CATHOLIC HEALTH
AUSTRALIA

Catholic Health Australia

SUBMISSION TO SENATE FINANCE AND PUBLIC ADMINISTRATION COMMITTEE

INQUIRY INTO RESIDENTIAL AND COMMUNITY CARE IN AUSTRALIA

Catholic Health Australia welcomes the opportunity to make a submission to the Inquiry into Residential and Community Care in Australia. Catholic Health Australia requests to be kept informed of the inquiry's progress and to be offered the opportunity for further input as the Inquiry progresses.

SUMMARY RESPONSE

By way of **summary response** to the Inquiry into Residential and Community Care in Australia's Terms of Reference we submit that:

- The funding system for aged care be based on a defined and properly costed benchmark of care, This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual
- That the aged care regulations be reviewed and that their impact on consumer choice and access is assessed.
- That the ACATs apply the ACFI as the assessment for residential care admission.
- In the absence of this approach, the determination as to whether a resident is assessed as High or Low care for the purposes of paying an Accommodation Charge or Bond, be the ACFI, as submitted for care subsidy claiming by the Approved Provider.
- The regulations around eligibility to pay a Bond or Charge be abolished and providers be required to publish bed rental amounts and provide consumers with the choice of either a daily rental charge or a refundable Bond lump sum.
- The government provide funding for an acceptable minimum standard, to ensure the socio-economically are not disadvantaged.
- The Building Quality Certification process be abolished with the privacy and space requirements to be included in either the Building Code of Australia 9C or other quality frameworks.
- The adoption of a new indexation benchmark weighted at 75% for wage growth and 25% for non-wage growth, using the Labour Price Index (Health and Community Services) for the wage element and the Consumer Price Index (CPI) for general prices.
- That the government review the adequacy of the current viability supplement in order to meet the true cost of service delivery and ensure sustainability in rural and remote areas.
- Capital grants programs for the development and redevelopment of residential services that target lower socio-economic communities is continued and expanded.

- Uniform user payments across HACC and Community Care services be adopted.
- Higher concessional supplements be made available to mitigate the inequitable subsidisation of in residential aged care by non concessional bond paying low care residents.
- Until the existing planning and allocation systems are abolished, planning and allocation of residential places be on the basis of 88 places per thousand people aged 70 plus.
- The government combine CACPs, EACH and EACHD packages into the one allocation with funding according to dependency.
- Prior to making place distribution decisions, ACPACs seek from stakeholders in each planning region their assessment of needs in their relevant geographic catchment areas.
- DoHA make available to the industry the demographic and allocated and operational place data for each planning region and LGAs within those regions.
- ACATs become fully owned and controlled by the Australian government and assess eligibility for a subsidy.
- This eligibility and subsidy for new clients be transportable and follow the consumer thus allowing the consumer to choose whether the care is received at home or in a residential aged care facility.

This brief submission in response to the Terms of Reference is an initial expression of the concern of CHA for the impact of the current status of funding, planning, allocation, capital and equity in the residential and aged care sector in Australia.

BACKGROUND

Catholic Health Australia (CHA) represents the largest non-government grouping of not-for-profit health and aged care services in Australia.
Catholic Health Australia recommends that the following issues frame any further review of funding, planning, allocation, capital and equity in the residential and aged care sector in Australia.

1. Older Australians receive the care they need in the accommodation of their choice, whether in their own home, in the community or residential facility.

Population based planning

- Planning for aged care services is reflective of current population projections. Projections for planning regions must be reviewed and re-modelled regularly as more timely data in relation to demand and demographics are available.

Informal Care

- Informal care is supported and encouraged through appropriate levels of income support, flexible employment options, adequate respite services and through the taxation system.

Accessing Care

- Implementation of a fully Commonwealth funded national entry and access assessment service. This service would comprise multi-disciplinary teams, located according to revised planning regions.

2. Demographic based funding will be oriented to ensure the delivery of excellence in person centred, compassionate care.

Equitable Access

- A single, simplified and consistently applied national aged care program, in order to receive the right care, in the right place, at the right time.
- Regular assessment of unmet need by planning regions.
- The establishment of a Health and Aged Care Access Ombudsman to examine and review complaints regarding access to aged care services.

Person Centred

- Funding and quality monitoring systems rewards and enhances the capacity of aged care services to deliver person centred care.

3. The funding framework will ensure that the care of older Australians is delivered by an appropriately skilled and qualified workforce.

Coordination

- Establishment of a National Health Workforce Commission that consolidates all current initiatives aimed at health workforce planning and development.

Licensing and Competency

- All aged care workers have completed a minimum competency based training program, and are licensed under a national regulatory system.

Scope of Practice

- Broaden scope of practice to reflect consumer needs and workforce availability.

Workforce Support

- Support provided to ensure access to continuing education initiatives. This will assist in the recruitment and retention of aged care workers.

Palliative Care

- All aged care workers have completed a minimum competency based training program in the provision of a palliative care approach in Residential Aged Care.
- That pain assessment and management, symptom management, end of life care, support of and communication with the family, grief and bereavement support and advanced care planning be incorporated into a review of the Aged Care Standards and quality monitoring processes.

CURRENT AGED CARE CHALLENGES

The Productivity Commission has released a research paper, titled Trends in Aged Care Services: Some Implications (September 2008). This document analyses major

trends in both demand and supply within the Aged Care Sector over the next 40 years. The study draws out implications for the future structure and mix of aged care services, the aged care workforce and for the capacity for greater productivity in the sector. Emerging opportunities for improving productivity include greater use of: information technology (although cost is often prohibitive); assistive technologies that allow individuals to perform tasks that they would otherwise be unable to do, or to increase the ease and safety with which tasks may be performed; changed work practices through the use of innovative workplace agreements; restructuring of activities; and most importantly regulatory reform.

DIVERSITY

Aged Care policy has tended to assume that older people are an homogenous population group – but older people are as diverse as any other part of the population. Policies and programs that use age as a criterion for exclusion may not deliver the most appropriate health care response. The differences within this population group are important to understand if the system is to respond effectively to the diverse health needs of older people.

UNMET NEED

CHA members and consumers tell us there is unmet need particularly in relation to Home and Community Care Services (HACC) – with growing waiting times to gain access to care. It would be useful to quantify this unmet need, particularly to inform the development of new funding models. The programmic nature of residential aged care, rehabilitation and sub acute services do not allow for ease of movement across programmes. The future should see consumers being able to move in and out of residential aged care – back into their homes or into rehabilitation services. Future funding approaches should support this.

LACK OF CONSULTATION

Policy that is uninformed by the population it affects will be inflexible and will not meet the needs of the population it is trying to serve. Hence CHA advocates for a policy process, or audit, whereby involvement of older people in planning, developing, evaluating and using integrated services occurs, in order to ensure that older people and their carers are central to the planning of these services.

AFFORDABILITY

There are serious short-term operational and long term capital problems facing the residential aged care sector – these have been well documented. There are strict government certification standards but the requirements leave the high care component of the sector heavily dependent upon cross subsidies from low care funding. Overall there is a lack of access to capital funding which is clearly unsustainable. Capital stock will not be built unless other means of accessing capital funds are made available, or certification standards are relaxed. Added into this mix is the increasing cost of wages and higher interest rates. It is estimated that currently over 40% of high care providers operate at a loss.[1]

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[1] Sammut Jeremy: Spin won't make 'high care' aged care sector sustainable, http://www.onlineopinion.com.au/view.asp?article=7631, posted Thursday, 17 July 2008

Finally, there must be a recognition that into the future different consumers will have different abilities to pay for aged care services.

REGULATION

The Aged Care industry in Australia is heavily regulated and according to Professor Warren Hogan this regulation allows providers to avoid competition, which would have the potential to create greater efficiencies and improved quality of service.[2] Whilst national competition policies are in place, with the ACCC being established in order to promote competition and fair trade in the market place in order to benefit consumers, businesses and community - the aged care sector's ability to improve both efficiency and cost effectiveness is limited.

It is argued that the degree of regulation that is in place exists in order to secure the provision of quality services, equity of access and gate keeping in terms of government expenditure – all laudable goals. CHA argue that these goals could still be achieved with a loosening of regulation – but not a complete deregulation.

CHA calls for existing planning and allocation systems to be abolished and for ACATs to become fully owned and controlled by the Australian Government. ACATs could then assess eligibility for a subsidy. This eligibility and subsidy could then be transportable and follow the consumer. This approach would assist in the implementation of consumer directed care models for the Australian Government subsidised Community Care Packages.

In addition, regulations surrounding accommodation bonds have had the effect of reducing available capital investment within the sector. In order to grow capital investment, providers should be allowed to publish bed rental amounts and provide consumers with the choice of either a daily rental charge or a refundable lump sum or combination of both. The current disparity between who is charged an accommodation bond and who is not creates perverse incentives. A bed rental scheme addresses this issue with the government providing funding for an acceptable minimum standard, hence ensuring the socio-economically are not disadvantaged. It also offers greater flexibility and choice to the consumer.

ADDRESSING THE TERMS OF REFERENCE:

Catholic Health Australia offer the following comments in relation to the Terms of Reference for the Inquiry.

1.Whether current funding levels are sufficient to meet the expected quality service provision outcomes

[2] Hogan, W.P. (2007) 'The Organisation of Residential Aged Care for an Ageing Population', Papers in Health and Ageing (1), The Centre for Independent Studies Policy Monograph 76, Sydney

The current funding system for residential aged care is an inadequate basis on which to provide quality care because the funding is inadequately indexed and does not reflect the real costs of providing care based on resident outcomes.

As there is no real relationship between the care subsidies and the cost of care and the quality outcomes required, CHA calls for the funding system for aged care to be based on a defined and properly costed benchmark of care. Without the CAP, we know that funding is inadequate. In it's place CHA advocate for the development of a more robust system of establishing the cost of delivery of care.

This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.

The regulation over the current income levels available to approved services, ie the subsidies from the Government and the resident daily care fees, imposes a tight operating regime on the sector. It is interesting to note that the current subsidy regime is based on a cost contribution model, however, with Commonwealth Review Officers validating RCS claims resulting in annual clawbacks by the Department of Health and Ageing of around $20 million, the Government has imposed a "cost containment" approach to the essential care of sick and frail older people. CHA calls for a review of the regulations and their impact on consumer choice. It is CHA's view that the current suite of regulations are limiting consumer access and choice

The subsidy is a contribution to the cost of providing care in the same way that the pre 1 October 1997 hostel subsidy regime operated. However, under that arrangement, hostels were able to charge variable fees to residents with income above the pension and also an entry contribution, now known as an accommodation bond.

Nursing homes pre 1 October 1997 operated on a cost reimbursement model. Whilst residents paid no more than 87.5% of the then Pension and Rent Assistance and didn't make an entry contribution nor pay variable fees, the CAM subsidy level was adjusted with changes in nurses' wages. In addition there was an automatic reimbursement of certain costs such as Workers Compensation premiums and Payroll Tax through the Other Cost Reimbursement Expenditure (OCRE) payments by the Government.

The Aged Care Structural Reforms of 1997 moved the cost reimbursed nursing homes into a cost contribution model along with the hostels but removed from the hostels the right to additional variable income. This saddled the sector with an unsustainable funding model in the long term.

The current funding model also fails to recognise the cost of providing good quality management systems to support the complex Government payments, regulation and accreditation systems.

The funding pool was originally set in 1988 based on a 1984-85 nursing home cost study. With the introduction of the Aged Care Act 1997, the pool established at that time comprised the then nursing home subsidy pool and the hostel subsidy pool. The 1984-85 nursing home cost study is still the only industry cost reference point for the subsidy pool.

In 1999 the aged care standards accreditation framework came into being requiring all approved providers to have their approved residential aged care services independently quality assessed against 44 set Standards Outcomes. Neither the care subsidy levels nor the subsidy indexation factor were adjusted to incorporate any increased cost of accreditation.

In 1999 a new building quality certification instrument was introduced that laid down minimum space and privacy requirements to be achieved by 2008. This meant that new residential aged care facilities constructed since 1999 have been required to have no more than an average of 1.5 persons per bedroom and 3 per toilet and 4 per shower.

The resultant capital and staffing cost increases have not been reimbursed through any increase in basic subsidies, nor a change in the subsidy indexation factor nor the capacity to finance the capital cost of High care through refundable lump sum loans known as Accommodation Bonds as is the case in Low care.

Based on a simple analysis, to build a high care residential place at a conservative minimum cost of **$180,000** per bed, the following would apply:

- Where such a cost is wholly debt funded at an annual interest of **7.6%** payable over **15** years, it would cost a provider **$20,146** per annum, or more significantly **$55.23** per bed per day to cover this debt. Such a cost is well in excess of what is provided by way of the Accommodation Charge, which is **$26.88** per bed per day.

- It must be noted too, that as part of the roll-out of ACFI, the previous Pensioner Supplement of $7.60 per day was taken away, being instead included in the adjusted Accommodation Charge. In real terms the Accommodation Charge was only increased by a couple of dollars compared to how it was under pre-March '08 arrangements

- Rather, by using the same rate of interest and term, the Accommodation Charge of $26.88 per day is only sufficient to support a capital cost of **$87,600** per place.

- However, if the adjustment of the removal of the Pensioner Supplement is factored, the Accommodation Charge more realistically is only capable of supporting a capital cost of **$63,000** per place whereas the real cost can now vary between **$200,000** and **$300,000** per bed.

Industry bench-mark analysis is demonstrating, on a recurrent basis, High Care facilities are progressively becoming more and more marginal, which results in there being no surplus from ordinary operations to cross-finance capital debt.

It is fair to say the strictures of the Accommodation Charge, as the only capital funding option permitted in non-extra service high care facilities is an enormous problem for the sector spanning all the way back to 1997.

The current high care / low care separation is an artificial one based on the classification levels under the ACFI and unrelated to the support needs of the resident population. The split was set on a basis of the proportion of new residents being assessed as High care under the Resident Classification Scale (RCS).

Whereas under the RCS the split occurred at the midpoint of the 8 level RCS classification system, under the ACFI, of the 64 funding levels, only 12 are Low care and of these, 50% generate less care subsidies than was the case under the RCS. Providers are finding fewer incoming residents are assessed as low care with a number attracting too little funding to be admitted.

CHA members report that ACATs are deliberately assessing some people as High care so as they will not have to pay a Bond. In one case an ACAT assessed a resident as High care but when assessed under the ACFI, attracted Nil funding for Activities of Daily Living (ADL), Nil funding for the Behaviour Supplement (BEH) and Nil funding for Complex Health Care (CHC).

CHA recommends that the ACATs apply the ACFI as the assessment for admission. In the absence of this approach, the determination as to whether a resident is assessed as High or Low care for the purposes of paying an Accommodation Charge or Bond, be the ACFI as submitted for care subsidy claiming by the Approved Provider.

The regulations surrounding accommodation bonds have had the effect of reducing available capital investment within the sector. To grow capital investment, providers should be allowed to publish bed rental amounts and provide consumers with the choice of either a daily rental charge or a refundable lump sum. The current disparity between who is charged an accommodation bond and who is not creates perverse incentives. A bed rental scheme addresses this issue with the government providing funding for an acceptable minimum standard, hence ensuring the socio-economically are not disadvantaged. It also offers greater flexibility and choice.

Building certification, introduced in 1997 and enhanced in 1999, only serves to replicate the Building Code of Australia Standards. The two criteria that do not replicate the standards – privacy and space requirements – could and should be dealt within either the Building Code 9C or other quality frameworks.

Community Aged Care Packages (CACPs), Extended Aged Care in the Home (EACH) packages and Extended Aged Care in the Home Dementia (EACHD) packages have only one funding level each regardless of the hours of care each individual package recipient requires. The service provider is required to pool the total package income received and fund the varying hours of care accordingly.

Again, no cost study has been undertaken to establish a proper benchmark of care cost.

Recommendations:

1.1 CHA calls for the funding system for aged care to be based on a defined and properly costed benchmark of care. This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.

1.2 CHA calls for a review of the aged care regulations and their impact on consumer choice. It is CHA's view that the current suite of aged care regulations are limiting consumer access and choice.

1.3 That the ACATs apply the ACFI as the assessment for residential care admission.

1.4 In the absence of this approach, the determination as to whether a resident is assessed as High or Low care for the purposes of paying an Accommodation Charge or Bond, be the ACFI as submitted for care subsidy claiming by the Approved Provider.

1.5 The regulations around eligibility to pay a Bond or Charge be abolished and providers be required to publish bed rental amounts and provide consumers with the choice of either a daily rental charge or a refundable Bond lump sum.

1.6 The government provide funding for an acceptable minimum standard, to ensure the socio-economically are not disadvantaged.

1.7 The Building Quality Certification process be abolished with the privacy and space requirements to be included in either the Building Code of Australia 9C or other quality frameworks.

2. How appropriate the current indexation formula is in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services.

Basic subsidy rates are adjusted annually in line with movements in the Commonwealth Own Purposes Outlays (COPO) index formula. The particular index used for residential aged care is Wage Cost Index 9 (WCI_9), which is weighted at 75% for wage costs and 25% for other costs. WCI_9 uses the growth in the Safety Net Adjustment (SNA) for indexing wage costs and the growth in the CPI for non-wage costs.

Over the four years following the introduction of the Conditional Adjustment Payment (CAP) in 2004-05, national average basic subsidies (excluding CAP) increased by an average of 1.8% per annum for High care rates and 2.0% per annum for Low care rates. Most notably, increases in both High care subsidy rates (average 3.5% per annum) and Low care rates (average of 3.7% per annum) only kept pace with CPI growth and, indeed, slightly exceeded it when topped up by the CAP payment set at 1.75%.

CHA's submission to the **CAP Review** argued that the basic subsidies paid for residential and community care should be indexed in line with a benchmark that better captures cost pressures in the health and aged care sector than the one currently used. We recommended the adoption of a new benchmark weighted at 75% for wage growth and 25% for non-wage growth, using the Labour Price Index (Health and Community Services) for the wage element and the Consumer Price Index (CPI) for general prices.

In the absence of a change in the indexation factor, CHA considers that the CAP should continue to be indexed. Support for this view can be found in the Grant Thornton Aged Care Survey 2008.

This survey found that overall, average returns (EBITDA) for aged care providers dropped away by 10 per cent in just one year, from $3,211 per bed per annum in 2007 to $2,934 in 2008.

Modern high care facilities with single bedrooms reported the worst results, $2,191 per bed per annum. Grant Thornton estimates that the average return on investment for new, single room facilities is now just 1.1 per cent and falling.

Recommendations:

2.1 CHA recommends the adoption of a new indexation benchmark weighted at 75% for wage growth and 25% for non-wage growth, using the Labour Price Index (Health and Community Services) for the wage element and the Consumer Price Index (CPI) for general prices.

3. Measures that can be taken to address regional variations in the cost of service delivery and the construction of aged care facilities

There is no equity between metropolitan and rural and remote Australia in the current capital and operational funding regimes. Failure to correct this imbalance in the funding arrangements will lead to the demise of many rural services.

A CHA unpublished independent research report (2003) into the financial viability of residential services in rural and remote regions of New South Wales found that generally residential aged care services in remote areas are operating with both operating and net losses due to a range of extra costs including the following:

- The small population on which to draw their client base results in a resident mix with a higher proportion of lower dependency residents and hence lesser funding;
- Unfavourable occupancy levels sometimes influenced by other residential aged and community care services within the same client catchment areas;
- Lower than average Accommodation Bond levels and in some cases no capacity to charge a bond or charge due to the family home being unsaleable;
- Having to maintain staffing levels that are not necessary when the resident profile changes;
- Higher staff recruitment, retention and training costs;
- Higher costs for insurances, medicines, incontinence aids, laundry, food and maintenance.

The absence of aged care services in many rural communities and in outer metropolitan areas also strikes at the equity of the system.

CHA believe that there is a need to continue and expand the capital grants programs for the development and redevelopment of residential services that target lower socio-economic communities. These communities, most often found in rural and regional areas, often have a higher proportion of concessional residents – as well as

lower property values. Consequently residents who do pay bonds, pay a low bond rate.

Recommendations:

3.1 CHA recommends reviewing the adequacy of the current viability supplement in order to meet the true cost of service delivery and ensure sustainability in rural and remote areas.

3.2 CHA recommend the continuation and expansion of the capital grants programs for the development and redevelopment of residential services that target lower socio-economic communities.

4. Whether there is an inequity in user payments between different groups of aged care consumers and, if so, how the inequity can be addressed

HACC service user fee arrangements vary between jurisdictions and when compared with the regulated variable fee arrangements under Commonwealth funded community care packages, act to discourage consumers from moving from HACC to the packages despite their increased support needs.

In addition CHA believe that there is a clear inequity in the cross subsidisation of non concessional high care and concessional low care residents by non concessional bond paying low care residents.

Recommendations:

4.1 CHA recommends adoption of uniform user payments across HACC and Community Care services.

4.2 CHA recommends higher concessional supplements be made available to mitigate the inequitable subsidisation of in residential aged care by non concessional bond paying low care residents.

5. Whether the current planning ratio between community, high- and low-care places is appropriate; and

The Aged Care Planning Advisory Committees (ACPAC) in each State and Territory are convened with the role of distributing between regions and special needs groups the estimation of new places for allocation.

The ACPACs have only ABS Census data for the population 70 plus and between Census rounds the ABS and DoHA estimations by region and LGA. The data doesn't always reflect actual population shifts, particularly in geographic areas of high growth in older demographics. The methodology adopted for determining ratios must be made transparent and should include assumptions about socio economic status, access to services, ethnicity and expected utilisation rates of services.

The planning and allocation process fails to adequately reflect likely demand for places, particularly residential. An example is where an ageing parent lives interstate

or distant from children and is assessed as needing residential care. The children will generally want the approved care recipient parent to move into a residential aged care facility close to where the children live.

CHA believes that planning and allocation of residential aged care places should no longer be in accordance with the High/Low care split of 44 High and 44 Low care places. Only an approach of 88 places per thousand people aged 70 plus has any relevance, due to the way the Aged Care Funding Instrument (ACFI) arbitrarily determines High and Low care and the fact that the Aged Care Assessment Teams do not use the ACFI to determine access eligibility.

Also around 70% of people having a first time assessment in residential care are assessed as High care. Providers should be able to apply for new residential places and as long as they can demonstrate capability of supporting residents at a High level of care, admit either High or Low care.

Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages and Extended Aged Care at Home Dementia (EACHD) packages should be rolled into the one allocation process with funding according to dependency.

The demographic data given to ACPACs to assist them with their recommendations is not publicly available and not given to providers thus hindering them in proper planning for the application process. It also makes it extremely difficult for providers to identify areas of unmet need due to the gap between allocated places and the planning ratio estimates.

Input is not sought from the industry regarding the needs and priorities providers may have identified in their local catchment areas. It is also unclear as to how DoHA estimates the need for and appropriate levels of capital grants.

Recommendations:

Pending the strategic reform of the aged care program, as set out in the CHA Aged care Policy Blueprint, CHA recommend:

5.1 Planning and allocation of residential places be on the basis of 88 places per thousand people aged 70 plus, rather than the current high/low distinction.

5.2 Combine CACPs, EACH and EACHD packages into the one allocation with funding according to dependency.

5.3 Prior to making place distribution decisions, ACPACs seek from providers, local government and other stakeholders in each planning region, their assessment of needs in their relevant geographic catchment areas.

5.4 DoHA make available to the industry the demographic and allocated and operational place data for each planning region and LGA within those regions.

6. The impact of current and future residential places allocation and funding on the number and provision of community care places.

The planning ratios of 88 residential places and 25 community care packages per thousand people aged 70 plus appear to be the appropriate level to meet the current and expected demand providing the allocation keeps pace with the population movements between census collections.

As the baby boomer bulge starts to impact on the demand for places, this may prove not to be the case. Therefore, CHA recommends that the existing planning and allocation systems be abolished, and in it's place a more rigorous methodology applied to planning. In addition ACATs should become fully owned and controlled by the Australian government. ACATs would then assess eligibility for a subsidy. This eligibility and subsidy should then be transportable and follow the consumer. This approach would assist in the implementation of consumer directed care models for the Australian Government subsidised Community Care Packages

Recommendations:

6.1 CHA recommends that the existing planning and allocation systems be abolished;

6.2 ACATs become fully owned and controlled by the Australian government and assess eligibility for a subsidy;

6.3 That this eligibility and subsidy for new clients be transportable and follow the consumer thus allowing the consumer to choose whether their care is received at home or in a residential aged care facility.