UTS

Support at Home

A Commentary on the design of the proposed unified program

September 2022 | UTS Ageing Research Collaborative

About the UTS Ageing Research Collaborative

The University of Technology Sydney Ageing Research Collaborative (UARC) adopts a multi-disciplinary approach to research with the aim of identifying evidence-based solutions to the issues facing ageing and aged care. UARC prioritises research that will improve the quality of ageing for all Australians, including by supporting reforms that promote more equitable, effective, efficient and sustainable aged care services.

The Co-Directors of UARC are Professor David Brown of the UTS Business School and Professor Deborah Parker of the UTS Faculty of Health. UARC collaborates with a range of academic, industry, workforce and government organisations which are respected contributors in the fields of ageing and aged care.

UARC would like to acknowledge its partnership with StewartBrown, a highly regarded provider of services and advice to the aged care sector, and its access to deidentified data from StewartBrown's Aged Care Financial Performance Surveys.

UARC publishes the biannual report on Australia's Aged Care Sector. The report provides a multi-disciplinary analysis of the sector's performance, offers commentary on key policy and operational issues and publishes policy-relevant research.

Acknowledgements

UARC researchers have received valuable insights into issues needing to be addressed in the design and operation of the new unified Support at Home program. We wish to thank the various members of peak sector bodies, providers and other sector stakeholders, with whom we consulted, although the authors take full responsibility for the contents of this Commentary. UARC is grateful for the co-authorship of David Sinclair, Partner with StewartBrown.

This research has been independently funded and supported by UARC.

Suggested Citation

Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., Sinclair, D. (2022) *Support at Home: A Commentary on the design of the proposed unified program*. The University of Technology Sydney.

Disclaimer

The authors have used all due care and skill to ensure the material is accurate as of the date of this report. UTS and the authors do not accept responsibility for any loss that may arise by anyone relying on its contents.

Contents

Executive summary

The following Commentary on the strengths and shortcomings of the current proposals for a unified Support at Home program and the submission of specific proposals for consideration in the next round of consultations, is offered by researchers at the UTS Ageing Research Collaborative (UARC).

In 2021, the then Government announced its intention to consolidate three existing programs for delivering in-home aged care into a new, unified Support at Home Program. In January 2022, the Department of Health released an Overview paper containing an initial framework for the reforms, alongside a schedule for consultation with the sector.

The new Support at Home program is now expected to commence on 1 July 2024. The incoming Minister for Aged Care announced the deferral by one year to facilitate additional consultation and ensure that reforms will "bring genuine improvements for older Australians in the long and short-term."[1]

Current programs have a diversity of client cohorts, services and providers

The three programs to be unified have different objectives, scopes, funding models and cohorts. This diversity must be recognised and accommodated in all facets of the design of the new program, as should the differences of aged care from disability care.

The program should have a clear set of principles which guide its design

Aged care reform in Australia has followed a broadly consistent approach over the past decade. Design of the Support at Home program should be guided by a set of principles that reflect this approach and are centred on the independence and wellness of senior Australians. In the absence of a published statement of principles to date, this Commentary suggests the following:

- Senior Australians to have choice and control over the services they are assessed as needing and that those services change as their needs change.
- Services to be delivered within a competitive market-based environment.
- Regulation to be proportionate in setting quality and safety standards for the services and the providers of those services and correcting for market failures.
- The allocation, management, delivery and outcomes of subsidised services to be transparent and have clear lines of accountability.
- Subsidised services to be funded sustainably and equitably between taxpayers and clients.

Consumer choice and control does not substitute for provider accountability

A key feature of the Support at Home program is its multi-provider, fee-for-service model in which clients can elect to fully manage their own care. While this shift toward self-management and service-level contracting is consistent with the principle of consumer choice and control, it also increases the complexity of accountability for the allocation, management, delivery and outcomes of subsidised services. Such issues are likely to arise, for instance, when the initial care planning process by assessors is separated from ongoing care management and the delivery of those plans by providers. Effective accountability can only occur when assessors, care managers, and provider(s) have clear and controllable roles and responsibilities.

Integrated assessment is welcome but requires careful calibration

An integrated assessment process will simplify access for all senior Australians but must be carefully calibrated to ensure the processes are efficient, equitable and responsive to changing needs. The process should be proportionate to the needs of clients who require only one or two entry-level services as well as for those clients with more complex and changing needs. Assessment should include consideration of restorative care across all cohorts wherever it could add value.

Service and price lists enhance transparency but can limit responsiveness to clients' changing needs

The development of a comprehensive service catalogue and "efficient" price list may improve the transparency and consistency of offerings across the sector. However, overly narrow definitions of services and prices may constrain consumer choice and competition and inefficiently restrict the flexibility of senior Australians and providers in responding to changing needs. The use of fixed prices may limit the ability of providers to compete on price and does not reflect the heterogeneity of business models in a mixed market setting.

Ongoing transparency of the price-setting process will be essential to ensure government accountability for the decisions it makes based on the expert advice it receives from the independent pricing authority.

Program sustainability requires appropriate client contributions

In-home aged care services need to be funded sustainably into the future, but the proportion of funding that is currently borne by taxpayers (more than 90% of program costs) is not sustainable.[2] To date, there is no discussion of how contributions toward the cost of in-home aged care will be shared between cohorts of senior Australian clients and current and future taxpayers.

This Commentary proposes a set of funding models and identifies two models for further consideration. One proposes fixed prices published in the Service List, a means-tested and capped client contribution and a balancing public subsidy. The second model provides for recommended prices to be published in the Service List, a fixed subsidy and a means-tested discretionary but capped client contribution. More detailed consideration of the complex equity and sustainability consequences of the various possible options will be required.

Achievement of the program's objectives starts with the right design

Developing the right design of the Support at Home program in the first instance will be crucial for ensuring community acceptance of the reforms, and for the sustainability of the aged care system overall.[3]

Introduction

Purpose of this Commentary

Publicly subsidised in-home aged care services make important contributions to the lives of over one million senior Australians, assisting them to live independently for as long as possible.[4] There are considerable opportunities to improve the quality, equity, effectiveness, efficiency and sustainability of the current arrangements.

The Government's 2021 reply to the final report of the Royal Commission into Aged Care Quality and Safety included a reaffirmation of its commitment to develop a unified Support at Home program. The new program is to replace the Commonwealth Home Support Programme (CHSP), the Home Care Packages (HCP) Program and the Short-Term Restorative Care (STRC) Programme. The Government announced a period of sector consultation and a commencement date of 1 July 2023. To assist in the consultation, the then Department of Health (now Department of Health and Aged Care – DoHAC) published a Paper on 6 January 2022 titled "Support at Home Program Overview".[5]

Subsequently, on 28 July 2022, the Minister for Aged Care under the incoming Labor Government announced that the commencement date would be deferred by one year to 1 July 2024 and that there will be further consultations with senior Australians, their families and carers, workers, advocates and providers.[6]

Researchers at the UTS Ageing Research Collaborative (UARC) offer a Commentary on the earlier Overview paper in terms of whether it sufficiently addressed the current and longer-term issues facing senior Australians who are assessed as needing subsidised in-home care services. In light of the Labor Government's willingness to revisit many of the issues discussed in the Overview, the UARC Commentary also takes the opportunity to put forward specific proposals that could be considered in this next round of consultations.

One general strength of the Overview is that it openly recognised many of the challenges with the current disparate in-home care arrangements. A number of the proposed reforms also had merit – noting that in some cases they have been long foreshadowed.

However, there were at least three key areas of significant concern with the Overview. First, it lacked a clear statement of the Government's intended program objectives. Second, it did not always create a line of sight between the identified problems – such as accountability for client outcomes, workforce availability, provider viability and overall sustainability – and the program's proposed design. Finally, the Overview failed to provide analyses of the benefits and costs of feasible design options.

The remaining parts of this section address some of the overarching issues while subsequent sections provide more detailed analysis of several design features which were either proposed in the Overview or deserve consideration in this next consultation phase.

Before proceeding further, however, it is worth noting that the data available from the Report on the Operation of the Aged Care Act 1997 (such as in Table 1) is not as comprehensive nor analytic as that published by the former Aged Care Financing Authority. In addition, neither report has been sufficiently

comprehensive across all programs to enable the public to hold the Government, providers and regulators accountable for their actions. There is an opportunity to correct these omissions in the design of data collection and public reporting as part of the new unified program.

The current programs vary in important respects

A first consideration in designing the unified Support at Home Program is to acknowledge that while there is some overlap in the services provided across the three programs (CHSP, HCP and STRC), some significant distinctions must be recognised and accommodated in the new design.

CHSP delivers a high volume of lower-cost entry-level support services

CHSP provides entry-level support to senior Australians to live independently in their homes and communities. Services provided under CHSP include domestic support, community transport, social support, home modifications, and nursing care. In 2020-21, CHSP services were delivered to 825,383 clients and totalled $2.7 billion in public subsidies through the Commonwealth Government.

Significantly, in 2019-20 around 50% of clients received only one service.[7] The two largest services by public expenditure in 2019-20 were Social Support and Domestic Assistance. Other high-expenditure services were Nursing, Respite, Allied Health and Therapy services, Personal Care, Transport and Home Modifications and Maintenance. While there is less public expenditure on Meals and other Food Services, it is a high-volume service.

In 2020-21, 69% of the 1,452 providers were not-for-profit organisations. A further 24% of providers were government bodies, reflecting in part the large contribution of local governments in supplying some of these services. Recent decisions by some local councils to close their in-home services represent a loss of connection between the third level of government and their local communities.

HCP provides a lower number of more complex and costly services

HCP provides services to senior Australians with more complex needs who wish to remain living in their home. Numbers of HCP packages and public expenditure are growing rapidly, with 176,105 home care clients at the end of 2020–21 and a public cost of $4.2 billion. A large survey of HCP providers indicates that in 2018–19 the highest volume service types provided under HCP were Personal Care, Cleaning and Household Tasks, and Social Support (including shopping services and community access).[8] Notably, and despite the more complex needs of HCP recipients, nursing care represented a very small proportion of service volume (1–2% of total service hours) and expenditure (0–2% of package funds) across all package levels.[9] More significant costs were associated with care management (13% of package funds) and administration charges (15% of package funds).

There is a high level of unspent funds in many packages, which demonstrates that the assessed need exceeds the realised service provision.

At the end of 2020-21, there were 939 operational approved providers, and 63.8% of clients received services from not-for-profit organisations. For-profit providers delivered care to 30.1% of clients. Although each package is required to be managed by a specific approved provider, there is some scope for consumer self-management and engagement of other providers for some services.

STRC is currently a targeted small-scale program

The aim of the STRC Programme is to reverse and/or slow functional decline in older people and improve overall health and wellbeing through the delivery of allied health and other support services (for up to 8 weeks). Only 6,227 people received these services throughout 2020-21 at a public cost of $67.3 million. At the end of that financial year, only 859 people were receiving assistance from 93 operational STRC services, delivered by 58 approved providers.

In summary, in terms of reach to senior Australians, CHSP accounted for 62% of all consumers of subsidised aged care services (including residential care) in Australia in 2020-21 and over 80% of those who benefited from the three target programs.[10] Half of all CHSP clients receive only one service and not-for-profit and government providers have been its mainstay. The average cost per consumer is greatest under the HCP program and there is a high level of unspent funds compared to assessed need. Despite the significant potential benefit of restorative care, STRC funding is very low.

Table 1: Summary statistics of subsidised in-home aged care services (2021-21)

	CHSP	HCP	STRC
Number of clients	825,383 clients during 2020-21	176,105 HCP, as of 30 June 2021	6,227 people during 2020-21 (including 859 people as of 30 June 2021)
Public expenditure (2020-21)	$2,712 million	$4,193 million	$67.3 million

Source: Department of Health (2021). 2020-21 Report on the Operation of the Aged Care Act 1997

Aged care and disability care program designs should reflect their differences

The proposed changes to the delivery of subsidised in-home aged care services follow many other episodes of reform of human services and the operation of the care economy in Australia. Notably, the transition of disability service provision to the National Disability Insurance Scheme (NDIS) similarly sought to increase the ability of clients to exercise greater choice and control in the services and providers they choose. As noted by the NSW Ageing and Disability Commissioner, Robert Fitzgerald AM, there are many similarities between aged care and disability care programs. However, there are also important differences which should be reflected in program design.

First, there is much greater expectation and incidence of ageing compared to disability. In most circumstances, ageing brings with it an increasing need for care and support later in life, which typically arises from frailty or reduced cognitive capacity. Many aged care services are required for a shorter duration and with lower lifetime costs.

Second, there are systematic differences between the personal financial circumstances of people with disability and cohorts of senior Australians. Many people with disability, especially those who acquired their disability early in life, have comparatively lower incomes and wealth: a characteristic which has informed the decision not to require consumer contributions from NDIS participants in most instances. However, while many senior Australians have limited financial means, others have had the opportunity to accumulate a level of wealth such as home ownership and superannuation, which can be drawn down to fund care and support services. Superannuation also generates income which can also help pay for goods and services in retirement.

As observed by Commissioner Fitzgerald, there are valuable lessons to be learned from the design and implementation of the NDIS. These include: the need to consider grant funding to ensure consumer access to services in thin markets; the unintended outcomes from the application of “one-size-fits-all” fees for diverse services and programs; and the costs and consequences associated with complex and legalistic assessment processes. The experience of the NDIS also suggests several transition and implementation concerns, such as how to respond to workforce constraints and the potential for significant increases in provider numbers, especially for many of the high-volume services currently provided through CHSP.

These issues and insights are considered in the later sections of this Commentary paper.

Development of the UARC Commentary

The analysis contained in this Commentary draws on several documents which have framed the reform pathway that commenced a decade ago with the passage of the Aged Care (Living Longer Living Better) Act 2013, including the reports of the Royal Commission into Aged Care Quality and Safety (Royal Commission) and the Government’s responses to those reports. It also analyses data on the sector’s financial performance provided through StewartBrown financial performance surveys, UARC’s Aged Care Sector Report and from publicly available Department of Health and Aged Care administrative reports.

Structure of the Commentary

The structure of this paper is as follows:

Section 2: Program design principles examines the evolution of principles underpinning aged care sector reform and suggests how these could be applied to the unified in-home aged care services program.

Section 3: Responsibilities and accountabilities assesses the implications of the proposed multi-provider service delivery model for the distribution of responsibility and accountability between assessors, care managers, approved providers and senior Australians.

Section 4: Specification and delivery of services considers how implementing a new Classification Framework, Service List and tightly specified Individualised Support Plans will affect the ability of clients to access services and exercise choice and control.

Section 5: Pricing and business models explores the possibilities and challenges of price-setting in a mixed market, fee-for-service model regarding effects on transparency, competition, and efficiency.

Section 6: Program funding explores several options for how the Support at Home program could be funded, focusing on the balance between taxpayer funding and consumer contributions.

2. Program design principles

Introduction

The design of the Support at Home program should be based on a clear set of policy principles. The Overview paper does not articulate such a set of principles and yet, over the last decade, successive Governments have adopted a broadly consistent approach to the reform of aged care.

This section examines the evolution of the reforms over time and suggests a possible set of principles which are consistent with the broader reform agenda and could underpin the proposed Support at Home program.

Evolution of the principles underpinning aged care reform

The Productivity Commission's 2011 report 'Caring for Older Australians' identified a set of principles to guide aged care policy change.[11] They were centred on promoting the independence and wellness of senior Australians and enabling them to exercise choice and control. The report underlined the importance of incentives to ensure the efficient use of resources as well as affordability for both senior Australians and society more generally.

The 2016 Aged Care Sector Committee's 'Aged Care Roadmap' affirmed and refined these principles. It specified one of the goals in the following terms: "Greater consumer choice drives quality and innovation, responsive providers and increased competition, supported by an agile and proportionate regulatory framework".[12]

The Government's 2015 and 2017 home care package reforms gave clients more choice over the services they receive, how and when they receive them and who provides them. The Government also opened up the supply side to competition between providers who meet the required standards.[13]

The 2017 'Legislated Review of Aged Care' noted that: "There is a broad consensus shared by government and sector stakeholders that aged care requires further reform to become a more consumer-centred system. This includes orienting care and the supply of different care types around the demands of clients, and giving clients greater choice and control."[14]

The 2020 Impact analysis of alternative arrangements for allocating residential aged care places restated the foundations of aged care reform in the following terms: "... aged care services should be consumer driven, market based, equitably and sustainably subsidised and proportionately regulated."[15]

In 2021 the Government reinforced this approach when it announced that the Aged Care Approvals Round (ACAR) would cease and be replaced with the assignment of residential care places directly to senior Australians from 1 July 2024. Supply-side caps would be removed, enabling competition between providers who meet the required standards.[16]

In a subsequent 2022 Discussion Paper, 'Sustainability of the Aged Care Sector', UARC researchers argued that system effectiveness must be a core feature of the design of the new Support at Home program to ensure its sustainability from the fiscal, societal, workforce and financial perspectives.[17] The Discussion Paper emphasised the importance of transparency and accountability in facilitating the effectiveness of the system and its constituent services and the importance of equitable funding and efficient delivery of services.[18]

Under the umbrella of its generational plan for aged care,[19] the then Department of Health set out the intended characteristics of a reformed aged care sector, being a system that:

- is simpler to navigate, with face-to-face services
- empowers senior Australians to make informed choices
- is strongly regulated
- is more transparent
- makes sure providers are accountable
- values and grows the aged care workforce

While these characteristics generally align with the principles that have guided the reforms to date, there are two matters of concern. The first is the lack of reference to a market-based competitive environment that gives senior Australians greater choice and gives providers incentives to be more responsive to senior Australians' needs and preferences and to be more efficient in delivering services.

Second, the departmental list refers to a system which is 'strongly regulated'. However, strong regulation that is poorly designed can result in excessive compliance and administration costs as well as other deleterious impacts on competition and responsiveness – as was the case with the regulation of the supply of residential care services through restricted bed licences.[20] The Overview paper, however, offers the more nuanced objective of recognising the need for regulation to be proportionate.

Suggested principles for in-home care reform

As a basis for discussion and drawing on the experience of the last decade, the following set of principles could inform the design and development of a Support at Home program. At their core is promotion of the independence and wellness of senior Australians:

- Senior Australians to have choice and control over the services they are assessed as needing and that those services change as their needs change.
- Services to be delivered within a competitive market-based environment.
- Regulation to be proportionate in setting quality and safety standards for the services and the providers of those services and correcting for market failures.
- The allocation, management, delivery and outcomes of subsidised services to be transparent and have clear lines of accountability.
- Subsidised services to be funded sustainably and equitably between taxpayers and clients.

3. Responsibilities and accountabilities

Introduction

The multi-provider model proposed in the Department's Overview paper represents a significant change in the distribution of responsibility and accountability across the interdependent roles of assessors, care managers, approved providers and clients. Each party should be held accountable for the particular processes and outcomes for which they have clear responsibility. Mechanisms are required for assuring the overall effectiveness, quality and safety of each client's Individualised Support Plan.

While acknowledging that the proposed arrangements are still to be developed in a further round of consultations, this Commentary identifies potential areas of overlap in responsibilities between the various parties as well as significant gaps in accountabilities. Consideration is given to the implications of a multi-provider model for accountability, with specific discussion of the roles of assessors and care managers within the proposed framework.

Implications of a multi-provider model for accountability

Accountability within existing programs

Current in-home care programs have diverse accountability mechanisms. Under the current CHSP, which accounts for over 80% of all in-home aged care clients, services can either be coordinated through a single provider which offers a full range of funded programs (more common in metropolitan areas) or a partial range, with other providers delivering such services as transport, meals and social engagement. This is particularly relevant given that CHSP delivers only one service type to around 50% of clients. A further 43% of CHSP clients in 2019/20 received two to four service types.[21]

The Aged Care Act 1997 requires HCP recipients to select one Approved Provider to take full responsibility for the coordination of various care professionals, the integration of the services to the benefit of the consumer and the exercise of professional judgement as to the appropriate service mix (in consultation with the consumer) under their package.[22] This applies even in the common circumstance where service delivery is subcontracted by the approved provider or delivered directly to the consumer by a separate provider.

Some HCP clients currently choose to self-manage all of their care. In these instances, they must still engage an approved provider which is responsible for the care plan and is required to undertake an annual review of the package. In a recent Aged & Community Care Reform Conference (jointly organised by COTA and ACCPA), the Department characterised the multi-provider model proposed in the Overview as being more aligned with a CHSP model than with the current HCP.

Accountability within the proposed program

The Overview proposes, instead, that clients of the unified program would be able to engage multiple service providers directly and have the option to fully self-manage their care.[23] Further, it proposes that only some clients would be supported by a care manager to assist them with co-ordination, scheduling and management of services.

The proposed multi-provider fee-for-service model is consistent with the principle of facilitating consumer choice and control, but also presents challenges in assigning accountabilities for holistic client outcomes.

Self-management within a multi-provider model is a much more complex proposition for many clients and their informal carers, in particular because service provision is narrowed to a transactional, service-by-service set of events. Senior Australians would need to independently assess the quality of the various individual providers to be contracted, to coordinate and integrate the care services they receive, and to hold each of the providers accountable for the promised standard of service (in conjunction with the regulator) and their specific care outcomes.

The reformed regulatory framework will be crucial in delivering a governance system in which each of the parties has clear responsibilities and can be held accountable. While few details of the proposed framework are provided at this stage, the Overview notes that "a risk-proportionate regulation model is being developed to support care businesses and care workers".[24] The Overview suggests that options under consideration include market-entry requirements which are able to assure the quality and safety of care without imposing onerous administrative requirements on care providers.

A risk-proportionate model would differentiate the regulatory and market entry requirements based on the type of services being provided and the related level of client contact, control and risk. Such an approach would also be consistent with a subsequently discussed option of separating out certain entry-level services from the new program, at least for the initial implementation years.

Controllability within the proposed program

A central issue in the design of effective accountability structures is the degree of controllability over a function or outcome by each of the parties to the system. Without controllability, there is no sound basis for accountability. However, the more complex the system and the greater the number of parties, the more difficult it becomes to develop measures of performance which are under the control of each of those parties. Some of the conditions which exacerbate the controllability problem and are salient to the in-home care setting include:[25]

- Complexity and plurality of objectives and purposes
- Interdependence of tasks and need for cooperation between parties
- Requirement that individuals exercise judgement
- Inability to adequately measure some outcomes in quantitative terms
- Complexity and uncertainty of the environmental context

Where accountability is expected in the absence of explicit controllability, there is an incentive for parties to attribute delivery shortfalls to perceived uncontrollable factors, making it more difficult for clients to hold individual providers accountable for the standard of service they receive.

From the information available in the Overview, it is not clear how responsibility for the outcomes of an Individualised Support Plan will be distributed between the independent, and yet interdependent, parties (assessors, care managers where appointed, primary providers, other service providers, and clients). A further ambiguity relates to the mechanisms proposed for assuring the appropriateness, quality and safety of each Plan as a whole.

Two of the key roles will be those of assessors, whose functions will be substantially expanded, and care managers, whose role appears to be modified to function as independent service providers for some clients. These specific roles and responsibilities are considered next.

Assessors and assessments

A feature of the Support at Home proposal is the development of a single Integrated Assessment Tool which is service agnostic, and which will be used to assess eligibility across all aged care programs (including support at home care, residential care, transition care, multi-purpose services, and respite care).[26]

As proposed in the Overview paper, this Tool is to be administered by assessors to assign clients within a new classification framework, ranging from "low-needs" to classes of higher need and complexity.[27] Assessors will determine the needs of clients and work with them to develop personalised plans which customise the mix of services offered within the range permitted for the class, based on individual needs, circumstances and preferences.

Merits of an integrated assessment approach

The introduction of an integrated assessment approach is a welcome step in reducing the challenges of accessing aged care by clients with varying abilities to navigate a complex system. In addition, it is an important precursor to ensuring that a person's essential care needs are assessed and addressed regardless of the accommodation setting in which the services are to be delivered – while noting that certain services may be more appropriately delivered to some senior Australians in a residential aged care setting.

One of the challenges will be to ensure the right balance between simple assessment processes for those clients who need a limited number of clearly identifiable entry-level services and more detailed processes that identify instances where more complex issues are present. The assessment processes should also have the ability to reveal opportunities for restorative care services across both groups of clients. The proposed two-level intensity of assessment is discussed further in section 4.

Changes to the role and responsibilities of Assessors

The proposed development of Individualised Support Plans by assessors represents a move toward more granular specification of the eligibility and "entitlements" of senior Australians, including the type, frequency and duration of services to be provided.[28] This will involve a longer and more involved assessment engagement with new clients, particularly those with more complex needs of higher intensity. A significant issue will be the need for significantly greater assessment skills in many instances, the availability and funding of a sufficiently large assessment workforce that has those skills, and appropriate governance arrangements to ensure the equity, effectiveness and appropriateness of the assessment processes.

It is proposed that assessors will not be involved with clients in either care management or service delivery. This separation of responsibilities appears sensible, given that the combining of assessment processes with service delivery in previous episodes of reform within residential aged care exposed various conflicts of interest.

A related consideration is that experience with the HCP may suggest the occurrence of 'over assessments', or in at least some cases, 'prospective needs assessments' by assessors. The latter may result from an assessor's expectation that the system will move slowly in adjusting to a client's changing needs, either as they become more able after a period of restorative care or as their needs increase over time. As noted below, a more agile, timely and flexible set of processes will be required to help reduce these occurrences.

Specification and delivery of Individualised Support Plans

Under the proposed arrangements, the judgements of assessors have the potential to significantly constrain the choices available to clients, care managers and providers.

It is unclear from the Overview how care managers or providers will be able to provide feedback to assessors on the suitability of initial Individualised Support Plans, or account for the part played by assessments in determining what was delivered and whether the client's needs were met. With clients and providers having only limited scope to modify the Plan post-assessment, this raises the critical question of how granular the assessor's initial care plan should be, and how extensive should be the subsequent constraints on care management and delivery.

The assessment process needs to allow for minor changes in the condition or circumstances of participants without the need for intrusive and costly reassessments. Some level of agility and flexibility is required to avoid overloading the system with significant demands for assessment reviews and appeal, as has been experienced in the NDIS.

Where a senior Australian's needs change significantly, the Overview paper proposes that they would need to be reassessed into a new class within the Classification Framework.[29] Clarity around the triggers and process of reassessment will be important for understanding the consequences of separating care planning and care delivery activities in this way, including who can request a reassessment, the timing and responsiveness of reassessments, and how the risks and costs of unwarranted reassessments will be managed.

Separation of the initial care planning process from the ongoing management and delivery of the plan also highlights the issues of accountability for the respective roles of the assessors (in terms of the effectiveness of the services included in the individual plans and any impact they may have on the outcomes for clients) and of provider(s) (for the delivery of the plans and for the part the provider plays in client outcomes). It is not clear who in this arrangement will advocate on behalf of clients, particularly in circumstances where no care management has been specified in the Individualised Support Plans. If providers are to play an advocacy role in relation to assessments, there are concerns as to how this is incorporated and funded within the proposed model.

Care management

Within the current HCP program, care management is a support service which includes periodic review of a senior Australian's care plan, assistance with coordination and scheduling of care and services. A care manager liaises between the provider and the senior Australian and their representatives, and also identifies and addresses risks to the senior Australian's safety.[30]

Within Support at Home, it is proposed that care management would be included within the Draft Service List as a discrete service category which includes both co-ordination and clinical oversight components.[31] However, the Overview also indicates that care management services are to be offered only to senior Australians who have a complex mix of services and care needs. Care management funding is quarantined from other service categories. It is not proposed that separate care management will be available to the majority of senior Australians, yet current experience within both HCP and CHSP is that care management equivalent services are provided to clients across a range of service types and package levels. In the case of HCP, an average of 0.65 hours per client per fortnight was being provided to clients with Level 1 packages in 2018-19, increasing to an average of 2.01 hours per fortnight for clients with Level 4 packages (Table 2).[32]

The wording of the Overview implies that the client's care manager will function independently from their provider(s) and that there will be a predominance of self-management of care services. This raises a further question as to whether and how the relationship between the provider(s) and assessor and their respective accountabilities will be affected in situations where there is no dedicated care manager. Similarly, the Overview is not clear about the intended relationship between care manager and provider(s) in those instances where a care manager is appointed.

Table 2 Average care management hours for surveyed Home Care Packages, FY 2018-19

	2018-19 Financial Year				
	All	**Level 1**	**Level 2**	**Level 3**	**Level 4**
Total number of packages	54,823	3,222	27,234	9,973	14,394
Total number of subsidised days	19,999,171	1,174,852	9,935,652	3,638,668	5,249,998
Care management (average hours per package per fortnight)	1.23	0.65	0.82	1.43	2.01

Source: *StewartBrown (2020) Home Care Provider Survey - Analysis of Data Collected*, p. 43

Roles and responsibilities of care managers

Perhaps in recognition of the complexity of this issue, the Overview acknowledges the need to further define "the roles and responsibilities of the care manager" as well as "providers' accountability for client care outcomes".[33] As part of this process, it would be important to clarify the specific roles and responsibilities a care manager will have, and, subsequently, to whom and for what care managers are accountable. Options could include but are not limited to:

- To act on behalf of the client, to ensure that their care needs are met, and the best possible outcomes are achieved
- To act on behalf of the Department, to ensure that services are delivered within the cost and service constraints of the Individualised Service Plan
- To act as a point of liaison for the Aged Care Quality and Safety Commission in relation to the quality and safety of the services being delivered to the client within a multi-provider model.

If care managers are to have any form of accountability for client outcomes, they would require sufficient skills, information and authority to be able to influence the services and their delivery which lead to those outcomes.

In terms of their skills, there are questions of what professional training and attributes will be required to support care managers in an expanded, more clinically-focused role.

In relation to information, the model presupposes that care managers will have access to adequate information about clients, flowing from sufficiently frequent engagement with clients (as specified and funded through the Plan) and from the effective transfer of information from provider(s).

As noted earlier above, there will need to be clear and efficient mechanisms for care managers to have the authority to modify Plans through flexibility provisions or by way of requests for formal reassessment, to ensure the continuing suitability of Plans.

4. Specification and delivery of services

Introduction

A significant feature of the Support at Home program is the Classification Framework and associated Service List, which will be used in the assessment of senior Australians' care needs and the development of Individualised Support Plans.

The proposed Classification Framework incorporates five categories of care needs. The first category caters for low needs by providing one or two services. The second is a system-wide program of restorative care that can be made available to all clients when an assessor determines they would benefit from the program. The final three categories reflect the increasing intensity and complexity of needs and attendant services.

Developing a comprehensive catalogue of services (including short-term restorative care) will improve the transparency and consistency of offerings across the sector. However, inappropriately restrictive specifications of service entitlements may result in a reduction in consumer choice and control.

Classification Framework

The hierarchy of needs has been reflected in the Framework through a proposed two-level intensity of assessment. Senior Australians with low needs would be assigned one or two services at the initial assessment. In principle, this is appropriate, noting the high proportion of CHSP clients who will be transitioned into the Support at Home program, around half of whom currently receive only one service.[34] There would be a higher intensity assessment process for senior Australians with more complex needs.

The positioning of restorative services in the framework

The Overview makes an important commitment to offering restorative services "to all senior Australians who would benefit from them", for initial periods of up to 12 weeks.[35] Access to this form of care can contribute to overcoming or delaying functional decline and, as the Overview notes, may "help people improve or maintain independence without reliance on ongoing services."[36]

However, there is currently a lack of clarity in the proposed Framework design between the 'entry-level' services of the first care category and the role to be played by restorative care, which is classified as the second care category. Restorative care is likely to be just as appropriate for many clients assessed as low need as it would be for those who may otherwise commence receiving more intensive and complex support and care.

The effectiveness and efficiency arising from delivering more restorative care would be enhanced by not only having an independent assessment of need but also a post-delivery reassessment process.

Further program design is required. One approach may be to identify restorative care as the general aged care entry path (noting that it could also be appropriate later in a senior Australian's life) and to deliver certain entry-level services separately from the Support at Home program after the initial assessment. Giving prominence to restorative care would reinforce to senior Australians and to the community more generally that an "essential outcome" of subsidised aged care is to help people improve or maintain independence for as long as possible before requiring ongoing services.[37]

Social supports

Related to this approach is the recommendation of the Royal Commission that the provision of social supports should be considered a specific category within the aged care program.[38] Within the current CHSP, entry-level services such as meals, transport and social support are often provided by single service stand-alone organisations or local government bodies. In many cases, these organisations have a long history of engagement with their local communities, and have well-established volunteer bases (COVID-19 notwithstanding) and governance processes. Some integrated providers also deliver these services.

The final design of the program needs to reconcile two competing considerations. On the one hand, there are benefits to including entry-level services within an integrated Support at Home structure. They include having a single point of access for clients; a lower intensity assessment process where appropriate; and a relatively seamless escalation of service types, complexity and intensity as clients' needs increase.

On the other hand, client access to entry-level services should be as simple and direct as possible. There are also dubious merits in burdening these services and their providers with the same administrative and regulatory processes required for more complex services such as personal care, nursing and allied health. Such processes include meeting approval criteria, detailed performance reporting, price setting, funding regimes, consumer contributions and the like.

Many clients are likely to develop supportive relationships with well-established and effective community service providers of these entry-level services, and would experience disruption if an increase in their care needs required changing to a new provider who also delivers those services. Similar interface issues experienced by clients transitioning from CHSP to HCP demonstrate this concern.

In terms of funding, the CHSP model of provider grants to these organisations may also be appropriate. Including such services within a fee-for-service model, as in the implementation of the NDIS, risks loss of service reliability and a reduction in social connectedness. Consumer advisors and advocates have cautioned against the

sudden removal of access to CHSP services in the transition to Support at Home, given the documented failure to ensure continuity of services and support in other areas of human services reform such as the NDIS.[39] The first stage of implementing the Support at Home program need not be complicated by burdening it with a high number of providers who already have well-established arrangements and the confidence of their local communities.

Complex needs

The remaining three categories within the Classification Framework bear a resemblance to HCP Levels, with care needs being classified according to increasing intensity and with each incorporating a further three levels of complexity.

An issue needing clarification is whether clients will be assigned to one of the three levels of care need, or one of the nine permutations of care need and complexity. The greater the granularity of assessment, the greater the accountability of the assessor for the client outcomes and the less flexibility afforded to providers (or potentially to care managers) in responding to changing client needs.

A further issue relating to the Classification Framework is the assessment and classification of clients requiring palliative care. Palliative care has been incorporated within the AN-ACC model for residential care as a direct entry classification but not specifically addressed within the proposed Classification Framework for Support at Home. A similar direct entry classification could provide greater certainty and more timely responsiveness for both clients and providers.

Service List

The Overview proposes that the Support at Home program will use a Service List to identify the subsidised services that will be available to senior Australians, in accordance with their assessment and Individualised Support Plans. The Service List included in the Overview is a draft and subject to consultation and further development. While the CHSP has also operated from a Service Catalogue, providers have at times offered clients a more limited range of services depending on their business scope and delivery capacity. The HCP does not have an itemised list of eligible services. Although this has enabled clients to negotiate with providers on a case-by-case basis, it has also led to inconsistencies in the services offered by providers and inequitable receipt of effective care and support by senior Australians.

Merits of a Service List

The concept of a Service List has merit in that it can aid the development and ongoing transparent review of the efficient, equitable and sustainable funding of subsidies for specified in-home care services. Such reviews could be supported by evidence arising from periodic research, analysis and debate regarding the cost-effectiveness of each service category (and item) and inform decisions about their net public good and the calibration of efficient subsidy levels.

One outcome could be the emergence of evidence which supports an argument to differentiate the level of public subsidy offered for different service categories, types and sub-categories. By way of example, service types such as nursing and allied health could be found to warrant a higher level of taxpayer subsidy, consistent with the principles of universal health insurance and associated co-payments. Other service types, such as home maintenance and domestic support, align

more with general personal responsibility and appropriate safety nets. A range of possible pricing and funding models is discussed in greater detail in the following sections of this Commentary.

A Service List will also facilitate more consistent decision-making about allowable and disallowable items, especially with respect to digital technologies, Goods, Equipment, and Assistive Technologies (GEAT) and home modifications. The Overview suggests that further work is being undertaken to determine how best to provide access to these higher cost items.[40] The increased emphasis on digital technologies in the Service List is noted and supported – it is specifically included in the two categories of 'Independence at Home' and 'Digital Technologies, Equipment and Home Modification'.

Risk of over-specification

A potential downside of Service Lists is over-specification of the services. Greater granularity can compound the rigidity of Individualised Support Plans were the latter themselves to be inappropriately specified. At the heart of this design issue is the need to strike a balance between the interest of senior Australians, taxpayers and providers, incorporate that balance into clearly defined eligibility criteria for services and subsidy levels, and guide the judgements of assessors. The development of Individualised Support Plans is considered next.

Individualised Support Plans

Although the Overview claims that the proposed program will result in Individualised Support Plans which reflects senior Australians' individual circumstances and personal preferences,[41] the nature of the specification of services has the potential to reduce choice and control compared to the client-directed framework of the current HCP program. By quarantining funding within specified service categories and for specified durations and frequencies of delivery, as determined by the decisions of assessors, the Support at Home program will reduce the ability of clients to make trade-offs between direct care categories and with other types of goods and services, such as transport and social support. In contrast, the separate assessment process for Digital Technologies, Equipment and Home Modifications will have the benefit of centralising eligibility decisions and reduce variation between providers regarding allowed items.

On the other hand, given that the service subsidies represent public expenditure, the separation of funding for direct care (such as nursing and allied health services) from other categories of support may be a positive step toward clearer accountability to taxpayers for the outcomes from that expenditure.

As noted by COTA, the proposed service categories also present a challenge in cases where a home care worker provides services which span multiple categories in a single visit, such as where a senior Australian might require assistance with showering (personal care) as well as meal preparation or general house cleaning (independence at home).[42] This challenge will be exacerbated where different price levels are established for the different service types provided by a care worker; a concern which has subsequently been acknowledged by the Department as requiring further consideration.

Flexibility provisions

The Overview recognises that there is a need for flexibility in the delivery of Individualised Support Plans to accommodate the frequent and often rapid changes in the needs of senior Australians.[43] It has proposed two strategies, the first being the ability for clients and providers to agree to a change of service types within the same service category, although, as noted above, the extent of flexibility will be dependent on the program design. While this strategy would enable some lateral modifications to the specific services delivered, it does not address the variability of senior Australian's needs over time. Some clinical services, such as wound care, may be required relatively more intensively for a short duration but only required as a periodic service. Care management may also be needed with different levels of intensity at different stages of the senior Australian's participation in the program, with more support required when first engaging with providers but potentially less once services have been established or while the number of service types remains limited.

The second strategy proposed by the Overview is the possibility of a flexibility pool which would allow service providers to deliver additionally funded services to their clients up to a set amount per month. While, in principle, this would enable providers to adapt to clients' changing needs by increasing the volume of services provided, it is not at all clear how such additional funding will be distributed within a multi-provider model and how accountability for client outcomes would be attributed.

These two models should be assessed against the previously explored option of not having unnecessarily granular specification of services and their duration and frequency, while having sufficient specification of more essential services to ensure transparency of the associated subsidies and outcomes.

Unspent funds

The Overview notes that one of the issues with the existing HCP program is the high level of unspent funds.[44] Reasons for this may range from inappropriate over-assessments to clients saving package funds for large purchases such as equipment and home modifications, to supply-side constraints on service availability which may make it difficult for clients to use the full value of their package.

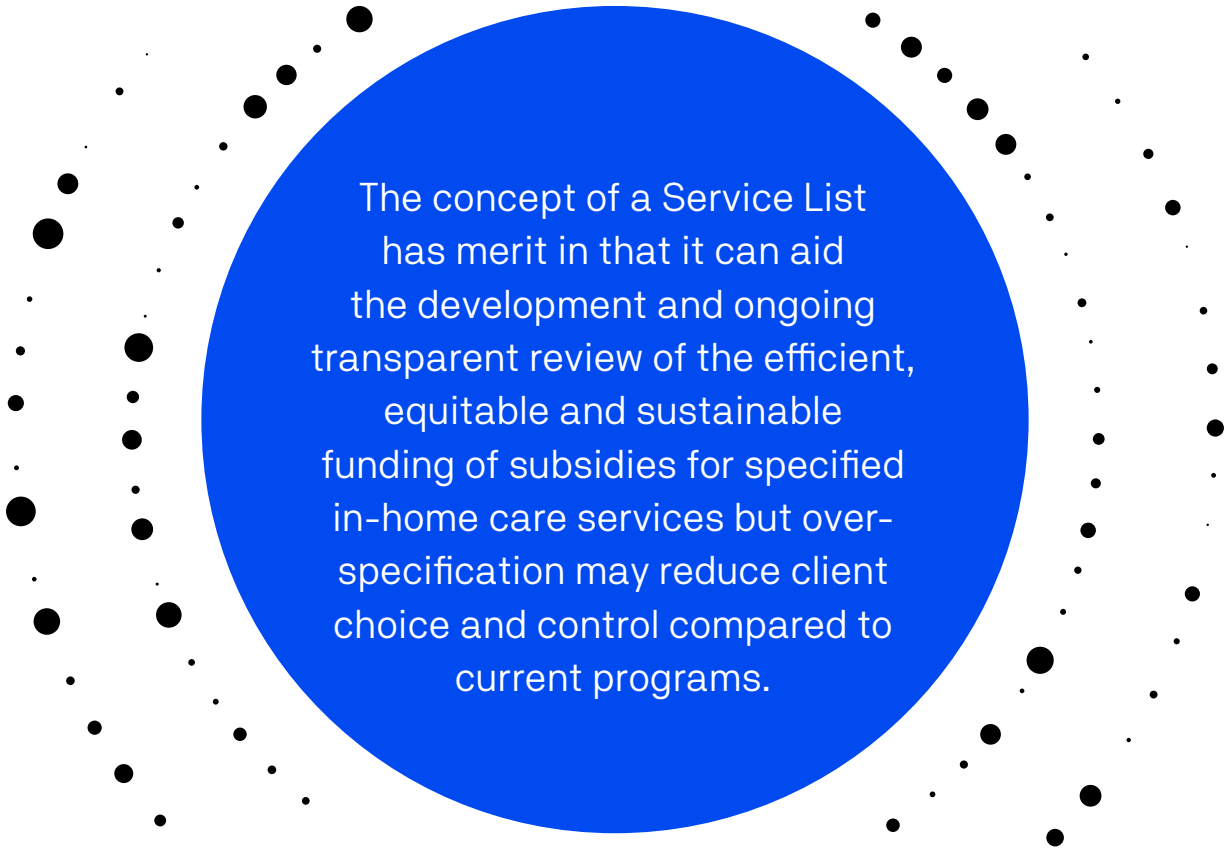
Unspent funds can also reflect conservative consumer behaviour in two areas. One is that there may be risk aversion and a response to uncertainty about future needs, in which senior Australians choose to keep funds aside for a "rainy day". Second, it may reflect a senior Australian's consideration of the value they may receive from a service where they are required to also incur additional private spending in the form of the income-tested basic daily fee. This explanation is less likely, however, given the very small proportion of provider revenue that is currently derived from income-tested client contributions ($39 million in 2019/20 of the $3.13 billion in total HCP revenue, with a further $64m being paid as basic daily fees).[45]

Under the Support at Home proposal, the issue of unspent funds will be addressed by the inability of clients to accrue entitlements. While the proposal's intention is understandable, the lack of an accrual capability potentially has several unintended consequences. First, instead of the Plan functioning as a funding envelope with some flexibility of timing and service choice, the services specified in the Plan may well be delivered by providers at the times and for the duration specified, regardless of the client's current need. Equally, the client may wish to consume all available services before access to them 'expires'.

An alternative scenario may be where a client needs fewer services in one period but a greater number in another. However, the more constrained the nature and timing of the entitlements, the less likely that clients will receive the services they require overall. The lack of appropriate mechanisms for feedback or review by senior Australian and their provider(s) to make necessary adjustments could also lead to more frequent, costly and burdensome reassessment processes.

One potential solution is to ensure the allotted timeframe is of a broader period, or to allow the carry-over of a quantum or percentage of assessed services into the next period. This could reduce the incentive to overspend and overservice.

Further research into actual and anticipated consumer behaviour in these settings is needed to develop clearer expectations about the effects that service-level entitlements and the inability to accrue funds would have on service volumes and the total cost to taxpayers.



5. Pricing and business models

Introduction

The Overview paper proposes that the Service List will be accompanied by a price schedule which will determine the revenue due to providers for the delivery of each service type. The Paper indicates that prices will reflect the efficient cost of delivering services, as determined by the newly established Independent Hospital and Aged Care Pricing Authority (IHACPA).

Transparency and the methodology of the price-setting process will be important elements of ensuring the equity and sustainability of the Support at Home program, noting that using fixed prices is only one of several possible price-setting mechanisms. The transition to a fixed, fee-for-service model has the potential to improve transparency and consistency of service offerings between providers. However, it will also limit the ability of providers to compete on price; does not reflect the heterogeneity of business models in a mixed market setting; and does not consider the variations in cost structures for certain client cohorts that will affect provider expenditure.

Prices and pricing models

The price of each service type included in the Service List will be determined by a fixed price schedule which will specify the revenue providers will receive for delivering the relevant services. It is to be developed with advice from the IHACPA. The Overview suggests that these set prices will reflect the "efficient" cost of delivering the services inclusive of administrative overheads – presuming that the cost is inclusive of not only a sufficient allocation of administration and support overheads, but also a viable rate of return to the provider. [46]

Transparency of pricing advice

In relation to funding to providers, it is concerning that the transparency of expert advice and the accountability of the Government for its decisions is uncertain. In the 1 July 2022 Fact Sheet issued by the Department, there are two conflicting statements regarding the transparency of IHACPA advice. Whereas the Fact Sheet states in the first instance that IHACPA "will provide *publicly available pricing advice to Government* on an annual basis.", later in the same document it is stated that "The IHACPA will report annually on its aged care functions, including its advice on pricing, and *the Government may choose to publish the pricing advice* that it receives from IHACPA." (italics added). [47]

The recent amendments to the National Health Reform Act 2011 provide for the Pricing Authority (IHACPA), at the request of the Minister or Secretary, to advise the Commonwealth in relation to health care pricing and costing matters and to publish reports and papers relating to those functions. In contrast, another of the Pricing Authority's functions is to provide advice to each relevant Commonwealth Minister in relation to aged care pricing or costing matters, there is no equivalent provision empowering the Authority to publish the related reports and papers. In a separate amendment to the Act, the Pricing Authority is required to prepare annual reports for presentation to the Parliament, which include details of the timing and content of the advice it provided to the Commonwealth. However, such a provision lacks the immediacy of publication of the advice at the time of the decision being taken by the Government.[48]

It is in the interests of senior Australians, taxpayers, providers and others that the new program be built on a foundation of transparency and accountability which applies to all parties – including the Government and its agencies. This is particularly important in the context of the increasing budgetary pressures, as outlined in UARC's Discussion paper on Sustainability of the Aged Care Sector.[49] Those pressures can be expected to contribute to tensions between the advice provided by IHACPA, the timely publishing of that advice, and actions taken by the Government on that advice.

Fixed price, fee-for-service model

In terms of the equity and sustainability of the system, the impact of the proposed fixed fee-for-service model is somewhat uncertain. While limited guidance has been issued on the proposed price-setting methodology, we note that various pricing models are available, as discussed later in this section.

Fixed prices, while potentially improving the consistency and transparency of service offerings, may have varying effects on the market for service provision, including the degree of competition within that market, depending on how those prices are determined. They can be set using industry benchmarks such as the average price for service type across the sector, by an alternative benchmark such as the price at a set percentile/quartile, or by independent determination of an efficient price for each service type.

Another concern is that a fixed price regime does not reflect the heterogeneity of provider business models and costs inherent in delivering to their market segment, particularly in relation to travel times and wage differentials to attract staff in certain situations. Nor does it allow providers to compete on price, resulting in a reduction of incentives for them in terms of innovation and efficiency in the delivery of services.

With the proposed incorporation of administrative costs into set prices, one of the ways for providers to improve their financial performance would be to seek economies of scale in their activities. There is some evidence of a scale effect in the expenses

of home care providers, with single service providers recording higher expenses ($67.84 per client per day) than larger scale providers ($61.38 for providers with two to six services, and $65.53 for those with seven or more services).[50] This can be achieved through the absorption of less efficient providers, which can raise sector productivity overall. However, any consequent reduction in competition could have more significant consequences in thin markets.

Further, innovation, investment in technology and achieving economies of scale also requires capital which requires sufficient return to providers to encourage and sustain this type of investment.

Price-setting methods

The Overview proposes that the set prices will be based on the cost of delivering each service type, each of which includes a diverse range of activities within a number of sub-categories. It is likely that the actual cost of delivering services within these sub-categories will vary within a significant range, such as between standard and complex nursing care. Similarly, the cost of providing services may vary by geographical area, with regional HCP providers reporting lower average expenses per consumer per day than those operating in metropolitan areas in 2019/20.[51]

Implicit in the suggestion that the IHACPA-determined prices will eventually reflect the efficient cost of service provision is an assumption that the activity-based funding model currently used for hospitals is appropriate for use in aged care. Cost estimation for in-home care services currently delivered under HCP is complicated given that the quantum of funding ascribed to a package level largely determines the activities and expenditure incurred. More fundamentally, delivery of care for a person, often for the remainder of their life, will need to reflect a frequent and significant variation in needs and cannot be likened to a case mix approach based on discrete medical procedures or other health interventions.

Alternatives to a fixed-price, fee-for-service model

There are alternatives to a fixed price model. They include the establishment of either a price cap and/or guidance in the form of a price range. The use of a price cap or price range could provide protection for clients through a price ceiling, while also encouraging price competition below the cap. However, the use of price caps may cause prices to trend toward the cap over time, rather than encouraging significant differentiation of prices in the market. Nonetheless, each option should be assessed and the analyses published.

Extension of AN-ACC to in-home and community aged care

Another proposal, developed by the Support at Home Alliance, is to extend the AN-ACC model for funding residential aged care into in-home and community aged care services. Proponents of this model note three points of difference from the Support at Home proposal.[52] First, an AN-ACC style model would include a base care tariff in addition to volume-based funding components. Second, volume-based funding components would be based on the assessed needs of clients rather than as fees in arrears for services delivered. Third, agency-level funding means that providers are able to cross-subsidise between clients. These differences are summarised by the Alliance in the following terms:

> "In the community care context, the AN-ACC will determine the total funding to the agency rather than the funding that has to be spent on each individual client. While the AN-ACC funding model relies on individualised assessment and care planning, the AN-ACC funding model is not an individualised funding model."[53]

The proposal to extend an AN-ACC style classification and funding model into in-home care has some merit where clients have complex care needs (equivalent to higher level packages within HCP) and a desire for a "one-stop-shop" relationship with a primary provider (and potentially a care manager). The provider could receive a base care tariff for providing services to the client together with volume-based funding reflecting the assessed needs. A move to an AN-ACC model in support at home would facilitate the continuum of care being provided in the setting of the senior Australian's choice - including their home.

However, adoption of the AN-ACC model need not extend to abandoning payment in arrears nor to the 'pooling' of clients' funding by the provider. In addition, as noted earlier in this Commentary, more than 80% of the clients who will transition into Support at Home from the three target programs are currently receiving services under the CHSP,[54] of whom more than half receive only a single service.[55] For this cohort, it is not clear that the benefits of a sophisticated case-mix model would outweigh the greater costs of assessment and administration, nor would fixed prices tied to a system-level calculation be relevant to services such as transport provision.

Further research into the benefits and costs of the various pricing models during this recently extended consultation period would help to ensure the efficiency, effectiveness, equity and sustainability of the final arrangements.

Heterogeneous business models and thin markets

The Overview recognises that a purely market-based structure will not incentivise the provision of quality in-home care services to senior Australians in regional, rural and remote areas or to specific cohorts of clients with special needs.[56] The provision of additional support for the delivery of services in thin markets becomes more important in a fixed price regime, given its greater rigidity. Matters needing to be addressed include the viability of these providers, staff availability and stability including the relationships between clients and care workers, and other quality and safety considerations.

Supplementary funding and flexibility mechanisms will be needed to avoid forcing these less financially viable (but nonetheless often efficient) providers of high-quality care out of the sector and decreasing the availability of sector capacity to serve these sub-markets. In developing the appropriate model, mechanisms will be needed to ensure that any viability grant funding is quarantined to the sites that service specific cohorts in need, rather than to providers who operate in a number of diverse sites.

As a final observation in this section, a long-running and unresolved issue is whether (and how) the Government should take into account the different taxation treatments applied to charitable organisations and for-profit businesses. Input taxes, in particular payroll tax and fringe benefits tax (FBT) concessions, represent an advantage for eligible organisations by reducing their employment costs. As the Productivity Commission noted nearly a decade ago, competitive neutrality

could be restored if input tax concessions are considered when assessing value for money.[57] However, it is unlikely that the proposed fixed price schedule would be modified to differentiate between the two types of organisations. The matter could be put to the new pricing authority for further advice once the new arrangements have been finalised.

Fixed prices, while potentially improving the consistency and transparency of service offerings, may have varying effects on the market for service provision, including the degree of competition within that market, depending on how those prices are determined.

6. Program funding

Introduction

A reading of the Overview suggests that Services that will be included on the Service List are to be made available at a price which is to be funded by the Government subsidy and an implied but as yet unspecified contribution from senior Australian clients.[66]

One issue of concern is striking the balance between funding by taxpayers in general and by the clients who directly benefit from the services. A second, inter-related issue, is ensuring there are strong safety nets for clients who have insufficient income or wealth to access essential services while requiring others to make a fair contribution to the cost of the services they receive.

With the Overview providing few details of how payment arrangements will be designed, this section sets out several options and discusses the relative merits and concerns from three perspectives: senior Australians assessed as needing in-home care services; providers who deliver the services; and current and future taxpayers.

Balancing taxpayer funding and client contributions

UARC's Discussion Paper on the Sustainability of the Aged Care Sector noted that care services, whether delivered in home or in a residential setting, are funded primarily by taxpayers – to levels of 90% or more.[58] While the Royal Commission recommended that client contributions should not be required for certain services including social supports, assistive technologies and home modifications, and care at home,[59] the Discussion Paper sets out the reasons why the Royal Commission's approach is not sustainable or necessarily aligned with patient co-payment arrangements for many health services.

In part, UARC's Discussion Paper observed that the Government's budgetary outlook over at least the next four decades is dire, giving it limited capacity to make other than the most pressing increases in funding across all of its programs. This pressure will be compounded by increases in budget outlays to support necessary increases in aged care worker award rates, let alone additional defence spending and interest payments for the high level of government debt.

Client contributions to cost of services

Client contributions are an important mechanism for improving the sustainability of the system, as observed by the 2017 Legislated Review. Furthermore, the requirement that senior Australians with sufficient means make contributions could moderate demand through clients assessing the value for money of the services they are partially funding as well as increasing their expectations of the quality of the services they expect their providers to deliver.

Consumer advocacy group COTA, in a submission to the Royal Commission, supported an increase in contributions from senior Australians who had sufficient means. This submission acknowledged that:

> "Most older Australians generally accept that, to fund a high-quality aged care system, they will need to make a greater contribution towards the cost of their care, as long as the contribution is transparent and fair, and they get better aged care in exchange. There is recognition that the levels of taxpayer support required for the quality of aged care they want are likely to be unsustainable."[60]

Client contributions within existing programs

There are material differences in the client contribution regimes that are applied across the three programs which are being brought together under the Support at Home program. They include significant inequity between clients with similar needs and in similar financial circumstances both within and between the programs. There is also some evidence of a distortionary bias in program selection where clients with higher means do not generally take up low-level HCP packages but seek CHSP services instead, noting the absence of an income-tested fee for those services.[61]

There are also differences in the overall amounts funded by the clients. As reported in the UARC Discussion Paper on Sustainability:

> "In CHSP, client contributions for care services are not based on a formal means test. Instead, they are set at each provider's discretion, guided by the CHSP Client Contribution Framework. In 2019-20, CHSP recipients contributed $251 million (8.7% of total program expenditure)."

> "For HCP, care contributions are intended to comprise a basic daily fee (up to 17.5% of the single age pension) and an income-tested fee, so those with higher income pay a higher contribution level. As noted elsewhere in this Paper, many providers do not charge the basic daily fee – in part a response to competition in the marketplace. Income tested contributions are capped on an annual and lifetime basis and the value of the assessed payment is deducted from the subsidy paid by the Government. In 2019-20, HCP recipients contributed only $102 million (3.0% of total program expenditure)."[62]

While the Overview introduces a new Point of Delivery Payment Platform which is intended to allow providers to receive payments in real-time from the Government and clients, many questions remain about how client fees are to be set, collected and distributed to providers within a fee-for-service, multi-provider model.

Alternative funding models

There are at least four potential options for the apportionment of payments for services between taxpayers and different cohorts of clients, each having different implications for the equity and sustainability of the aged care system. The following is a brief review of four possible options.

In all but one case (option 3), many, if not all, clients would be expected to contribute. The principles on which these contributions would be designed would require detailed development and consultation. Possible principles, drawn from previous reviews of aged care and other social services, could include:

- Contributions from clients who meet the relevant income and assets thresholds should be mandatory. Exceptional circumstances should be approved by the Department, not the providers.
- There should be a strong safety net for those with the least means (income and assets), and the rates of contribution for clients with higher means should be progressive.
- The current two-fee arrangement for HCP should be replaced by a single fee across the new program. If certain entry-level services are not included in the initial phase of program implementation (such as transport, meals and social engagement), it may be sufficient for providers of those services to be block funded to a certain level and continue to operate under a client contribution framework that can be adapted to local and individual circumstances.
- The rates of contribution could vary between services, with all clients making some contribution for basic daily services (as was the intention of the basic daily fee under the HCP program), but those with the least means not being required to contribute to personal care or health services.
- There should be annual and lifetime caps. They have a role to play both as a form of social insurance and as a means of facilitating community acceptance of the fairness of the scheme. The cap values should be significantly greater than those currently applied in HCP.
- Services Australia should administer the income and assets assessments where these were required.

A consideration for each option involving a consumer contribution is whether the service provider or the Government is responsible for collecting fees from clients. Where service providers are required to invoice clients directly for their contribution to the service, they would face both increased risk and costs associated with bad debts, but have a strong incentive to collect the fees. On the other hand, government social agencies have mixed reputations for collecting client fees or other client financial obligations. In cases where there are multiple providers, clients face increased administrative burdens in the form of multiple invoices as well as increased potential for fraud.

Option 1 Fixed prices published in the Service List, a means-tested and capped client contribution and a balancing public subsidy

Under Option 1, the Government would determine and publish a price for each item on the Service List based on the publicly provided advice from IHACPA as to the efficient price.

The Government would set a minimum client contribution for each item which would be paid by all clients, including those assessed as being fully supported as well as a capped maximum level of contribution for each item that would be paid by clients who were fully self-funding. For partially supported clients, a tapered contribution would be required. Fully supported clients would have the benefit of a strong safety net and would only pay the minimum contribution.

The public subsidy would be the balancing amount in each case.

Many of the services which are proposed for the Service List (and are currently offered within the CHSP/HCP programs) relate to support with basic daily activities rather than personal and health care. This option provides scope for discussion about differentiating the levels of client contributions (and hence the public subsidies) for different service types.

Option 2 Fixed prices in the Service List, a fixed subsidy and a fixed client contribution

The second option involves prices in the Service List being fixed and inclusive of a fixed subsidy component and a fixed level of client contribution. However, a fixed contribution would require all clients to pay the same amount for the service irrespective of differences in their income and wealth. This fixed contribution would be regressive in nature, as those senior Australians with low-income and assets would be required to pay proportionately more of their means for access to aged care services.

Should the level of contribution be negligible, however, proportionately more of the cost of aged care services would be charged to taxpayers and would further exacerbate the fiscal burden facing the Government.

Option 2 would not require Services Australia to conduct an income and assets test.

Option 3 Fixed prices in the Service List which are fully funded by taxpayers

The use of fully publicly funded fixed prices is the option recommended by the Royal Commission. It has the benefit of simplicity and would be attractive from a client perspective. However, it does not represent equitable funding between client cohorts or between clients and taxpayers overall. It would be inconsistent with the many examples of co-payments in Australia's healthcare system and other policy settings.

This option would have increasingly significant consequences in terms of future fiscal sustainability. In addition to removing the current revenue stream, fee-free models can be expected to drive additional demand as more of the care currently being provided by informal carers and communities could be directed to publicly funded aged care services. Additional demand has obvious implications for public costs and the availability of a workforce to service that demand.

Design choices about client contributions for in-home care also have implications for community acceptance of care contributions in residential aged care homes.

Option 4 Recommended prices in the Service List, a fixed subsidy and a means tested discretionary but capped client contribution

A fourth option draws on the existing HCP model. The Government's Service List would inform clients of the recommended price it considers appropriate for each service (based on the efficient price publicly advised by IHACPA) and provides a strong safety net for fully supported clients. It also enables providers some flexibility to compete for clients via the level of client contribution.

It could be designed in various ways, such as the following:

- The Government would set the level of subsidy for each item that it would pay to providers and could vary the subsidy according to the nature of the service.
- Providers could determine the level of contribution they would charge fully supported and partially supported clients, provided the combined public subsidy and client contribution did not exceed the recommended price published in the Service List.
- Providers could determine the level of contribution they would charge fully self-funding clients provided the combined public subsidy and contribution did not exceed a fixed percentage of the recommended price published in the Service List (for example, 120%).

Such a system would have some alignment to the Medicare style of a scheduled payment and discretionary gap fee, though the Government would be undertaking the income and asset test.

Provider flexibility in setting client contributions already occurs for CHSP where providers collect fees and operate under a client contribution framework. [63],[64] Competition-driven pricing is also evident in HCP, where few providers choose to collect the Basic Daily Fee.[65]

Under option 4, individual providers would be able to consider the extent of competitive pricing in the marketplace and the level of premium that higher means clients would be prepared to pay for services from that provider. However, whereas some flexibility in setting consumer contributions is consistent with supporting a market-based environment, the aforementioned experience with HCP in relation to the waiver of the Basic Daily Fee has seen providers engage in a competitive race to the bottom in charging client contributions. In cases where providers completely waive contributions for some clients, the option would be inconsistent with the principle of mandatory contributions for all eligible clients.

Funding model conclusions

Given the complex equity and sustainability consequences of these options, additional consideration and evaluation will be required. Options 1 and 4, or some variation of each, are likely to be the worthiest for closer modelling and analysis. Option 1 appears to be particularly aligned with the client contribution principles set out in this section. This further work is critical as policy decisions on these matters will significantly influence community acceptance of the new program and the sustainability of the aged care system overall.

Research team

UTS Ageing Research Collaborative

Dr Rachael Lewis

Dr Rachael Lewis is a lecturer at the UNSW Business School. She conducts research into the role of management accounting in shaping managerial cognition. She specialises in understanding how managers think and make decisions, with a particular interest in the development of expertise. Her PhD research examined the use of performance measurement and other management systems in an aged care setting.

Professor Michael Woods

Professor Michael Woods is Professor of Health Economics at the UTS Centre for Health Economics Research and Evaluation, focusing on aged care. He was a former Deputy Chair of the Productivity Commission and has held appointments to Government Boards, health and aged care policy reviews, multilateral development agencies and foreign government reform programs.

Professor David Brown

Professor David Brown is Professor of Management Accounting in the UTS Business School. His research focuses on the design and use of accounting systems for decision making in organisations with an interest in business models and determinants of performance. He has published research internationally.

Professor Deborah Parker

Professor Deborah Parker is a Professor of Nursing Aged Care (Dementia) in the Faculty of Health at UTS. Her primary research is in palliative care for older people. She has published and is recognised both nationally and internationally. Her research incorporates her clinical background. She is former President of Palliative Care NSW and is a member of the Palliative Care Nurses Association, Australian Association of Gerontology and the Australian College Nursing.

Dr Nicole Sutton

Dr Nicole Sutton is a Senior Lecturer in management accounting at the UTS Business School. Her research examines the design and use of accounting systems to support decision-making within and across organisations. She has published research internationally. In 2019, she joined the Management Committee of Palliative Care NSW as Treasurer.

Dr Gillian McAllister

Dr Gillian McAllister is a Senior Researcher at the UTS Business School. Her research interests examine organisational practices and structures along with public policy development and impact. She has extensive experience on both research and consulting.

David Sinclair

David Sinclair is a Partner at chartered accountancy firm StewartBrown. David specialises in providing services and advice to aged care and community services businesses, particularly consulting, accounting and internal audit.

Endnotes

1. Department of Health and Aged Care. (2022, July 28). Getting In-Home Care back on track [Press release]. https://www.health.gov.au/ministers/the-hon-anika-wells-mp/media/getting-in-home-care-back-on-track
2. Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022) *Sustainability of the Aged Care Sector: Discussion Paper.* UTS, p. 46, available at https://www.uts.edu.au/uarc#reports-and-publications.
3. Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022) *Sustainability of the Aged Care Sector: Discussion Paper.* UTS, p. 46, available at https://www.uts.edu.au/uarc#reports-and-publications.
4. Department of Health (2021). *2020-21 Report on the Operation of the Aged Care Act 1997.* Canberra, available at https://www.health.gov.au/resources/publications/2020-21-report-on-the-operation-of-the-aged-care-act-1997.
5. Department of Health (2021). Support at Home Program Overview, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
6. Department of Health and Aged Care. (2022, July 28). Getting In-Home Care back on track [Press release]. https://www.health.gov.au/ministers/the-hon-anika-wells-mp/media/getting-in-home-care-back-on-track
7. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*, p. 35.
8. StewartBrown (2020) Home Care Provider Survey - Analysis of Data Collected, p. 44, available at https://www.health.gov.au/resources/publications/home-care-provider-survey-analysis-of-data-collected
9. StewartBrown (2020) Home Care Provider Survey - Analysis of Data Collected, p. 41, available at https://www.health.gov.au/resources/publications/home-care-provider-survey-analysis-of-data-collected
10. Department of Health (2021). *2020-21 Report on the Operation of the Aged Care Act 1997.* Canberra, available at https://www.health.gov.au/resources/publications/2020-21-report-on-the-operation-of-the-aged-care-act-1997.
11. Productivity Commission (2011). *Caring for Older Australians*. Volume 1, No. 53. Canberra, p. xxviii, available at: https://www.pc.gov.au/inquiries/completed/aged-care/report
12. Aged Care Sector Committee (2016). *Aged Care Roadmap*. Department of Health, Canberra, p. 3, available at: https://www.health.gov.au/resources/publications/aged-care-roadmap
13. Department of Health (2021) *Home Care Packages Program reforms*, available at https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/home-care-packages-program-reforms
14. Department of Health (2017) *Legislated Review of Aged Care 2017*. Department of Health, Canberra, p. 7.
15. Woods, M. & Corderoy, G. (2020). *Impact Analysis: Alternative Models for Allocating Residential Aged Care Places*. CHERE, UTS and StewartBrown, Sydney, p. 59, available at: https://www.health.gov.au/resources/publications/final-report-impact-analysis-alternative-models-for-allocating-residential-aged-care-places
16. See https://www.health.gov.au/initiatives-and-programs/competition-in-residential-aged-care.
17. Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022) *Sustainability of the Aged Care Sector: Discussion Paper.* UTS, p. 28, available at https://www.uts.edu.au/uarc#reports-and-publications.
18. Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022) *Sustainability of the Aged Care Sector: Discussion Paper.* UTS, p. 31, available at https://www.uts.edu.au/uarc#reports-and-publications.
19. Department of Health (2021). *Respect, care, dignity. A generational plan for aged care.* Canberra, available at https://www.health.gov.au/resources/publications/respect-care-dignity-a-generational-plan-for-aged-care-in-australia.
20. Woods, M. & Corderoy, G. (2020). *Impact Analysis: Alternative Models for Allocating Residential Aged Care Places.* CHERE, UTS and StewartBrown, Sydney, p. 59, available at: https://www.health.gov.au/resources/publications/final-report-impact-analysis-alternative-models-for-allocating-residential-aged-care-places
21. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*, p. 35.
22. *Aged Care Act 1997* (Cth), retrieved from https://www.legislation.gov.au/Details/C2017C00241

23. Department of Health (2021). *Support at Home Program Overview*, p. 11, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
24. Department of Health (2021). *Support at Home Program Overview*, p. 3, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
25. Emmanuel, C, Otley, D. & Merchant, K. (1990) *Accounting for Management Control*. Springer, Boston, MA, p. 176.
26. Department of Health (2021). *Support at Home Program Overview*, p. 4, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
27. Department of Health (2021). *Support at Home Program Overview*, p. 6, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
28. Department of Health (2021). *Support at Home Program Overview*, p. 11, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
29. Department of Health (2021). *Support at Home Program Overview*, p. 15, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
30. *Quality of Care Principles 2014* (Cth), available at https://www.legislation.gov.au/Details/F2020C00096
31. Department of Health (2021). *Support at Home Program Overview*, p. 9, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview
32. StewartBrown (2020) Home Care Provider Survey - Analysis of Data Collected, p. 43, available at https://www.health.gov.au/resources/publications/home-care-provider-survey-analysis-of-data-collected
33. Department of Health (2021). *Support at Home Program Overview*, p. 10, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
34. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*, p. 35.
35. Department of Health (2021). *Support at Home Program Overview*, p. 12, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
36. Department of Health (2021). *Support at Home Program Overview*, p. 12, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
37. Royal Commission into Aged Care Quality and Safety (2021). *Final Report: Care, Dignity and Respect. Royal Commission into Aged Care Quality and Safety*, p. 97.
38. Royal Commission into Aged Care Quality and Safety (2021). *Final Report: Care, Dignity and Respect. Royal Commission into Aged Care Quality and Safety*, p. 232.
39. COTA Australia, *COTA response to draft Home Care propositions*, available at https://agedcare.royalcommission.gov.au/media/28296.
40. Department of Health (2021). *Support at Home Program Overview*, p. 10, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
41. Department of Health (2021). *Support at Home Program Overview*, p. 7, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview.
42. COTA Australia, *COTA response to draft Home Care propositions*, p. 2, available at https://agedcare.royalcommission.gov.au/media/28296.
43. Department of Health (2021). *Support at Home Program Overview*, p. 11, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview
44. Department of Health (2021). *Support at Home Program Overview*, p. 3, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview
45. StewartBrown (2020) Home Care Provider Survey - Analysis of Data Collected, p. 34, available at https://www.health.gov.au/resources/publications/home-care-provider-survey-analysis-of-data-collected
46. Department of Health (2021). *Support at Home Program Overview*, p. 7, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview

47. Department of Health and Aged Care (2022). *Ensuring AN-ACC funding remains aligned with the cost of delivering residential aged care,* available at https://www.health.gov.au/resources/publications/ensuring-an-acc-funding-remains-aligned-with-the-cost-of-delivering-residential-aged-care

48. *Aged Care and Other Legislation Amendment (Royal Commission Response) Act 2022* (Cth), retrieved from https://www.legislation.gov.au/Details/C2022A00034

49. Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022) *Sustainability of the Aged Care Sector: Discussion Paper.* UTS, available at https://www.uts.edu.au/uarc#reports-and-publications

50. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*, p. 48.

51. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*, p. 48.

52. Eagar, K., (2022) Extension of the AN-ACC funding model to include community aged care available at https://www.acsa.asn.au/ACSA/media/General/Documents/Extension-of-the-AN-ACC-funding-model-to-include-community-aged-care.pdf

53. Support at Home Alliance (2021) Extending the AN-ACC to community care: frequently asked questions, retrieved from https://www.acsa.asn.au/ACSA/media/General/Documents/Extending-the-AN-ACC-to-community-care_FAQs.pdf

54. Department of Health (2021). *2020-21 Report on the Operation of the Aged Care Act 1997.* Canberra, available at https://www.health.gov.au/resources/publications/2020-21-report-on-the-operation-of-the-aged-care-act-1997.

55. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*, p. 35.

56. Department of Health (2021). *Support at Home Program Overview*, p. 12, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview

57. Productivity Commission (2010). *Contribution of the Not-for-Profit Sector, Research Report*, Canberra, available at https://www.pc.gov.au/inquiries/completed/not-for-profit/report/not-for-profit-report.pdf.

58. Department of Health (2021). *Support at Home Program Overview*, p. 7, available at https://www.health.gov.au/resources/publications/support-at-home-program-overview

59. Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022) *Sustainability of the Aged Care Sector: Discussion Paper.* UTS, p. 46, available at https://www.uts.edu.au/uarc#reports-and-publications.

60. Royal Commission into Aged Care Quality and Safety (2021). *Final Report: Care, Dignity and Respect. Royal Commission into Aged Care Quality and Safety*, p. 292.

61. COTA Australia, *COTA Australia - Financing Aged Care*, p. 10-11, available at https://agedcare.royalcommission.gov.au/media/28540

62. Tune, D.M. (2017) *Legislated Review of Aged Care*, p.87

63. Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022) *Sustainability of the Aged Care Sector: Discussion Paper.* UTS, p. 46, available at https://www.uts.edu.au/uarc#reports-and-publications.

64. Department of Health (2022) *Commonwealth Home Support Programme – Program Manual 2022-23,* available at https://www.health.gov.au/resources/publications/commonwealth-home-support-programme-chsp-manual

65. Department of Health (2022) *National Guide to the CHSP Client Contribution Framework*, available at https://www.health.gov.au/resources/publications/national-guide-to-the-chsp-client-contribution-framework

66. Aged Care Financing Authority (2021). *Ninth Report on the Funding and Financing of the Aged Care Industry*, p. 46

UTS

For more information

UTS Ageing Research Collaborative
Email: uarc_inquiries@uts.edu.au
Website: www.uts.edu.au/uarc

UTS CRICOS: 00099F