet the eligibility requirements. In line with the National Aged Care Alliance Blueprint for aged care reform, this additional funding will provide higher wages and better conditions for aged care workers.

The aim of the Aged Care Workforce Supplement is to:

- improve the aged care sector's capacity to attract and retain a skilled and productive workforce; and
- provide Australian Government funding to assist the sector in delivering fair and competitive wages in the short-term, while longer term options for meeting the challenges of the sector are considered by the Aged Care Financing Authority.

Further information regarding the Workforce Supplement has been provided for the Committee's information at **Attachment 2**.

Draft guidelines for the supplement will be released for consultation in late April 2013.

Community Visitors Scheme

The Community Visitors Scheme aims to decrease social isolation and loneliness, including through the use of technology to facilitate and support interactive relationships between volunteers and aged care recipients

The Community Visitors Scheme has historically only been available for people in residential care. In recognition of the fact that people in their own homes can also be socially isolated, under these legislative changes people receiving home care will also be eligible to receive support under the Community Visitors Scheme.

Aged Care Commissioner powers

Changes will be made to the Aged Care Commissioner's powers from 1 July 2013 to strengthen the independence of the Commissioner and give the Commissioner greater power in relation to examining decisions made by the Aged Care Complaints Scheme's officers. Specifically the Commissioner will be able to:

- direct the Scheme to undertake a new complaints resolution process taking into account the Commissioner's views following an examination of a Scheme decision;
- require the Scheme to provide the Commissioner with information requested in respect of a matter under examination; and
- provide a report directly to the relevant Minister if the Commissioner is not satisfied with the response of the Scheme in undertaking a new complaints resolution process.

These changes will be described in detail in Principles. The Commissioner's current powers to examine complaints about the Scheme's processes for handling matters will remain unchanged.

Changes from 1 January 2014

The changes proposed from 1 January 2014 are outlined in Schedule Two of the Aged Care (Living Longer Living Better) Bill 2013, the Australian Aged Care Quality Agency Bill 2013 and the Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013. These changes primarily focus on the commencement of a new Aged Care Pricing Commissioner and the establishment of the Australian Aged Care Quality Agency.

Aged Care Pricing Commissioner

The Aged Care Pricing Commissioner will be established to assess applications from approved providers who, from 1 July 2014, wish to charge residents a Daily Accommodation Payment (or equivalent Refundable Accommodation Deposit) above a threshold determined by the Minister. Subordinate legislation will require providers to publish the accommodation prices they intend to charge from 1 April 2014. The Aged Care Pricing Commissioner will also be responsible for approving extra service fee applications from approved providers from 1 July 2014.

The Aged Care (Living Longer Living Better) Bill 2013 provides for the Commissioner to commence operations in January 2014 so that he or she can help the sector be ready for some of the changes that commence on 1 July 2014.

Australian Aged Care Quality Agency

From 1 January 2014 the Australian Aged Care Quality Agency (Quality Agency) will be established as the sole agency that providers of aged care (both residential care and home care) will deal with in relation to quality assurance of aged care services.

Under the proposed legislation and in line with the Uhrig Review, the new Quality Agency will be prescribed under the *Financial Management and Accountability Act 1997*. Operating independent to the Department, the new Quality Agency will have its own budget appropriation, report to the Minister and Parliament and have a streamlined governance structure similar to that of other recently established *Financial Management and Accountability Act 1997* agencies.

The Australian Aged Care Quality Agency Bill 2013 describes the roles and functions of the CEO and ensures transparency and accountability in its operations. Under this legislation, it is proposed that the Quality Agency commence operation on 1 January 2014 with a focus on residential care quality and accreditation. Then, from 1 July 2014, functions relating to quality review in home care, currently done by the Department, will transfer to the Quality Agency.

The Australian Aged Care Quality Agency (Transitional Provisions) Bill 2013 supports the transition of functions from the Aged Care Standards and Accreditation Agency to the new Quality Agency by:

- providing for a smooth transition of staff to the new agency;
- transferring the assets and liabilities of the Aged Care Standards and Accreditation Agency to the Commonwealth;
- providing for the transfer of records and documents; and
- deeming applications made to the Aged Care Standards and Accreditation Agency, that have not been decided, to automatically become applications to the Quality Agency. This means that decisions and processes that are underway on 31 December 2013 will be able to continue on 1 January 2014.

These changes will require consequential amendments to subordinate legislation. New principles will be created under the Australian Aged Care Quality Agency Act. These will reflect current standards and processes. Overtime, this will provide opportunities to better align the quality arrangements across the aged care sector.

Aged Care Commissioner's jurisdiction in relation to the Australian Aged Care Quality Agency

The Commissioner will also be able to examine complaints about the Australian Aged Care Quality Agency's processes relating to accrediting residential care services and conducting quality reviews of home care services. As is the case now the Commissioner may not consider a complaint about the merits of a particular decision because there will be separate processes for reconsideration of Quality Agency decisions along with opportunities for providers to seek review of such decisions by the Administrative Appeals Tribunal.

Given that Quality Agency officers will be officers of the Australian Public Service who may be subject to disciplinary procedures under the *Public Service Act 1999* if they breach the Australian Public Service Code of Conduct, the Commissioner will not examine the conduct of individual officers.

Changes from 1 July 2014

The changes proposed from 1 January 2014 are outlined in Schedules Three to Five of the Aged Care (Living Longer Living Better) Bill 2013. These changes include provisions for new subsidy and fee arrangements and consumer protections in home care and residential care, as well as changes to accommodation arrangements. In addition, from 1 July 2014, the Aged Care (Bond Security) Amendment Bill 2013 and the Aged Care (Bond Security) Levy Amendment Bill 2013 amend the existing legislation that protects lump sum payments made by care recipients for residential care accommodation.

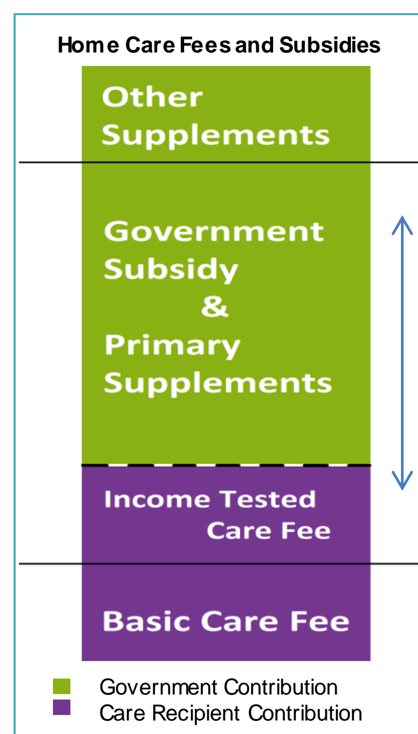
Home care

From 1 July 2014 there will be changes to the way that home care subsidy and fees are calculated for care recipients who enter home care on or after 1 July 2014. Changes will include requiring some care recipients with greater means to contribute more to the cost of their care through an income tested care fee.

In essence what the Government pays in subsidy and primary supplements will be reduced by what the care recipient may be asked to pay as an income tested care fee (see diagram).

A care recipient, entering care from 1 July 2014, may be asked to pay one or more of the following components toward the cost of their care:

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



Income testing will be performed by the Department of Human Services consistent with the current income testing arrangements for care recipients in residential aged care.

The Government's contributions to home care costs will be comprise three parts:

1. The basic daily subsidy amount (Government Subsidy). The amount of subsidy will depend on the type of home care package provided.
2. Any primary supplements (Primary Supplements). For example, the oxygen supplement and the enteral feeding supplement.
3. Any other supplements (Other Supplements) such as the viability supplement and the hardship supplement.

The Government's contribution, in regards to subsidy and primary supplements, will reduce in proportion to the value of a care recipient's income tested care fee.

Under this arrangement the amount that the Government will pay in care costs will be reduced by the amount that the care recipient is able to pay, based on an income test. This

will be known as the care subsidy reduction – i.e. the amount by which the Government subsidy and primary supplements are reduced based on the ability of the care recipient to pay.

Current arrangements allow a provider to charge a care recipient an income tested care fee. However, the amount the Government contributes towards the person's care costs does not vary even where the person is paying an income tested care fee.

Worked examples of the income tested fee arrangements for new home care packages are provided for further information at **Attachment 3**. The Department of Human Services will administer the income testing arrangements and advise providers of the maximum income tested fee they can charge each care recipient.

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

People receiving home care on 30 June 2014 will continue under their current arrangements unless they leave care for more than 28 days and subsequently re-enter care or they move between service types (i.e. from home care to residential care) or they move between services and choose to have the new rules apply to them as if they entered home care on or after 1 July 2014.

Annual and lifetime caps
New annual and lifetime caps on income tested care fees will apply from 1 July 2014. The annual cap on income tested care fees in home care will be specified in a determination. However, the Government has announced that the amounts will be:
- $5,000 (indexed annually) for part-pensioners or those with annual income greater than $22,701 but not greater than $43,186 (March 2012 prices); and
- $10,000 (indexed annually) for self-funded retirees with annual income greater than $43,186 (March 2012 prices).

The Government has announced the lifetime cap will be set at $60,000 (indexed). The cap applies to both home care and residential care.

If a care recipient moves from home care to residential care, the income tested care fees the care recipient paid in home care will count towards both the residential care annual cap and the lifetime cap.

Likewise, if a person moves from residential care to home care, any means tested care fees that the person paid in residential care will be taken into account in determining whether the person meets the annual and lifetime caps on the income tested fees for home care.

Once a care recipient reaches the annual cap, they cannot be asked to pay any more income tested care fees until their next anniversary date. Similarly, once a care recipient reaches the lifetime cap they cannot be asked to pay an income tested (or means tested) care fee for the rest of their life. However, in both cases they can still be asked to pay the basic fee.

The calculation of the care recipient's annual and lifetime cap will commence on the day the person commences care, regardless of whether they first commenced receiving home care or residential care. The Department of Human Services will administer the annual and lifetime

caps for each care recipient; with the payment system automatically increasing the Government subsidy and primary supplements once a care recipient reaches their respective cap.

Financial Hardship

The Bill introduces hardship provisions in home care. If a care recipient is suffering financial hardship such that the person is unable to pay either part or the entire basic daily fee, or part or all of the income tested care fee, the Secretary may grant a hardship determination. If such a determination is granted, the Government will increase its contribution to the person's care up to the amount of the determination, and the amount the care recipient can be asked to pay must be reduced by a corresponding amount.

Residential Care

Removal of high care/low care distinction

Consistent with the Government's commitment to increase consumer choice and ensure that funding is commensurate with care needs, the legislation amends the Act to remove the distinction between high level residential care and low level residential care. Care recipients will continue to be approved as recipients of residential care based on an assessment of their care needs; however, the approval will be for residential care without any distinction between whether the person requires a low level of residential care or a high level of residential care. The effect of this is that care recipients will be able to access the level of care that they need at their time of entry into residential care rather than being limited by their approval.

All approvals of care recipients for residential care will become non-lapsing (unless they are expressly time limited). This reduces the need for re-assessment if a person does not immediately enter care after being approved as a recipient of residential care.

As at 30 June 2014, there will be care recipients who have been approved for residential care and had their approval limited to low care but have not yet entered care, and also care recipients who have been approved for residential care and had their approval limited to low care and are currently receiving low level residential care.

Provisions have been included in the legislation to ensure that from 1 July 2014:

- approvals (regardless of when they were given) for residential care will be for residential care, without limitation as to the level of residential care; and
- residential care approvals (that were in force on 30 June 2014) will not lapse but may expire if they were explicitly time limited.

There will also no longer be different rules for providers of high care versus low care. It will be up to the provider to determine if they are able, within the legislation, to deliver appropriate care to a care recipient. This supports greater flexibility in residential care and gives providers greater autonomy over how they chose to deliver services.

In order to support the removal of the low care / high care distinction the schedule of specified care and services which residential aged care providers are required to provide to residents is being reviewed.

The Department of Health and Ageing, together with the National Aged Care Alliance, has established a Specified Care and Services Reference Group including provider, consumer, union, and health professional representatives to provide advice on the Schedule of Specified Care and Services. The Reference Group has met six times since August 2012 to discuss the sector's views about expected levels of 'standard' and 'additional' care and services in an environment in which there is no low care / high care distinction, noting that aged care

providers are currently able to negotiate with residents to include in the resident agreement fees for 'additional services' above the care and services required by the Schedule.

NACA is expected to make preliminary recommendations on amendments to the Schedule by late June 2013. Recommendations that have potential cost implications for providers, consumers and aged care workers will be referred to the Aged Care Financing Authority for analysis, by the end of December 2013, of impact on subsidies and charges.

In relation to respite care, care recipients continue to be assessed as requiring a higher or lower level of care. Because there is no Aged Care Funding Instrument to determine their funding level, this will be determined through the assessment process.

Changes to subsidy and fees from 1 July 2014

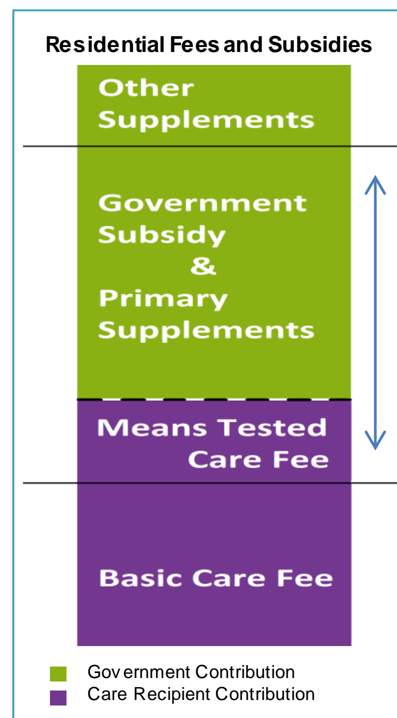
There will be changes to the way that residential care subsidy and fees are calculated for care recipients who enter care on or after 1 July 2014. The key changes are that a resident's contribution to their care will be determined through a means test that considers both assets and income rather than just an income test, which is currently the case. If the family home is occupied by their spouse or other protected person it will not be counted in the means test. When the family home is included its value will be capped at $144,500 (as at March 2012).

In addition, no care recipient will be asked to pay more per year in means tested care fees than the annual cap ($25,000 indexed annually) and no care recipient will pay more means tested care fees than the lifetime cap ($60,000 indexed annually). Care recipients experiencing hardship will continue to be able to apply for a hardship supplement.

In essence what the Government pays in subsidy and primary supplements will be reduced by what the care recipient may be asked to pay as a means tested care fee (see diagram).

A care recipient, entering residential care from 1 July 2014, may be asked to pay one or more of the following components toward their care:

1. A basic daily fee (Basic Care Fee), also referred to as the standard resident contribution. As is currently the case, a care recipient may be asked to pay a basic daily fee, it is an amount that is negotiated between the care recipient and the approved provider, but can be no more than 85% of the basic age pension amount.
2. A means tested care fee (Means Tested Care Fee). This is an amount determined, by a means test on the care recipient's assets and income (conducted by the Department of Human Services), which a care recipient may be asked to pay toward the cost of their care.
3. Any other amounts agreed between the care recipient and the approved provider, such as the Extra Service Fees. Care recipients will be able to opt in and opt out of additional care and amenities as it suits their needs.
4. An accommodation payment or contribution.



The Department of Human Services will administer the means test as they do for the current income test in residential care.

The Government's contribution to residential care costs will be comprised of three parts:

1. The basic subsidy amount (Government Subsidy). This is worked out based on the care needs of the care recipient, as determined by the approved provider applying the ACFI.

2. Any primary supplements (Primary Supplements). These are supplements paid by government for particular purposes. For example, the enteral feeding and oxygen supplements provide additional funding where there are specific additional care needs.
3. Any other supplements (Other Supplements) such as the viability supplement or hardship supplement. These are additional amounts that are paid by Government because, for example, the service is particularly isolated (and has higher costs) or because the care recipient is experiencing financial hardship.

The Government's contribution, in regards to subsidy and primary supplements, will reduce in proportion to the value of a care recipient's means tested care fee.

Worked examples of the new residential means testing arrangements are provided at **Attachment 4**.

People in care on 30 June 2014 will continue under their current arrangements unless they leave care for more than 28 days (and subsequently re-enter care) or they change care types (for example move from residential care to home care) or they move services and choose to have the new rules apply to them as if they entered care on or after 1 July 2014. This ensures that the financial arrangements that people in care on 30 June 2014 have put in place are not disturbed by the legislative changes, while providing flexibility for people who move to new services and wish to change to the new arrangements.

Accommodation Arrangements

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

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

Accommodation supplement

The accommodation supplement is paid to approved providers on behalf of residents who have been assessed as not being able to meet all or part of their own accommodation costs.

From 1 July 2014 the Government accommodation supplement paid to aged care providers for supported residents will increase by more than 50% from approximately $32 per day to approximately $50 per day (2012 prices) for homes newly built or significantly refurbished from 20 April 2012. This is an important and significant increase in funding. The definition of significant refurbishment was announced by the Minister in late 2012 after public consultation and advice from the Aged Care Financing Authority. Further information in relation to the definition of significant refurbishment is provided at **Attachment 5**.

Accommodation contribution

The accommodation contribution is the amount paid by a care recipient who can afford to pay some of the cost of their accommodation based on their means at entry. If the resident's means tested amount is less than the maximum accommodation supplement they will not be eligible to pay an accommodation payment. The accommodation contribution can be no greater than the difference between the maximum accommodation supplement for that facility and the amount of accommodation supplement the Government is paying on the care recipient's behalf. The accommodation contribution can be no greater than the difference

between the maximum accommodation supplement for that facility and the amount of accommodation supplement the Government is paying on the care recipient's behalf.

Accommodation payments
Care recipients with higher means may be asked to pay an accommodation payment toward the cost of their accommodation. The accommodation payment arrangements are being fundamentally reformed. The system will move from one where the value of an accommodation bond varies depending on the means of the prospective resident, to one where it is based upon the value of the accommodation on offer.

To increase transparency and improve consumer choice in selecting appropriate care, residential aged care providers charging for accommodation will be required, from 1 April 2014 to publish the accommodation payment prices they intend to charge from 1 July 2014. Providers can set more than one price, for example if the service has rooms of different sizes.

Providers will need to publish a justification for the amount they propose to charge so potential residents can consider whether they think it is value for money. If the provider wishes to charge level 3 prices, that is prices above a threshold determined by the Minister (to be $85 a day), the provider will need to apply to the Aged Care Pricing Commissioner and receive approval to charge the higher amount.

On 9 April 2013 the Department released a consultation document on proposed accommodation pricing guidelines. The paper outlines the proposed guidelines that will support the new arrangements for accommodation payments in residential aged care, which will apply for new entrants to residential care from 1 July 2014. This included the arrangements for justifying prices and for those seeking approval from the Aged Care Pricing Commissioner for level 3 prices. The consultation document is available on the *Living Longer Living Better* website.

The consultation document includes proposed arrangements for care recipients to make complaints regarding the value of the accommodation.

If a resident is concerned that a provider may not have followed the required legislative process for setting prices, for example they do not follow the prescribed process for setting prices or they do not publish prices as required, an individual could raise such concerns through the Aged Care Complaints Scheme or otherwise through the Department.

As is the case with other complaints, the initial focus would be on supporting the provider and the complainant to resolve the issue. However, if it emerges that the provider has failed to meet their obligations under the Act, the Department could impose sanctions.

Sanctions that the Department may apply include requiring the repayment of an amount (with interest) to a care recipient who has been overcharged an accommodation payment or contribution requiring repayment of a refundable deposit balance where not refunded as required; and restricting the permitted uses of refundable deposits.

Care recipients paying an accommodation payment will also be covered by consumer protection laws in the same way as consumers of other services are covered.

Consumer choice in paying for accommodation
The ability for residents to choose payment methods reflects the recommendations of the Productivity Commission to make the system more transparent and ensure appropriate consumer choice. These are important objectives. It is also important to consider these changes in the context of a number of other key changes from the *Living Longer Living Better* package. A number of aspects of the reforms can be expected to strengthen the sector and encourage investment.

From 1 July 2014 a care recipient who is asked to pay an accommodation payment or accommodation contribution may choose to pay this amount as a:

- daily amount (known as a daily payment); or
- a refundable lump sum (known as a refundable deposit); or
- a combination of both.

Care recipients will have up to 28 days after entering an aged care facility to decide how to pay for their accommodation. As currently, care recipients electing to pay a refundable lump sum will have six months to make the payment from the date of entry. During this time, the care recipient will pay the daily payment.

If a resident chooses to pay part or all of their accommodation cost as a lump sum, then the daily payment, plus any other amounts agreed in writing, and any other amounts specified in the Fees and Payments Principles, can be deducted from that lump sum. Unless specified in the law, the written agreement should also specify the frequency of these deductions, noting that providers must not charge more than one month of daily payments in advance. This arrangement allows payment of a lump sum as well as an ongoing regular income flow for providers through the part of the accommodation amount being made as a daily payment.

If amounts are deducted from the lump sum, the accommodation payment amount that the provider is receiving will be reducing, because the lump sum is reducing. The resident can be required to maintain the agreed total accommodation payment. This can be done by paying or increasing a daily accommodation payment, topping up the refundable deposit, or a combination of these.

Providers will be required to publish prices in the form of a daily payment, a refundable deposit and examples of combination payments. Prices for particular rooms or types of rooms must be published by the provider in advance on their own internet site (where available), on the Government's My Aged Care website and in relevant printed materials.

With the removal of the high care/low care distinction, the *Living Longer Living Better* reforms will allow all residents, who can afford to, to contribute toward the cost of their accommodation through a lump sum, daily payment or combination of the two. This is a reform that has been long championed by industry and will provide a new investment into residential aged care accommodation.

Further information regarding accommodation payment arrangements is at **Attachment 6**. Worked examples of accommodation payment arrangements are provided at **Attachment 7**.

Extra service and purchase of optional additional amenities

During the consultations consumers strongly supported measures to give them greater choice and control over the services they received in residential care. Under the new arrangements there will be greater scope for care recipients and their families to purchase additional amenities or supplementary care services from their residential care provider.

This will be achieved in the legislation by continuing to allow residential care places to be offered on a dedicated extra service basis (where a fee is paid for an agreed set of extra services), but also enabling care recipients, whether or not they are in an extra service place, to opt in and out of additional amenities offered by the provider.

From 1 July 2014 all services will be able to offer additional amenities such as increased entertainment choices on an opt-in/opt-out basis and charge a fee to be agreed with the resident. These optional additional amenity costs can be deducted from the accommodation lump sum with agreement between the resident and provider.

Approved providers of residential care will also continue to be able to offer care on a dedicated 'extra service basis'.

The arrangements relating to new applications for extra service status and the granting of extra service status will remain largely the same. Applications for extra service status will continue to be competitively assessed, with the following differences from the current arrangements:

- providers will be able to apply for extra service status not just for an entire service or distinct part of a service (as they can currently) but also for extra service status for one or more rooms in the service. This increases flexibility and also potentially provides a greater choice for the care recipient;
- the fees for extra service will be approved by the new Aged Care Pricing Commissioner, a role currently undertaken by the Department; and
- while care recipients who enter into a dedicated extra service place from 1 July 2014 will be required to pay the agreed extra service fee, there will no longer be an additional 25 per cent charge that is recovered by the Government. This will result in a cost reduction for the care recipient.

Accommodation bond security

On 20 April 2012 the Government announced as part of the *Living Longer Living Better* aged care reform package that residential aged care providers would be required to insure accommodation payments taken in the form of a refundable lump sum.

After consulting with industry and consumers the Government has decided not to introduce private insurance arrangements for accommodation payments from 1 July 2014. This decision has been largely based on the lack of availability of a developed private market to insure accommodation payments, creating significant uncertainty around costs for providers and potential flow on costs to consumers.

To ensure consumers are protected the Government has decided to instead extend the existing Government-backed bond guarantee scheme to cover new lump sum accommodation payments and contributions.

The changes proposed in the *Aged Care (Bond Security) Amendment Bill 2013* and the *Aged Care (Bond Security) Levy Amendment Bill 2013* extend the current provisions to protect new lump sum accommodation payments and contributions from 1 July 2014 and change the name of the Acts to reflect this new scope.

Transitional Arrangements

From 1 July 2014 the *Aged Care Act 1997* will describe the subsidy and fee arrangements for care recipients who enter care on or after 1 July 2014. Rather than also including the varying arrangements for existing care recipients in the Act, these arrangements will be preserved in a new Act, known as the *Aged Care (Transitional Provisions) Act 1997*. It will operate alongside the *Aged Care Act 1997*.

The new *Aged Care (Transitional Provisions) Act 1997* will only describe the arrangements for continuing care recipients. In other words, the arrangements for people who were in care before 1 July 2014 and have not, since 1 July 2014, left care for more than 28 days, changed care type (e.g. from home care to residential care) or have not moved services and elected to be subject to the new arrangements.

Other Amendments

In addition to the substantial changes being made in relation to home care, residential care and governance, some changes are also being made to improve the operation of the Act and address some anomalies.

Special needs

Currently 'people with special needs' are listed in both the Act and the Principles. This makes no legal difference but is purely historical. An amendment to the Act therefore moves all descriptors of people with special needs into the Act itself. Special needs groups that will now be included in the Act are:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- veterans;
- people who are homeless or at risk of becoming homeless;
- care-leavers; and
- lesbian, gay, bisexual, transgender and intersex people.

Aged Care Funding Instrument appraisals

Currently the Department can suspend an approved provider from making appraisals and reappraisals but can only do so if the provider is repeatedly using the Aged Care Funding Instrument in a way that is false, misleading or significantly incorrect.

The Bill provides that, from 1 July 2013, the Department is able to suspend an approved provider from making appraisals or reappraisals, with respect to care recipients in *one or more of the approved provider's services*. In other words, if an approved provider has a good record of appraisals at some services and a poor record at others, the Department can suspend the approved provider from undertaking appraisals or reappraisals at one or more services and not necessarily at all.

The Bill provides for a three step process before suspension occurs:

1. the Department must be satisfied that the approved provider (or a person acting on the approved provider's behalf) gave false, misleading or inaccurate information in relation to one or more appraisals or reappraisals;
2. after the approved provider has provided false, misleading or inaccurate information, the Secretary must have changed one or more classifications in connection with the appraisal or reappraisal; and
3. after the classification change, the approved provider must have again given false, misleading or inaccurate information in relation to one or more appraisals or reappraisals.

Only in these circumstances, and following receipt of any submission by the provider, may the Department suspend the capacity of the provider to undertake Aged Care Funding Instrument appraisal or reappraisals.

Any decision made by the Department to suspend a provider from undertaking appraisals will continue to be subject to reconsideration and ultimately review by the Administrative Appeals Tribunal.

Redundant provisions

The Act currently includes a number of redundant provisions. The opportunity has been taken to remove these. For example, to remove references to grants that no longer exist and replace references to publication in the Government Gazette with publication on the relevant website.

Amendments to other Acts

The Aged Care (Living Longer Living Better) Bill 2013 also makes consequential changes to other Acts. These Acts include the:

- *Social Security Act 1991*;
- *Social Security (Administration) Act 1999;*
- *Veterans' Entitlements Act 1986;*
- *A New Tax System (Goods and Services Tax) Act 1999;*
- *Human Services (Medicare) Act 1973; and*
- *Health and Other Services (Compensation) Act 1995.*

These changes are consequential and ensure that existing arrangements are preserved. For example, lump sum accommodation payments will continue to be exempt for the purposes of the aged pension just as bonds currently are.

Changes to delegated legislation

Consistent with the principles of good regulation, the Department's approach has been to:

- describe the broad legal and policy framework in the Act:
- ensure that important safeguards are expressly included in the Act; and
- enable the Principles and Determinations to deal with matters of detail that are likely to change over time and where flexibility is needed.

For example, the primary legislation includes how subsidy and fees will be calculated. This will be supported by operational details in the Principles and Determinations, such as the asset and income thresholds to be used in the calculators.

Changes to delegated legislation will be largely consequential to the changes to primary legislation. Where there are significant changes to delegated legislation the Department will consult on these changes through relevant National Aged Care Alliance working groups and stakeholder forums.

Subject to passage of the Bills, changes to delegated legislation will occur in three tranches.

Tranche One - 1 July 2013

The majority of these changes are minor and consequential to the changes proposed in the Bills, such as:

- Changes to *Community Care Subsidy Principles 1997,* to:
  - change the name to Home Care Subsidies Principles;
  - replace community care packages with home care packages;
  - provide new home care package levels; and
  - remove redundant provisions.
- Changes flowing on from changes to the Act relating to administrator and advisor panels.
- Changes to *Flexible Care Subsidy Principles 1997,* to
  - remove EACH and EACHD provisions; and
  - remove redundant provisions.
- Consequential changes to remove 'people with special needs' from the *Allocation Principles 1997* (these groups will instead be included in the Act).
- Minor and technical changes and removal of redundant provisions from the *Residential Care Subsidy Principles 1997.*
- Changes to *User Rights Principles 1997,* to:
  - replace community care packages with home care packages; and
  - minor and technical changes and removal of redundant provisions.
- Minor and technical changes to:
  - *Advocacy Grants Principles 1997;*
  - *Community Visitors Grant Principles 1997:*
  - *Residential Care Grant Principles 1997*
  - *Information Principles 1997.*

The areas where there are more significant changes, the Department is consulting directly with consumers and providers including through dedicated National Aged Care Alliance Working Groups. These changes are:

- Amending and strengthening the powers of the Aged Care Commissioner through changes to the *Complaints Principles 2011.*
  - draft Principles are being developed in partnership with the Aged Care Commissioner and the National Aged Care Alliance Complaints Subgroup.
- Determining the eligibility for the new Dementia, Veterans' and Workforce Supplements:

    - draft guidelines for the Dementia and Veterans' Supplements are being developed in partnership with the Dementia and Veterans' Supplement Working Group, these will be available for public consultation by late April 2013; and
    - the requirements for the Workforce Supplement were announced in early March 2013 following consultation with the sector through the Strategic Workforce Advisory Group and by the Minister. Draft program guidelines will be released by late April 2013.
- Guidelines for the expanded Home Care Packages Program, including the principles and implementation arrangements underpinning the delivery of home care on a Consumer Directed Care basis.
    - a consultation draft, developed in conjunction with the National Aged Care Alliance Home Care Packages Working Group, is being released on 26 April 2013. Comments and feedback from stakeholders on the consultation draft will inform the final Guidelines for the program.

Tranche Two - 1 January 2014

Changes will be made to support the creation of the new Australian Aged Care Quality Agency and the Aged Care Pricing Commissioner. This involves creating new delegated legislation, based on the existing arrangements for the Aged Care Standards and Accreditation Agency.

Additionally, delegated legislation will be created to establish the rules around, for example, applications for approval by the Aged Care Pricing Commissioner of higher accommodation payments.

Tranche Three - 1 July 2014

From 1 July 2014, the changes will be more substantial and include consolidation of existing Principles to make the delegated legislation more navigable. For example, all matters relating to subsidy will be in one set of Principles.

The Principles will include substantial new content to support implementation of new arrangements for:

- accommodation contributions and payments;
- residential care subsidy and fees; and
- home care subsidy and fees.

The Department is committed to ongoing consultation with relevant stakeholders as drafting of the delegated legislation is progressed. In some cases this is already occurring, for example through the consultation document on accommodation pricing guidelines recently released by the Department.

A detailed Navigation Guide to these changes is provided for the Committee's information at **Attachment 8**.

Attachment 1

Overview of the Australian Aged Care System

Background

Currently, over one million older Australians receive aged care services subsidised by the Australian Government ('the Government'). By 2050, over 3.5 million Australians are expected to use aged care services each year[3].

The aged care sector is comprised of a number of government, not-for-profit and for profit service providers, and a number of associated supporting businesses (corporate services, clinical supplies and ancillary services).

This document provides an overview of the Australian aged care system and prior to implementation of any policies announced on 20 April 2012 as part of the *Living Longer Living Better* aged care reform package.

Overview of the aged sector

Australia has one of the most advanced aged care systems in the world, however it can be complex and difficult to navigate. On 30 June 2012, there were some 252,890 operational aged care places across packaged community care and residential care under the *Aged Care Act 1997* (the Act) across Australia. Additionally, there are approximately another 3,660 Home and Community Care (HACC) agencies* which provide government funded services under the HACC program.

**A HACC agency is a HACC-funded organisation or organisational sub-unit that is responsible for the direct provision of HACC-funded assistance to care recipients.*

Components

The basic structure of Australia's aged care system has been in place since 1985. This formalised support can be characterised against two dimensions of care funded by governments, these are: the intensity of the care provided; and the location where care is delivered. The first dimension, intensity of the care, is a notional care continuum passing through three levels of acuity:

a) low intensity levels of support (for example, meals on wheels, domestic assistance, home nursing and respite care), which is generally delivered in the care recipient's home as individual and often uncoordinated interventions;

b) low-level (coordinated) care which provides more intense and coordinated assistance with activities of daily living, generally provided in an institutional setting, but similar levels of care are delivered in the community as a package of care, usually involving case management; and

c) high-level (coordinated) care which provides nursing care or intensive non-nursing assistance (for example, for people with severe dementia) as well as low-level care, generally provided in an institutional setting, but again similar levels of care are delivered in the community through packaged care.

The second dimension refers to the location in which the care is delivered: home and community care is delivered in the care recipient's own home or a community care centre;

[3] Caring for Older Australians 2011, Productivity Commission

and residential care is delivered in purpose-built facilities and includes accommodation services.

Organisations working in aged care in Australia may traverse these care dimensions or specialise in a particular type of care. The following table (**Figure 1**) outlines the major programs that provide funding for the provision of aged care services in Australia against the two care dimensions.

Figure 1: Care services on offer in Australian

First Dimension	Second Dimension: Home and Community Care	Second Dimension: Residential care providers
Low intensity interventions	Information, assessment and referral services Support for carers	Information, assessment and referral services Support for carers
Low intensity interventions	Commonwealth HACC Program National Respite for Carers Program Veterans' Home Care Department of Veterans' Affairs' Community Nursing program Day Therapy Centres	Respite residential care
Low-level Care	Community Aged Care Packages (some packaged care through HACC) Carer Payment and Carer Allowance	Low-level permanent residential care
High-level Care	Extended Aged Care at Home Packages EACH (Dementia) Packages (some packaged care through HACC) Transition care	High-level permanent residential care

The majority of formal aged care services are provided by private (profit and not-for-profit) providers, but some state, territory, and local government agencies also provide aged care services. Service providers vary from small community based groups to large charitable and for-profit organisations that operate nationally.

Australian Government community care is primarily provided by religious, charitable and community-based providers (84 per cent of providers) with the remaining 16 per cent of places provided by private-for-profit organisations, and state and local governments.

Size of the Aged Care Sector

More than 500,000 older Australians (and their carers) who receive government-subsidised services receive low intensity support through the HACC program. Formal aged care services are delivered through around 8,000 outlets across Australia, including approximately 3,660 agencies registered as delivering services funded through the HACC Program, 2,095 operational community care services delivering community packaged care and 2,725 operational residential aged care facilities (as at 30 June 2012).

During 2011-12, Australian Government expenditure in aged care was more than $12.5 billion, an increase of 13.8 per cent from 2010-11. This provided around 188,000

residential care places, 61,000 community care places and 4,000 transition care places as at June 2012, an increase of 2.2 per cent over the previous year[4].

Public and private expenditure on aged care in 2011-12, at an estimated $17 billion, accounted for 1.0 per cent of Australia's Gross Domestic Product (GDP), with the Australian Government's contribution to that expenditure accounting for about 3.6 per cent of Australian Government revenues. It is expected that by 2050 aged care expenditure will account for 3 per cent GDP and that aged care workers will represent 5 per cent of the Australian workforce. Capital formation is also significant in the sector, accounting for 4.2 per cent of non-residential building activity over the last decade.

The Department estimates that there are currently more than 304,000 people employed in the delivery of aged care services, with around 206,000 employed in the residential care sector and around 98,000 employed in the delivery of community care. The aged care sector accounts for 2.7 per cent of all employees in Australia. At the occupational level, the sector employs 15.3 per cent of registered nurses, and 21.9 per cent of enrolled nurses.

By 2050 the Department estimates that 827,100 workers may be engaged in the provision of aged care.

Funding

The Home and Community Care (HACC) and Day Therapy Centre Programs
The Government subsidises access to a wide range of community care services by block funding service organisations. Fixed budgets are allocated to providers who have responsibility for assessing people to determine their priority for accessing subsidised services within broadly consistent parameters.

Providers range from very large consolidated organisations to local community groups with very small budgets (less than $50,000 per annum). In some instances providers contribute additional resources in kind, or funds to cover the cost of service delivery or to increase the level of services available. Most services are delivered by paid workers but volunteers play a substantial role in the delivery of some services. Care recipients can be asked to contribute towards the cost of services. It is estimated that these fees account for about 5 per cent of the service delivery cost.

Community care packages
The Government subsidises community care through the Community Aged Care Package (CACP) program and the Extended Aged Care at Home (EACH) program, including the EACH Dementia (EACH-D) program.

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

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[4] 2011-12 Report on the Operation of the Aged Care Act 1997

Residential Care
Government funding for residential care is provided through subsidy and supplements paid in respect of individuals, with the level of the care subsidy determined by the care recipient's care needs as determined by the Aged Care Funding Instrument (ACFI).

Residents in Government subsidised residential aged care can be asked to pay fees as a contribution towards accommodation costs, living expenses and the cost of their care. These contributions are classified under three categories:

1. *Basic daily fee* is a contribution towards living expenses and is negotiated between the resident and the provider:
    - The Government sets the maximum level of this fee using a percentage[5] of the single basic age pension. It increases in March and September in line with the basic aged pension;
    - As at 20 March 2013, residents will pay up to $44.54 per day; and
    - In respect to residents who cannot afford to pay the basic daily fee, providers are entitled to a hardship supplement, paid by Government.
2. *Income tested fee* is in addition to the basic daily fee. It is:
    - only charged for residents with total assessable income above the maximum income of a full pensioner ($23,764 as at 20 March 2013 – Single rate)[6];
    - 5/12th of assessable income above this maximum income; and
    - capped at $70.74 per day ($25,749.30 per annum).
3. *Accommodation costs*:

    High Care
    - Residents with assets in excess of $43,000 (20 March 2013) and requiring high care (other than extra service) may be asked to pay an accommodation charge, which is a daily charge fixed from the date of entry into care and approved by the Department based on an asset test.

    Low Care and Extra Service
    - Residents requiring low care or entering an extra service place may be asked to pay an accommodation bond, which is an interest free loan from the resident to the provider. There is no fixed amount which apprises to the level of the accommodation bond. However, once the bond has been paid the resident must be left with assets to the value of at least 2.25 times the basic aged pension ($43,000 as at 20 March 2013). There are a few ways residents can choose to pay a bond, including: a lump sum; periodic payment or a combination of both.

Extra service places
Extra-service homes offer residents a higher (hotel like) standard of accommodation, services and food at a higher fee. The provider must be approved to offer extra service places and the fees and charges are set in accordance with the extra-service agreement.

Approximately 70 per cent of all funding for residential care was provided by the Government. The remaining funding was received by providers through resident contributions.

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[5] Currently 85%, as at 20 September 2012

[6] The aged care income free area is equal to the maximum basic pension rate plus the maximum pension supplement less the minimum pension plus the pension free area. The minimum pension and the Seniors Supplement (which is the same amount) are not treated as assessable income.

Government Regulation

Given that aged care providers are caring for some of the most frail and vulnerable citizens the aged care system has robust regulation in place in which there are tight controls over the scope, quality and price of services offered by providers of care in both aged care homes (residential care) and in community settings (home and community care). There are several key elements to the aged care regulatory framework; regulation, standards, monitoring and quality and support.

To receive government supplements for services provided under the Act, an aged care service must be operated by an organisation that has been approved by the Government (an approved provider). Additionally, approved providers (providers) wanting to operate a residential aged care service must be accredited by the Aged Care Standards and Accreditation Agency (the Accreditation Agency). These two regulatory processes ensure that a provider has appropriate knowledge, skills, training, ongoing quality improvement processes and appropriate premises to care for the elderly.

Following approval, providers must meet approved standards and are subject to ongoing regulatory oversight, including accreditation audits, compliance checks and the operation of the Aged Care Complaints Scheme (the Complaints Scheme). Extensive monitoring arrangements are in place for providers in relation to their responsibilities under the aged care legislation. This includes accreditation and quality reporting, corporate governance (changes to key personnel, financial management and prudential compliance) and protecting the physical safety of residents. Providers found not to be complying with these standards may be subject to compliance action. The Department is responsible for managing the majority of these activities. However, the Aged Care Commissioner (the Commissioner), a statutory appointment independent of the Department and the Accreditation Agency, is able to review certain decisions made by the Complaints Scheme and to examine complaints about the Complaints Scheme's processes for handling matters under the *Complaints Principles 2011*.

Providers not regulated under the Act, are subject to the terms of government funding agreements and associated standards, which dictate quality, access and accountability requirements. A summary of the aged care regulation and monitoring framework for providers regulated under the Act is included in **Figure 2.**

With respect to consumers and their families, in order to be approved to receive subsidised residential aged care or community aged care packages, an Aged Care Assessment Team (ACAT) is required to assess the needs of a potential care recipient under the *Approval of Care Recipients Principles 1997*. ACATs are health care professionals that are funded jointly by the Commonwealth and states and territory governments and are usually based at a hospital or community centre. Additionally, ACATs assist potential care recipients, who are found to be eligible for aged care services, to find appropriate care.

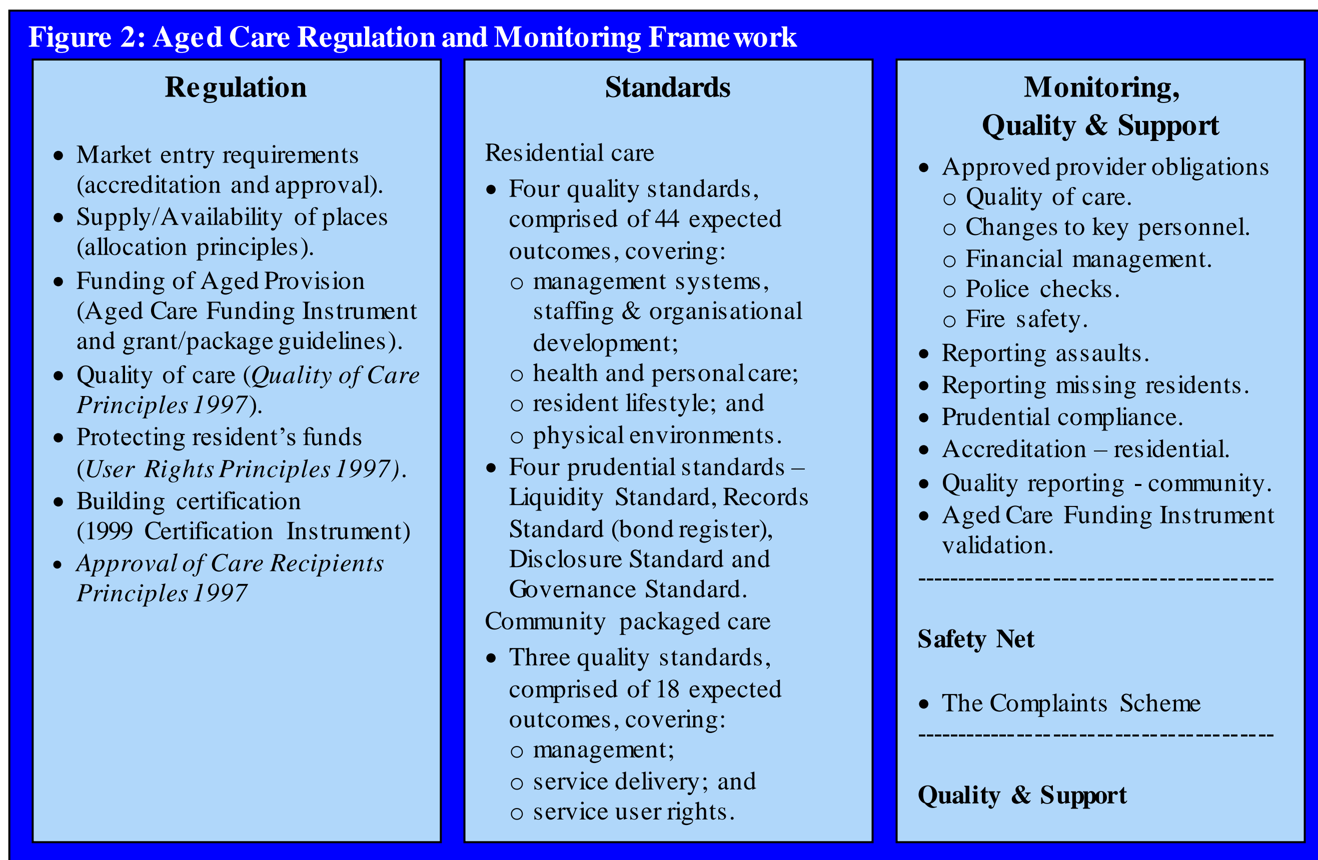

Figure 2: Aged Care Regulation and Monitoring Framework

Market culture

The aged care sector has a unique market culture. The Government has been crucial to the corporatisation of aged care in Australia, being the majority funder in the aged care sector.

Current policies are relatively effective in providing for equitable access to aged care services. However there is scope to achieve equitable access in ways which are less complex, provide for greater flexibility and stronger competition.

Consumers currently face restricted choices in the range of care available and inconsistent price signals. Aged care charges are often difficult to understand as a result of different approaches to pricing like services and means testing arrangements. Consequently consumers find it difficult to understand how the aged care system works and feedback suggests that this can lead to a sense of frustration with the existing system. At the same time, there has been a gradual decline in occupancy rates in residential aged care over the last few years, reflecting in part greater access to and interest in community care. Consumers want more emphasis on care in the home in preference to residential care, and this is out of line with the current aged care planning arrangements.

In the community sector (covering packaged care, HACC and HACC like services), government regulation has been inconsistent across states and territories and along the care continuum. This has led to varying levels of sophistication in operators, ranging from single owner/operator organisations which provide limited services (like lawn mowing or assistance shopping) to large national providers that deliver complex care.

Principal Concerns

Population ageing is placing increasing pressure on the aged care system. Assuming the share of older people who receive aged care remains constant, the absolute number of people

receiving aged care will increase by about 150 per cent in the next 40 years, with over 2.5 million older people utilising aged care services by 2049-50[7].This will have two major effects on the provision of aged care in the future. Firstly, there will be a significant increase in the demand for aged care and older Australians will continue to become frailer on entry to aged care homes. Secondly, the proportion of working age people compared with older Australians is expected to decline, placing greater financial pressure on the economy.

There is increasing preference amongst older Australians for greater flexibility in aged care, including independent living arrangements and increased choice. Additionally, there is a greater expectation regarding the quality of care services being provided.

Increasing numbers of aged people requiring care

It is clear that the demand for residential care is changing with care recipients only entering as they get significantly older (entering into high care) when their health has deteriorated to a point where they cannot remain at home. This is supported by the increasing unmet demand in community care (estimated by the Department to be between 30,000-50,000 packages) and the decline in the average level of occupancy for aged care homes over the last decade. Across Australia there has been a steady decline in residential aged care occupancy since March 2002 (96.9 per cent) to 92.8 per cent in 2011-2012. Whilst there is a strong preference for people to stay in their homes longer, it is likely that there will be significant increase in the demand for residential high care places as older Australians' care needs reach the point where they can be best met in a residential setting.

Expectation of greater choice and control in quality care services

There is strong evidence that consumer demand is changing toward a greater emphasis on home care and community aged care. Consumers are demanding greater ability to make informed choices about the types of care available. Additionally, there is a demand for greater flexibility in aged care, with a strong consumer belief that people should be able to choose to stay at home for as long as possible.

Decreasing (relative) numbers of people to care and pay for the aged

Australia's population is getting older. Around 9 per cent of our population is aged 70 years or older and this is expected to rise to 13 per cent by 2021 and to 20 per cent (around 5.7 million people) in 2051. The impact of a change in the number of informal carers has a direct implication on the relative increase in the demand for formal carers[8]. This can be linked to the increased numbers of people who have never married, or who are divorced or separated and also the current trend for having fewer children. This means Australians will have fewer voluntary carers to draw on when they reach old age.

There are currently 16.3 people of working age for every person aged over 80. By 2050, there will be 5.5 people of working age for every person aged over 80. This change in working demographic will mean there are fewer taxpayers to fund aged care in the future. Additionally, the greater scarcity of working age people in the future population will decrease the number of people choosing to remain at home as an informal carer.

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[7] Caring for Older Australians 2011, Productivity Commission

[8] The impact of differential mortality on demand for long term care is examined in Lakdawalla D and Philipson T (2002) '*The Rise in Old-Age Longevity and the Market for Long-Term Care*', American Economic Review 92:295-306; and Lakdawalla D and Schoeni R (2003) 'Is Nursing Home Demand Affected by the Decline in Age Difference Between Spouses?', Demographic Research 8:279-304.

Workforce challenges

An adequately, skilled and well-qualified workforce is fundamental to the delivery of quality aged care. Aged and community care services continue to experience difficulties in attracting and retaining workers. The very high community expectations around ensuring that high quality of care is delivered to older Australians, and the discouragement of the current aged care workforce with finances, training and conditions has been evidenced by public submissions and the Productivity Commission's report.

While lower levels of wages are certainly an issue for both nurses and personal care workers, they form part of the larger aged care workforce equation. Recognition of the value and importance of their work provides rewards that are important to most workers, beyond the compensation represented by pay. Conditions and training are equally important components to consider, and leaving one or more of these components unaddressed would potentially compromise the effectiveness of initiatives in this area.

Key Challenges

The Australian aged care system faces a number of key challenges. Demographic, social and economic pressures will impose a large and continuing adjustment burden on the aged care sector. The sector is heavily dependent on government supplements and there are limits on the amount providers can ask care recipients to pay. Whilst regulation is necessary because of the nature of the services being provided and the frailty of the care recipients accessing services, the system is ultimately highly regulated which places a large burden on providers and affects the capacity to adjust to the coming challenges.

There are a number of key challenges that will impact on the aged care sector's capacity to respond to emerging pressures and that have led to the need for reform.

Improving sustainability of funding

The Intergenerational Report 2011 reported that (under the policy parameters of the time) Australian government spending on aged care was projected to increase as a proportion of GDP from 0.8 per cent in 2009-10 to around 1.8 per cent in 2049-50.

The main driver of this projected increase was spending on residential aged care. Residential aged care expenditure grew much faster than anticipated when the Aged Care Funding Instrument (ACFI) was introduced in 2008 – around 7 per cent per annum compared with less than 1.5 per cent under the previous funding tool. In addition, growth in the number of people aged 85 and over is very high, and this was expected to translate into higher demand for services.

Another funding pressure was the unmet demand for community care services. It was estimated that there are between 30,000 and 50,000 people living in the community who may be in need of complex aged care but not receiving home care and support funded by the Australian Government.

Moreover, there will be increasing demand for residential aged care places as the population ages. While there is a strong preference from older Australians to receive aged care in the community, longer life expectancy and advances in medical technology will ultimately mean that more and more older Australians will require the intensive support that is only available in a residential setting.

Discontinuities in care services

Currently the Department estimates that there are 30,000 to 50,000 too few aged care places in the aged care sector and this figure would grow under current policies. Inefficiencies in

transitions between care types often mean that care recipients will experience a large gap in the service provision levels.

Under current policy, there is no structure between package levels meaning that there is a considerable difference in the services provided between each package. Additionally, moving between providers and states and territories may mean that equipment and services available in one area are not available in others. Furthermore some consumers may not be able to access any services in their area due to large waiting lists caused by higher demand.

Difficulties in navigating aged care services

A key challenge is ensuring that service providers have the flexibility and capacity to meet the level and diversity of demand for aged care services. Once a consumer is assessed as requiring aged care services, it is up to them, their carer or family to contact individual providers to determine the best place for care and support. Consumers have identified that they have difficulty getting comprehensive and timely information about the aged care system, their rights and responsibilities with regard to the services they can access, and the level of co-contributions they are required to make.

There is no comprehensive information portal that consumers can access to seek information on aged care services. Additionally, there is no ability for consumers to compare aged care providers, the services on offer or the cost of care for those services. Additionally consumers expressed a desire for a single authoritative body responsible for providing accurate and high quality information.

Inequalities between care recipients

Different care recipients with similar means receiving the same level of care face different costs. The levels of user co-contributions are inconsistent and inequitable within and between community and residential care.

Community care is not currently required to be means tested. Relative to residential aged care this creates inequities to the extent that the level of user co-contributions are significantly lower in community than in residential aged care.

Generally, it can be more challenging to establish services in smaller, rural areas, where providers have a smaller pool of prospective residents and are therefore vulnerable to fluctuation in occupancy levels. Additionally access to an appropriately trained workforce can limit the type of services that providers can offer. For these reasons, there may be less certainty around funding streams which may in turn make it more difficult for them to access finance.

Attachment 2

Addressing Workforce Pressures Initiative

The Aged Care Workforce Supplement - Better Wages, Better Training, Better Care—Building a sustainable aged care system

1. Building a better aged care system

On 20 April 2012, the Prime Minister and the Minister for Mental Health and Ageing released a comprehensive 10 year package to reshape aged care. The Living Longer Living Better aged care reform package will build a better, fairer, sustainable and nationally consistent aged care system to meet the social and economic challenges of the nation's ageing population.

The reform package included an announcement that up to $1.2 billion would be made available through the Addressing Workforce Pressures initiative to better support the people who work in aged care. This initiative will be delivered in two parts—through the Aged Care Workforce Supplement, and the Aged Care Workforce Development Plan which will be developed during 2013.

Aged care providers that meet the eligibility criteria will be paid an Aged Care Workforce Supplement.

2. Aims of the Aged Care Workforce Supplement

The aims of the Aged Care Workforce Supplement are to:

- Improve the aged care sector's capacity to attract and retain a skilled and productive workforce.
- Provide Australian Government funding to assist the sector in delivering fair and competitive wages in the short-term, while longer term options for meeting the challenges of the sector are considered by the Aged Care Financing Authority.

3. Requirements and commitments

The Aged Care Workforce Supplement will be available from 1 July 2013 to eligible aged care providers that meet the eligibility criteria outlined in this document. Aged care providers whose employees are paid under State and Territory Government awards or public sector enterprise agreements will not be eligible for the Aged Care Workforce Supplement.

- Providers who put in place arrangements to meet the eligibility criteria of the Supplement prior to 1 July 2013 are eligible for increased funding from 1 July 2013.
- Providers meeting the eligibility criteria for the Supplement between 1 July 2013 and 31 December 2013 will be eligible for increased funding from the date pay rises to their staff take effect (so long as all other requirements have been met).
- Providers who meet the eligibility criteria for the Supplement after 31 December 2013 will be eligible for increased funding from the date the application is received by the Department of Health and Ageing.

For those aged care providers that have an enterprise agreement in place

- In order to access the Aged Care Workforce Supplement, aged care providers must ensure that their enterprise agreement is consistent with the eligibility criteria.

For those aged care providers that do not have an enterprise agreement in place

- In order to access the Aged Care Workforce Supplement, residential aged care providers with 50 or more operational places must put in place an enterprise agreement consistent with the eligibility criteria.
- Residential aged care providers with fewer than 50 operational places and home care providers will need to certify that they meet the eligibility criteria, including that they have written to all employees advising that they have applied for the Aged Care Workforce Supplement.
- Providers of the Commonwealth Home and Community Care program, the National Respite for Carers program, and the Day Therapy Centre program will need to certify that they meet the eligibility criteria, including that they have written to all employees advising that they have applied for the Aged Care Workforce Supplement.
- Providers of the Veterans Home Care and Community Nursing programs will need to satisfy the Department of Veterans' Affairs that they meet the eligibility criteria.

Aged Care Workforce Census and Survey

- In order to access the Aged Care Workforce Supplement, aged care providers must take part in the Department of Health and Ageing's regular Aged Care Workforce Census and Survey.

4. Aged Care Workforce Supplement

Wage increases—minimum requirement

In order to access the Aged Care Workforce Supplement, aged care providers must:

- Ensure that annual increases in wages are a minimum of 2.75 per cent per annum, or the Fair Work Commission annual minimum wage increase, whichever is higher; and
- Maintain a margin over the relevant Award rates for all employees of at least:

Table 1—Percentage margin over the relevant Award rates that providers must maintain

Aged care occupations	2013-14	2014-15	2015-16	2016-17
Personal and community care workers and other aged care staff	1.50%	3.00%	3.00%	3.00%
Enrolled nurses	2.50%	5.50%	8.50%	8.50%
Registered nurses	4.00%	8.00%	12.60%	12.60%

The Aged Care Workforce Supplement must then be passed in full to each provider's aged care employees as wage increases. The Aged Care Workforce Supplement will be required to deliver a minimum additional one per cent wage increase for all employees each year in 2013-14 to 2015-16, and an additional 0.5 per cent increase in 2016-17.

On-costs are to be borne by the employer (through improved wages or conditions resulting from productivity gains for example, through decreasing staff turnover).

Improving capacity to attract and retain employees—minimum commitments

In addition to the wages requirements, there are other minimum commitments for aged care providers to meet in order to access the Aged Care Workforce Supplement, which are intended to improve the capacity of the aged care sector to attract and retain employees. These are summarised at Table 2.

It is open to providers to improve upon these provisions, based on agreed operating requirements at the enterprise level, and in line with the objectives of enterprise agreements or employment arrangements.

Table 2—Summary of minimum commitments to attract and retain employees

Area	Minimum commitment
Enhancing training and education opportunities	Access to training and education Professional development Representation leave
Improved career structures Improved career development and workforce planning	Review of part-time hours Conversion of casual employees to permanent employees Workload management Workplace health and safety Disciplinary matters

Enhancing training and education opportunities

Access to training and education

- Aged care employees are to be given access to appropriate and targeted education, training and development opportunities that are necessary and relevant to their roles and responsibilities.
- Such training should be provided to employees during normal rostered hours of work.

Professional development

- Employers commit to the professional development of employees, and that this commitment can be supported in a variety of ways at the enterprise level.

Representation leave

- Employers recognise the importance of training for those who play a representative role in the workplace through consultative committees and dispute resolution. This can be recognised in different ways at the enterprise level.

Improved career structures, improved career development and workforce planning
Employers make a commitment to taking action in areas identified as contributing to supporting improved retention rates for aged care employees.

Review of part-time hours — work-life balance and flexible working arrangements
The inclusion of work-life balance and flexible working arrangements is an essential part of attracting and retaining employees.

Providers will need to commit to cover processes and arrangements for managing and systematically reviewing the working hours of part-time employees.

- Where an employee is regularly working more than their guaranteed minimum number of hours the employee may request to have their hours reviewed annually.
- The hours worked in the following circumstances will not be incorporated in any adjustment:
    - o If the increase in hours is as a direct result of an employee being absent on leave, such as for example, annual leave, long service leave, maternity leave, workers compensation; and
    - o If the increase in hours is due to a temporary increase in hours only due, for example, to the specific needs of a resident or client.
- If a review establishes a consistent pattern of greater hours is being worked, the employer will offer the employee those additional hours as part of their guaranteed minimum number of hours.

Providers may set this provision, at the enterprise level, in the context that any adjusted guaranteed minimum number of hours resulting from a review is to reflect roster cycles and shift configurations.

Conversion of casual employees to permanent employees
Employers will use an agreed mechanism for converting casual employees who work regular and systematic hours, covering the following:
- A casual employee who has been rostered on a regular and systematic basis over a period of 26 weeks has the right to request conversion to permanent employment. An employee, who does not make a request within four weeks of the right to request falling due, is deemed not to have elected to convert.
- The new contract would generally be on the basis of the same number of hours as previously worked: however, the hours must be capable of fitting within the existing shift and rostering arrangements. Other arrangements may be implemented by agreement between the employer and the employee.
- The employer may consent to or refuse the request, but shall not unreasonably withhold agreement to such a request.

Providers may set this provision, at the enterprise level, in the context that the hours must be capable of fitting within the existing shift and rostering arrangements.

Workload management
- Employees and management have a responsibility to maintain a balanced workload and recognise the adverse effects that excessive workloads may have on employee/s and the quality of resident/client care.

- Workload management should be dealt with as and when the need arises, as determined at enterprise level.

Workplace health and safety
In recognition that improved occupational health and safety is a priority for improving the working lives of employees and the overall productivity of the sector more broadly, the minimum expectation is as follows:

Employers should set up consultative structures to support positive change in the area of workplace health and safety, supported by a program of training for participants and managers, and staff more broadly.

Disciplinary matters
Employers should ensure that in disciplinary procedures, provision is made to cover representation and procedural fairness.

Further information is available on the *Living Longer Living Better* website.

All information in this document is correct as at March 2013

Worked Examples - Home Care

Home care - *Income tested care fee calculator*

Care recipients entering home care after 1 July 2014 may be asked to make a contribution towards their care, based on their income.

The calculator is used by the Department of Human Services to work out how much a care recipient can be asked to pay in income tested care fees. This is also the amount by which the Government subsidy will be reduced.

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

Income tested care fee calculator

Step 1. Work out the care recipient's total assessable income on a yearly basis using section 44-24 of the Act. This is the definition of income that is currently used for residential care.

Step 2. Work out the care recipient's total assessable income free area using section 44-26 of the Act. For a single, this is $22,700.60 in March 2012 rates.

Step 3. If the care recipient's total assessable income does not exceed the care recipient's total assessable income free area, the care recipient cannot be asked to pay an income tested care fee.

Step 4. If the care recipient's total assessable income exceeds the income free area but not the income threshold ($43,186 for a single), the income tested care fee is equal to the lowest of the following:

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

(b) 50% of the amount by which the care recipient's total assessable income exceeds the income free area (worked out on a per day basis); and

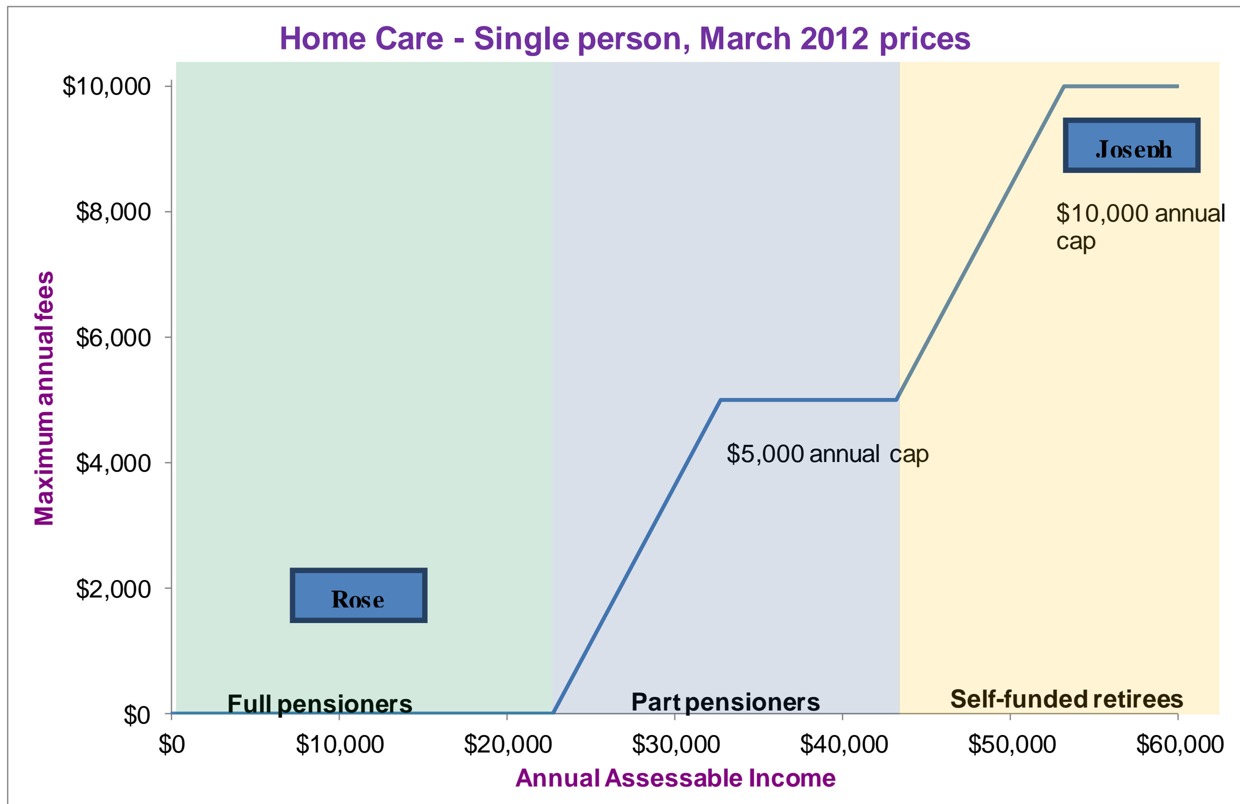
(c) the first cap (ie $5,000 per year or $13.74 per day).

Step 5. If the care recipient's total assessable income exceeds the income threshold ($43,186 for a single), the income tested care fee is equal to the lowest of the following:

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

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

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



Home care example 1 – Rose:

Rose lives with her husband, Robert, and will start to receive home care from 1 November 2014. Rose and Robert have a combined annual income of $29,000. Rose's contribution to her care is calculated as follows:

> ***Assumptions***
>
> The **income free area for a married person** is $17,605
> The **income threshold for a married person** is $33,046
> The **first cap** is $13.74 (being the daily calculation of a $5,000 annual cap)
> The **second cap** is $27.47 (being the daily calculation of a $10,000 annual cap)

Rose's contribution to her care is calculated as follows:

Step 1: A care recipient who is a member of a couple is taken to have half of the couple's combined assessable income. Rose's total assessable income is ($29,000/2) = $14,500.

Step 2 & 3: Rose's income free area is $17,605 per annum. As Rose's total assessable income does not exceed the income free area. Rose cannot be asked to pay an income tested care fee.

Note: These examples relate only to the calculation of income tested care fees in home care and means tested care fees in residential care. They do not relate to the basic daily care fee in Home Care which continues to be 17.5% of the basic aged pension, or the

standard resident contribution in residential care which continues to be 85% of the basic aged pension.

The basic daily care fee, standard resident contribution, accommodation payments and accommodation contributions are not included under the caps. The caps only relate to the income tested care fees in home care and means tested care fees in residential care.

Home care example 2 – Joseph:

Joseph lives alone. He will begin to receive home care from 29 September 2014. His basic subsidy (ie cost of his package) plus any primary supplements are calculated as $37.36 per day. His annual assessable income is $65,000.

Assumptions

The **income free area for a single person** is $22,701
The **income threshold for a single** is $43,186
The **first cap** is $13.74 (being the daily calculation of a $5,000 annual cap)
The **second cap** is $27.47 (being the daily calculation of a $10,000 annual cap)

Joseph's contribution to his care is calculated as follows:

Step 1: Joseph's total assessable income is $65,000 per annum.

Step 2: Joseph's total assessable income free area is $22,701 per annum.

Step 3: As Joseph's income is more than the income free area Joseph can be asked to pay an income tested care fee and there will be a care subsidy reduction.

Step 4: This step does not apply as Joseph's total assessable income exceeds the income threshold (ie $65,000 > $43,186).

Step 5: This step calculates Joseph's income tested care fee. It will be the lower of:

- the basic subsidy plus primary supplements, that is $37.36 per day; or
- the first cap plus half of Joseph's income above the threshold (worked out on a per day basis). That is, $13.74 + 0.5 x [(65,000-43,186)/364] = $43.70 per day; or
- $27.47 per day (the second cap).

The lowest of these three amounts is the second cap, so the maximum Joseph can be asked to pay in income tested care fees is $27.47 per day.

Worked Examples - Residential Care

Residential Care - *Calculating the means tested care fee*

To determine a person's contribution to their care, if any, the **maximum accommodation supplement** is subtracted from a person's **means tested amount**.

The means tested amount is calculated by the Department of Human Services as follows:
Work out the **income tested amount** using steps 1 to 4:

Step 1. Work out the care recipient's total assessable income. There is no change to how this is currently calculated.

Step 2. Work out the care recipient's total assessable income free area. For a single this is $22,700.60 in March 2012 rates.

Step 3. If the care recipient's total assessable income does not exceed the care recipient's total assessable income free area, the income tested amount is zero.

Step 4. If the care recipient's total assessable income exceeds the care recipient's total assessable income free area, the per day income tested amount is 50% of that excess divided by 364.

Work out the **asset tested amount** using steps 5 to 10:

Step 5. Work out the value of the care recipient's assets.

Step 6. If the value of the care recipient's assets does not exceed the asset free area, the asset tested amount is zero.

Step 7. If the value of the care recipient's assets exceeds the asset free area but not the first asset threshold ($144,500 in March 2012 rates), the asset tested amount is 17.5% of the excess.

Step 8. If the value of the care recipient's assets exceeds the first asset threshold but not the second asset threshold ($353,500 in March 2012 rates), the asset tested amount is the sum of the following:
- a) 1% of the excess;
- b) 17.5% of the difference between the asset free area and the first asset threshold.

Step 9. If the value of the care recipient's assets exceeds the second asset threshold, the asset tested amount is the sum of the following:
- a) 2% of the excess;
- b) 1% of the difference between the first asset threshold and the second asset threshold;
- c) 17.5% of the difference between the asset free area and the first asset threshold.

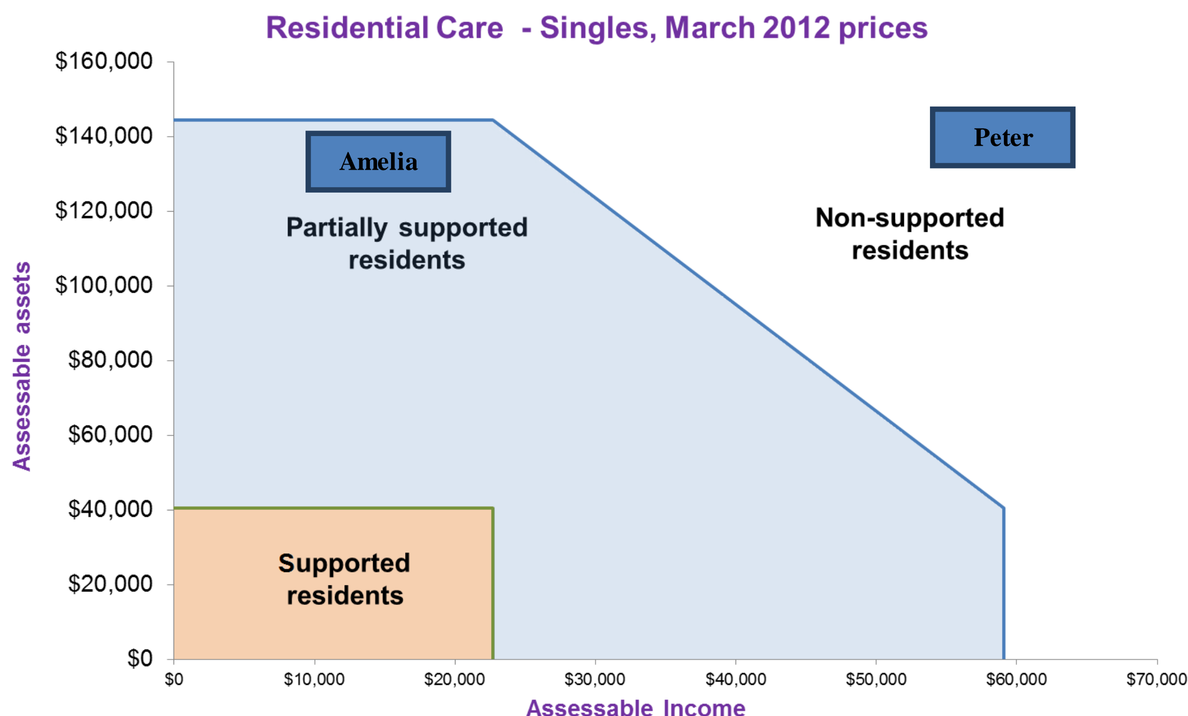
Step 10. Divide this amount by 364.

Step 11. Add the **income tested amount** and the **asset tested amount**. This is the **means tested amount**.

Step 12. Subtract the **maximum accommodation supplement amount** from the **means tested amount**.

If the amount worked out at Step 12 is:

- zero or less than zero – the person cannot be charged a means tested care fee.
- greater than zero – the person can be charged a means tested care fee. This is limited to the lower of what Government would otherwise pay in subsidy and primary supplements, or the amount worked out under Step 12 (noting this is subject to annual and lifetime caps).



Residential care example 1 – Amelia:

Amelia is entering a residential care facility on 4 July 2014. Amelia receives the full age pension and has assets valued at $120,000.

Assumptions

The **income free area** is $22,701
The **asset free area** is $40,500
The **first asset threshold** is $144,500
The **second asset threshold** is $353,500
The **maximum accommodation supplement** is $50 per day
The **annual cap** is $25,000

Amelia's contribution to her care is calculated as follows:

<u>Working out the income tested amount</u>

Step 1: Amelia's total assessable income is $19,643 per annum.

Step 2 and 3: The **income free area** is $22,701 per annum.
Amelia's total assessable income is less than the income free area; therefore, the income tested amount is zero.

<u>Working out the asset tested amount</u>

Step 5: Amelia's assets are valued at $120,000.

Steps 6 and 7: Amelia's assets exceed the asset free area ($40,500), but do not exceed the first asset threshold. This step calculates the asset tested amount:

0.175 x (120,000 – 40,500) = $13,912.50
Asset tested amount = $13,912.50

Steps 8 to 9: Do not apply as assets are not greater than the first asset threshold.

Step 10: Amelia's daily asset tested amount is ($13,912.50/364) = $38.22

Step 11: Amelia's **means tested amount** is her **income tested amount** (zero) **plus** her **asset tested amount** ($38.22).

Calculating means tested care fee, if any

Step 12: The **maximum accommodation supplement** ($50) is subtracted from the means tested amount ($38.22). This equals -$11.78.

As this amount is negative, Amelia cannot be asked to pay a means tested care fee.

Residential care example 2 – Peter:

Peter is entering a residential care facility on 30 August 2014. Peter's assets are $1,344,500, which includes the capped value of Peter's former principal residence ($144,500 at March 2012). Peter's annual assessable income is $65,000.

Assumptions

The **income free area** is $22,701
The **asset free area** is $40,500
The **first asset threshold** is $144,500
The **second asset threshold** is $353,500
The **maximum accommodation supplement** is $50 per day
The **annual cap** is $25,000
The value of the principal residence is capped at $144,500. The principal residence is not considered an asset if occupied by a protected person (as currently defined in *Aged Care Act 1997*).

Peter's contribution to his care is calculated as follows:

Working out the income tested amount

Step 1: Peter's total assessable income is $65,000 per annum.

Step 2: The income free area is $22,701 per annum.

Step 3: Peter's total assessable income is above the income free area. The excess is the difference between the two = $42,299.

Step 4: The income tested amount is 50 per cent of this excess calculated on a daily basis.
=0.5 x $42,299/364
=$21,149.50/364
=$58.10 (rounded to the nearest cent).

Working out the asset tested amount

Step 5: Peter's assets are valued at $1,344,500

Step 6: Peter's assets exceed the asset free area which is $40,500.

Steps 7 to 9: As Peter's assets exceed the second asset threshold the asset tested amount is as follows:

= 0.175 x (144,500 – 40,500)
= $18,200
+
= 0.01 x (353,500 – 144,500)
= $2,090
+
= 0.02 x (1,344,500 – 353,500)
= $19,820

Asset tested amount = $40,110.00

Step 10: Peter's daily asset tested amount is ($40,110/364) = $110.19

Step 11: Peter's daily **means tested amount** is his **income tested amount** ($58.10) **plus** his **asset tested amount** ($110.19), which is $168.29 (subject to annual and lifetime caps).

Calculating means tested care fee, if any

Step 12: The maximum accommodation supplement ($50) is subtracted from the means tested amount ($168.29). This equals $118.29.

As this amount is greater than zero, Peter could be asked to pay a means tested care fee of up to $118.29 to contribute to his care costs, until he reaches an annual or lifetime cap.

However, Peter will pay no more than the amount the Government would pay for his care in subsidy and primary supplements. Furthermore the caps will mean that Peter pays no more than $25,000 in means tested care fees in a year, or $60,000 in his lifetime. Peter may also be asked to pay an amount for his accommodation.

Encouraging greater investment in residential aged care

Key Points:
To enable people who need it to continue to access aged care, the Government is providing $486.9 million, through the *Living Longer Living Better* aged care reform package, to increase the accommodation supplement the Government pays on behalf of residents who cannot meet all or some of their own accommodation costs.

The Government is reforming aged care financing arrangements to recognise the true cost of providing aged care accommodation and give aged care providers the certainty they need so that more aged care homes (services) can be built, and existing services can be significantly refurbished.

From 1 July 2014, the maximum level of this supplement will be increased from $32.58 to $52.84. This higher accommodation supplement will apply to services that are built or significantly refurbished on or after 20 April 2012.

The definition of 'Significant Refurbishment'
The Government asked the Aged Care Financing Authority (the Authority) to advise on the definition of Significant Refurbishment. After considering stakeholder feedback, the Authority provided its final advice to the Minister on 21 November 2012.

The Government accepted the Authority's advice which will be incorporated within amendments to the Aged Care Principles and used to support applications for the higher accommodation supplement.

A refurbishment is a 'Significant Refurbishment' if it meets the following criteria:

a. the refurbishment includes alterations, updates, upgrades or other improvement that mean that the aged care home after refurbishment is significantly different either in form, quality or functionality than before refurbishment, the refurbishment predominantly provides benefit to residents and provides significant benefits to supported residents;

b. the costs of the refurbishment would be capitalised consistent with Australian Accounting Standards – that is, they are either capitalised as structural improvements where they are integral to the structure or depreciated if they relate to fixtures, fittings or anything removable intact[1];

c. i) the refurbishment involves a significant refurbishment to a minimum of 40% of the beds in the facility; or
ii) the refurbishment involves a physical extension to the size of the facility increasing the number of beds in the facility by at least 25%.

   For the purposes of i) the 40% will be calculated by using the pre-refurbishment or post-refurbishment number of beds, whichever is the lower.

d. the percentage of beds available for supported residents as a proportion of the total beds in the facility is not reduced as a result of the refurbishment; and

e. the refurbishment is of (or greater than) a prescribed minimum monetary value.

The prescribed minimum monetary value would be determined by calculating: 40% of the total beds in the facility and multiplying that number by $25,000. For example, for a 100 bed facility the prescribed minimum monetary value would be 40% x 100 x $25,000 = $1,000,000.

This same aggregate level calculation based on 40% of total beds (the lower of pre or post refurbishment numbers) would apply irrespective of whether the refurbishment involves changes to existing rooms or an extension involving the building of new rooms.

What the changes will mean for the Higher Accommodation Supplement
Services that are built or are significantly refurbished (as will be defined within the Aged Care Principles) on or after 20 April 2012 and which meet the post-end July 1999 building requirements set out in the Principles, will receive the maximum amount of accommodation supplement of $52.84 per day (estimated July 2014 rates) for each eligible care recipient.

Other services that meet the post-end July 1999 building requirements set out in the Principles will receive $32.58 per day (March 2012 rates) for each eligible recipient.

Services that meet the building certification requirements set out in the legislation, but do not meet the post-end-July 1999 building requirement, will receive $27.39 per day (March 2012 rates) for each eligible care recipient.

Services that do not meet the building certification requirements set out in the aged care legislation will receive no accommodation supplement.

Significant Refurbishment criteria
Before applying for the higher accommodation supplement, providers will need to assess whether their application is likely to meet the criteria incorporated within the Significant Refurbishment definition.

Refurbishments to the service can take the form of alterations, updates, upgrades or other improvements, implemented in any area of the service including bedrooms and common areas. They can result in improved care, facilities and amenities, privacy, access and safety systems, however, it is a requirement that the improvements to the service must predominantly benefit residents and provide a substantial benefit to supported residents.

A Significant Refurbishment project may include alterations and upgrades to the existing service and its equipment and contents. In such cases, the cost of the improvements or the minimum monetary value will need to meet a minimum level of $25,000 multiplied by 40% of the total number of beds in the service.

For example, for a 100-bed facility the minimum monetary value would 40% x 100 x $25,000 = $1,000,000.

Improvements that result in reductions in the total number of beds may also be eligible provided all other criteria were met. In such cases the 40% rule (above) would apply to the post refurbishment total number of beds.

For example, for a 100 bed facility which reduced its beds to 80 as a result of the Significant Refurbishment, the minimum monetary value is calculated as 40% x 80 x $25,000 = $800,000.

It is expected that some Significant Refurbishment projects will involve building an additional accommodation wing – i.e. a physical extension. In these cases, the criteria may be satisfied where the additional beds represent at least a 25% increase on the previous total. This lower percentage reflects the higher costs of new buildings. Where the additional beds within a new wing represented less than 25% of the previous total, the provider would need to ensure improvements were also made to the existing service, and that the combined aggregate costs were based on the 40% of total beds calculation (the lower of either pre- or post-refurbishment numbers).

In all cases of Significant Refurbishment, the percentage of beds available for supported residents as a proportion of the total beds in the facility cannot be reduced as a result of the Significant Refurbishment.

Implementation arrangements:
The new arrangements will be introduced on 1 July 2014.

Application process
Approved Providers seeking a higher accommodation supplement on the basis that they have undertaken a Significant Refurbishment will be required to apply to the Department of Health and Ageing.

Applications cannot be lodged until after the necessary amendments to the legislation and administrative arrangements have been settled. The necessary amendments to principal and sub-ordinate legislation are unlikely to be in place before mid-2013.

In early 2013, the Department will begin to work with industry to develop the necessary application process including identifying the types of information that will be required to substantiate an Approved Provider's application. In many cases it can be expected that it will be clear that a refurbishment qualifies, and only minimal supporting information will be likely. In cases where there is some uncertainty, additional information may need to be provided.

Attachment 6

Accommodation Payments for entry into residential care from 1 July 2014

Key Points:

- Australians entering aged care homes from 1 July 2014 will have more flexibility and choice about how they pay for their accommodation under the *Living Longer Living Better* reforms. The changes (outlined below) will assist people entering residential care in making informed choices and will provide them with stronger consumer protections.

- These changes will only affect residents who have a capacity to contribute to the cost of their accommodation. Those with low means will have their accommodation costs met by Government in full or met in part by Government through the Government accommodation supplement.
- Accommodation payments will be split into three levels:
  - Level 1: From $0 to the amount of the maximum Government accommodation supplement ($50 per day from 1 July 2014, or lump sum Refundable Accommodation Deposit equivalent is $238,845);
  - Level 2: From the maximum Government accommodation supplement to $85 per day (indexed, Refundable Accommodation Deposit equivalent is $406,037)
  - Level 3: Amounts greater than Level 2.
- All Approved Providers will be required to publish their accommodation prices.
- Those residents of low means for whom the Government pays some level of accommodation supplement will continue to have their accommodation payments capped by the relative level of Government accommodation supplement for the facility (falling within Level 1).
- Approved Providers will publish a self-assessment of the reasonableness of their Level 2 prices.
- All Level 3 prices must be pre-approved by the relevant government authority.

Consultation with industry and consumer groups will take place to develop guidelines for reasonable pricing and to determine how best to ensure residents can raise any concerns they have over pricing. These guidelines will be finalised by April 2013.

All residents may choose to pay for accommodation as a Daily Accommodation Payment, an equivalent Refundable Accommodation Deposit, or a combination of both and will have up to 28 days to decide from entering care.

Methods of payment

Accommodation payments can be paid as a Daily Accommodation Payment, a lump sum Refundable Accommodation Deposit, or a combination of both. Daily Accommodation Payments can be paid by the resident from external sources or can be drawn down from a lump sum Refundable Accommodation Deposit that the resident has paid to the provider. In this case the provider could increase the Daily Accommodation Payment by an amount that compensates for the impact of the decreasing Refundable Accommodation Deposit balance.

The Refundable Accommodation Deposit equivalent of a Daily Accommodation Payment will be calculated using a rate up to the maximum permissible interest rate (currently 7.62%).

For example, accommodation priced at $80 per day could be paid as follows:

A Daily Accommodation Payment of $20 per day and the balance of the price ($60 per day) paid as a lump sum Refundable Accommodation Deposit, calculated as follows:

$$\frac{\text{balance of price per day} \times 364}{\text{Interest Rate}} = \frac{\$60 \times 364}{7.62\%} = \$286,614$$

The maximum amount of a Refundable Accommodation Deposit that a resident can pay must leave the resident with at least the minimum permissible asset level (currently $41,500) calculated as 2.25 times the basic age pension amount at the entry time.

Choice of payment method period
Residents will have up to 28 days after entering an aged care home in which to decide how they will pay for their accommodation, whether it be by Daily Accommodation Payment, Refundable Accommodation Deposit or a combination of both.

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

Publishing of prices
Approved providers will be required to publish the current level of accommodation payments showing the Daily Accommodation Payment, the equivalent Refundable Accommodation Deposit and at least two examples of combination payments, which must include:
- An example of a Daily Accommodation Payment paid in addition to a Refundable Accommodation Deposit; and
- An example of a Daily Accommodation Payment drawn from a Refundable Accommodation Deposit.

This information must be readily available on their website and in documentation provided to prospective residents and their families.

This information will also be published on the *My Aged Care* website by the Government to facilitate comparison of prices.

Providers will be required to publish accommodation prices for rooms that will be available to residents entering care from 1 July 2014. Providers will be required to publish their 1 July 2014 prices from 1 April 2014. This will ensure that residents have the relevant information with which to make decisions regarding their accommodation.

Approved providers and residents may agree an amount that is less than the published price.

Guidelines
Consultation with industry and consumer groups will be undertaken on the development of guidelines for reasonable pricing, including how residents can raise concerns about prices.

Self-assessment and pre-approval of prices
Providers will be required to conduct a self-assessment of their prices that fall within Level 2 and publish that self-assessment alongside their prices. Before a provider can publish or charge a Level 3 price, they must apply to the Government for approval. Self-assessment and pre-approval will be based on the guidelines.

Residents with low means who are eligible for a Government accommodation supplement will have their total accommodation payment capped by the relevant maximum accommodation supplement for the facility.

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

Retention Amounts
While providers will not be able to deduct retention amounts from Refundable Accommodation Deposits paid by residents who enter care from 1 July 2014, daily accommodation payments will be deducted from the Refundable Accommodation Deposit if requested by the resident.

In this case, the provider may increase the Daily Accommodation Payment by an amount that compensates for the impact of the decreasing Refundable Accommodation Deposit balance (calculated using the same interest rate used in determining equivalence of Daily Accommodation Payment and Refundable Accommodation Deposit). This needs to be clearly explained to the resident.

Attachment 7

Worked Examples - Accommodation Payments

Scenario 1
A resident and approved provider agree on an accommodation price of $60 per day. The equivalent refundable deposit (using December 2012 equivalency of 7.62%) is $286,614.17. The resident has 28 days to decide on their method of payment.

During this time, they pay the daily payment. There are three payment methods by which the resident can pay for their accommodation:

1. The resident can make periodic payments of the daily amount of $60 up to one month in advance.

2. The resident could pay by a full refundable deposit of $286,614.17, and no daily payment.

3. The resident could pay by a combination of daily payment and refundable deposit. For example, the resident could pay half by daily payment ($30 per day) and the balance by a refundable deposit of $143,307.08.

Draw-down of the daily payment from the refundable deposit
If a resident is paying by a combination, they could request in writing that their daily payment of $30 is 'drawn-down' from the refundable deposit. The approved provider may increase the daily payment in proportion to the reduction, to compensate for the lower investment earnings that would result from the reducing refundable deposit balance. The provider would be expected to explain the reason for increasing the daily payment to the resident.

After the first month (30 days) of daily payments is deducted, the refundable deposit balance is reduced to $142,407.08. The daily payment amount increases to $30.19.

After each agreed deduction from the refundable deposit, the daily payment amount can be recalculated to maintain the agreed accommodation payment.

Scenario 2 – Low range Level 1 Accommodation Payment
Vera lives in rural NSW. She is about to enter residential aged care. Vera is not eligible for the Government to pay an accommodation supplement on her behalf.

The aged care home has advertised an accommodation payment for the type of room that Vera would occupy within the Level 1 pricing band at a Daily Accommodation Payment of $35.06 (equivalent to a Refundable Accommodation Deposit of $167,500).

Vera has 28 days after entering care to decide whether she wishes to make her accommodation payment as a Daily Accommodation Payment, Refundable Accommodation Deposit, or through a combination of both.

Vera decides to pay entirely by a Daily Accommodation Payment of $35.06.

Scenario 3 – High range Level 1 Accommodation Payment
Yuri's family is helping him look for residential aged care in central Brisbane. Centrelink has assessed Yuri's assets at $350,000. The result of Yuri's means test is that he is not eligible for an accommodation supplement to be paid on his behalf.

They select an aged care home with an advertised accommodation payment of $48.15 Daily Accommodation Payment (equivalent Refundable Accommodation Deposit of $230,000). Yuri and his family meet with the home, and they agree to pay the advertised price.

It is discussed with Yuri that he could make this accommodation payment through a combination of a Refundable Accommodation Deposit and a Daily Accommodation Payment. One of the examples discussed was paying a Daily Accommodation Payment of $25.12 per day and a Refundable Accommodation Payment of $110,000 (in lieu of the balance of the Daily Accommodation Payment of $23.03.) Alternatively, Yuri could choose to pay the entire amount as a Daily Accommodation Payment of $48.15 per day, or any other equivalent combination of Daily Accommodation Payment and Refundable Accommodation Deposit.

Yuri still has 28 days from the date he enters care in which to make his decision as to how he wishes to make his accommodation payment.

Scenario 4 – Low range Level 2 Accommodation Payment
Janice lives in regional Victoria. She is about to enter residential aged care, and Centrelink has assessed her assets to be $310,000. Janice is means tested and the Government does not pay an accommodation supplement on her behalf.

Janice has high care needs. Under the current aged care system, she would not be eligible to pay for her accommodation through an accommodation bond unless she entered an extra services place. After 1 July 2014, the distinction between high care and low care residents will be removed.

The local aged care home she wishes to enter has advertised an accommodation payment for the type of room that Janice would occupy within the Level 2 pricing band at a Daily Accommodation Payment of $54 per day (Refundable Accommodation Deposit equivalent of $257,953).

Janice decides to make her accommodation payment through a Refundable Accommodation Deposit of $257,953 with no Daily Accommodation Payment. This leaves her with $52,047 in assets, which exceeds the minimum permissible level of assets of $41,500.

Scenario 5 – High range Level 2 Accommodation Payment
Li-Chin found an aged care home that she wishes to enter with an advertised Daily Accommodation Payment of $73.27 per day (Refundable Accommodation Deposit equivalent of $350,000). Centrelink has assessed Li-Chin's assets at $380,000 and she is a part pensioner.

Li-Chin agrees to pay the advertised price and plans to make her accommodation payment through a combination of a Daily Accommodation Payment of $31.40 and a Refundable Accommodation Deposit of $200,000, with the Daily Accommodation Payment to be drawn

down monthly from her Refundable Accommodation Deposit. She has 28 days after entering care to finalise her decision on how she wishes to make her accommodation payment.
The accommodation payment agreement describes how the daily payments will increase in proportion to the reduction, to compensate for the lower investment earnings that would result from the reducing Refundable Accommodation Deposit.

Scenario 6 – Low Level 3 Accommodation Payment
Anwar is a self-funded retiree with an annual income of $40,000 and assets of $800,000. The home he wishes to enter has advertised a Daily Accommodation Payment of $106.76 (Refundable Accommodation Deposit equivalent of $510,000). As this is a price within the Level 3 pricing band, this price would have been required to be assessed and approved by the Aged Care Pricing Commissioner. Anwar agrees to pay this amount.

Anwar decides to pay a Refundable Accommodation Deposit of $388,500 (equivalent Daily Accommodation Payment of $81.33) and a Daily Accommodation Payment of $25.43 per day (Refundable Accommodation Deposit equivalent of $121,500). Anwar elects to pay the Daily Accommodation Payment from his income and will not have it drawn down from his refundable deposit.

Situation 7 – Accommodation contribution
Joe has assets of $100,000, and his only income is the full age pension, Joe would be eligible for some accommodation supplement, as shown below.

Calculate the means tested amount:

Income tested amount	= income is not greater than the income free area, therefore	$0.00
Asset tested amount	= 0.175 x (Assets - asset free area) = 0.175 x (100,000-41,500)	$10,237.50
Means tested amount	=	$10,237.50

(in September 2012 figures)

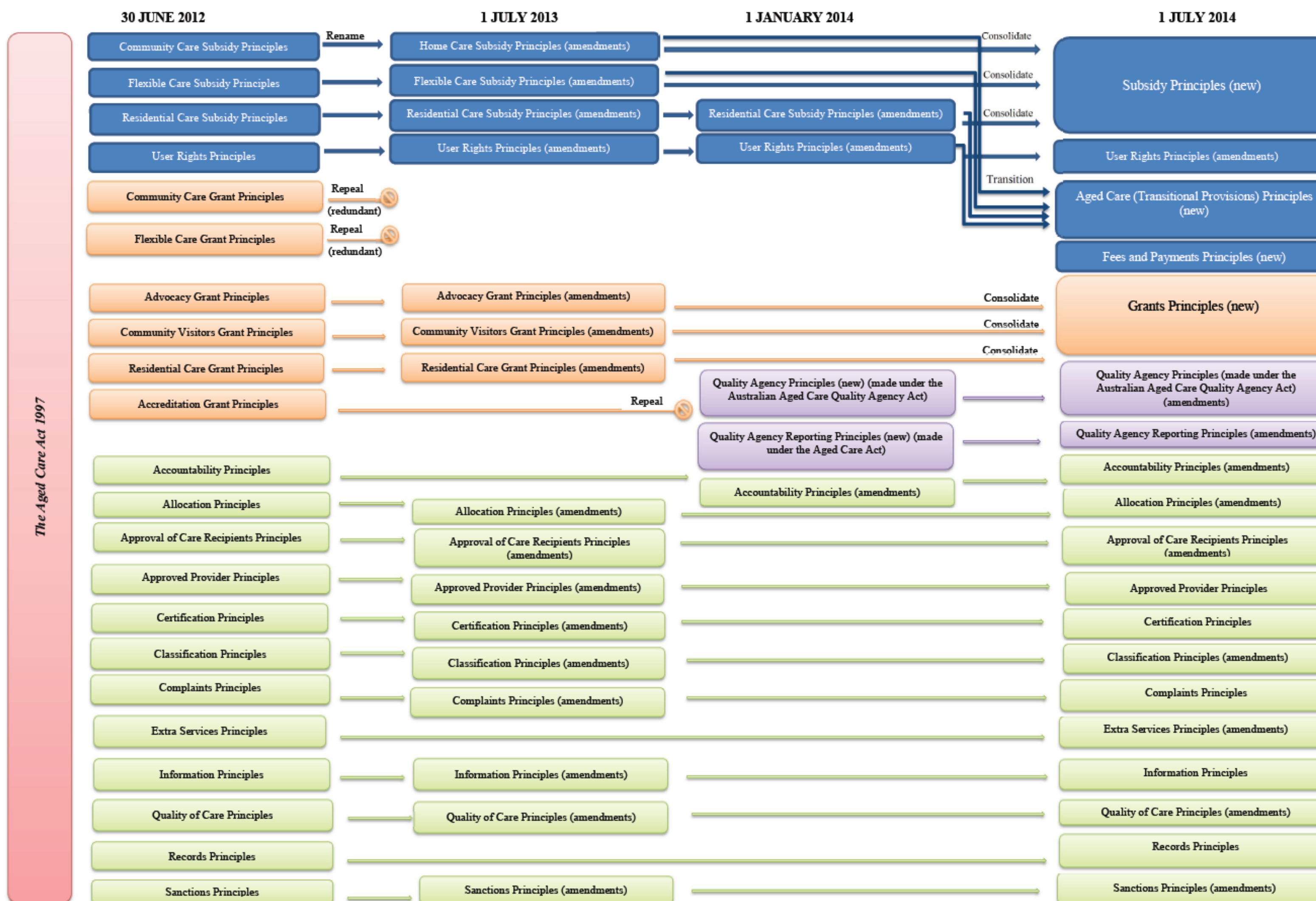
The means tested amount is $10,237.50 (or $28.125 per day). As this amount is less than the maximum accommodation supplement payable ($18,301 in September 2012 rates), the person will be eligible for some accommodation supplement.

The accommodation supplement amount is the difference between the maximum accommodation supplement for the facility (assume this is $32.76) and the means tested amount. On a daily basis this is $32.76 - $28.12 = $4.64.

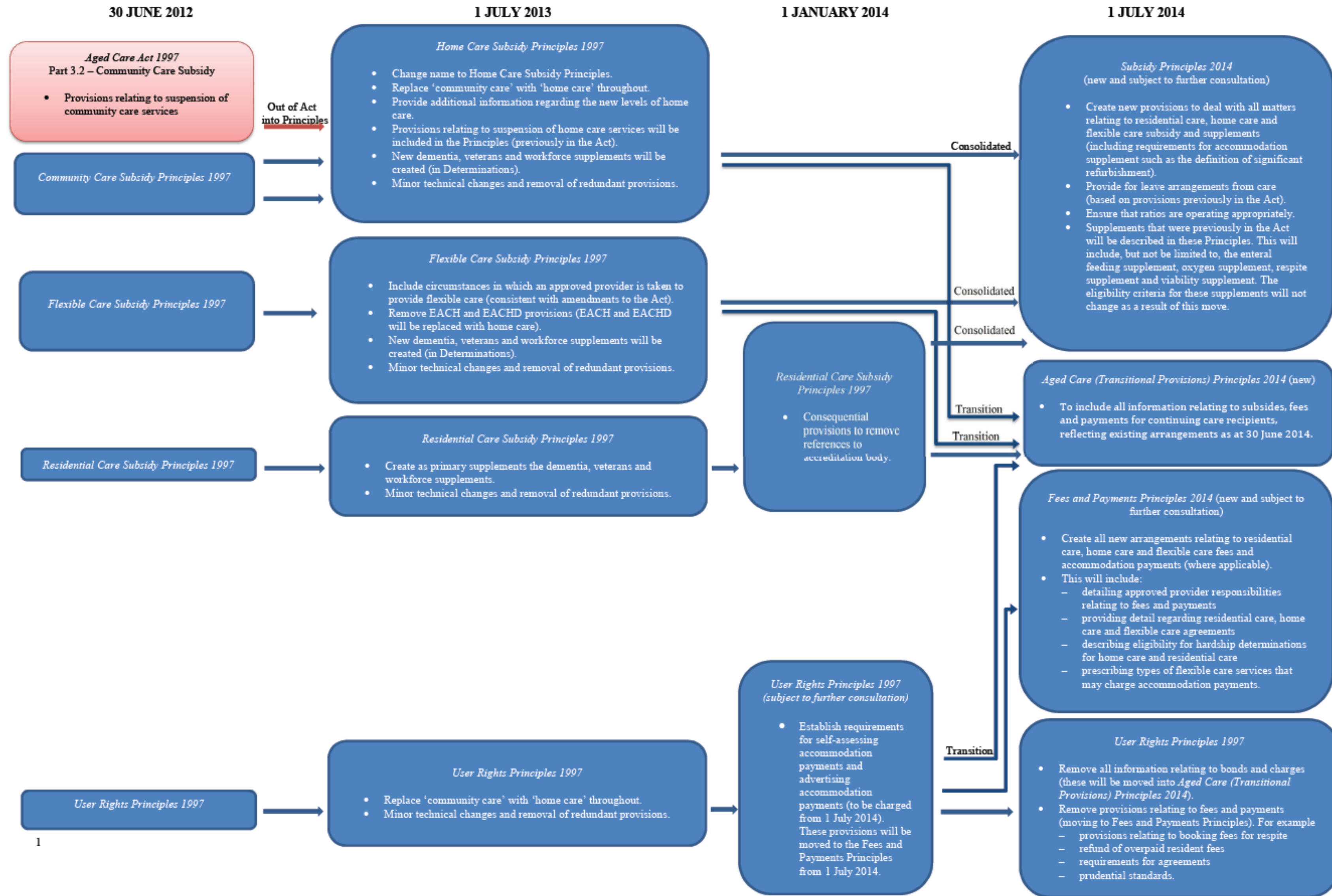
This means that the Government would pay $4.64 in accommodation supplement and the provider can ask the care recipient to contribute up to $28.12 per day (because the person is eligible for some accommodation supplement, the amount that they pay is referred to in the legislation as an accommodation contribution, not an accommodation payment). The resident could choose to pay this as a refundable accommodation contribution (lump sum), a daily accommodation contribution, or a combination of both.

Attachment 8

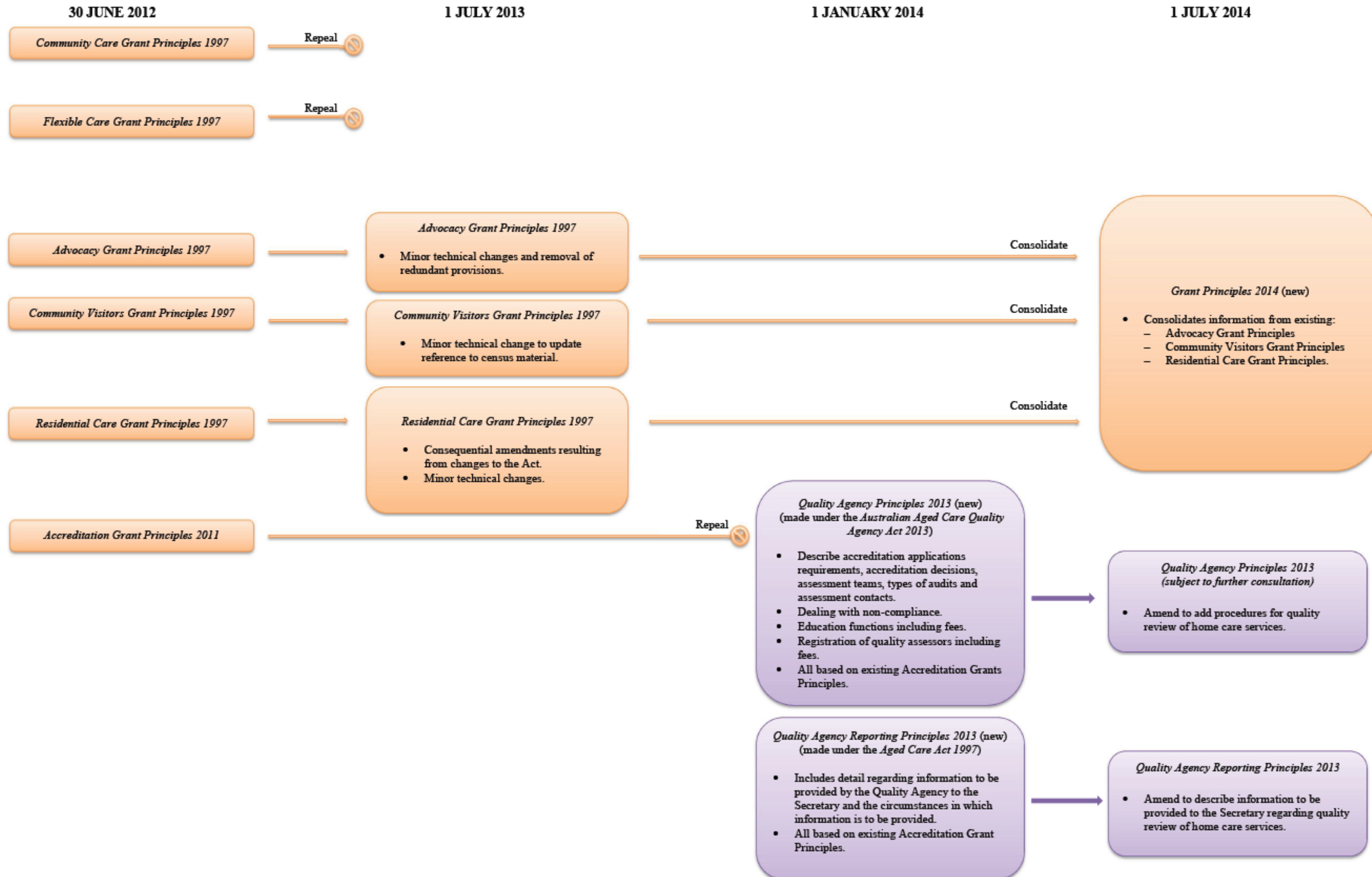
Aged Care Principles Navigation Guide



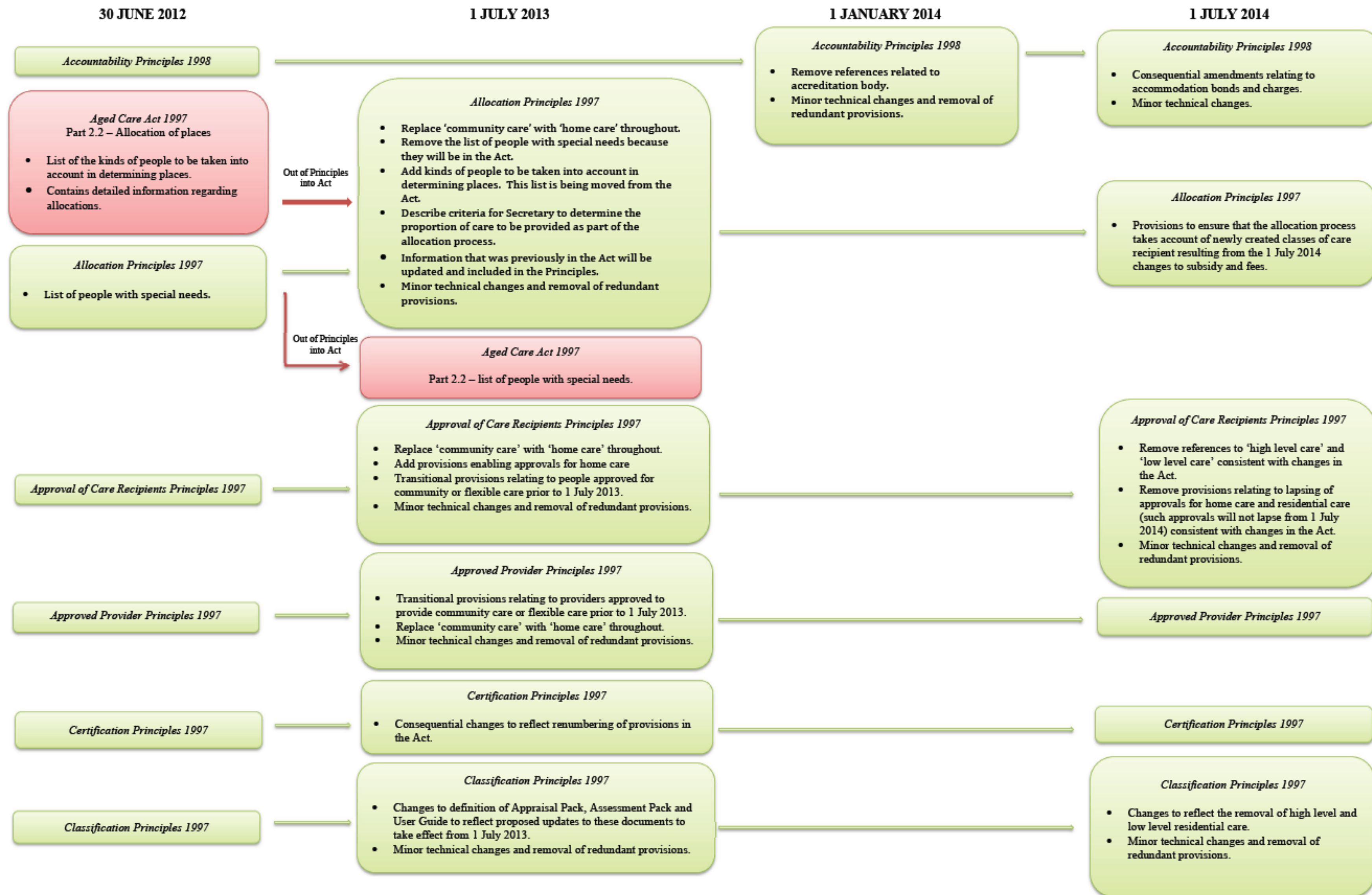
Detailed Amendments to Subsidy Principles– as at 18 March 2013



Detailed Amendments to Grant Principles and Quality Agency Principles – as at 18 March 2013



Detailed Amendments to Other Principles– as at 18 March 2013



Detailed Amendments to Other Principles– as at 18 March 2013