2014–15
REPORT ON THE OPERATION OF THE *AGED CARE ACT 1997*

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MINISTER'S FOREWORD

FOREWORD

By the Minister for Aged Care, the Hon Sussan Ley MP

I am pleased to present to Parliament the 2014–15 Report on the Operation of the *Aged Care Act 1997*.

It is a great privilege to have the portfolio responsibility for aged care.

We have a lot to celebrate, with Australians living longer, healthier and more active lives than ever before.

The number of Australians aged 65 years or over is expected to increase from 3.6 million in 2015 to 6.2 million in just 20 years.

By 2050 we'll even have around 41,000 centenarians living among us!

It is wonderful to think about the many rich life stories that our older Australians will share with future generations.

These are some of the reasons I am excited to welcome aged care back into the Health portfolio, and to build on the progress made by the previous Minister, Mitch Fifield, in reforming the aged care system.

The Health portfolio aims to promote better health and wellbeing for all Australians – and as aged care plays an important role in the overall health system, having aged care alongside the Ministries of Health and Sport will help us achieve this goal.

I share the vision of a high quality and sustainable aged care system that better meets people's needs and ensures dignity in their final years.

Aged care is more than just residential aged care homes or facilities – after all only one in 11 Australians aged 70 years or over actually receive permanent residential care.

The Australian Government recognises that older Australians want to remain living independently at home for as long as possible. In 2014–15, over:

- 812,000 people accessed Home and Community Care (HACC) services;
- 24,900 people accessed transition care; and
- 83,800 people accessed home care packages.

Over the past twelve months, the Government has worked to introduce a range of changes to help support people to remain living at home.

The Commonwealth Home Support Programme combined several home support programmes into one programme, streamlining and simplifying the way entry-level aged care is accessed and delivered.

Consumer directed care was introduced into all home care packages from 1 July 2015 – providing greater choice and flexibility to people who need help at home.

If a person can no longer remain living independently at home, residential aged care can provide the support and assistance they need. In 2014–15, over 170,000 people accessed permanent residential aged care.

Providing people with more choice and flexibility in the care they receive can only be achieved when we have informed and engaged consumers. My Aged Care – the national contact centre that provides information on aged care services was expanded to encompass a greater variety of functions.

The stage has been set for more reform which will give consumers more choice and more control over the services and supports they receive.

As a Minister with a strong record of consultation, I intend to continue to work with the aged care industry as we progress the planned changes. With my colleague the Hon Ken Wyatt MP who, in his role as Assistant Minister, will work with me with a specific focus on aged care, I'm looking forward to a third wave of reform.

We will work together with the aged care community, its providers and its consumers, to determine these future directions for our aged care system.

Sussan Ley
Minister for Aged Care

EXECUTIVE SUMMARY

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This year, the Australian Government continued to reform the aged care system to improve its responsiveness and flexibility and to better meet the needs of older Australians. These reforms, which included the introduction of the consumer-driven care approach, the enhancement of My Aged Care, and the start of the Commonwealth Home Support Programme, will significantly increase older Australians ability to choose services and improve their access to services.

This Report on the Operation of the *Aged Care Act 1997* meets the requirements outlined in section 63-2 of the *Aged Care Act* 1997 (the Act) that the Minister responsible for aged care present to Parliament a report on the operation of the Act in respect of the 2014–15 financial year. In addition, the report also provides additional information to aid an understanding of aged care programmes and policies.

Responsibility for operation of the Act transferred from the Department of Social Services to the Department of Health in September 2015, following Machinery of Government changes.

The Australian Government ensures the provision of aged care services in a range of settings, including in residential aged care and within the home. Depending on the type of care provided, aged care is governed by the Act and associated principles, or through contractual arrangements. These frameworks aim to promote the delivery of quality, affordable and accessible aged care for older people, including through subsidies and grants, industry assistance, training and regulation of the aged care sector.

In 2014–15, over:

- 812,000 people aged 65 years and over (50 years and over for Indigenous Australians) accessed Home and Community Care (HACC) services, which helped enhance the independence of frail older people and their carers through the provision of basic maintenance, support and care;
- 24,900 people accessed transition care upon discharge from hospital to provide them with more help to recover and time for them to consider longer term support options;
- 83,800 people accessed home care packages, which provide home-based care that can improve older Australians' quality of life through coordinated packages of services tailored to individual care needs; and
- 231,000 people accessed permanent residential aged care.

Some people received care through more than one care programme throughout the year.

EXPENDITURE

In 2014–15, expenditure for Australian Government programmes provided under the Act was:

- $10.6 billion for residential care subsidies and supplements, compared with $9.8 billion in 2013–14 – an increase of 7.9 per cent;
- $1.28 billion for home care packages, compared with $1.27 billion in 2013–14 – an increase of 0.8 per cent; and
- $407.5 million for flexible care programmes, compared with $367.4 million in 2013–14 – an increase of 10.9 per cent.

The largest single component of Australian Government expenditure outside the Act was $1.9 billion for Home and Community Care (HACC) services, comprising:

- $1.3 billion for the Commonwealth HACC programme; and
- $579.7 million through Treasury Certified Payments to Victoria and Western Australia for HACC services in those states.

NEW AGED CARE PLACES

The process by which new residential and home care places are allocated is the Aged Care Approvals Round (ACAR). The 2014 ACAR saw:

- a total of 17,849 new aged care places (11,196 residential aged care places and 6,653 home care places) allocated across Australia, with an estimated annual recurrent funding value of over $833.6 million; and
- $103 million in capital grants was allocated to assist aged care providers to build new or improve existing residential aged care services.

RED TAPE REDUCTION

In line with the Red Tape Reduction Action Plan developed by the Aged Care Sector Committee, the Government reduced red tape, including:

- streamlining of the 2014 ACAR;
- streamlining of the reporting requirements for home care package providers;
- providers removal of red tape associated with the Conditional Adjustment Payment; and
- removal of duplicative reporting requirements where reporting through states and territories already exist.

CHAPTER 1

1. INTRODUCTION

The Australian Government funds and regulates the provision of residential care, home care, home support and flexible care to those approved to receive it, and provides capital grants to assist in the establishment of new services and the expansion or upgrade of existing aged care services where providers are unable to meet these costs through other sources. It also has in place quality assurance and consumer protection programmes.

The *Aged Care Act 1997* (the Act) and associated Aged Care Principles (the Principles) provide the legislative framework for the regulatory, funding and quality foundation of Australia's aged care system and are based on the set of objectives set out in the Act, namely to:

- provide funding that takes account of the quality, type and level of care;
- promote a high quality of care and accommodation;
- protect the health and well-being of residents;
- ensure that aged care services and funding are targeted towards people and areas with the greatest needs;
- ensure that care is accessible and affordable for all residents;
- provide respite for families and others who care for older people;
- encourage services that are diverse, flexible and responsive to individual needs;
- help residents enjoy the same rights as all other people in Australia;
- plan effectively for the delivery of aged care services; and
- promote ageing in place through the linking of care and support services to the places where older people prefer to live.

Australian Government expenditure for aged care throughout 2014–15, including aged care support and assistance provided under and outside the Act, totaled $15.2 billion, an increase of 7.1 per cent from the previous year (Figure 1).

The aged care system represents a sizeable component of the economy, with public and private expenditure, making up approximately one per cent of gross domestic product.

In 2014–15, expenditure for Australian Government programmes provided under the Act comprised:

- $10.6 billion for residential care subsidies and supplements, compared with $9.8 billion in 2013–14 – an increase of 7.9 per cent;
- $1.28 billion for home care packages, compared with $1.27 billion in 2013–14 – an increase of 0.8 per cent; and
- $407.5 million for flexible care programmes[1], compared with $367.4 million in 2013–14 – an increase of 10.9 per cent.

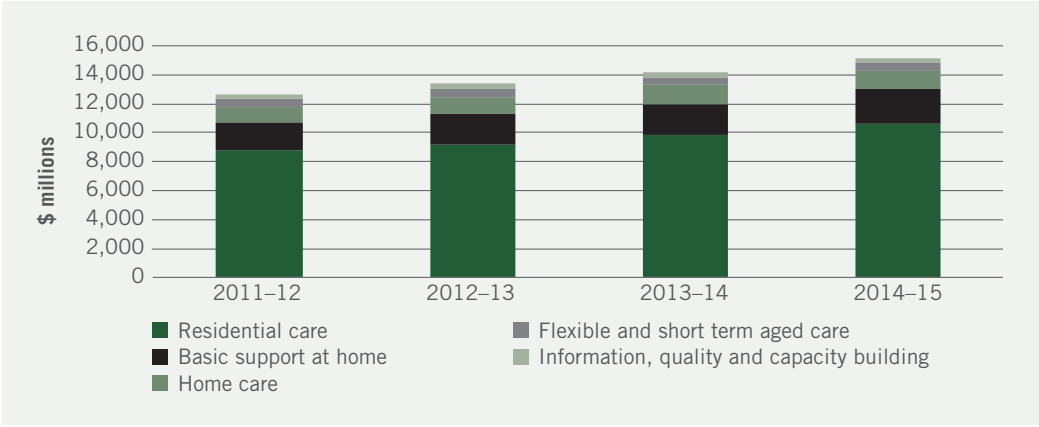
[1] Flexible care programmes includes the Transition Care Programme, Multi-Purpose Services and Innovative Care Services.

The largest single component of Australian Government expenditure outside the Act was $1.9 billion for Home and Community Care (HACC) services, comprised of:

- $1.3 billion for the Commonwealth HACC programme; and
- $579.7 million through Treasury Certified Payments to Victoria and Western Australia for HACC services in those states.

Additionally in 2014–15, $240.7 million was provided for the National Respite for Carers Programme (NRCP), $42.6 million was provided to deliver therapy services through the Day Therapy Centre (DTC) programme and $6.4 million was provided for the Assistance with Care and Housing for Aged Programme (ACHA). There were also a range of other funded services that provide support to consumers and service providers.

Figure 1: Australian Government outlays for aged care, 2011–12 to 2014–15



The outlays in this figure includes administered funding provided by the Departments of Social Services and Veterans' Affairs, and administered funds provided through the National Partnership Payments to the states and territories.

Over 1.3 million older people received some form of aged care each year, with approximately one in 11 people aged 70 or over receiving permanent residential care. During 2014–15, through aged care programmes administered by the Australian Government under the Act:

- 231,255 people received permanent residential care with 8.9 per cent of people aged 70 years or over, and 29.7 per cent of people aged 85 years or over receiving permanent residential care;
- 83,838 people received care through a home care package (levels 1 to 4) with 3.2 per cent of people aged 70 years or over receiving a home care package;
- 53,021 people received residential respite care, of whom 26,029 were later admitted to permanent care. 2.0 per cent of people aged 70 years or over, and 6.1 per cent of people aged 85 years or over received residential respite care; and
- 24,914 people received care under the Transition Care Programme – an increase of 5.9 per cent from 2013–14.

In 2014–15, many older people were receiving support through the Commonwealth HACC programme. In 2014–15, 530,210 individual clients aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) received assistance through the Commonwealth HACC programme.

In Victoria and Western Australia, 368,905 people received services through jointly funded Commonwealth-state HACC programmes, of which 282,174 were aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people).

Some people received care through more than one of these programmes throughout 2014–15.

1.1. PURPOSE OF THIS REPORT

This report details the operation of Australia's aged care system throughout the 2014–15 financial year and is the seventeenth in the series. It is delivered to Parliament and the Australian community by the Minister in accordance with section 63-2 of the Act, which requires that the report include information about:

- the extent of unmet demand for places;
- the adequacy of the Australian Government subsidies provided to meet the care needs of residents;
- the extent to which providers are complying with their responsibilities under the Act and the *Aged Care (Transitional Provisions) Act 1997*;
- the amounts of accommodation payments and accommodation contributions paid;
- the amounts of those accommodation payments and accommodation paid as refundable deposits and daily payments;
- the amounts of accommodation bonds and accommodation charges charged;
- the duration of waiting periods for entry to residential care;
- the extent of building, upgrading and refurbishment of aged care homes; and
- the imposition of any sanctions for non-compliance under Part 4.4 of the Act, including details of the nature of non-compliance and the sanctions imposed.

In addition to information required by the Act, the report includes information on related matters to provide a more useful and comprehensive picture of the Australian aged care system.

1.2. SOURCES

Information for this report was collected primarily from Departmental information systems and records.

CHAPTER 2

2. AUSTRALIA'S AGEING POPULATION AND THE AGED CARE CONSUMER

The ageing process affects each person differently and there is no typical aged care consumer. In part, the ageing process depends on the life choices individuals make and whether they take practical measures to adapt to the normal ageing process. Ageing is also influenced by a range of interdependent drivers – from the protection of people's rights, to the critical issues of employment, liveable housing and community environments, lifelong learning, retirement incomes, and healthy ageing.

2.1. AUSTRALIA'S POPULATION AND DEMOGRAPHICS

Longevity

It is recognised that Australia's population is ageing, with Australians living longer and healthier lives. This will bring about significant challenges and opportunities for the aged care system in the years ahead. Many of the recent changes to the aged care system have been made in recognition of this fact – as Government aims to provide an aged care system that meets the needs of older Australians both now and into the future.

As at 30 June 2015, 15 per cent of Australia's population were aged 65 years and over (3.6 million people) and two per cent were aged 85 years and over (473,000 people). By 2025, it is estimated that 17 per cent of the population will be aged 65 years and over (4.9 million people) and 2.2 per cent (621,000) over the age of 85[2].

The life expectancy of people in Australia compares well with those of other developed nations, with life expectancies at birth of 80.3 years for males and 84.4 years for females, with both expected to live many years beyond 'retirement'.

Culturally and Linguistically Diverse Australians

There is significant cultural diversity among Australians and many people from culturally and linguistically diverse (CALD) backgrounds are seeking culturally appropriate aged care information and services.

Additionally, nearly half of Australians were born overseas or are 'second generation' Australians with one or both parents born overseas. While many of these people have come from European countries, in the 1970s many migrants arrived in Australia from South-East Asia. In recent migration streams, a number of Asian countries have made a large contribution[3].

[2] Revised population projections based on 2012 Estimated Resident Population prepared for the Department of Social Services by the Australian Bureau of Statistics, according to assumptions set by the Department.

[3] Australian Bureau of Statistics, ABS 2071.0 Reflecting a Nation: Stories from the 2011 Census.

Under the Partners in Culturally Appropriate Care Programme, $3.8 million is allocated to each state and territory over two years to, among other things, support sustainable partnerships between CALD communities and aged care services and provide culturally appropriate skills and training to aged care staff.

Between 1 July 2014 and 30 June 2015, 2,581 callers to the My Aged Care contact centre identified themselves as being from a CALD background (noting this information is collected on a voluntary basis and callers are not required to provide this information).

Since 1 July 2014, the My Aged Care website has been expanded to include translated material in 18 languages, an increase of 11 available languages since 2013–14. Throughout 2014–15, there were 15,464[4] visits to the translation pages.

Independence

The majority of older people continue to live active, independent lives in the community and go on contributing to their communities and the economy. Where possible, the Australian Government provides supports and assistance to help people remain living independent and active lives.

According to the 2011 Census, around 94 per cent of older Australians (65 years and over) lived in private dwellings in the community. Of these, approximately 135,900 people lived in retirement villages, with almost two-thirds of this group being women.

During 2014–15, 68 per cent of Australians aged 65 years and over lived at home without accessing Government subsidised aged care services, 25 per cent accessed some form of support or care at home, while only seven per cent accessed residential aged care.

Workforce Participation

Population ageing is changing the ratio of working age to retirement age for people. The *2015 Intergenerational Report* recognises "that the proportion of the population participating in the labour force is expected to decline as our community ages."

In June 2014, 34 per cent of men and 20 per cent of women aged between 65 and 69 were active in the labour force.

For each older person (aged 65 years or more) in 2015, there were 4.4 'traditional' working-age people (15 to 64 years) and by 2025, this ratio will decrease to 3.7 'traditional' working-age people for every older person.

The *2015 Intergenerational Report* indicates that by 2054–55, the participation rate for Australians aged over 15 years is projected to fall to 62.4 per cent, compared to 64.6 per cent in 2014–15.

This change is opening opportunities for older people to continue participating in the workforce.

[4] This figure is based on total visits during the 2014–15 financial year period and may include individuals who visited the translation pages more than once.

2.2. WHO IS THE AGED CARE CONSUMER?

In 2014–15, the majority (68 per cent) of people aged 65 and over live at home without accessing Government-subsidised aged care services, and only about seven per cent access residential aged care at some time over the year.

Aboriginal and Torres Strait Islander people comprise three per cent of the total population, or 2.9 per cent of people in the aged care planning aged range (50 and over for Aboriginal and Torres Strait Islander people).

With Australia being a culturally diverse nation, Australia's aged care system needs to meet the aged care needs of people from a wide range of cultural and linguistical backgrounds. People from CALD backgrounds make up 18.7 per cent of all residential care recipients aged 70 years and over and 26.6 per cent of all home care recipients 70 years and over.

In 2015, 342,800 people in Australia are estimated to be living with dementia. Dementia is one of the major reasons why older people enter residential aged care or seek assistance to remain living at home. Given the prevalence of dementia, it is important that the needs of people with dementia are considered throughout the aged care system. More information on how dementia is a core part of Australia's aged care system can be found in Chapter 3.

Younger people accessing aged care services

While younger people with disabilities and people with dementia are not specified as people with special needs under the *Aged Care Act 1997* (the Act), each case warrants careful consideration based on individual circumstances.

Younger people with disabilities are eligible for services provided under the Act if they are approved for those services by an Aged Care Assessment Team (ACAT), and only when there are no other more appropriate care facilities or services able to meet the person's needs. The reason for this is that residential aged care facilities being designed and staffed to meet the needs of frail older people, and not necessarily equipped to meet the needs of younger people with disabilities. Generally, it is more appropriate for a younger person with disabilities to be cared for through specialist disability support services, than through aged care services.

In areas where the National Disability Insurance Scheme (NDIS) has not rolled out, it is the responsibility of the relevant state or territory disability services agency to initially assess younger people with disability and ensure they are referred to the most appropriate care service available. All options for specialist disability accommodation and support services should be fully explored and utilised before an ACAT accepts a referral for assessment and approval.

As the NDIS rolls out, younger people will have the opportunity to be assessed for NDIS services and may become eligible for supports to help them to live independently in alternative accommodation.

At 30 June 2015, there were 8,431 younger people (those under the age of 65) receiving home care services or permanent residential aged care: 2,179 accessing home care services and 6,252 receiving permanent residential aged care.

Non-Australian Citizens

Citizenship and residency status are not part of the assessment for eligibility to aged care programmes. As such, people who are not Australian citizens are able to access Australian Government subsidised aged care services, provided they are assessed as meeting the eligibility criteria for the aged care programmes and services they wish to access.

2.3. PALLIATIVE CARE

The Australian Government is committed to ensuring that all Australians and their families have the support and assistance to allow end-of-life planning to be about personal choice and control.

Palliative care is provided in almost all settings where health care is provided, including neonatal units, paediatric services, acute hospitals, hospices, general practices, residential aged care facilities, and in the community.

The Australian Government provides financial assistance to state and territory governments to operate palliative care services as part of their health and community service provision responsibilities, and as the system managers of public hospitals.

State and territory governments are responsible for the provision and delivery of palliative care and hospice services as part of state health and community service provision responsibilities. As such, decisions on the use of this funding, and the delivery of palliative care and hospice services in each jurisdiction, are the responsibility of individual state and territory governments.

In addition, the Australian Government funds a range of national palliative care projects primarily focussing on education, training, quality improvement and advance care planning. The Australian Government also provides funding for palliative care through the Pharmaceutical Benefits Scheme and the Medicare Benefits Scheme.

The National Palliative Care Projects (NPCP) focus on education, training, advance care planning and quality improvement. Some of these projects include training for the health workforce to provide quality palliative care, and identifying and measuring the impact of palliative care. Other funded projects include developing online resources to assist health professionals to address cultural and religious issues surrounding palliative care, and training to support the carers of palliative care patients.

During 2014–15, the Health Portfolio had policy responsibility for palliative care, and supported national palliative and end-of-life care projects. The Social Services portfolio maintained a close interest in the area of palliative care to ensure aged care clients requiring palliative or end-of-life care are able to access high quality services in their place of choice, whether it is in residential facilities or in the community.

The Australian Government also supports the provision of complex care including palliative care through the Aged Care Funding Instrument (ACFI) Complex Health Care domain; subsidisation of palliative medicine specialist services through the Medicare Benefits Schedule; and subsidisation of palliative care related prescriptions through the Pharmaceutical Benefits Scheme.

Further support from the Australian Government within the aged care system is provided through funding a range of projects such as the Palliative Approach Toolkit. The Toolkit has been developed and disseminated to all Government-funded residential aged care services. The Toolkit promotes advanced care planning and case conferencing, and guides quality end-of-life clinical care, with the aim of ensuring the delivery of high quality palliative care in residential aged care facilities.

The Government has also funded the Improving Palliative Care for People with Advanced Dementia Living in Residential Aged Care Project. The project aimed to improve the quality of palliative care and wellbeing for residents with advanced dementia living in aged care homes. Outcomes of this project included improvements in family and staff understanding of advanced dementia and palliative care. A suite of materials for organising case conferencing for aged care residents with advanced dementia is currently under development and will be promoted to aged care providers and made freely available online later this year.

The Aged Care Accreditation Standards require approved aged care providers to ensure that the comfort and dignity of terminally ill residents is maintained.

CHAPTER 3

3. PLANNING FOR THE FUTURE

3.1. DEMENTIA

Dementia has a profound life-changing impact – not only on the person with dementia, but their carers, family members and friends.

In 2011, dementia was estimated to be the fourth leading cause of the overall burden of disease and the second leading[5] cause of all deaths in Australia, with an estimated 298,000 people living with dementia. In the absence of effective prevention or cure options, estimates suggest that by 2020 around 400,000 people will be living with dementia in Australia.

After the age of 65 the likelihood of developing dementia doubles every five years. Dementia is one of the major reasons why older people enter residential aged care or seek assistance to continue to live in their own homes. Over 53 per cent of people living in aged care homes have a diagnosis of dementia.

Around 70 per cent of all people living with dementia live in the community, and access mainstream primary and acute care services.

Dementia is a significant chronic disease, a national health priority and recently became the second leading cause of death in Australia. Recognising dementia as a National Health Priority Area creates opportunities to improve the health status and wellbeing of people with dementia and their carers.

While the Government funds a suite of dementia specific programs they represent a small component of the broader support available to people through the aged care system. Dementia is core business for all parts of the aged care system.

Severe Behaviour Response Teams (SBRTs) are a mobile workforce of clinical experts who provide timely and expert advice to residential aged care providers that request assistance with addressing the needs of people with the most severe behavioural and psychological symptoms of dementia. SBRTs will form a new top tier to Dementia Behaviour Management Advisory Services for specialist dementia advice and assistance for aged care providers in 2015–16.

This programme resulted from a recommendation from the inaugural Ministerial Dementia Forum.

The inaugural Ministerial Dementia Forum was held in September 2014 and was hosted by the former Assistant Minister for Social Services, Senator the Hon Mitch Fifield and the former Minister for Health, the Hon Peter Dutton MP.

The forum was a useful mechanism for Government to articulate an issue that needed to be addressed and co-design strategies and programmes with the sector to improve the adoption of better practice dementia care in both residential care, and care and support in the home.

The other major recommendation of the forum was that the Government undertake an analysis of dementia support programmes with the aim of improving their national coordination, alignment and effectiveness.

[5] Australian Bureau of Statistics, ABS 3303.0 - Causes of Death, Australia, 2013, http://www.abs.gov.au/ausstats/abs@.nsf/mf/3303.0

The aim of the analysis, which was undertaken in 2014–15, was to improve national coordination and alignment of the current suite of specialised dementia support and education programmes. The final report was released on 5 November 2015 and is currently being considered by Government. The outcomes from the analysis will help inform future policy direction and programme design.

The Australian Government continues to fund residential care providers to support the care needs of residents, including needs associated with dementia, through residential care subsidies determined using the Aged Care Funding Instrument (ACFI). The extent to which a person's dementia impacts on their assessed care needs will influence the amount of subsidy the provider receives. In particular, the Behaviour domain assesses cognitive skills, wandering, verbal behaviour, physical behaviour and depression. Almost 60 per cent of residents currently attract the highest rating in the ACFI Behaviour domain.

More information on the Government's funding of programmes to support people with dementia can be found in Chapter 11.

3.2. NEEDS BASED PLANNING FRAMEWORK

The Australian Government's needs-based planning framework aims to ensure sufficient supply of residential and home care places by ensuring that the growth in the number of aged care places matches growth in the aged population. It also seeks to ensure balance in the provision of services among metropolitan, regional, rural and remote areas, as well as among people needing differing levels of care.

Under the framework, the Government seeks to achieve and maintain a specified national provision level of subsidised operational aged care places for every 1,000 people aged 70 years or over. This is known as the aged care provision ratio.

Table 1 shows the operational provision ratio at 30 June over the past five financial years and 2015.

Table 1: Aged Care Operational Provision Ratio

DATE	RESIDENTIAL CARE	HOME CARE	OVERALL RATIO
30 June 2010	86.8	24.5	111.3
30 June 2011	85.8	27.0	112.8
30 June 2012	84.4	27.4	111.8
30 June 2013	84.5	27.2	111.7
30 June 2014	82.6	28.7	111.3
30 June 2015	81.1	30.4	111.5

Current Provision

The total number of operational aged care places rose from 263,788 at 30 June 2014 to 273,503 at 30 June 2015, an increase of four per cent. This includes 195,953 residential care places, 73,550 home care places and 4,000 transition care places.

The number of operational aged care places per 1,000 people aged 70 years or over at 30 June 2015 is 111.5 (excluding transition care places).

3.3. AGED CARE APPROVALS ROUND

The process for allocating aged care places as set out in the Act provides for open and clear planning that identifies community needs and allocates places in response to those needs. It can broadly be broken down into three distinct steps: the creation of places, the distribution of places, and the allocation of places.

Creation of Places

Each year, the Minister determines the number of new residential care, home care and flexible care places that should be made available for allocation in each state and territory. The number of new places made available each year considers the target aged care provision ratio, the number of people aged 70 years or over and current levels of service provision, including newly allocated places that have not yet become operational. The majority of these places will be created for allocation through the open and competitive Aged Care Approvals Round (ACAR) process. Additionally, a small number of places are created for allocation through programmes outside of the ACAR process, for example flexible care places for the Multi-Purpose Service (MPS) Programme.

Distribution of Places

The Secretary of the Department (or the Secretary's delegate) will then distribute the places created by the Minister to planning regions established in each state and territory. The distribution of places created for allocation through the ACAR may specify a proportion of places that may be provided to certain groups of people specified in the Act, such as those with special needs, and any other particular care requirements, such as the need for dementia care or residential respite care.

In making this determination, the Secretary will take into consideration the views of aged care stakeholders on the aged care needs of each planning region.

Allocation of Places

Providers are invited to apply for places through the ACAR. The ACAR is an open, competitive process where the Department invites applications from new and existing approved aged care providers for an allocation of new residential care places (and/or capital grants) and home care places. Places are allocated to applicants that demonstrate that they can best meet the aged care needs within a particular planning region.

The capacity of applicants to bring places into operation as quickly as practicable is a consideration in the ACAR's assessment process.

An approved provider can only receive a subsidy for providing aged care if a place has been allocated to them, the allocation has taken effect and there is a care recipient in place. A place can either take effect at the time of allocation or it can be provisionally allocated. A place is provisionally allocated when the approved provider is not in a position to provide care in respect of that place at the time the decision to allocate the place is made.

The Act gives approved providers two years to operationalise provisionally allocated places. In practice, the time taken can be longer, particularly for residential care places which are often reliant on the acquisition of land, finance, planning and construction approvals, and the availability of builders. Home care packages generally become operational soon after allocation.

Approved providers with provisionally allocated places are required to lodge regular reports on progress towards making these places operational. Approved providers unable to operationalise their places within the legislated timeframe may apply for extensions. If no reasonable progress is being made, the Department may refuse to grant an extension at which point the allocation would lapse.

Provisionally allocated places have been a focus of a number of red tape reduction measures aimed at streamlining the management of aged care places. The Government's proposed changes will make it easier for approved providers to operationalise provisionally allocated places by reducing the associated regulatory burden by up to 75 per cent. This will enable approved providers to focus less on administrative processes and more on the timely delivery of care to older Australians who require it.

2014 Aged Care Approvals Round

The application period for the 2014 ACAR was from 24 May 2014 until 4 July 2014. A total of 17,849 new aged care places (11,196 residential aged care places and 6,653 home care places) were allocated across Australia in the 2014 ACAR. These new places have an estimated annual recurrent funding value of over $833.6 million.

In addition, $103 million in capital grants was allocated to assist aged care providers to build new or improve existing residential aged care services.

Table 2: 2014 ACAR Results

STATE/ TERRITORY	RESIDENTIAL PLACES	HOME CARE PLACES	ESTIMATED ANNUAL RECURRENT FUNDING ($M)	CAPITAL GRANTS ($M)
NSW	3,267	2,378	$257.6	$21.2
Vic.	3,113	1,768	$231.2	$19.9
Qld	2,982	1,013	$198.3	$24.0
WA	1,316	672	$92.4	$11.2
SA	212	550	$29.3	$5.8
Tas.	95	179	$10.1	$5.8
ACT	211	68	$13.9	-
NT	-	25	$0.8	$15.1
Total	**11,196**	**6,653**	**$833.6**	**$103.0**

Overall, competition for new residential aged care places was the strongest in several years. A total of 9,330 residential aged care places were advertised on 24 May 2014 and an additional 1,866 residential aged care places were created on 26 November 2014 through a variation to the original Ministerial Determination. The Department received applications for 19,169 new residential aged care places, this means that approximately two new places were sought for every place available.

A total of 11,196 new residential aged care places were allocated, with 57 per cent of places being allocated to new residential aged care facilities, and 43 per cent of the places being allocated to expand existing residential aged care facilities.

Competition for new home care places was also extremely high, with the Department receiving applications for 108,281 new home care places in respect of the 6,653 places available. This means that approximately 17 new places were sought for every place available.

A total of 6,653 new home care places were allocated, with 45 per cent being allocated to new home care services, and 55 per cent being allocated to existing home care services.

2015 Aged Care Approvals Round

The Government announced the opening of the 2015 Aged Care Approvals Round on 15 August 2015. The Invitation to Apply for 10,940 residential places, 6,045 home care places and up to $67 million in capital grants was advertised in major metropolitan and leading regional newspapers as well as culturally and linguistically diverse (CALD) and Indigenous newspapers and radio.

Future Aged Care Approvals Rounds

Changes were announced in the 2015–16 Budget to ensure that the aged care system in Australia continues to meet the needs of an ageing population. From February 2017, older Australians receiving home care packages each year will be able to choose who provides their care, because the Government has changed the funding arrangements to attach the package to the individual, rather than the provider. As a result, the 2015 ACAR will be the last in which providers will have to apply for home care places.

Changes to the planning ratio to support increased restorative care

In the 2015–16 Budget, the Australian Government announced it will expand the number of restorative places, to increase the care options available to older people, and improve their capacity to stay independent and living in their homes longer.

Places under the new Short-Term Restorative Care Programme, including existing transition care places, will be included in the aged care provision ratio from 1 July 2015. This ensures that the total number of short-term restorative care places will increase over time in line with population growth.

This will not change the overall aged care provision ratio of 125 aged care places for every 1,000 people aged 70 years or over by 2021–22, however, the balance of care types within the ratio will change from 1 July 2015 to accommodate the new care type as follows:

- residential care places – 78 places (reduced from 80 places);
- home care places – 45 places (unchanged); and
- short-term restorative care places – two places.

More information on this measure is available in Chapter 8.

3.4. FUTURE DIRECTION

The aged care system is moving towards a more consumer-driven, market based system with more streamlined regulation. The changes made on 1 July 2015, and those announced in the 2015–16 Budget will contribute to this vision of the aged care system.

July 2015 Changes

1 July 2015 saw the introduction of a number of changes to the aged care system. These changes included:

- the significant enhancement of My Aged Care to become the national gateway for aged care information and services;
- streamlining programme arrangements and reducing red tape by consolidating existing grants programmes that provide entry level support for people to remain at home into the Commonwealth Home Support Programme (CHSP); and
- the transition of all home care packages to a consumer directed care basis, giving people greater choice and flexibility in their care.

Further information on these changes can be found in Chapters 4, 5 and 6.

Changes announced in the 2015–16 Budget

The 2015–16 Budget further set the direction of the aged care system, continuing to build on the changes already introduced. As a result of the 2015–16 Budget, the Department will make further changes, including:

- changing the way home care packages are delivered: from February 2017, funding will follow the consumer, rather than be allocated to individual providers;
- to create a single, integrated careathome programme from 2018 that combines the new CHSP and the Home Care Packages Programme;
- bringing in a new form of short-term restorative care to help older people live longer in their own homes, building on the success of the current Transition Care Programme;
- increasing the independence of the Aged Care Complaints Scheme by transferring the complaints powers of the Secretary to the existing Aged Care Commissioner from 1 January 2016; and
- establishing a single quality framework for all aged care services, and developing options for private market provision of accreditation services.

These changes will help boost genuine understanding, choice, and flexibility for consumers, while reducing the administrative burden for providers and ensuring a robust and independent safety net to resolve concerns about the quality of care and services.

3.5. RED TAPE REDUCTION

The Government is committed to working with the aged care sector and industry stakeholders to reduce unnecessary regulation. The Aged Care Sector Committee developed a Red Tape Reduction Action Plan. The action plan sets out a range of actions that can be taken to reduce red tape for aged care providers and consumers, and identifies areas where there are opportunities to expand the scope of red tape reduction.

In 2014, the following items on the action plan were completed:

- streamlining of the 2014 ACAR;
- removal of red tape associated with the Conditional Adjustment Payment;
- streamlining of the reporting requirements for home care package providers (stage 1);
- removal of building certification requirements;
- removal of the requirements for a progressive financial activity report for some National Respite of Carers Programme and Day Therapy Centre providers; and
- recognising that it is the state, territory and local authorities that are responsible for building regulation, fire safety and enforcement, the repeal of certification and fire safety reporting removed duplicative processes that were no longer necessary.

In 2015, two items on the action plan were completed. These are:

- removal of the requirement for approved providers to notify the Aged Care Complaints Scheme of infectious disease outbreaks, as Public Health Units within state and territory health departments have responsibility for receiving notifications of outbreaks of infectious diseases and for ensuring effective infection control practices are followed; and
- revision and streamlining of aged care management of places forms.

Furthermore, the simplification of reporting requirements for changes to key personnel in approved aged care services is proposed for inclusion in a future Repeal Day.

3.6. REGULATOR PERFORMANCE FRAMEWORK

The Department has developed performance indicators in accordance with the Australian Government Regulator Performance Framework (the framework) in consultation with the Aged Care Sector Committee. The framework requires regulators to assess their performance annually, with 2015–16 as the first assessment period. The Department will complete a self-assessment using the indicators and have the self-assessment validated by the Aged Care Sector Committee.

The indicators are designed to allow the Department and stakeholders to assess whether aged care regulatory functions are undertaken with the minimum impact necessary to meet the regulatory objectives of the *Aged Care Act 1997.*

The Department will continue to review and improve how it measures its performance as a regulator for future assessment periods.

3.7. THE AGED CARE ROADMAP

The Government tasked the Aged Care Sector Committee to develop a Roadmap to advise on future directions for aged care by December 2015. An Aged Care Sector Committee Roadmap Advisory Group has been set up to progress this work.

The Advisory Group is investigating and prioritising what more needs to be done to realise the shared vision provided by the Aged Care Sector Statement of Principles (which aim to guide future changes in the aged care system and embed a constructive and lasting partnership between consumers, providers, the aged care workforce and the Government) and to build on reforms to date.

CHAPTER 4

4. INFORMED ACCESS TO AGED CARE

The Australian Government aims to promote improved wellbeing for older Australians. In line with this, the Government provides support and assistance to older people and their carers in the community to ensure people are fully informed and their needs are properly assessed.

Good information and comprehensive, needs-based assessment services are essential to ensure that older people on the threshold of aged care, and their carers, know about the support services available to meet their needs and how to access them.

4.1. ENABLING OLDER PEOPLE TO MAKE INFORMED CHOICES

My Aged Care was launched on 1 July 2013 with the My Aged Care website[6] and contact centre (1800 200 422). My Aged Care assists older people, their families and carers to access aged care information, and find Commonwealth funded aged care services in their local area. The contact centre phone line operates 8am–8pm weekdays and 10am–2pm on Saturdays, across Australia.

In 2014–15, 161,448 calls were made to the My Aged Care Contact Centre. During 2014–15, the My Aged Care contact centre referred 94,190 callers. Table 3 provides a breakdown of referrals[7].

Table 3: My Aged Care referrals in 2014–15

REFERRALS TO	NUMBER	PERCENTAGE OF CALLS
Service Provider	36,252	38.5%
Assessment	15,935	16.9%
DHS	23,522	25.0%
Other	18,481	19.6%
Total	**94,190**	**100.0%**

In 2014–15, the My Aged Care website had a total of 2,048,669 visits, this includes 1,396,395 unique visits. The percentage of views by category are provided in Table 4.

[6] My Aged Care website, www.myagedcare.gov.au.

[7] Information specified in this section is for 1 July 2014 to 31 March 2015 as the early implementation of Stage 2 of expanding services commenced in April 2015. This changed a number of reporting processes which changed the data collected at the contact centre.

Table 4: Visits to My Aged Care by page type

PAGE CATEGORY	PERCENTAGE
Service Finders	53.6%
General Aged Care Information	2.3%
Aged Care Homes	18.7%
Home Care Information	14.6%
Fee Estimators	10.9%

To support access to information on aged care services, the website has three service finders: a Help at Home finder, an Aged Care Home finder and an Assessment finder.

Since 19 May 2014, the My Aged Care website Aged Care Home finder was expanded to include descriptions and prices for all different room types offered across all aged care homes listed on the My Aged Care website.

For 2014–15, the number of visits for each of the website's service finders are provided in Table 5.

Table 5: My Aged Care service finder visits by category

SERVICE FINDERS	JULY – SEPTEMBER 2014	OCTOBER – DECEMBER 2014	JANUARY – MARCH 2015	APRIL – JUNE 2015	TOTAL	PERCENTAGE
Aged Care Home Finder	163,139	107,269	116,078	117,268	503,754	62.2%
Assessment Finder	18,724	14,481	16,913	19,847	69,965	8.6%
Help at Home Finder	65,208	45,359	52,450	73,798	236,815	29.2%

The Department also disseminates information such as fact sheets, newsletters and updates on ageing and aged care to consumers, care providers, health professionals and the general community.

Over 200,000 individual information products were distributed to consumers during 2014–15 including:

- 70,894 items from the Department's stock of aged care information products, such as the *5 Steps to Entry into Residential Aged Care*;
- 37,005 continence information products such as application guidelines for the Continence Aids Payment Scheme;
- 36,851 information resources, such as fact sheets on legal arrangements, managing money, and services available to consumers from the carer information products published by the Department;
- 42,376 Commonwealth Respite and Carelink Centre products; and
- 19,529 dementia information products such as fact sheets, brochures and DVDs for consumers and health professionals.

4.2. ASSESSMENTS FOR SUBSIDISED CARE

The Australian Government engages state and territory governments to manage and administer the Aged Care Assessment Programme (ACAP), including the employment of assessment staff for Aged Care Assessment Teams (ACATs) and the delivery of assessment services in each state or territory. Australian Government expenditure in 2014–15 for the ACAP was around $107 million.

ACATs comprehensively assess the care needs of frail older people and assist them to access services most appropriate to meet their care needs. This may involve referring clients to services that do not require approval under the Act, such as those that were available under the Commonwealth HACC Programme. Alternatively, they may approve a person as eligible for residential aged care, home care and/or flexible care services.

A person must be assessed and approved by an ACAT before they can access residential aged care, home care or flexible care services. In 2014–15, requirements for the approval of care recipients were outlined in Part 2.3 of the Act and in the *Approval of Care Recipients Principles 2014.*

At 30 June 2015, 84 ACATs operated across all regions in each state and territory, based in hospitals or in the local community. Assessments are conducted in accordance with the aged care legislation and Commonwealth guidelines for the programme.

ACATs generally comprise, or have access to, a range of health professionals including geriatricians, physicians, registered nurses, social workers, physiotherapists, occupational therapists and psychologists. Their role is to expertly assess the care needs of frail older people and to work closely with the client, their carer and their family to identify the most suitable aged care services available. Throughout 2014–15, the ACAT recommendations no longer distinguished between people eligible for 'low' or 'high' care in residential aged care as this distinction was removed from legislation; the distinction remains for residential respite services.

Once a person is approved as eligible for aged care services, ACAT assessors normally assist clients by making direct referrals to a service provider or by providing information on how to apply for services. Following up on referrals may also be part of the care coordination function performed by ACATs, however an ACAT approval does not guarantee that a person will receive either a place in an aged care home or a home care place.

ACATs are encouraged to develop and maintain links with hospital services and provide an interface between acute care, home care and residential aged care. These links are critical for effective hospital discharge planning and continuity of care. Where appropriate, ACATs are involved in discharge planning to facilitate the referral and linkage of clients to post-discharge care and other forms of support required.

Table 6 provides an overview of the number of complete ACAT assessments between 2009–10 to 2013–14, broken down by state and territory.

Table 6: Number of complete ACAT assessments: 2009–10 to 2013–14

STATE/ TERRITORY	2009–10	2010–11	2011–12	2012–13	2013–14
NSW	60,562	59,499	60,176	60,996	62,269
Vic.	49,776	49,210	51,384	53,374	54,467
Qld	29,096	28,677	30,049	30,640	26,609
WA	19,447	19,106	18,382	18,097	16,883
SA	16,533	13,625	13,690	13,338	13,651
Tas.	4,994	4,864	5,170	4,854	6,155
ACT	2,212	1,942	2,294	2,089	2,285
NT	959	1,057	1,044	892	1,071
Total	**183,579**	**177,980**	**182,189**	**184,280**	**185,390**

Note: The data for 2011–12, 2012–13 and 2013–14 was extracted from the Ageing and Aged Care Data Warehouse in August 2015. Future extracts of this data may change and thus alter final numbers.

4.3. ACAT REASSESSMENTS

Since 1 July 2009, a number of legislative amendments have been made to the Act and associated principles which have resulted in a reduction in the number of assessments (and reassessments) undertaken. The legislative changes have empowered assessors to provide ongoing approvals to care under the Act. This has significantly reduced the need for reassessment and has been designed to improve the timeliness of the assessment so the ACATs could focus on conducting assessments for people in most need of their services.

The total number of complete assessments has reduced from 201,393 in 2008–09 to 185,390 in 2013–14, a decrease of 16,003 assessments or eight per cent[8]. In addition to the reduction in assessments, there have also been improvements in the time from referral to assessment by ACATs.

Between 2008–09 and 2013–14, the average elapsed (waiting) time nationally from referral to assessment (first intervention) has reduced to 12.0 days in 2013–14 from 19.7 days in 2008–09. Over that same period the average elapsed (waiting) time from referral to approval of an assessment reduced to 20.2 days in 2013–14, from 29.4 days in 2008–09.

[8] Data for 2014–15 is not available at the time of publication.

4.4. SUPPORT FOR CONSUMERS

National Aged Care Advocacy

The Department funds aged care advocacy services in each state and territory under the National Aged Care Advocacy Programme (NACAP). There are nine NACAP services that provide information to consumers, their families and carers about their rights and responsibilities when accessing aged care services. Advocacy services are free, confidential and independent. The National Aged Care Advocacy Line can be contacted on freecall 1800 700 600 (calls made from mobile phones may incur additional costs).

In 2014–15, services under the NACAP undertook more than 4,230 advocacy cases, handled more than 3,740 general enquiries, and provided over 1,930 facetoface education sessions, at a cost of more than $3.85 million (GST inc.). The total number of services provided in 2014–15 increased slightly compared to 2013–14. Changes to the aged care system, such as the introduction of consumer directed care, has increased the importance of having a national aged care advocacy programme able to support older people and their loved ones interact with aged care services.

In 2014–15, the Department commenced a review of Commonwealth aged care advocacy services being delivered through the NACAP and Commonwealth Home Support Programme (CHSP). The review is being undertaken to identify how advocacy services can best support consumers to effectively interact with the aged care system. The outcomes of the review will inform the design of a nationally consistent, end-to-end aged care advocacy programme focussed on individual advocacy support and accessible to all consumers of Commonwealth aged care services.

Community Visitors Scheme

The Community Visitors Scheme (CVS) provides volunteer visitors to residents of Australian Government subsidised aged care homes and consumers of home care packages who are socially or culturally isolated, and whose quality of life would be improved by companionship. CVS organisations work with aged care providers to match individuals with CVS volunteers in their aged care planning region.

In 2013–14, the CVS expanded to include visits to people receiving home care packages, and group visits in residential aged care. The expansion also included a focus on targeting special needs groups, including people from culturally and linguistically diverse backgrounds, people from lesbian, gay, bisexual, transgender and intersex communities, veterans, care-leavers (including Forgotten Australians, Former Child Migrants and Stolen Generations) and Aboriginal and Torres Strait Islander peoples.

In 2014–15, the Department funded, monitored and supported 147 community-based organisations to deliver visits to residents of aged care homes, and 116 organisations to deliver visits to people receiving home care packages. CVS visitors undertook more than 148,000 visits to residents in aged care homes.

Independent Financial Advice

People who are considering accessing aged care services are encouraged to obtain independent financial information about how aged care arrangements will impact their individual services. The Department of Human Services provides a Financial Information Service (FIS). Through this service, prospective care recipients are able to obtain comprehensive information about the rules regarding aged care fees and charges and their interaction with the pension or superannuation. This service is free and available to anyone. The FIS can provide information to people at financial information seminars, at personal interviews (for more complex issues) or over the phone on 132 300.

The Australian Securities and Investments Commission's MoneySmart[9] website also has tips and tools to help people manage their money. The MoneySmart website provides a range of information to help consumers, including information on retirement planning and aged care.

People experiencing financial difficulties can get help from a free and confidential financial counsellor who can help negotiate with creditors, organise their finances, and create a budget. Community organisations are funded to provide these services across Australia and they can be found through the MoneySmart website.

My Aged Care Changes

The Productivity Commission's *Caring for Older Australians* report of June 2011 identified the need for an improved entry point to the aged care system, to help older Australians to retain control over their lives. The report recommended that this includes information being more readily available and easy to understand, the development of a simple and more accessible standardised needs assessment process, and access to aged care services from approved providers.

The My Aged Care website and contact centre, which was introduced on 1 July 2013, was expanded from 1 July 2015 to include:

- A central client record to facilitate the collection and sharing of client information between the client and their representatives, assessors and service providers.
- The introduction of the My Aged Care Regional Assessment Service (RAS), in all jurisdictions except Victoria and Western Australia, to conduct face-to-face assessments of people seeking entry-level support at home, provided under the CHSP.
- My Aged Care contact centre staff and assessors using the National Screening and Assessment Form (NSAF) to ensure a nationally consistent and holistic screening and assessment process.
- Web-based portals for clients, assessors and service providers to access client records, service information and assessment tools.
- The ability for service providers to self-manage information about the services they deliver. This service information is displayed via enhanced service finders on the My Aged Care website and is used by My Aged Care contact centre staff and assessors to make service referrals for clients. The service finders on the My Aged Care website are also being enhanced to include information about non-Commonwealth funded services.

From July 2015, people seeking access to aged care services for the first time should contact the My Aged Care contact centre to discuss their aged care needs and have a client record created. People receiving services prior to July 2015 do not need to contact My Aged Care unless their needs change.

ACATs will continue to conduct face-to-face comprehensive assessments to determine a person's eligibility for care types under the Act with approval subject to a decision by an ACAT Delegate. From early 2016, ACATs will start to transition to using My Aged Care to conduct comprehensive assessments, create support plans, make Delegate decisions and make referrals.

Following the expansion of My Aged Care from 1 July 2015, the functionality and new business processes will be bedded down over the next 12 months.

[9] MoneySmart, https://www.moneysmart.gov.au/

4.5. ACAT FAMILIARISATION WORKSHOP

An ACAT Familiarisation Workshop was held in Canberra on 25 and 26 June 2015 to provide an overview of the 2014 and 2015 aged care changes and to enable attendees to become familiar with the My Aged Care assessor portal functions.

Participants were encouraged to share the information they received at the Workshop. The Workshop was well attended with 73 ACAT representatives from all states, participating across the two days.

CHAPTER 5

5. HOME SUPPORT

Home support, including respite, provides basic aged care support services to people in their homes and offers support to carers. In 2014–15, services were delivered through the Commonwealth Home and Community Care (HACC) Programme, the jointly funded, state operated, HACC programmes in Victoria and Western Australia, the Day Therapy Centres Programme, the Assistance with Care and Housing for the Aged Programme, and through residential respite in aged care homes.

5.1. WHAT WAS PROVIDED IN 2014–15?

HACC Services

This year was the third and last year of the Commonwealth HACC Programme, pending its replacement by the Commonwealth Home Support Programme (CHSP), except in Victoria and Western Australia. The Commonwealth HACC Programme provided 19 basic maintenance, support and care services to assist people to remain in the community. These were:

- domestic assistance;
- personal care;
- social support;
- respite care;
- other meal services;
- assessment;
- client care coordination;
- case management;
- carer counselling/support, information and advocacy;
- client counselling/support, information and advocacy;
- nursing care;
- allied health care;
- centre-based day care;
- goods and equipment;
- home modifications;
- home maintenance;
- formal linen services;
- meals; and
- transport.

The services focused on supporting different areas of need that an individual may have due to a limitation in their ability to undertake tasks of daily living. The services support these people to be more independent at home and in the community, and to reduce the potential or inappropriate need for admission to residential care.

In Victoria and Western Australia, HACC services continue to be delivered through the jointly funded Commonwealth-State programmes that provide services to older people and younger people with disabilities. The Australian Government and the Victorian and Western Australian Governments maintain bilateral agreements for that purpose.

Carer Support Services

The Australian Government recognises the vital role that carers play by providing care and support to family and friends who are frail aged, disabled, or have a mental or physical illness.

Respite care is an important support service for frail older people and their carers. Respite care is provided in a number of settings to allow greater flexibility for carers and consumers.

In the last twelve months, respite services outside of the Act were available under the National Respite for Carers Programme (NRCP), the Commonwealth HACC Programme, and the HACC programmes in Victoria and Western Australia. Funding is also supplied by the Australian Government for Multi-Purpose Services to provide respite care in rural areas.

The settings in which respite is delivered includes:

- day respite in community centres;
- respite in the home – both day and overnight;
- overnight respite in community cottages;
- community outings – either group or individual;
- mobile respite;
- employed carer respite; and
- day respite in a residential home.

National Respite for Carers Programme

Throughout 2014–15, the NRCP continued to support the maintenance of caring relationships between carers and the people for whom they cared, by providing respite, facilitating access to information, and providing other support.

Commonwealth Respite and Carelink Centres (CRCCs) were funded under the NRCP to provide information and respite services. The centres helped frail older people and their carers by arranging short-term and emergency respite, and by linking people to support services available in their local area.

National Carer Counselling Programme

The National Carer Counselling Programme provides short-term emotional and psychological support services to carers in order to reduce carer stress, improve carer coping skills, and facilitate wherever possible the continuation of the caring role. Counselling can be offered in different ways to suit the different needs of carers with individual face-to-face sessions, web-based, telephone or group counselling sessions offered. Funding also supports provision of specialist advice to carers and guided referrals to other support services.

Carer Information Support Service

The Carer Information Support Service assists carers in their role by providing timely and high quality information, specialist advice and community awareness raising that is both culturally and linguistically sensitive.

Assistance with Care and Housing for the Aged

In 2014–15, the Assistance with Care and Housing for the Aged (ACHA) Programme helped eligible clients – those who were at risk of becoming homeless or were already homeless – to remain in the community through accessing appropriate, sustainable, and affordable housing and linking them where appropriate to community care.

While the ACHA Programme provided linkage assistance with care and housing, it did not provide direct care or ongoing support. The programme linked clients to the most appropriate range of housing and care services in order to meet their immediate and ongoing needs.

It was a flexible service which was based on priority, with each client's length of assistance differing according to their level of need. As such, there was no set time limit for provision of services under the ACHA Programme. However, if care needs appeared to be long term, a permanent referral to the most appropriate care or housing service may have been required.

In 2014–15, $6.4 million was provided to 55 ACHA services, assisting 6,087 clients.

Day Therapy Centres

Throughout 2014–15, the Day Therapy Centres (DTC) Programme provided a range of therapy services aimed at assisting older people to maintain their independence. Services were aimed at frail aged people living in the community and to some residents of residential aged care (based on the resident's Aged Care Funding Instrument classification).

The programme assisted frail aged people to regain or maintain physical and cognitive abilities which support them to either maintain or recover a level of independence. The main types of services provided in DTC included:

- physiotherapy;
- podiatry;
- occupational therapy;
- diversional therapy;
- nursing services;
- speech therapy;
- social work;
- preventative therapies;
- personal services;
- transport to and from the DTC; and
- food services provided in conjunction with therapies.

In 2014–15, the Australian Government provided $42.6 million to 148 DTC outlets across Australia, assisting 46,573 clients. From 1 July 2015, DTC services will be provided through the CHSP.

5.2. ACCESS TO CARE

In 2014–15, the Commonwealth HACC programme assessed 530,210 clients through 1,084 HACC organisations. These organisations assessed the clients' individual needs and the identified range of appropriate basic maintenance, support and care services. The assessment process also considered the needs of the client's carer where applicable.

From 1 July 2015, the Australian Government replaced the HACC assessments with the Regional Assessment Service (RAS) delivered through My Aged Care.

The RAS is a national assessment workforce, operating at a regional level in all states and territories (except Victoria and Western Australia). The RAS will be responsible for conducting face-to-face assessments of older people seeking entry-level support at home, provided under the CHSP.

CHSP providers will use the My Aged Care provider portal to manage referrals for services. CHSP providers will be able to view the client record which includes information about the client, assessment outcomes and a support plan.

My Aged Care helps people to navigate the aged care system and provides referrals for assessment and service provision.

5.3. WHO PROVIDED CARE?

The home support market has traditionally been dominated by small, and not-for-profit organisations with large volunteer bases. Providers delivering home support services range from small meals providers funded less than $10,000, to large Non-Government Organisations receiving more than $100 million. Historically, state and local governments have played a role in direct service delivery of home support services, however they are increasingly transitioning out of these arrangements.

Commonwealth HACC Services

Throughout 2014–15, all Commonwealth HACC organisations were required to provide services in accordance with the Home Care Standards and the Commonwealth HACC Programme Manual. At 30 June 2015, there was a total of 1,084 Commonwealth funded HACC service providers. Table 7 provides details, by state and territory, of the types of providers that delivered Commonwealth HACC services.

Table 7: Commonwealth HACC service providers by organisation type, at 30 June 2015, by state and territory

STATE/ TERRITORY	RELIGIOUS	CHARITABLE	COMMUNITY BASED	PRIVATE INCORPORATED BODY	PUBLICLY LISTED COMPANY	STATE/ TERRITORY GOVT.	LOCAL GOVT.	TOTAL
NSW	16	120	218	39	1	19	72	485
Qld	9	78	174	24	3	13	33	334
SA	8	30	62	9	-	7	28	144
Tas.	3	13	29	6	-	2	4	57
ACT	2	9	14	1	-	3	-	29
NT	2	6	15	1	-	1	10	35
Australia	40	256	512	80	4	45	147	1,084

Note: This table does not include Victorian or Western Australian HACC service providers.

Across all home support programmes, volunteers play an important role in the delivery of vital services to older people. Volunteers make a significant contribution to the lives of those they support, and are involved extensively in delivering meals, and providing transport and social interaction at day care centres and in the community.

The HACC programme delivers high quality, affordable and accessible aged care services in the community that are essential to the well-being of older people, younger people with a disability, and their carers. In 2014–15, 530, 210 people aged 65 years and over (50 years for Aboriginal and Torres Strait Islander people) received services through the Commonwealth HACC Programme. In Victoria and Western Australia, 368,905 people received services through the joint HACC programmes in these states, of which 282,174 were aged over 65 years and over or 50 years and over for Aboriginal and Torres Strait Islander people.

Table 8: Number of older clients receiving HACC services during 2014–15, by state and territory

STATE/TERRITORY	CLIENTS
NSW	238,944
Qld	167,007
SA	87,059
Tas.	24,152
ACT	10,317
NT	2,731
Vic.	221,791
WA	60,383
Australia	812,384

Note: For Victoria and Western Australia clients, these figures only include those people who were aged over 65 years or 50 years and over for Aboriginal and Torres Strait Islander people.

During 2014–15, 132,857[10] people received assistance including:

- 59,699 carers who received information, carer support and emergency respite through CRCCs;
- 6,461 carers who received counselling services;
- 34,152 carers who received information and support services; and
- 32,545 carers who received planned respite services.

5.4. HOW WERE THESE SERVICES FUNDED?

In 2014–15, the Australian Government funding for the Commonwealth HACC Programme totalled $1.3 billion. The Government provided 1,084 funding agreements to HACC organisations to provide services to 530,210 clients.

The Australian Government's contribution to the jointly funded HACC programmes in Victoria and Western Australia (through Treasury Certified Payments) was $579.7 million. This brings the total expenditure by the Australian Government for HACC services to $1.9 billion, an increase from $1.7 million in 2013–14.

Table 9: Australian Government expenditure for HACC services during 2014–15, by state and territory

STATE/TERRITORY	2014–15 $M
NSW	591.8
Vic.	404.9
Qld	466.7
WA	174.8
SA	175.4
Tas.	58.3
ACT	26.5
NT	15.9
Australia	1.9

Note: the Victorian and Western Australian Governments contributed a further $385.5 million to support the joint HACC Programmes in their state.

[10] Note: This figure includes multiple counting of clients as many carers receive more than one type of the respite services listed.

The Commonwealth HACC Programme Fees Policy

Client fees play an important role in the ability of the Commonwealth HACC Programme to respond to the needs of its clients by supplementing the cost of community aged care made by the Australian Government.

The Commonwealth HACC fees policy aims to ensure a fair and equitable approach to user charging in the HACC programme. Clients assessed as having a capacity to pay are to be charged fees. Fees are scaled appropriate to the client's level of income, amounts of services they use and any changes in circumstances.

5.5. COMMONWEALTH HOME SUPPORT PROGRAMME

In addition to the continued support for the home support services, throughout the year, the Department worked with providers and consumers to prepare for the major changes to the aged care system including the introduction of the Commonwealth Home Support Programme (CHSP).

The CHSP is one of the changes being made to help older people stay independent and in their homes and communities for longer.

The CHSP has brought together four programmes:

- Commonwealth HACC Programme;
- Planned respite from the National Respite for Carers Programme (NRCP);
- Day Therapy Centres (DTC) Programme; and
- Assistance with Care and Housing for the Aged (ACHA) Programme.

The CHSP is a consolidated programme that provides entry-level home support for older people who need assistance to keep living independently at home and in their community. Carers of these clients will also benefit from services provided through the CHSP. Entry to CHSP services will be simplified and streamlined for older people and carers through My Aged Care. There will also be a standardised national assessment process through My Aged Care Regional Assessment Services. Importantly, people who received services under the existing programmes will continue to receive the same level of support when the CHSP begins.

The CHSP and relevant support documents were developed through a comprehensive and collaborative consultation process, which has included advice from the National Aged Care Alliance and its CHSP Advisory Group peak bodies and sector representatives.

The finalised documents including the CHSP programme manual, CHSP programmes guidelines and the *Living well at home: CHSP Good Practice Guide* was released on 1 July 2015.

Victoria and Western Australia

In 2014–15, Victoria and Western Australia, HACC programmes continued to be administered by the state governments and jointly funded with the Australian Government. However, NRCP, DTC and ACHA services that were delivered in Victoria and Western Australia have formed part of the new CHSP. Victorian HACC services for older people will also form part of the CHSP from 1 July 2016. Negotiations are continuing with Western Australia regarding joining the CHSP.

CHAPTER 6

6. HOME CARE

The Australian Government recognises that people want to remain living independently in their own homes for as long as possible. To support this, the Government subsidises home care packages, through the Home Care Packages Programme, to provide home-based care that can improve older Australians' quality of life and help them to remain active and connected to their communities.

A total of 6,653 new home care places were allocated across Australia in the 2014 Aged Care Approvals Round (ACAR). These new places have an estimated annual recurrent funding value of over $173.1 million.

As at 30 June 2015, there were 72,702 operational home care packages across Australia.

6.1. WHAT IS PROVIDED?

The Home Care Packages Programme provides four levels of packages:

- Home Care Level 1 – to support people with basic care needs;
- Home Care Level 2 – to support people with low level care needs;
- Home Care Level 3 – to support people with intermediate care needs; and
- Home Care Level 4 – to support people with high care needs.

Under a home care package, a range of personal care, support services, clinical services and other services is tailored to meet the assessed needs of the consumer. A summary list of the types of services available can be found on the My Aged Care website[11].

Accessing Care

In order to access a package, a person needs to be assessed and approved as eligible for home care by an Aged Care Assessment Team (ACAT), and then offered a package by an approved home care provider.

ACATs conduct comprehensive assessments, taking account of a person's physical, medical, psychological, cultural, social and restorative care needs.

If a person has been assessed as eligible for a particular level of package, but none is available, the person can be offered a lower level package, as an interim measure, until a higher level package is available.

Further information on accessing home care packages can be found on the Department's website[12].

[11] Home Care Package – Care and Services, http://www.myagedcare.gov.au/aged-care-services/home-care-packages/home-care-packages-care-and-services

[12] Five-steps-to-accessing-home-care-packages, https://www.dss.gov.au/ageing-and-aged-care/programs-services/home-care/five-steps-to-accessing-home-care-packages

Allocation of Packages

Packages are available in all states and territories, including rural and remote locations. As at 30 June 2015, there were 72,702 operational home care packages (Table 10). The vast majority of operational home care packages are Level 2 packages.

Table 10: Number of operational home care packages, by level and state and territory, as at 30 June 2015

STATE/TERRITORY	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	TOTAL	% OF TOTAL
NSW	755	17,342	1,268	3,926	23,291	32.0%
Vic.	572	13,127	981	3,039	17,719	24.4%
Qld	423	9,631	715	2,897	13,666	18.8%
WA	214	4,797	367	2,911	8,289	11.4%
SA	190	4,309	320	903	5,722	7.9%
Tas.	59	1,298	104	336	1,797	2.5%
ACT	28	691	40	487	1,246	1.7%
NT	10	761	20	181	972	1.3%
Australia	2,251	51,956	3,815	14,680	72,702	100%
% of Total	**3.1%**	**71.5%**	**5.2%**	**20.2%**	**100%**	

6.2. WHO PROVIDES CARE?

Home care packages are delivered by service providers who have been approved under the Act. Providers are required to comply with a range of responsibilities under the Act relating to factors such as quality of care, user rights, accountability requirements, and conditions that have been attached to places.

Similar to 2013–14, home care packages are primarily (81.6 per cent) provided by religious, charitable and community-based (not-for-profit) providers (Table 11).

Table 11: Operational home care packages, by provider type and state and territory, as at 30 June 2015

STATE/ TERRITORY	RELIGIOUS	CHARITABLE	COMMUNITY BASED	FOR PROFIT	STATE/ TERRITORY AND LOCAL GOVT.	TOTAL
NSW	6,551	8,635	4,732	2,292	1,081	23,291
Vic.	6,271	4,030	2,859	1,102	3,457	17,719
Qld	5,826	3,476	2,650	1,380	334	13,666
WA	2,667	3,161	362	1,694	405	8,289
SA	1,535	2,800	665	269	453	5,722
Tas.	539	490	488	225	55	1,797
ACT	189	593	293	171	0	1,246
NT	172	0	287	241	272	972
Australia	23,750	23,185	12,336	7,374	6,057	72,702
% of Total	**32.7%**	**31.9%**	**17.0%**	**10.1%**	**8.3%**	**100.0%**

6.3. WHO RECEIVES CARE?

Although there are no minimum age requirements for eligibility purposes, the Home Care Packages Programme is primarily designed to assist frail older Australians remain in their homes. In 2014–15, the average age of admission into a package was 82.5 years, an increase from an average of 81.0 years in 2013–14.

The number of home care consumers as at 30 June 2015 was 59,506 (Table 12).

Table 12: Number of home care consumers, by care level and state, as at 30 June 2015

CARE LEVEL	LEVEL 1	LEVEL 2	LEVEL 3	LEVEL 4	TOTAL	% OF TOTAL
NSW	360	14,494	960	3,738	19,452	32.7%
Vic.	330	12,094	734	2,931	16,089	27.0%
Qld	130	6,816	493	2,710	10,149	17.7%
WA	55	2,770	212	2,647	5,684	9.6%
SA	75	3,426	266	883	4,650	7.8%
Tas.	49	1,163	83	336	1,629	2.7%
ACT	11	530	36	454	1,031	1.7%
NT	5	649	14	154	822	1.4%
Total	**1,015**	**41,942**	**2,698**	**13,851**	**59,506**	**100.0%**
% of Total	**1.7**	**70.5%**	**4.5%**	**23.3%**	**100.0%**	

Note: Location of home care consumers is based on the physical address of the service delivering the care.

6.4. HOW ARE HOME CARE PACKAGES FUNDED?

What the Australian Government pays

Government financial assistance for packages is paid to service providers as a contribution to the cost of providing care. Financial assistance is predominantly provided in the form of a subsidy with the amount increasing as the level of package rises (from Level 1 to Level 4). The Government also pays various supplements to providers, with the following supplements available in 2014–15:

- Dementia and Cognition Supplement – payable to a provider of home care services to a consumer who has been assessed as having behavioural and psychological symptoms associated with dementia or mental illness;
- Veterans' Supplement – payable to a provider in recognition that additional funding may be required to deliver services to veterans with service related mental health conditions;
- Oxygen Supplement – payable to a provider of home care services to a consumer who has a medical requirement to receive oxygen treatment on an ongoing basis;
- Enteral Feeding Supplement – payable to a provider of a consumer has a medical requirement to receive enteral feeding on an ongoing basis;
- Home Care Viability Supplement – payable to providers in rural and remote areas in recognition of higher costs of doing business (as part of the 2014–15 Budget Measure *Reprioritising the Aged Care Workforce Supplement*, the Viability Supplement was increased by 20 per cent); and
- Top-up Supplement – payable to a provider for a consumer who previously held an Extended Aged Care at Home – Dementia (EACH–D) package, prior to 1 August 2013.

The subsidy and supplement rates for 2014–15 can be found on the Department of Social Services' website[13].

The Australian Government's expenditure on home care packages increased from $1.27 billion in 2013–14 to $1.28 billion in 2014–15, an increase of 0.8 per cent (Table 13).

Table 13: Australian Government expenditure (in $millions) for home care packages 2010–11 to 2014–15, by state and territory

STATE/ TERRITORY	2010–11	2011–12	2012–13	2013–14	2014–15	INCREASE/ DECREASE: 2013–14 TO 2014–15
NSW	294.9	329.7	352.2	383.1	389.0	1.5%
Vic.	226.3	257.7	275.4	299.9	313.8	4.6%
Qld	154.4	201.2	219.3	246.6	244.0	-1.1%
WA	93.5	129.1	153.6	174.9	161.2	-7.8%
SA	73.2	76.2	83.8	88.7	92.2	3.9%
Tas.	24.8	27.0	29.2	29.0	32.3	11.2%
ACT	15.1	21.6	25.6	29.5	29.7	0.6%
NT	14.3	15.8	17.6	19.2	18.6	-3.2%
Australia	896.5	1,058.2	1,156.6	1,270.9	1,281.2	0.8%

What the consumer pays

Consumers who have taken up a home care package on or after 1 July 2014 are required to pay one or both of:

- a basic daily fee – the maximum basic daily fee is 17.5 per cent of the single rate of the basic Age Pension ($9.77 as at 30 June 2015); and
- an income-tested care fee – paid by those assessed as having sufficient income to contribute to the cost of their care. The income-tested fee reduces the amount of the subsidy paid by the Government to the provider.

To ensure the system is affordable, there are annual and lifetime limits to how much a consumer has to pay in income-tested care fees. Once these limits have been reached, the Government will pay the consumer's share of income-tested care fees to the provider.

These fee arrangements started on 1 July 2014 and do not apply to consumers who were receiving a home care package on or before 30 June 2014.

[13] Aged Care Subsidies and Supplements, https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/aged-care-subsidies-and-supplements

Consumers who were receiving a home care package on or before 30 June 2014 can still be asked to pay a basic daily fee as well as an additional fee calculated on income they receive above the basic Age Pension. However the Government contribution to the cost of their care is not reduced.

Further information on the fee arrangements for home care packages can be found on the Department's website[14].

6.5. 1 JULY 2015 CHANGES TO HOME CARE PACKAGES

From 1 July 2015, all home care packages are required to be delivered on a Consumer Directed Care (CDC) basis. CDC provides greater transparency to consumers about what funding is available under their package and how those funds are spent through the use of an individualised budget. CDC also gives a consumer more choice and flexibility about the types of care and services they access and how the care is delivered to best meet their needs.

Under CDC, home care providers:

- are required to have conversations with consumers about their needs and goals to provide them with more choice and flexibility;
- will have a restorative approach to service delivery focusing on re-ablement and wellness;
- provide greater transparency to consumers about what funding is available under their package of care and how those funds are spent through the use of an individualised budget and monthly statement;
- conduct ongoing monitoring and formal reassessment to ensure the package continues to be appropriate for the consumer; and
- reskill and retrain their workforce to provide a consumer focused service delivery model.

The Department has been assisting service providers and consumers with the transition to CDC. The following initiatives were put in place to support the sector:

- the CDC Transition Hotline provides support to consumers;
- $20 million in additional funding is available to support approximately 500 providers to help meet their costs of reskilling and retraining their workforce to deliver a CDC service model; and
- funding for the Home Care Today website, which offers a range of tools, resources and learning modules to assist providers in implementing CDC.

[14] Aged Care Fees and Charges, https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/aged-care-fees-and-charges

6.6. FUTURE OF HOME CARE SERVICES

From February 2017, funding for a home care package will follow the consumer, allowing eligible consumers to choose their approved provider. Packages will also be portable, allowing consumers to change their provider, including where the consumer moves to another location.

Once these changes come into effect, providers will no longer have to apply for home care places through the ACAR, significantly reducing red tape. The 2015 ACAR is expected to be the last ACAR in which providers will have to apply for new home care places. The changes will increase competition in the home care sector, allowing more consumer focused and innovative providers to expand their business to meet local demand and consumer expectations.

The Government has also announced that it intends to integrate the Home Care Packages Programme with the Commonwealth Home Support Programme from July 2018. A single care at home programme will simplify the way that services are delivered and funded. This will make the system easier for consumers to navigate and further reduce red tape for providers.

The Department is working closely with stakeholders to co-design how these changes will be implemented.

CHAPTER 7

7. RESIDENTIAL CARE

Residential aged care provides a range of supported accommodation services for older people who, for various reasons, are unable to continue living independently in their own homes. Those reasons can include illness, disability, bereavement, an emergency or the changing needs of their carer, family or friends. Australian Government subsidised residential aged care is governed by the Act, the *Aged Care (Transitional Provisions) Act 1997* (*Transitional Provisions Act*) and the Aged Care Principles.

At 30 June 2015, there were 2,681 operational aged care homes delivering residential care under these arrangements, with an average occupancy rate of 92.5 per cent over 2014–15 (Table 14). This compares to 93.0 per cent in 2013–14.

Table 14: Occupancy rates of residential care places, throughout 2014–15, by state and territory

STATE/TERRITORY	RESIDENTIAL CARE OCCUPANCY RATES
NSW	92.5%
Vic.	91.6%
Qld	92.7%
WA	94.4%
SA	93.2%
Tas.	90.6%
ACT	94.5%
NT	92.8%
Australia	92.5%

At 30 June 2015, there were 192,370 operational aged care places compared with 189,283 at 30 June 2014, an increase of 1.63 per cent.

7.1. WHAT IS PROVIDED?

Residential care is provided on a permanent or respite basis. Residential respite provides short-term care on a planned or emergency basis in aged care homes to people who have been assessed and approved to receive it (see Chapter 5).

The services provided through residential aged care include personal care services (help with the activities of daily living such as dressing, eating and bathing); accommodation; support services (cleaning, laundry and meals); and some allied health services, such as physiotherapy. For people who need almost complete assistance with most activities of daily living, residential aged care can provide 24 hour care.

When a person enters residential care, an approved provider must provide the person with a resident agreement that both the provider and the resident sign. The resident agreement sets out the policies and practices the provider will follow in setting fees for the resident and the resident's date of permanent entry to the aged care service.

Previously, residential aged care was delivered as either high care or low care. From 1 July 2014, this distinction was removed for permanent residential aged care. A person with a permanent residential aged care approval may be admitted to any residential aged care place that meets the resident's needs, subject to availability of places and the provider's agreement. The services offered by an aged care home will depend on the capacity of the individual home to meet the care needs of the residents within their physical environment and staffing arrangements. Services that are unable to accommodate residents needs into the future must clearly identify any limitations in the resident agreement.

Residential Respite

Residential respite provides short-term care in Australian Government subsidised aged care homes to people who have been assessed as eligible and approved by an ACAT. It can be used on a planned or emergency basis. The ACAT assessment can recommend someone for either high care or low care residential respite.

Residential respite care may include assistance with meals, laundry, room cleaning, personal grooming, as well as nursing care and a variety of services such as physiotherapy or podiatry.

A person can receive residential respite in aged care facilities for up to 63 days in a financial year. If a person needs more than 63 days, the ACAT can approve extension periods of 21 days at a time if it is considered necessary because of carer stress, severity of the care recipient's condition or absence of the carer. More than one 21-day extension may be approved for a person in a financial year. As approvals for respite do not cease, a care recipient automatically becomes eligible for a new allotment of respite days at the commencement of each financial year.

Providers of residential respite care do not have a separate allocation of residential respite places. Rather, a portion of each permanent allocation of residential care places is used for the provision of respite care. It is a matter for the provider as to what mix of respite and permanent residential care places to deliver at any point in time within the financial year.

Under the NRCP, there were 290 respite services and 54 CRCCs across Australia (Table 15). In addition, the Carer Information Support Service had one service outlet in each state and territory.

The NRCP complemented the respite services provided under the Act in Australian Government funded residential aged care homes. In 2014–15, there were 2,433 residential aged care homes that provided residential respite services.

Table 15: Respite service providers at 30 June 2015, by state and territory

STATE/TERRITORY	NRCP RESPITE SERVICES[15]	CRCCS	RESIDENTIAL RESPITE
NSW	195	17	835
Vic.	136	9	683
Qld	95	7	367
WA	41	4	198
SA	52	11	248
Tas.	24	3	68
ACT	8	1	22
NT	9	2	12
Australia	560	54	2,433

Who received care?

In 2014–15, there were 70,333 admissions to residential respite care, and the number of residential respite days used in 2014–15 was 1.8 million (Table 16). On average, each recipient received 1.3 episodes of residential respite care during 2014–15, and their average length of stay per episode was 25.22 days.

Table 16: Residential respite care days by level of care, during 2014–15, by state and territory

STATE/TERRITORY	HIGH CARE	LOW CARE	TOTAL
NSW	493,246	283,140	776,386
Vic.	169,899	253,953	423,852
Qld	138,680	76,249	214,929
WA	54,554	36,465	91,019
SA	158,236	54,369	212,605
Tas.	24,230	11,074	35,304
ACT	9,106	5,772	14,878
NT	7,704	3,643	11,347
Australia	1,055,655	724,665	1,780,320

[15] 2014–15 planned respite services only.

There was an increase in respite admissions post 30 June 2014. While this has started returning towards trend levels they remain higher than pre 30 June 2014. The increase likely reflects changes to fee arrangements that took effect from 1 July 2014 with respite care being used while means assessments and financial positions are settled.

There was a marked increase in permanent admissions to residential care pre 30 June 2014, followed by a sharp decline before admissions started to gradually increase again. This likely reflects a move by consumers to enter care before 1 July 2014 to 'lock in' pre 1 July 2014 arrangements for accommodation payments and means tested care fees and thus avoid potentially higher payments and fees under the 1 July 2014 reforms, which were designed to ensure that people who have the capacity to do so contribute to the cost of their care and accommodation.

Although respite admission levels have started to return towards trend levels, they do remain higher than pre 30 June 2014. This increase may, in part, be due to administrative issues arising from delays in processing of means test assessments.

Expenditure

Across Australia, expenditure on residential respite care was $267.00 million in 2014–15, compared with $206.00 million in 2013–14, an increase of 29.66 per cent (Table 17).

Table 17: Australian Government expenditure for residential respite care between 2010–11 and 2014–15, by state and territory

STATE/TERRITORY	2010–11 $M	2011–12 $M	2012–13 $M	2013–14 $M	2014–15 $M
NSW	83.2	84.1	88.4	89.8	120.7
Vic.	34.5	37.5	40.3	43.6	53.5
Qld	22.8	24.5	25.3	27.2	33.5
WA	11.0	11.6	12.1	11.7	13.6
SA	19.4	20.9	23.8	25.3	36.0
Tas.	3.9	4.3	5.2	5.3	5.7
ACT	2.0	2.1	2.0	1.7	2.2
NT	1.4	1.5	1.0	1.4	2.1
Australia	178.2	186.4	198.8	206.0	267.0

Extra Service

Some aged care homes may be approved under the Act to offer extra services to recipients of residential care. This involves a significantly higher than average standard of accommodation, services and food. Approval may be for the whole of a residential home or for a distinct part. Extra Service does not affect the care provided to care recipients, as all aged care homes are required to meet designated care standards for all care recipients. Residents are usually charged a higher daily fee for the extra service.

Providers are increasingly suspending or relinquishing Extra Service places in favour of entering into more flexible 'additional services' contracts with residents.

At 30 June 2015, there were 22,127 residential care places approved for extra service status. The total number of places approved for extra service represented 9.7 per cent of all allocated non-flexible residential care places. In comparison, at 30 June 2014 there were 23,950 residential care places approved for extra service status, which represented 11 per cent of all allocated non-flexible residential care places.

7.2. WHO PROVIDES CARE?

Residential aged care is delivered to older Australians by service providers who have been approved to provide this under the Act. Matters considered in approving service providers include the suitability and experience of key personnel, previous experience in providing aged care, record of financial management, and ability to meet standards for the provision of aged care.

Approved providers are also required to comply, on an ongoing basis, with a range of responsibilities under the Act relating to factors such as quality of care, user rights, accountability requirements, and conditions that have been attached to certain aged care places (see Appendix C).

At 30 June 2015, there were 2,681 services of residential aged care, a slight decrease from the previous year. At the same time, there were 972 residential aged care providers. This year, the Department received 30 applications from organisations wanting to become a new residential aged care provider; of the applications assessed, 60 per cent of these applications were successful.

Residential aged care in Australia is delivered by providers from the religious and charitable, community, for-profit and government sectors. In 2014–15, the not-for-profit group (comprising religious, charitable and community-based providers) were responsible for 57.1 per cent of operational residential care places, for-profit providers were responsible for 38.0 per cent, and government providers were responsible for 4.9 per cent (Table 18).

Table 18: Operational residential care places, other than flexible care places, by provider type, at 30 June 2015, by state and territory

STATE/ TERRITORY	RELIGIOUS	CHARITABLE	COMMUNITY BASED	FOR-PROFIT	STATE/ TERRITORY GOVT.	LOCAL GOVT.	TOTAL
NSW	16,910	15,985	10,358	22,144	405	422	66,224
Vic.	7,285	4,151	7,009	26,717	5,239	315	50,716
Qld	12,445	5,576	3,359	11,790	1,172	111	34,453
WA	4,829	2,728	1,965	5,791	66	287	15,666
SA	4,885	3,842	2,169	5,486	864	432	17,678
Tas.	2,176	1,344	878	412	87	0	4,897
ACT	493	734	398	622	0	0	2,247
NT	65	0	289	135	0	0	489
Australia	49,088	34,360	26,425	73,097	7,833	1,567	192,370
% of Total	**25.5**	**17.9**	**13.7**	**38.0**	**4.1**	**0.8**	**100**

7.3. WHO RECEIVES CARE?

Residential care is targeted at frail older people who require a level of continuing personal care, and are unable to remain living in the community without support.

The average age on entry for new admissions to residential aged care is 82 years for men and 84 years for women. The average completed length of stay in residential aged care during 2014–15 was 35.4 months.

Throughout 2014–15, a total of 231,255 people received permanent residential care in aged care homes, and 53,021 people received residential respite care. On 30 June 2015, there were 172,828 people receiving permanent residential care and 4,992 people receiving residential respite (Table 19).

Table 19: Number of permanent and respite residents at 30 June 2015, by state and territory

STATE/TERRITORY	PERMANENT RESIDENTIAL	HIGH CARE RESPITE	LOW CARE RESPITE	TOTAL
NSW	59,131	1,444	692	61,267
Vic.	45,152	491	756	46,399
Qld	31,275	391	211	31,877
WA	14,657	142	85	14,884
SA	15,868	496	127	16,491
Tas.	4,366	67	31	4,464
ACT	1,948	21	13	1,982
NT	431	15	10	456
Australia	172,828	3,067	1,925	177,820

People entering into Australian Government subsidised residential care must first be approved as a care recipient under Part 2.3 of the Act. Under these arrangements, comprehensive assessments are conducted to take account of the restorative, physical, medical, psychological, cultural and social dimensions of the person's care needs. This assessment is undertaken by an Aged Care Assessment Team (ACAT) (see Section 4.2). In emergency situations, a person in need of care may be placed in an aged care home before an ACAT assessment.

People who have been approved for care will often take time to consider their options, visit different aged care homes, settle their affairs, and make arrangements with the home of their choice before entering care. People who are entering aged care from 1 July 2014 are able to request a means test assessment from the Department of Human Services prior to entry to aged care and receive an initial fee notification advice which will be valid for 120 days prior to entry to aged care, unless there is a significant change in circumstances during that time.

Table 20 shows the proportion of residents placed in permanent residential care within a specified time period after assessment (and recommendation for residential care) by an ACAT.

Table 20: Proportion of new entrants to permanent residential care entering within a specified period after an ACAT assessment during 2014–15

2 DAYS OR LESS	7 DAYS OR LESS	LESS THAN 1 MONTH	LESS THAN 3 MONTHS	LESS THAN 9 MONTHS
2.9%	9.8%	30.6%	58.4%	81.3%

This entry period measure is not a proxy for waiting time for admission to an aged care home. The ACAT recommendation is simply an option for that person. Many people who receive a recommendation for residential care may also receive and take up a recommendation for a home care package, or they may simply choose not to take up residential care at that time. The increased availability of home care, transition care and respite care has a significant effect in delaying entry into residential care.

7.4. HOW IS RESIDENTIAL AGED CARE FUNDED?

The cost of residential aged care is met by both public (Australian Government) and private (individual) funding. The arrangements for the funding are set out in the Act or in the *Transitional Provisions Act*, with some of the arrangements differing depending on when a person entered care.

Changes were introduced from 1 July 2014 to improve the fairness and sustainability of the aged care sector. While the Government continues to be the majority funder of aged care, the changes were designed to ensure that people who have the capacity to do so contribute to the cost of their care and accommodation.

What the Government pays

During 2014–15, approximately two-thirds of the total funding for residential care was provided by the Australian Government. Subsidy and supplement payments are paid directly to approved providers of aged care services on behalf of the residents in those services. Where they can afford to do so, residents are asked to contribute to the cost of their care and accommodation. The arrangements for the calculation of the subsidy differ for continuing care recipients and new care recipients.

Figure 2: Determining the residential care subsidy

Payments for Continuing Care Recipients: care recipients who entered before 1 July 2014

The payment of subsides and supplements for residents who entered care prior to 1 July 2014 (unless they left care for more than 28 days or moved to a new facility and elected to be covered by the new arrangements) are subject to the arrangements outlined in the *Transitional Provisions Act*. The *Transitional Provisions Act* sets out the following process for determining the payments for continuing care recipients (as demonstrated in Figure 2):

- a basic subsidy amount determined, for permanent residents, by the resident's classification under the ACFI;
- plus any primary supplements for accommodation (supported residents, concessional residents, assisted residents or charge exempt), respite, oxygen, and enteral feeding; or additional primary supplements including transitional supplement, accommodation charge top-up supplement, transitional accommodation supplement, basic daily fee supplement;

- less any reductions in subsidy resulting from the provision of extra service, adjusted subsidies for government owned aged care homes or the receipt of a compensation payment[16];
- less any reduction resulting from the income testing of residents who entered residential care on or after 1 March 1998; and
- plus any other supplements, including the pensioner supplement, the viability supplement and the hardship supplement.

Payments for New Residents: care recipients who entered on or after 1 July 2014

Residents who entered on or after 1 July 2014 are subject to the arrangements outlined in the Act. The Act sets out the following process for determining the payments for care recipients (as demonstrated in Figure 2):

- a basic subsidy amount determined, for permanent residents, by the resident's classification under the ACFI or, for respite residents, by the ACAT approval of the resident for care;
- plus any primary supplements including respite, oxygen and enteral feeding;
- less any reductions in subsidy resulting from the provision of extra service, adjusted subsidies for government owned aged care homes or the receipt of a compensation payment;
- less any reduction resulting from the income and asset testing of residents who entered residential care on or after 1 July 2014; and
- plus any other supplements, including the accommodation supplement, viability supplement, veterans' supplement, homeless supplement and the hardship supplement (the last of which reduces fees and accommodation payments for residents who would otherwise experience financial hardship).

Subsidies and Supplements

The Minister determines the rates for subsidies and care supplements to be paid from 1 July of each year and the rates of accommodation-linked supplements on 20 March and 20 September each year (at the same time the Australian Government's Age Pension changes). The current rates of payment are available on the Schedule of Subsidies and Supplements on the Department's website[17] and from My Aged Care.

Australian Government funding for residential care subsidies and supplements has risen from $9.8 billion in 2013–14 to $10.6 billion in 2014–15 (Table 21). This includes funding appropriated through the Department of Social Services portfolio, and funding for veterans in residential care through the Department of Veterans' Affairs. These combined appropriations are paid as subsidies and supplements to aged care homes through payment systems managed by the Department of Human Services.

[16] The adjusted subsidy reduction was removed from former Government owned homes effective from 1 July 2007. Transfers of places from Government to a non-Government owned service have the adjusted subsidy reduction removed from the date of transfer.

[17] Current Australian Government subsidies and supplements, www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-funding/aged-care-subsidies-and-supplements

Table 21: Australian Government recurrent residential care funding, 2010–11 to 2014–15, by state and territory

STATE/TERRITORY	2010–11 $M	2011–12 $M	2012–13 $M	2013–14 $M	2014–15 $M	INCREASE 2013–14 TO 2014–15
NSW	2,734.4	2,998.9	3,115.1	3,348.9	3,563.5	6.4
Vic.	2,032.8	2,237.8	2,363.3	2,539.8	2,758.6	8.6
Qld	1,407.5	1,573.8	1,655.2	1,762.6	1,926.4	9.3
WA	669.1	727.3	791.6	860.3	921.1	7.1
SA	800.7	872.6	911.8	942.4	1,018.2	8.0
Tas.	196.1	215.3	234.7	239.9	258	7.5
ACT	80.9	91.0	96.9	94.0	110.6	17.7
NT	25.1	29.0	34.0	26.5	33.1	24.9
Australia	7,954.4	8,738.4	9,192.0	9,814.4	10,589.4	7.9

Totals may not sum exactly, due to rounding. This table includes funding through the Department of Veterans' Affairs. This table presents recurrent funding to residential care providers using accrual based reporting. Due to accrual adjustments, for smaller jurisdictions in particular, this can lead to significant year on year variation. Based on claims data, recurrent funding for each state and territory grew between 4.2 per cent and 11.2 per cent between 2013–14 and 2014–15.

Table 22: Summary of Australian Government payments by subsidies and supplements, 2010–11 to 2014–15

TYPE OF PAYMENT		2010–11 $M	2011–12 $M	2012–13 $M	2013–14 $M	2014–15 $M
Basic Subsidy	Permanent	6,560.30	7,288.50	7,561.60	8,027.40	9,662.4
	Respite	153.7	160	168	173.6	239.0
	Conditional Adjustment Payment*	581.9	645.5	674.9	716.4	$0
Primary Care Supplements	Oxygen	12.8	13.4	14.6	15.3	16.4
	Enteral Feeding	8.6	8.6	8.3	7.8	6.7
	Payroll Tax**	126.4	147.1	178.8	191.3	107.4
	Respite Incentive	12.9	13.7	14.9	15.9	22.6

TYPE OF PAYMENT		2010–11 $M	2011–12 $M	2012–13 $M	2013–14 $M	2014–15 $M
Other Supplements	Viability	20.6	28.4	28.6	29.8	35.4
	Veterans'				2.1	3.5
	Homeless				4.5	7.4
Hardship	Hardship	4	3.6	3.4	3.6	4.1
	Hardship Accommodation	2.1	2.9	3.7	4.1	4.1
Accommodation Supplements	Accommodation Supplement	328.7	446.9	525.2	580.9	592.5
Supplements Relating to Grandparenting	Concessional	175.2	132.4	101.7	76.1	72.3
	Transitional	17.4	14.2	11.3	9.2	7.4
	Accommodation Charge Top-up	14.8	10	6.9	4.7	3.1
	Charge Exempt	1.8	1.6	1.3	1.3	1
	Pension	146.2	112.1	83.8	63.7	48
	Resident Contribution Top-up**	12.5	12.6	5.2	0.03	0.000453
	Basic Daily Fee			1.5	1.1	0.8
	Transitional Accommodation Supplement	80.4	76.1	58.3	44.8	31.7
Reductions	Means Testing Reduction***	-304.1	-323.1	-329.5	-320.5	-377.0
	Other Reductions	-60.4	-60.5	0	0	0
	Other	86.1	27.1	69.5	39.9	100.5
Total ($million)		**7,954.4**	**8,738.4**	**9,192.0**	**9,814.4**	**10,589.4**

*On 1 July 2014, the Conditional Adjustment payment was rolled into the basic subsidy amount.

** The payroll tax supplement ceased on 1 January 2015.

*** New means testing arrangements (combined income and asset assessments) were introduced on 1 July 2014. Prior to these arrangements residents were subject to income testing only.

The average level of Australian Government payments for permanent residents in aged care was $60,200 per care recipient, an increase of 7.3 per cent per care recipient from 2013–14 (Table 23).

Table 23: Average Australian Government payments (subsidies plus supplements) for each permanent residential care recipient, 2009–10 to 2014–15

2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	INCREASE 2013–14 TO 2014–15
$43,050	$46,900	$51,400	$53,100	$56,100	$60,200	7.3%

Care payments

The basic care subsidy is based on the appraised care needs of a resident by applying the ACFI. The ACFI consists of questions about assessed care needs, some of which are supported by specified assessment tools and two diagnostic sections. The ACFI consists of 12 questions which are rated by the aged care home on a scale of A, B, C, or D and used to determine the actual ACFI rating.

The ACFI has three funding categories or domains: Activities of Daily Living (ADL), Behaviour (BEH) and Complex Health Care (CHC). Funding in each of these domains is provided at four levels, namely high, medium, low or nil. The defined daily funding rates, as at 30 June 2014, are set out in Table 24. The subsidy paid for a resident is made up of the sum of the amounts payable for the three care domains (ADL + BEH + CHC).

Table 24: ACFI subsidy rates as at 30 June 2015

LEVEL	ACTIVITIES OF DAILY LIVING	BEHAVIOUR	COMPLEX HEALTH CARE
Nil	$0.00	$0.00	$0.00
Low	$35.65	$8.14	$16.04
Medium	$77.61	$16.88	$45.68
High	$107.52	$35.20	$65.96

Quarterly reports of the proportion of residents in each of the ACFI categories are provided on the Department's website[18].

In 2014–15 primary supplements included the:

- oxygen supplement, payable for residents (including respite residents) who have a medical requirement to receive oxygen treatment on an ongoing basis. The oxygen supplement covers the cost of oxygen, oxygen equipment and other costs associated with the administration of continual oxygen therapy;
- enteral feeding supplement, which is payable for residents (including respite residents) who have a medical requirement to receive enteral feeding assistance on an ongoing basis. There is a higher level of supplement for non-bolus feeding and a lower level for bolus feeding; and
- respite supplement, which is payable for each eligible day a respite resident is in care.

[18] Aged Care Funding Instrument (ACFI) Reports, https://www.dss.gov.au/our-responsibilities/ageing-and-aged-care/tools-and-resources/aged-care-funding-instrument-acfi-reports

The payroll tax supplement, which provided assistance to providers required to pay state or territory-based payroll tax, ceased on 1 January 2015.

Accommodation supplement

The accommodation supplement is paid to approved providers on behalf of residents who have been assessed as not being able to meet all or part of their own accommodation costs. The accommodation supplement is only payable for eligible permanent residents who entered an aged care service from 20 March 2008.

From 1 July 2014, the maximum amount of accommodation supplement increased from $34.20 to $52.49 for services that have been newly built or significantly refurbished on or after 20 April 2012. This amount increased with indexation on 20 March 2015 to $53.39.

The intention of the higher accommodation supplement is to encourage the development of additional capacity in the residential aged care sector and enhanced quality and amenity of accommodation for residents.

The level of a new resident's accommodation supplement depends on:

- whether a service is significantly refurbished or newly built;
- the level of their assessable income and assets;
- whether the aged care service in which they are a resident (applies to pre1 July 2014 care recipients only) meets the 1999 fire safety (this requirement was repealed on 1 July 2015) and 2008 privacy and space requirements; and
- whether the aged care service provides more than 40 per cent of its eligible care days to supported residents.

Table 25: Movement in the maximum rate of the accommodation supplement

DATE RANGES	MAXIMUM SUPPLEMENT (SIGNIFICANTLY REFURBISHED)	MAXIMUM SUPPLEMENT (NON-SIGNIFICANTLY REFURBISHED)
20 September 2014 to 19 March 2015	$53.04	$34.56
20 March 2015 to 19 September 2015	$53.39	$34.79
20 September 2015 to 19 March 2016	$53.84	$35.08

Hardship Supplement

The Hardship Supplement is payable to reduce the rate of a resident's fees or accommodation payment, if they meet certain requirements or if they are having difficulty paying their fees and payments. Further information is provided in Section 9.5.

Veterans' Supplement

From 1 August 2013, a Veterans' Supplement became available for approved providers for veterans living in a Commonwealth-subsidised residential aged care facility whose mental health condition has been accepted by the Department of Veterans' Affairs (DVA) as associated with their service.

Viability Supplement

The Viability Supplement for residential care is a payment made under the Act to assist aged care services in rural and remote areas with the extra cost of delivering services in those areas. As part of the 2014–15 Budget measure *Reprioritising the Aged Care Workforce Supplement*, the Viability Supplement was increased by 20 per cent.

The residential Viability Supplement is payable for care recipients in residential care homes which meet specific criteria, such as the location of the service and the number of allocated places. Eligible services are generally those with fewer than 45 places in less accessible locations.

The Viability Supplement also provides funding to better support:

- aged care homes in very remote to moderately accessible locations that have more than 50 per cent of care recipients of the service classified as having lower care;
- eligible aged care homes that provide specialist aged care services to Indigenous Australians; and
- eligible aged care homes that provide specialist aged care services to people with a history of (or who may be at severe risk of) homelessness.

The Australian Government also provides a Viability Supplement to provide additional practical support to eligible Multi-Purpose Services (MPS), services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme (NATSIFlex) and home care services in rural and remote areas.

During 2014–15, the Australian Government contributed $48.5 million (excluding home care component) in Viability Supplement funding (Table 26).

Table 26: Australian Government expenditure for the residential Viability Supplement, and the number of aged care homes receiving the residential Viability Supplement, during 2014–15, by state and territory

STATE/ TERRITORY	MAINSTREAM RESIDENTIAL CARE SERVICES	MAINSTREAM RESIDENTIAL CARE EXPENDITURE $,000	NATSIFLEX SERVICES	NATSIFLEX EXPENDITURE $,000	MPS SERVICES	MPS EXPENDITURE $,000
NSW	100	7,866.3	2	224	56	5,165
Vic.	97	7,577.4	2	614	10	732
Qld	92	9,371.9	3	830	33	4,201
WA	29	3,757.3	2	671	28	3,837
SA	51	3,089.8	5	1,570	24	3,331
Tas.	21	1,312.7	0	0	3	285
ACT	0	0	0	0	0	0
NT	11	2,375.6	11	2,821	1	72
Australia	401	35,350.9	25	6,730	155	17,623

Note: This table includes all services receiving a payment, including positive adjustments, based on a previous year's entitlement. At 30 June 2015, there were 165 operational Multi-Purpose Services, 155 of which received the Viability Supplement.

Homeless Supplement

The Homeless Supplement commenced from October 2013, to better support aged care homes that specialise in caring for people with a history of, or at risk of, homelessness. This funding is in addition to the funding provided under the Viability Supplement. Aged care homes registered for the homeless component of the Viability Supplement with greater than 50 per cent of their residents meeting the homeless criterion automatically receive the Homeless Supplement.

Grand-parented supplements

Grand-parented supplements, which only apply to those residents retained on previous arrangements (and do not apply to new residents) include the:

- concessional supplement, payable for concessional and assisted residents who entered an aged care home from 1 October 1997 but before 20 March 2008 or transferred within 28 days: a higher level of concessional supplement is paid for all concessional residents in homes where more than 40 per cent of their post-30 September 1997 residents are concessional or assisted;

- transitional supplement, payable for residents who entered an aged care home prior to 1 October 1997 and have remained in the same home (in lieu of a determination of their concessional status);
- charge exempt supplement, payable for residents who were in high care (nursing home) on 30 September 1997 and who moved to another home where they would otherwise be eligible to pay an accommodation charge. Aged care providers cannot ask charge exempt residents to pay the accommodation charge;
- pensioner supplement, payable for residents who entered before 20 March 2008 and who were on an income support payment or who had a dependent child. The supplement recognises that pensioners who are aged care residents are not entitled to rent assistance with their pension;
- transitional accommodation supplement payable for permanent residents who entered low level care after 20 March 2008 and before 19 September 2011, for whom the level of the accommodation supplement would be less than the level of the pensioner supplement that it replaced; and
- accommodation charge top-up supplement payable for high care residents who were on an income support payment and entered aged care from 20 March 2008 to 19 March 2010. The supplement recognises that pensioners who entered high care during that period may pay a lower accommodation charge than self-funded care recipients.

What residents pay

The Australian Government does not set the level of fees and accommodation payments that residents in aged care homes are asked to pay. However, it does set the maximum level of the daily fees that providers of care may ask residents to pay.

A new fee structure applies to residents who enter permanent residential care from 1 July 2014. Continuing care recipients will continue to be subject to their existing arrangements for fees and payments.

Continuing care recipients defined

Residents who were in care prior to 1 July 2014 will continue to be subject to their existing arrangements for fees and payments, unless one of the circumstances below applies:

- If a resident leaves their residential care for more than 28 days (other than on approved leave) and then re-enters residential care then they will automatically become subject to the new fee and payment arrangements; or
- If a resident leaves their residential care for 28 days or less and then enters a new residential care home they will continue to be subject to their existing pre1 July 2014 arrangements for fees and payments. However, in this case, they also have the option of choosing to have their fees and payments calculated under the new arrangements that apply from 1 July 2014. If a resident does choose to have the new arrangements apply they cannot in future decide to again be covered by their existing fee and payment arrangements.

Significant safeguards, including annual and lifetime caps on the means-tested care fees payable by recipients, have been built into the new arrangements to limit the amount a person can be asked to pay.

Daily Fees

Daily fees for continuing care recipients

For continuing care recipients, fees for residents fall into four categories: basic daily fees, income-tested fees, extra service fees, and additional service fees. Not all residents pay all types of fees.

The provider calculates the maximum daily amount that a resident may be asked to pay by:

- working out the applicable standard resident contribution, that is, the maximum basic daily fee;
- adding any compensation payment reduction that applies for the resident;
- adding any applicable maximum income-tested fee for the resident;
- subtracting any hardship supplement that applies for the resident;
- adding any other amounts agreed between the provider and the resident, in accordance with the *Aged Care (Transitional Provisions) Principles*;
- adding the extra service amount if the resident is in an extra service place and receiving care on an extra service basis; and
- adding the eligible remote area allowance amount if the aged care service is located in a remote area[19].

For residents who were in care prior to 1 July 2014, there are four rates of basic daily fee. These are the:

1. standard rate that applies to most aged care residents, including full pensioners and some part-pensioners with lower amounts of private income;
2. protected rate that applies to people who were in permanent care on 19 September 2009, including part-pensioners with private income amounts above the income threshold and self-funded retirees;
3. non-standard rate that applies to certain people who entered care prior to 20 March 2008, including: self-funded retirees, pensioners who have agreed to pay a big bond, or residents who chose not to disclose their financial information to Centrelink; and
4. phased rate that applies to people who entered permanent care from 20 September 2009 to 19 March 2013, including part-pensioners with private income amounts above the income threshold for phased residents, and self-funded retirees. From 20 March 2013, the phased resident rate equalled the standard rate.

The income-tested fee is paid by continuing care recipients who are assessed as having sufficient income to contribute to the cost of their care. Each resident was subject to an income test and the Government reduces the amount of care subsidies going to the provider (called the income test reduction amount) based on the amount that the resident's income exceeds the threshold amount. The provider could increase the amount of fee charged to the resident up to or equal to the income test reduction amount.

The maximum income-tested fee payable by all post-2008 reform residents was equal to 5/12 of the resident's total assessable income in excess of the maximum income of a full single pensioner.

[19] The remote area allowance amount is added to the maximum daily fee for residents residing in an aged care home that is located in a remote area. Approved providers can check whether their aged care home is located in a qualifying remote area by contacting the Department of Human Services. The maximum amount an approved provider could charge during 2014–15 was $1.06 per day.

However, a resident's income-tested fee could not be greater than the lesser of:

- 135 per cent of the basic Age Pension; or
- the value of basic subsidies and primary supplements paid by the Government to the provider of the residential care services in respect of the resident.

Daily fees for residents who entered permanent residential care on or after 1 July 2014

For residents who entered permanent residential care on or after 1 July 2014, daily fees also fall into four categories: basic daily fees, means-tested care fees, extra service fees, and additional service fees. Again, not all residents pay all types of fees.

The provider calculates the maximum daily amount that a resident may be asked to pay in a similar manner to that used for continuing care recipients, the main difference being the use of the means-tested care fee in the calculations instead of an income-tested fee.

All residents in aged care homes pay a basic daily fee (standard resident contribution). This fee is used by the home to cover costs such as cleaning, maintenance and laundry. Residents in financial hardship can apply for help paying the basic daily fee under financial hardship provisions.

The maximum basic daily fee is indexed on 20 March and 20 September each year, at the same time as changes to the Age Pension. Unlike the arrangements for continuing care recipients, there is only one rate of basic daily fee for residents who entered permanent care on or after 1 July 2014.

For residents entering care on or after 1 July 2014, their means-tested care fee is determined by calculating the amount by which the resident's means-tested amount exceeds the maximum accommodation supplement ($53.39 as at June 2015), which is determined by Ministerial determination. The means-tested amount is compared against the maximum accommodation supplement amount regardless of whether or not the residential care service is eligible to receive the higher accommodation supplement.

Daily fees that can apply to all residents

The extra service amount is the maximum amount a provider can charge a resident for receiving extra service in a residential care home with extra service status (see Section 7.1). A resident in an extra service place pays an extra service amount in addition to other fees, which may include the basic daily fee and the income-tested fee or means-tested care fee.

An approved provider may also charge a resident for additional services such as hairdressing, which the resident has asked the provider to provide. The amount of any charge for additional services must be agreed with the resident, with an itemised account given to the resident once the service has been provided.

Accommodation payments

Resident and government accommodation payments such as refundable deposits and bonds, daily payments, accommodation charges, and supplements, assist providers with the capital costs of maintaining and upgrading aged care homes.

Providers are expected to fund their own capital works. If however, providers are unable to meet the whole cost of essential capital works, in limited circumstances, capital grant funding is available.

The *Fees and Payments Principles 2014 (No. 2)* came into force on 1 July 2014, changing accommodation payment arrangements for residents who enter care on or after 1 July 2014. These changes include:

- allowing residents, who can pay for their accommodation, to be able to choose whether they do this through a refundable deposit, a daily payment or a combination of these methods;
- providing residents, who can pay for their accommodation, with 28 days after entering care in which to decide on their method of paying for their accommodation;
- allowing providers to be able to receive refundable deposits (bonds) in high care for new residents;
- removing the ability to charge new residents retention amounts;
- additional information that must be given to a resident before they enter care;
- additional information to be included in an accommodation agreement; and
- rules about charging accommodation payments including publishing, ensuring equivalence between a refundable deposit and a daily payment, matters regarding an application to the Aged Care Pricing Commissioner for approval to charge an accommodation payment that is higher than the Minister's maximum accommodation payment amount.

The Government continues to supplement or meet the cost of accommodation on behalf of residents with low means.

Increases to the accommodation supplement paid for new or significantly refurbished services supports providers accommodating residents with low means, and encourage investment in residential aged care homes.

These changes to the accommodation payment arrangements that commenced on 1 July 2014 are subject to close monitoring by the Aged Care Financing Authority.

Accommodation payment arrangements for residents entering care on or after 1 July 2014

Depending on their means test assessment (level of combined income and assets) some residents who enter care on or after 1 July 2014 will have their accommodation costs paid in full, or in part, by the Australian Government. Others will need to pay the accommodation price they negotiate with their aged care home. It is the means-tested amount as at the resident's date of entry to a facility which determines whether the resident is eligible to receive Australian Government assistance with their accommodation costs or is required to pay the accommodation price agreed with the aged care provider.

If at entry the resident's means-tested amount (expressed as a daily amount) is less than the Maximum Accommodation Supplement Amount then the resident will receive Australian Government assistance with their accommodation costs. The Australian Government will pay an accommodation supplement on behalf of this resident to the aged care provider. The resident may also be asked to make a limited contribution to their accommodation costs if their means-tested amount is greater than zero but less than the Maximum Accommodation Supplement Amount.

If at entry the resident's means-tested amount is equal to or greater than the Maximum Accommodation Supplement Amount, then the resident will be required to pay the accommodation price agreed with the aged care provider prior to entry. The Australian Government will not pay an accommodation supplement for this resident, irrespective of how their financial situation may later change, unless financial hardship is granted.

There are a range of accommodation supplement rates set by Ministerial determination. The Maximum Accommodation Supplement Amount is the highest of these. As at 30 June 2015, the Maximum Accommodation Supplement Amount is $53.39 per day. Even if this amount is not the maximum that a particular facility will receive, it is still the amount that is compared against the resident's means-tested amount at entry to determine their eligibility for Government accommodation assistance.

For those required to pay the price agreed with the home, the means test does not determine the actual price. Rather, providers determine the maximum prices they wish to charge for their accommodation (for residents who do not receive any government assistance with the cost of their accommodation) and publish these prices, along with information about the key features of the room, on My Aged Care and on their own website and in their printed materials.

The provider and the resident may negotiate any price up to the published amount and this is agreed in writing with the resident before they enter care. If the resident is eligible to make an accommodation payment, they will be liable to pay this agreed amount. They have up to 28 days after entering care to choose how they wish to do this and can make their decision at any time in this period. This can be by a refundable lump sum, an equivalent daily payment or a combination of the two. If the resident chooses to pay any of their accommodation payment by a refundable lump sum, the provider still needs to ensure they are left with the minimum permissible asset level ($46,000 as at 30 June 2015) and if necessary the resident will make up any difference by daily payments.

The amount of accommodation payment a resident pays is set at the date of entry. Once a resident has entered care the resident's care fees may change if their income and assets change.

The accommodation payment arrangements that apply to continuing care recipients are significantly different.

Accommodation payment arrangements for continuing care recipients

Prior to 1 July 2014, entrants to high care were usually required to pay an accommodation charge, which was capped and its value set at the time of entry. Entrants to low care could be asked to pay an accommodation bond, which was nominally uncapped; however, there was a requirement that the new resident be left with a minimum level of assets. All entrants to extra service, whether low or high care, could be asked to pay an accommodation bond.

As is still the case, the Australian Government assisted those residents who did not have sufficient means to pay their own accommodation costs.

In 2014–15, 82.4 per cent of homes collected accommodation charges, while 89.8 per cent of homes collected a daily accommodation payment or contribution. The average daily payment for new residents in 2014–15 was $37.73 compared with $30.06 in 2013–14 (Table 27).

Table 27: Proportion of homes collecting an accommodation charge and average daily payment for new residents, 2010–11 to 2014–15.

	2010–11	2011–12	2012–13	2013–14	2014–15
Homes collecting charges	77.1%	71.6%	75.9%	82.3%	82.4%
Average daily payment for new residents	$25.49	$28.18	$28.89	$30.06	$37.73

Approved providers could derive income from accommodation bonds by deducting monthly retention amounts though this is not allowed for refundable accommodation deposits paid post 1 July 2014.

Accommodation payment arrangements that can apply to all residents

There are strict prudential requirements related to the accounting and handling of bonds and refundable accommodation deposits and bonds collected by aged care providers. The Department closely monitors how effectively providers are meeting these requirements and conducts an annual review of providers' prudential arrangements (see Section 11.8).

The average accommodation price agreed with a new resident in 2014–15 was $343,540 with 42 per cent of residents choosing to pay by lump sum, 34 per cent by daily payment, and 24 per cent by a combination of both[20].

Table 28: Method of payment of accommodation bonds as a percentage of all bond-paying new residents, 2010–11 to 2013–14

	2010–11	2011–12	2012–13	2013–14
Lump sum	90.3%	88.8%	89.7%	87.3%
Periodic payments	3.7%	3.6%	3.0%	4.0%
Combination of lump sum and periodic payments	5.9%	7.6%	7.3%	8.7%

The Australian Government has taken measures to strengthen the protection of residents' bonds, as a bond can represent a significant proportion of a resident's life savings.

Further information on residential care fees and charges can be found through the My Aged Care contact centre.

7.5. AGED CARE PRICING COMMISSIONER

Throughout the year, the Aged Care Pricing Commissioner received applications from providers who wished to charge an accommodation price above the threshold determined by the Minister (currently $550,000) or who wished to charge a new or increased extra service fee. Further information on the Aged Care Pricing Commissioner's operations for the year will be available from the Aged Care Pricing Commissioner's Annual Report[21].

[20] Choice of payment data based on the Aged Care Financing Authorities reform monitoring survey. Data on refundable deposit and daily payment amounts is not currently available.

[21] Aged Care Pricing Commissioner Publications, http://www.acpc.gov.au/publications/

7.6. BUILDING ACTIVITY

Through accommodation payments, residential aged care providers can access funding to upgrade and maintain buildings. The sector is continuing to invest significant funds in new buildings, rebuilding, and upgrading of homes.

A total of $1,738 million of new building, refurbishment and upgrading work was completed during 2014–15, involving 19.6 per cent of all homes. A further $2,082 million of work was in progress at 30 June 2015, involving 17.3 per cent of all homes. At 30 June 2015, 20.0 per cent of homes were planning building work (Table 29).

Table 29: Estimated building work expenditure by residential care services, 2010–11 to 2014–15

		2010–11	2011–12	2012–13	2013–14	2014–15
Building Work	Estimated total building work completed during the year or in progress at 30 June ($m)	$1,953	$1,850	$2,533	$3,142	$3,820
	Proportion of homes that completed any building work during the year	12.90%	15.70%	16.40%	12.05%	19.55%
	Proportion of homes with any building work in progress at the end of the year	5.60%	6.90%	11.50%	16.91%	17.30%
New building work	Proportion of homes that completed new building work during the year	2.20%	1.70%	1.30%	1.79%	2.70%
	Proportion of homes with new building work in progress at the end of the year	1.50%	1.70%	2.00%	2.22%	1.76%
	Estimated new building work completed during the year ($m)	$750	$523	$440	$703	$945
	Estimated new building work in progress at the end of the year ($m)	$428	$464	$735	$865	$565
	Proportion of homes that were planning new building work	4.20%	3.60%	3.90%	3.50%	3.60%

		2010–11	2011–12	2012–13	2013–14	2014–15
Rebuilding work	Proportion of homes that completed rebuilding work during the year	0.40%	0.80%	0.80%	0.91%	0.91%
	Proportion of homes with rebuilding work in progress at the end of the year	0.90%	0.80%	1.40%	0.91%	1.10%
	Estimated rebuilding work completed during the year ($m)	$116	$85.30	$190	$337	$314
	Estimated rebuilding work in progress at the end of the year ($m)	$245	$251	$449	$240	$736
	Proportion of homes that were planning rebuilding work	2.20%	1.80%	2.70%	3.76%	3.06%
Upgrading work	Proportion of homes that completed upgrading work during the year	10.30%	13.30%	14.50%	9.31%	16.44%
	Proportion of homes with upgrading work in progress at the end of the year	3.20%	4.30%	8.40%	14.02%	14.69%
	Estimated upgrading work completed during the year ($m)	$184	$288	$290	$514	$479
	Estimated upgrading work in progress at the end of the year ($m)	$231	$237	$429	$484	$781
	Proportion of homes that were planning upgrading work	8.60%	9.20%	9.50%	11.97%	14.52%

New building work is defined as work relating to a new building to accommodate new or transferred aged care places. Rebuilding work is defined as the complete demolition and reconstruction of an approved service on the same site. Upgrading work is defined as renovation or refurbishment of an existing service including extensions.

Note: 2014–15 figures are preliminary and may be subject to change.

Capital assistance

The Australian Government acknowledges that some homes may not be in a position to attract sufficient residents who can pay accommodation payments because, for example, of their rural or remote location or because the homes target financially disadvantaged people or people from special needs groups as defined in the Act.

The Rural, Regional and Other Special Needs Building Fund provides targeted capital assistance to assist providers who, as a result of such circumstances, are unable to meet all or part of the cost of necessary capital works.

In the 2014 ACAR, $103 million in capital grants was allocated nationally to approved providers to undertake necessary capital works to establish, upgrade or expand residential aged care services.

7.7. MONITORING THE IMPACT OF THE JULY 2014 CHANGES

The Aged Care Financing Authority (ACFA) has been asked by the Government to monitor the impacts of the 1 July 2014 changes, specifically focusing on the impact of accommodation payments changes and the impact of changes to means testing arrangements on access to care. ACFA presented its 2015 Report on the Funding and Financing of the Aged Care Industry to the Government on 31 July 2015.

ACFA monitoring reports are showing positive impacts on the sector in aggregate from the changes. There has been a significant increase in the amount of lump sum held and receivable. This provides significant funds for providers to further invest in the residential care sector. More broadly, there has also been a noticeable increase in investor interest in the residential care sector.

ACFA will continue to monitor the impact of the changes and is now reporting to the Minister on a quarterly basis.

7.8. LOOKING FORWARD

The Government is committed to putting in place policies and programmes that are aimed at addressing the growing needs of Australia's ageing population. To support this work, the Government is progressing a number of red tape reduction measures that are focused on streamlining the management of aged care places. The proposed changes will make it easier for approved providers to operationalise places by reducing the associated regulatory burden by up to 75 per cent. This will enable approved providers to focus less on administrative processes and more on the timely delivery of care to older Australians who require it.

CHAPTER 8

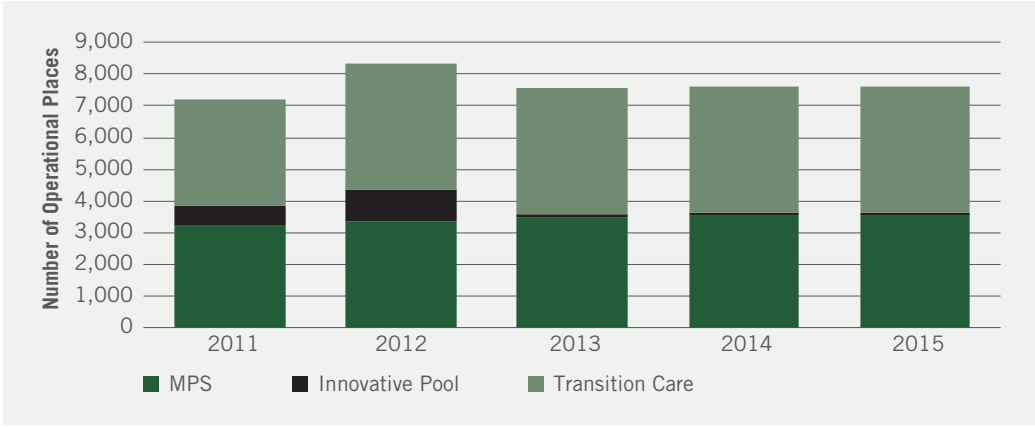
8. FLEXIBLE CARE

Flexible care acknowledges that the needs of care recipients, in either a residential or home care setting, may require a different care approach than that provided through mainstream residential and home care. Three types of flexible care arrangements are provided for under the Act: Transition Care, Multi-Purpose Services and Innovative Care. Arrangements for the various types of flexible care are set out in the *Subsidy Principles 2014*.

In addition to the support provided under the Act, flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme, which are administered through funding agreements with providers.

At 30 June 2015, there were 7,629 operational flexible care places (Figure 3).

Figure 3: Operational flexible care places, as at 30 June each year between 2011 and 2015



Note: The number of flexible care places does not include places allocated under the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme, which is a grants based programme administered by the Department of Social Services.

Equivalent amounts for the Dementia and Veterans' Supplements and the Viability Supplement are provided for in the Transition Care, Multi-Purpose Services, National Aboriginal and Torres Strait Islander Flexible Aged Care, and Innovative Care Programmes.

8.1. TRANSITION CARE

The Transition Care Programme was established in 2004–05 as a jointly funded initiative between the Australian Government and state and territory governments. Transition care service delivery is managed by the state and territory governments, administered by the respective health departments. Within the framework of the programme, state and territory governments have the flexibility to determine service delivery models for transition care that best respond to local service, and individual care recipient needs.

Most state and territory governments have subcontracted the provision of transition care services.

At 30 June 2015, there were a total of 4,000 operational transition care places nationally.

The Transition Care Programme enables older people to return home after a hospital stay, rather than prematurely entering a residential aged care home.

To enter transition care, an older person must have been assessed as eligible for transition care by an ACAT, while they are an inpatient of a hospital. A person can only enter transition care directly after being discharged from hospital.

The programme provides time-limited, goal-oriented and therapy-focused packages of services to older people after a hospital stay. These packages include low intensity therapy (such as physiotherapy and occupational therapy), social work and nursing support or personal care. The programme also gives older people, their families and carers, time to consider long-term care arrangements.

Transition care is provided for up to 12 weeks (with a possible extension of another six weeks) in either a homelike residential setting or in the community. In 2014–15, the average length of stay for completed episodes of transition care was 60 days.

Transition care is provided in metropolitan and rural settings. Transition care may be provided either in a person's own home or in a 'live-in' setting (either part of an existing aged care home or health facility). Where appropriate, care can be provided in hospitals in rural and remote areas.

At 30 June 2015, 3,575 people were receiving transition care. Overall, 24,914 people received transition care during 2014–15 (Table 30).

Table 30: Number of transition care recipients by state and territory, at 30 June 2015 and during 2014–15

STATE/TERRITORY	NUMBER OF PEOPLE RECEIVING TRANSITION CARE AT 30 JUNE 2015	NUMBER OF PEOPLE WHO RECEIVED TRANSITION CARE DURING 2014–15
NSW	1,247	7,786
Vic.	919	6,746
Qld	660	5,073
WA	300	2,264
SA	297	2,060
Tas.	83	588
ACT	49	302
NT	20	132
Australia	3,575	24,914

Note: Data for number of recipients across the financial year shows a distinct count of individual clients with one or more episodes of transition care at any time in the 12 month period to 30 June 2015. An individual client may receive care in multiple states, but will be only counted once in the total for Australia.

Australian Government funding for the Transition Care Programme is provided in the form of a flexible care subsidy payable to the provider for each person that receives transition care. In 2014–15, the Australian Government funding for the Transition Care Programme was $264 million. The state and territory governments, as the approved providers of transition care, also contribute, to the delivery of the Transition Care Programme through a mix of financial and in-kind support (Table 31).

Table 31: Australian Government expenditure on transition care, during 2014–15, by state and territory

STATE/TERRITORY	AUSTRALIAN GOVERNMENT $M
NSW	83.9
Vic.	73.7
Qld	49.7
WA	18.9
SA	25.4
Tas.	7.1
ACT	3.3
NT	1.6
Total	**263.6**

Similar to the arrangements in residential aged care, the subsidy is paid by the Australian Government for each occupied place. Providers may charge a daily care fee for the services provided under this programme. The fee is calculated on a daily basis for every day a person is receiving services through transition care. The maximum basic daily rate for transition care delivered in a:

- community setting, including in a person's own home is $9.77 per day (from 20 March 2015 to 19 September 2015); and
- residential setting is up to $47.49 per day (from 20 March 2015 to 19 September 2015).

Rates increase in March and September each year in line with changes to the Age Pension.

The Australian Institute of Health and Welfare's report, *Transition Care for Older People Leaving Hospital 2005–2006 to 2012–2013*, a statistical review of transition care, found that for those who completed planned care in the Transition Care Programme, 76 per cent had improved functioning. This improved functioning remained reasonably stable over time.

8.2. MULTI-PURPOSE SERVICES

The Multi-Purpose Service (MPS) Programme is a joint initiative between the Australian Government and all states and territories, other than the Australian Capital Territory. The programme recognises that the delivery of some health and aged care services may not be viable in rural and remote communities if they are provided separately. By bringing the services together, economies of scale are achieved to support the services.

Multi-Purpose Services operate under the Act and deliver a mix of aged care, health and community services in rural and remote communities. In general, they are operated by state, territory, and local governments, and are primarily located in hospital settings. The responsibilities of MPS providers are listed under section 56-3 of the Act.

At 30 June 2015, there were 165 operational Multi-Purpose Services, with a total of 3,545 flexible care places (Table 32).

Table 32: Multi-Purpose Services and operational places, at 30 June 2015, by state and territory

STATE/ TERRITORY	MULTI-PURPOSE SERVICES WITH OPERATIONAL PLACES	OPERATIONAL HIGH CARE RESIDENTIAL CARE PLACES	OPERATIONAL LOW CARE RESIDENTIAL CARE PLACES	OPERATIONAL COMMUNITY CARE PLACES	TOTAL OPERATIONAL PLACES
NSW	60	755	235	119	1,109
Vic.	11	225	131	19	375
Qld	33	268	143	141	552
WA	31	318	317	159	794
SA	26	390	203	14	607
Tas.	3	66	21	15	102
ACT	0	0	0	0	0
NT	1	4	0	2	6
Australia	165	2,026	1,050	469	3,545

Australian Government funding for Multi-Purpose Services is provided as a flexible care subsidy under the Act, depending on the number of flexible care places approved for each Multi-Purpose Service. One advantage of this arrangement is it provides a steady flow of funding that is not subject to variations in occupancy. Australian Government funding is combined with state and territory government health services funding to provide a range of integrated health and aged care services that meet the needs of the community.

There was continued growth in Australian Government expenditure for the MultiPurpose Services Programme, from $133.0 million in 2013–14 to $142.2 million in 2014–15 (Table 33).

Table 33: Australian Government expenditure for Multi-Purpose Services, 2010–11 to 2014–15, by state and territory

STATE/ TERRITORY	2010–11 $M	2011–12 $M	2012–13 $M	2013–14 $M	2014–15 $M	INCREASE 2013–14 TO 2014–15
NSW	36.7	38.8	41.8	44.5	47.9	7.6%
Vic.	8.6	12.4	12.6	12.8	13.4	4.3%
Qld	15.8	16.2	18.5	20.6	22.4	8.6%
WA	23.3	23.3	25.2	25.8	27.4	6.3%
SA	20.1	20.9	24.5	25.0	26.7	6.8%
Tas.	3.5	3.6	3.8	3.9	4.1	4.0%
ACT	0	0	0	-	-	0.0%
NT	0.3	0.3	0.3	0.3	0.3	7.9%
Australia	108.2	116.2	126.7	133.0	142.2	6.9%

Note: 1st quarter payment of 2010–11 was pre-paid in 2009–10.

Multi-Purpose Services Flexible Aged Care Round

The Department undertook a national targeted round for Multi-Purpose Services flexible aged care places for 2014–15, which closed on 19 December 2014.

At the time of publication, the Department was still finalising the application process, with the outcome expected to be announced by the end of 2015.

8.3. INNOVATIVE CARE SERVICES

The Aged Care Innovative Pool Programme was established in 2001–02 and provides opportunities to use flexible care places to test new approaches to providing care for specific target groups.

Pilot projects that are approved under the Innovative Pool have clear client eligibility criteria, and have controlled methods of service delivery.

At 30 June 2015, there were nine operational disability/aged care interface pilots with a total of 84 operational innovative care places. These services were operated by approved providers from the home care sector through five services in New South Wales, two in South Australia, and one in each of Tasmania, Victoria and Western Australia.

Following a recommendation in 2006, the nine pilots have been delivered to care recipients on an ongoing basis. However, the places cease as individual care recipients leave them.

The Australian Government provided $1.7 million for the nine services under the Aged Care Innovative Pool Programme in 2014–15.

8.4. NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER FLEXIBLE AGED CARE PROGRAMME

In addition to those provided under the Act, flexible models of care are also provided under the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme. Services funded under this programme provide culturally appropriate aged care to older Aboriginal and Torres Strait Islander people close to home, and are located mainly in rural and remote areas. These flexible aged care services operate outside the regulatory framework of the Act. As at 30 June 2015, 31 aged care services were funded $31.8 million to deliver 802 aged care places through this programme.

8.5. SHORT-TERM RESTORATIVE CARE

In the 2015–16 Budget, the Australian Government announced the expansion of flexible care initiatives. A new form of restorative care, the Short-Term Restorative Care Programme (the STRC Programme), is being established to increase the care options available to older people, and improve their capacity to stay independent and living in their homes. Short-term restorative care will be created as a new kind of flexible care under the Act.

The new care type builds on the success of the existing Transition Care Programme, which assists older people to return home after a hospital stay. However, unlike transition care, short-term restorative care will be available to people without the need for a hospital admission. The two programmes are distinct. From 2016–17, new short-term restorative care places will progressively become available.

An external engagement process on the STRC Programme's policy framework was conducted in September and October 2015. The approach consisted of the public release of a policy consultation paper for comment, three external stakeholder workshops and a webinar. The final policy framework for the STRC Programme will be informed by this stakeholder feedback.

CHAPTER 9

9. SUPPORT FOR PEOPLE WITH SPECIAL NEEDS

One of the objectives of the Act is to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location. To give effect to this objective, the Act designates certain people as 'people with special needs'.

The special needs groups that are included in section 11-3 of the Act are:

- people from Aboriginal and Torres Strait Islander communities;
- people from culturally and linguistically diverse (CALD) backgrounds;
- veterans;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are homeless or at risk of becoming homeless;
- care-leavers;
- parents separated from their children by forced adoption or removal; and
- lesbian, gay, bisexual, transgender and intersex (LGBTI) people.

In accordance with the Act's objectives, the Secretary may decide under section 125 of the Act that a number of aged care places will be made available to focus on the care of particular groups of people. People from special needs groups also have access to places allocated to service the needs of the general population.

Under the *User Rights Principles 1997*, all aged care providers must have regard to the particular physical, physiological, social, spiritual, environmental and other health related care needs of individual recipients. Establishing and maintaining links with representatives of relevant community groups, and other support agencies and organisations, is regarded as an integral part of providing relevant levels of care and facilitating the provision of culturally appropriate care.

Similarly to the Act, the Commonwealth HACC Programme provided appropriate and accessible services to people who needed them. In recognition that some people face greater challenges in accessing services, these groups include all those recognised under the Act as well as people with dementia.

9.1. PEOPLE FROM ABORIGINAL AND TORRES STRAIT ISLANDER COMMUNITIES

Health conditions associated with ageing often affect Aboriginal and Torres Strait Islander people earlier than other Australians. In some cases, planning for aged care services provided under the Act is therefore based on the Aboriginal and Torres Strait Islander population aged 50 years or older, compared with 65 years or older for non-Indigenous Australians.

As well as general access to all mainstream aged care services, a range of additional strategies are in place to ensure access for Aboriginal or Torres Strait Islander people. This includes:

- the allocation of specific places in residential and home care as part of the Aged Care Approvals Round; and
- a Viability Supplement for providers with more than 50 per cent Aboriginal and Torres Strait Islander residents, and workforce grants for rural and remote areas to support recruitment and retention of Aboriginal and Torres Strait Islander aged care staff.

Priority 5 under the Aged Care Service Improvement and Healthy Ageing Grants Fund (ACSIHAG) also supported services for older Aboriginal and Torres Strait Islander people through grants for (but not limited to) capital assistance to support the construction of new aged care services, major maintenance, purchasing equipment, and the provision of staff housing.

As well as having access to aged care services funded under the Act, Aboriginal and Torres Strait Islander people also have access to services funded through the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme. More information on this programme can be found in Chapter 8.

Aboriginal and Torres Strait Islander people were also able to access services funded through the Commonwealth HACC Programme. At 30 June 2015, the percentage of Commonwealth HACC recipients identifying as Aboriginal and Torres Strait Islander peoples was 3.4 per cent.

Information about workforce support for people from Aboriginal and Torres Strait Islander communities can be found in Chapter 10.

9.2. SUPPORT SERVICES FOR RURAL AND REMOTE AGED CARE

Providers of aged care services located in remote areas face particular challenges in service provision. These challenges can include issues related to the operation of small services which may be remote from professional assistance and support. There may also be higher infrastructure and supply costs and difficulties in attracting and retaining staff.

Peer and Professional Support

In recognition of these challenges, the Department administers the Peer and Professional Support Programme to provide funding to assist aged care providers delivering services to Aboriginal and Torres Strait Islander people located anywhere in Australia, and aged care providers located in remote and very remote areas. This programme makes available a range of professional services and emergency assistance.

Professional services are provided to build the capacity of eligible aged care services and assist in the areas of care delivery, quality delivery, financial and organisational management and governance. Emergency assistance is provided to eligible aged care services to ensure the continuity of aged care services and improve the health, safety and well-being of care recipients. In 2014–15, funds of over $2 million were provided under the programme.

Viability Supplement

The aged care planning system outlined in the Act ensures that aged care places are provided in rural and remote areas in proportion to the number of older people who live in these non-metropolitan areas.

In recognition of the higher costs of providing care in those regions, some aged care services in rural and remote areas receive a viability supplement. The viability supplement aims to improve the capacity of small, rural aged care services to offer quality care to older people.

As part of the repurposing of the aged care workforce supplement, the viability supplement was increased by 20 per cent from 1 July 2014. In 2014–15, the Australian Government provided viability supplement funding for mainstream residential care ($35.4 million), home care ($6.3 million), Multi-Purpose Services ($17.6 million), and the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme ($6.7 million).

Report on *Factors Influencing the Financial Performance of Residential Aged Care Providers*

On 5 May 2015, the Aged Care Financing Authority (ACFA) provided its initial report to the Government on *Factors Influencing the Financial Performance of Residential Aged Care Providers*[22].

In the chapter on regional providers, ACFA's report noted that the viability supplement is generally well targeted and a number of providers, who would otherwise have been categorised as Group 4[23], were instead categorised as Group 3[24] as a result of receiving the viability supplement. In ACFA's report, 'regional areas' covered both regional cities and rural and remote areas and, as such, could determine what the locational drivers of performance were for providers in rural and remote locations specifically.

In May 2015, the Government tasked ACFA with a further study of the financial issues of rural and remote providers. More detailed consideration of the impact of the Viability Supplement on rural and remote providers will be undertaken as part of this study. ACFA is due to report to the Government in December 2015.

Multi-Purpose Services Programme

The Multi-Purpose Services Programme supports improvement in the integration and provision of health and aged care services for small rural and remote communities. The flexibility inherent in the programme can be used to respond to the specific needs of each community, and to allow change as the community's needs change. More information on this programme can be found in Chapter 8.

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[22] *Factors Influencing the Financial Performance of Residential Aged Care Providers*, www.dss.gov.au/our-responsibilities/ageing-and-aged-care/aged-care-reform/aged-care-financing-authority/factors-influencing-the-financial-performance-of-residential-aged-care-providers

[23] Financial Performance Group 4– the study defined low financial performance as financial performance where net operating cash flow was below a notional level of repairs and maintenance considered necessary to maintain a facility to a good standard.

[24] Financial Performance Group 3 (Group 3) – providers whose – operating earnings before interest, taxes, depreciation and amortisation (OEBITDA) per resident per annum (prpa) is below that of providers in the second quintile, but does not include providers that are in Group 4.

Aged Care Service Improvement and Healthy Ageing Grants Fund

In the 2015–16 Budget, ACSIHAG was redesigned as the Dementia and Aged Care Services Fund (DACS). The Australian Government has previously provided funding under the ACSIHAG Fund to assist aged care services operating in remote areas, and those providing care to Aboriginal and Torres Strait Islander people.

Two of the projects that were funded under the 2014 ACSIHAG Grants Round focus on supporting aged care providers in regional, rural and remote areas of the Australian Capital Territory, New South Wales, South Australia and the Northern Territory. The projects aim to provide service providers with financial and governance tools to manage the changes to service delivery required under the aged care reforms.

9.3. PEOPLE FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS

Australia is one of the most culturally diverse nations in the world, with an estimated 20.1 per cent of people aged 65 years and over born overseas in countries other than main English speaking countries. The aged care needs and preferences of these groups can be very different and aged care services need to be sensitive to this diversity when delivering care and support.

The *National Ageing and Aged Care Strategy for people from Culturally and Linguistically Diverse Backgrounds* (CALD Strategy) informs the way Government responds to the special needs of older people and carers from culturally and linguistically diverse (CALD) backgrounds, and better supports the aged care sector to deliver care that is sensitive, appropriate and inclusive. The Department has successfully implemented a range of actions across the six goals, including funding to peak bodies, ethno-specific services and multicultural services under the ACSIHAG Fund.

The Department has also established an expert working group to inform the ongoing implementation of the Strategy and provide a platform for members to discuss key issues and concerns with the sector.

Members provide advice and guidance on policies, planning and future priorities as they effect older people and their families from CALD backgrounds.

Achievements to date under the CALD Strategy include:

- consultations with representatives of CALD communities on the aged care reforms to ensure inclusiveness is embedded in aged care practices;
- provision of key aged care information on My Aged Care in community languages and access to free translating and interpreting services for callers and assessment;
- cultural competency training for aged care service providers; and
- increased funding for advocacy services and the Community Visitors Scheme to meet the needs of all special needs groups.

A major programme supporting CALD communities is the Partners In Culturally Appropriate Care programme, which equips aged care providers with the necessary skills to deliver culturally appropriate care. This project is funded until 30 June 2017.

At 30 June 2015, the number of recipients in care, aged 70 years and over, from CALD backgrounds totalled 30,733 in residential care (18.7 per cent of all residential care recipients 70 years and over) and 14,285 in home care (26.6 per cent of all home care recipients 70 years and over) (Table 34).

Table 34: Number of residents 70 years and over from CALD backgrounds in residential care and home care, at 30 June 2015, by state and territory

STATE/TERRITORY	RESIDENTIAL CARE	HOME CARE
NSW	11,272	4,863
Vic.	10,455	5,098
Qld	2,977	1,437
WA	2,555	1,402
SA	2,742	959
Tas.	297	195
ACT	383	231
NT	52	100
Australia	30,733	14,285

Throughout 2014–15, older people from CALD backgrounds could also access services funded through the Commonwealth HACC Programme. At 30 June 2015, the number of CALD clients as a proportion of Commonwealth HACC recipients within the target population, where CALD is defined as country of birth, was 17.8 per cent.

Building Capacity for Ethno-specific Communities to deliver aged care

In recognition of the fact that ethnic communities with emerging aged care needs may require additional support to establish aged care services, the Department engaged a contractor to develop strategies and build tools to support them in the development of competitive 2015 ACAR applications.

These are the *Overview* and *Guide to improve aged care access for your community*. The documents have been translated into 10 languages and were published on the Department's website[25] on 31 July 2015.

9.4. PEOPLE WHO ARE VETERANS

Veterans are designated as people with special needs under the Act. The Department of Veterans' Affairs issues gold and white treatment cards to veterans, their war widows and widowers and dependents, to ensure they have access to health and other care services that promote and maintain selfsufficiency, well-being and quality of life.

[25] People from Diverse Backgrounds, www.dss.gov.au/CALD

There were 21,004 gold or white treatment card holders in residential care at 30 June 2015 (Table 35), a decrease from 24,678 at 30 June 2014.

Table 35: Number of gold or white treatment card holders in residential care, at 30 June 2015, by state and territory

NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT	TOTAL
7,437	5,159	4,115	1,549	1,850	635	247	12	21,004

Since 1 August 2013, a veteran living in a Commonwealth-subsidised residential aged care facility, or in receipt of a home care package, whose mental health condition has been accepted by the Department of Veterans' Affairs (DVA) as associated with their service, may attract the Veterans' Supplement.

9.5. PEOPLE WHO ARE FINANCIALLY OR SOCIALLY DISADVANTAGED

Frail older people who are financially or socially vulnerable are protected from being disadvantaged in gaining access to aged care services. There are special arrangements under the Act for supported residents, assisted residents and concessional residents and hardship provisions for care recipients in residential care. In home care, a person may not be denied a home care package because they cannot afford to pay. Support is also provided for people in insecure housing arrangements.

Low means, supported, concessional and assisted residents

Arrangements established under the Act mean that older people can access residential care, irrespective of their capacity to make accommodation payments. Assistance is provided to low-means, supported, concessional and assisted residents.

Low-means care recipients are those:

- who entered on or after 1 July 2014; and
- whose means tested amount is less than the maximum accommodation supplement amount.

Supported residents are those who:

- entered care for the first time on or after 20 March 2008, or who re-entered care on or after 20 March 2008 after a break of more than 28 days (referred to as post-20 March 2008 residents); and
- have assets equal to or less than an amount determined by the Secretary to be the maximum asset threshold for supported resident status.

Concessional residents are those who:

- entered care before 20 March 2008 and who have not re-entered care on or after 20 March 2008 after a break of more than 28 days; and
- receive an Australian Government means-tested income support payment; and

- have not owned a home for the last two or more years (or whose home is occupied by a 'protected' person, for example, the care recipient's spouse or long term carer); and
- have assets of less than 2.5 times (or if the resident transferred after 20 September 2009, 2.25 times), the annual single basic Age Pension.

For each aged care planning region, there is a minimum target ratio for supported and concessional residents to total residents, based on regional socio-economic indices. The lowest regional target ratio is 16 per cent and the highest is 14 per cent. The supported resident ratio includes low-means, supported, concessional and assisted residents, and certain residents approved under the hardship provisions.

The Australian Government gives additional supplements to aged care providers on behalf of low-means, supported, assisted and concessional residents. The amount of accommodation supplement paid for supported residents depends on the level of residents' means, whether or not the service meets fire and safety requirements, and the proportion of residents in the service that are low means, supported, concessional or assisted residents.

The rate of the concessional supplement depends upon the assets of the resident and whether or not more than 40 per cent of an aged care home's residents are supported, concessional or assisted residents.

Hardship provisions

Financial hardship assistance provisions under the Act cater for the minority of people who have difficulty paying care fees and/or accommodation payments in residential care, residential respite and home care. Applicants for financial hardship assistance in residential care may seek assistance with their daily fees, the income-tested or means-tested fee, accommodation charge, accommodation bond, accommodation payment or accommodation contribution. Financial hardship assistance for daily fees and income-tested care fee is also available to consumers who commenced a home care package from 1 July 2014. Hardship is payable if the person can demonstrate to the Department of Human Services (DHS) that they are in financial hardship as a result of paying their aged care fees and essential expenses. Where assistance is granted, an additional supplement may be payable by the Australian Government.

During 2014–15, DHS processed 2,247 applications for financial hardship assistance in residential care, residential respite and home care. Of these, 48 per cent were approved and 45 per cent were rejected as ineligible. Following advice from DHS, the remaining seven per cent of applications were withdrawn when, for example, DHS was able to recommend more appropriate ways to obtain needed support. Approvals of financial hardship assistance are reviewed on a case-by-case basis or when a resident's financial circumstances change.

Until 1 July 2014, there were some classes of care recipients who were automatically eligible for a hardship supplement. These classes included:

- Class A residents who are care recipients less than 21 years of age. These residents receive income of less than the Age Pension;
- Class B residents who are care recipients under 16 years of age. These residents seldom have income of their own;
- Class C residents who are self-funded retirees, who entered care prior to 20 March 2008, whose income is just above the pension cut-off and who may be disadvantaged by paying a higher (non-pensioner) rate of the basic daily fee;

- Class D residents who were in residential aged care prior to 1 October 1997 who lost eligibility for a payment called the residential care allowance. The automatic reduction in their fees is designed to leave them with income comparable to the amount they had retained after payment of their fees before the 1997 aged care arrangements; and
- Class E residents who were living in hostels on 30 September 1997 and who, with the alignment of nursing home and hostel fees, were left with less income after paying their fees. The automatic reduction in their fees is designed to leave them with an income comparable to what they received before the 1997 aged care arrangements.

Since 1 July 2014, there are no longer automatic financial hardship assistance provisions for new residents entering residential aged care from that date. Residents in care prior to 1 July 2014 who were receiving the hardship supplement automatically will continue to receive it while they continue to meet the eligibility requirements as noted above. Residents who entered care from 1 July 2014 continue to have access to the individual financial hardship assistance provisions under the Act.

The Australian Government provided $8.2 million in hardship supplements during 2014–15.

Care recipients who commenced receiving a home care package from 1 July 2014 are also able to seek financial hardship assistance with their daily fee and income-tested care fee. Hardship provisions for home care are part of the reforms relating to the strengthening of the income-tested fee arrangements for persons who commenced a home care package from 1 July 2014.

9.6. PEOPLE WHO ARE HOMELESS OR AT RISK OF BECOMING HOMELESS

Assistance with Care and Housing for the Aged

Throughout 2014–15, the Assistance with Care and Housing for the Aged (ACHA) programme supported older people who were homeless or at risk of becoming homeless. The programme linked clients to suitable accommodation services with the aim of helping clients to remain in the community rather than inappropriately entering residential care. While accommodation support was a key feature of the programme, clients are also referred to a range of care and other services to help them maintain their independence.

In 2014–15, Australian Government funding of $6.4 million was provided to the ACHA programme, supporting 55 services to assist 6,087 people.

After 1 July 2015, services formerly provided under the ACHA programme will be funded through the Commonwealth Home Support Programme (see Chapter 5).

Supplements

As part of the Viability Supplement, support was available for eligible residential services specialising in care for people at risk of homelessness, low care in rural and remote areas, and care for Aboriginal and Torres Strait Islander Australians.

In addition, more than $7.3 million in additional funding is being provided under the Homeless Supplement to better support aged care homes that specialise in caring for people with a history of, or at risk of, homelessness.

9.7. CARE-LEAVERS

A care-leaver is a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both). More than 500,000 such children were placed in institutions in Australia at some time during the 20th century. This includes the Forgotten Australians, Former Child Migrants and Stolen Generations. Institutional care refers to residential care provided by a government or non-government organisation, including (but not limited to) orphanages; children's homes; industrial, training or farm schools; dormitory or group cottage houses; juvenile detention centres; and mental health or disability facilities.

The experiences of care-leavers while in institutional or out-of-home care may affect their ongoing well-being and have an impact on members of this group who need to access aged care services or enter an aged care home later in life. An information package has been developed and endorsed by key stakeholders to assist aged care providers recognise the special needs of these groups and provide appropriate and responsive care. The package is currently in production.

9.8. PARENTS SEPARATED FROM THEIR CHILDREN BY FORCED ADOPTION OR REMOVAL

Since 1 August 2013, parents separated from their children by forced adoption or removal have been included in the Act as a special needs group. This was in recognition of the traumatic experiences, health issues and socio-economic disadvantages that parents affected by those adoption practices are disproportionately likely to face. It also recognised the importance of the identification of people who may require assistance from time to time in ensuring that they receive appropriate aged care services that are sensitive to their care needs.

In addition to considering this group of people in the allocation of aged care places, the Department provides funding to improve access to specialist support services.

9.9. LESBIAN, GAY, BISEXUAL, TRANSGENDER AND INTERSEX PEOPLE

It is recognised that people who identify as lesbian, gay bisexual, transgender or intersex (LGBTI) have specific needs, particularly as they age, stemming from decades of inequitable treatment and social isolation as a result of stigma and family rejection.

The *National LGBTI Ageing and Aged Care Strategy* informs the way the Government responds to the needs of older people who identify as LGBTI and better supports the aged care sector to deliver care that is sensitive, appropriate and inclusive.

The Department has successfully implemented a range of actions across the six goals, including providing specific funding to peak bodies, LGBTI specific services and general services under the Aged Care Service Improvement and Healthy Ageing Grants Fund.

These projects aim to raise awareness of the issues affecting older LGBTI people, support aged care services to better understand their needs, and break down the barriers of their real and perceived discrimination within the aged care system.

The Department has also established an expert working group to inform the ongoing implementation of the Strategy and provide a platform for members to discuss key issues and concerns within the sector.

Members will provide advice and guidance on direction and future priorities. Achievements to date under the LGBTI Strategy include:

- consultations with LGBTI representatives on the aged care reforms to ensure inclusiveness is embedded in aged care practices;
- enhanced capacity for service providers to identify their services on My Aged Care as inclusive;
- sensitivity training for the aged care workforce; and
- development of resources and support services for people who identify as LGBTI.

Additionally, the expansion of the Community Visitors Scheme (CVS) to specifically target special needs groups, including people who identify as LGBTI, addresses Goal 2 of this strategy. As part of the CVS expansion, LGBTI-specific organisations (Gay and Lesbian Switchboard (Victoria) Inc., and the Queensland Association of Healthy Communities Inc.) have been funded to deliver CVS visits specifically to older LGBTI people. A further 16 CVS auspices are targeting older LGBTI people, among other special needs groups.

CHAPTER 10

10. SUPPORT FOR THE AGED CARE WORKFORCE

Workforce training and education is a shared responsibility between Government and industry with providers having obligations under the *Aged Care Act 1997* to ensure that there are adequate numbers of appropriately skilled staff to meet the individual care needs of residents.

Over and above general funded subsidies paid to aged care providers, support for the aged care workforce currently includes a range of training and education funded activities provided through the Aged Care Workforce Fund. Under the Aged Care Workforce Fund $84 million was available in 2014–15.

The objective for improving workforce sustainability is to support and grow the aged care workforce so that it is effective in caring for older people within a consumer led market, in consultation with the aged care sector and other stakeholders.

The following three components make up the Department's Workforce and Quality Programme and support the Commonwealth Government's priorities and responsibilities:

- Improving Workforce Sustainability;
- Empowering Consumers; and
- Promoting Quality.

This includes:

- facilitating collaborations among the aged care, health training and research sectors;
- providing targeted training strategies for priority groups, such as Aboriginal and Torres Strait Islander people;
- responding to emerging issues; and
- supporting the introduction of innovative practices in aged care.

A range of projects are currently funded through this Fund.

10.1. AGED CARE WORKFORCE VOCATIONAL EDUCATION AND TRAINING

The Aged Care Workforce Vocational Education and Training (ACWVET) project provides funds to Registered Training Organisations (RTOs) to deliver relevant qualifications to personal care workers and enrolled nurses working in aged care. ACWVET provides qualifications including entry-level aged care certificates, short courses, skill-sets, through to professional development and Diplomas in Enrolled Nursing. Current Registered Training Organisation ACWVET funding agreements were due to expire on 30 June 2015, but have been extended to 31 March 2016.

Organisations delivering this training have reported that funded skill-sets and short courses, such as the Medication Management skill-set, are popular amongst Commonwealth approved aged care providers.

The Department also funded RTOs to deliver short courses as well as targeted skill-set training to aged care workers. Palliative and dementia care are among the specifically targeted areas of need. Between 2010–11 and 2014–15, the Department funded approximately 15,000 ACWVET certificate level places and 1,400 Diploma of Enrolled Nursing places.

10.2. DEMENTIA CARE ESSENTIALS

The Dementia Care Essentials measure provides funding for the delivery of dementia-specific units of competency to aged care workers across all states and territories, including nurses and ancillary staff employed in aged care homes. In 2014–15, funding was provided to support 5,899 training places for aged care workers to enhance dementia care skills. The project has since been extended to 31 March 2016. Current agreements will continue until that time.

10.3. AGED CARE EDUCATION AND TRAINING INCENTIVES

The Aged Care Education and Training Incentives (ACETI) programme, which began in 2010, continues to provide financial support for aged care workers to undertake training to improve their skills and build a career in aged care. In 2014–15, 12,282 payments were made to the value of $9.827 million.

In the 2015–16 Budget, the ACETI programme was extended for nine months until 31 March 2016.

10.4. AGED CARE NURSING SCHOLARSHIPS

The Aged Care Nursing Scholarships (ACNS) project provides financial support to eligible aged care workers to undertake nursing studies at a university or to attend continuing professional development activities. Scholarships are provided for undergraduate, postgraduate (including continuing professional development and nurse re-entry) and nurse practitioner courses. The Royal Australian College of Nursing administers these scholarships on behalf of the Department. Since July 2011, 2,183 aged care nursing scholarships have been offered. The final scholarships funded under this programme were offered in 2014–15.

10.5. NURSE PRACTITIONER AGED CARE MODELS OF PRACTICE INITIATIVE

The nurse practitioner aged care models of practice initiative, which was established in 2010–11, funded 31 organisations to deliver 32 projects through to June 2014. This initiative aims to identify appropriate models of practice and promote access to nurse practitioner services in aged care. A national evaluation was undertaken in early 2015. This evaluation is currently being considered by the Department.

10.6. TEACHING AND RESEARCH AGED CARE SERVICES

Teaching and research aged care services (TRACS) are aged care services that combine teaching, research and care provision, in the one location, to create a learning environment for aged care students and employers. Sixteen projects were funded from 2012–13, with universities and aged care providers equally represented amongst the successful organisations.

The funded projects collectively support training and professional development in a range of disciplines, including nursing, psychology, medicine, physiotherapy and occupational therapy. Under this measure, seed funding was provided to help establish and test a number of sustainable TRACS models and share the lessons learnt in establishing these models with the wider industry to inform future developments.

These projects have progressed well. The findings from the ongoing formative evaluation are being disseminated to the wider sector by the national evaluator, the Australian Workplace Innovation and Social Research Centre. The project ceased in December 2014, and the evaluation report was received in mid–2015. This evaluation is currently being considered by the Department.

10.7. ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

In 2014–15, the Department continued to build and support the five Indigenous Employment Initiatives which provide over 750 permanent part-time positions for Aboriginal and Torres Strait Islander people in aged care services nationally. Funding for these positions includes award wages, superannuation and leave entitlements. The current Indigenous Employment Initiatives will continue until 30 June 2017.

In 2014–15, funding was provided for two training projects, the Northern Territory Aged Care Training Project, and the Rural and Remote Aged Care Training Project. These projects provide culturally appropriate models of accredited training to Aboriginal and Torres Strait Islander aged care workers on-site within eligible communities, and provide workforce support for the Indigenous Employment Initiatives.

Under these programmes, approximately 130 rural and remote Aboriginal communities in the Northern Territory, Queensland, Western Australia and South Australia are currently receiving training. At any one time more than 1,000 students are enrolled across the two projects, with access to training made available to community members to potentially progress into careers in aged care. Both training programmes have been extended to 31 March 2016, with current agreements continuing until that time.

In 2014–15, the Department also provided 50 business and management traineeships to Aboriginal and Torres Strait Islander people under the Indigenous Remote Service Delivery Traineeships programme. These traineeships are available in remote and Aboriginal and Torres Strait Islander aged care and primary health care services and provide a range of training from certificate level to advanced diploma courses. This programme has been extended until 30 September 2016.

10.8. STOCKTAKE AND ANALYSIS OF COMMONWEALTH-FUNDED AGED CARE WORKFORCE ACTIVITIES

In 2014–15, the Australian Government undertook a stocktake and analysis of Commonwealth-funded aged care workforce activities implemented over a three year period from 2011–12 to 2013–14. Future priorities for the aged care workforce will be informed by the stocktake as well as ongoing sector consultations.

10.9. AGED CARE WORKFORCE DEVELOPMENT FUND

In the 2015–16 Budget, the Australian Government announced that it will redirect more than $220 million over the four years to 2018–19 to establish a new Aged Care Workforce Development Fund (the Fund), which replaces the current Aged Care Workforce Fund from 1 January 2016.

Priorities for the Fund will be informed by the stocktake. Activities to be supported through the Fund will include training and up-skilling to better meet the needs of the aged care workforce. The Fund will also provide specific workforce initiatives targeting Aboriginal and Torres Strait Islander people.

CHAPTER 11

11. AGEING AND SERVICE IMPROVEMENT

In 2014–15, support for aged care services and promoting healthy and active ageing was funded through the Aged Care Service Improvement and Healthy Ageing Grants Fund (ACSIHAG).

ACSIHAG's primary objective was to strengthen the capacity of the health and aged care sectors to deliver high quality aged care, and to promote healthy ageing by targeting the following six priority areas:

- promote healthy and active ageing;
- respond to existing and emerging challenges, including dementia care;
- build the capacity of aged care services to deliver high quality care;
- provide information and support to assist carers maintain their caring role;
- services providing aged care to Aboriginal and Torres Strait Islander people and people living in remote areas; and
- support for older people with diverse needs.

Under the 2014 funding round, $34.3 million was awarded to 54 organisations to deliver 64 time-limited, innovative projects to help strengthen the capacity of Australia's aged care system.

11.1. ENCOURAGING BETTER PRACTICE IN AGED CARE

The *Encouraging Better Practice in Aged Care* (EBPAC) initiative (2007–2015) aimed to:

- encourage and support the uptake of evidence-based, person-centred, better practice in Australian Government subsidised aged care services; and
- increase access and build the capacity of aged care services to deliver high quality, appropriate services and promote healthy ageing.

While there are a number of existing evidence-based guidelines to assist aged care staff in providing appropriate care for residents and people in the community, it is recognised that there is a need to establish strategies to translate the evidence into everyday practice.

EBPAC projects focussed on identifying and implementing evidence-based practice that improved clinical and personal care in residential aged care. The projects identified the following key areas of practice:

- leadership;
- social engagement and physical activity;
- emotional wellbeing; and
- person-centred dementia support;
- oral health; and
- wound management.

It also investigated a model of sustainable cultural change in residential aged care.

The University of Wollongong undertook a targeted evaluation to identify critical success factors to inform future national roll-out or wider dissemination of evidence-based materials/resources from the successful projects. This evaluation is currently being considered by the Department.

11.2. MEDICARE LOCALS AND PRIMARY HEALTH NETWORKS

The Department funds nine aged care trial sites under the *Better Health Care Connections: Aged Care Multidisciplinary Care Coordination and Advisory Services Programme*. Each project includes a dedicated Aged Care Coordinator who provides care coordination to assist aged care clients to access a range of healthcare services, a pilot assisting general practitioners to provide consultations by videoconference for clients in participating residential aged care facilities. The pilot aims to:

- reduce avoidable hospitalisations and emergency department presentations;
- improve the health outcomes for people with chronic conditions; and
- improve overall health outcomes for older Australians.

Feros Care, an approved provider of aged care, is funded in one of the trial sites and Medicare Locals were funded in the remaining trial sites across Australia.

As part of the 2014–15 Budget the Government announced that Primary Health Networks (PHNs) would replace the existing Medicare Locals from 1 July 2015. A separate project which commenced under Medicare Locals and is currently being trialled by the PHNs is the Better Health Care Connections Aged Care Multidisciplinary Care Coordination and Advisory Services Programme. In this trial, the Department is working with eight PHNs to trial multidisciplinary approaches, including GP videoconferencing, and strengthening the interface with aged care, and primary and acute care. The intended programme outcomes will continue to be measured over the remaining two years.

The initial findings from the pilot are currently being considered by the Department.

11.3. SUPPORT FOR PEOPLE WITH DEMENTIA

The Australian Government provides funding for a range of services to build the capacity of aged care services to deliver high quality care to people with dementia, including:

- Dementia Behaviour Management Advisory Services (DBMAS);
- Dementia Training Study Centres (DTSC);
- Dementia Care Essentials;
- National Dementia Support Programme;
- Improving acute care services for people with dementia; and
- Timely diagnosis of people with dementia.

The DBMAS provide clinical interventions to assist aged care workers, health professionals and family carers improve their care of people with dementia. The DBMAS will also be the primary point of referral to the SBRTs, (see below).

Dementia workforce training and education is provided through the Dementia Training Study Centres and Dementia Care Essentials programmes.

Through the National Dementia Support Programme, awareness raising, and support services are provided for people living with dementia, their families, carers, and health professionals.

The Improving Acute Care Services for People with Dementia programme funds a number of scoping and pilot projects aimed at developing and trialling better coordination and support systems to enable safe and appropriate hospital services for people with dementia.

The Timely Diagnosis of Dementia in Primary Care programme funds a number of scoping and pilot projects which support General Practitioners to make a more timely diagnosis of dementia.

All of these programmes are funded through ACSIHAG, with the exception of Dementia Care Essentials which is funded through the Aged Care Workforce Development Fund.

11.4. SEVERE BEHAVIOUR RESPONSE TEAMS

The SBRTs measure was announced on 4 February 2015 with the Government investing $54.5 million over four years. This includes $12.67 million allocated for the first phase commencing in 2015–16.

SBRTs will be a mobile workforce of multidisciplinary teams of clinical experts who will provide timely and expert advice to Commonwealth funded residential aged care providers that request assistance with addressing the needs of people with the most severe behavioural and psychological symptoms of dementia. SBRTs are a new top tier to Dementia Behaviour Management Advisory Services for specialist dementia advice and assistance for aged care providers in 2015–16.

An open competitive grant funding round for providers of the SBRT Programme opened on 4 June 2015. The national SBRT programme commenced in November 2015.

11.5. ANALYSIS OF DEMENTIA PROGRAMMES

On 4 February 2015, the Minister announced that the Government would conduct an analysis of Dementia Programmes to optimise the national coordination, integration and effectiveness of dementia support programmes funded by the Department of Social Services.

The scope of the analysis reflects the objectives of the first Ministerial Dementia Forum, which were to consider strategies within existing Department of Social Services dementia programme funding to improve the adoption of better practice dementia care and support. The outcomes from the analysis will help inform future policy direction and programme design.

The analysis report is available on the Department of Social Services website[26], and is currently being considered by Government.

[26] Analysis of Dementia Programmes funded by the Department of Social Services - Final report, https://www.dss.gov.au/ageing-and-aged-care/older-people-their-families-and-carers/dementia/analysis-of-dementia-programmes-funded-by-the-department-of-social-services-final-report

11.6. DEMENTIA AND AGED CARE SERVICE FUND

As announced in the 2015–16 Budget, the Australian Government will redirect more than $365.8 million over four years to establish the Dementia and Aged Care Services (DACS) Fund. The new fund will replace the current Aged Care Service Improvement and Healthy Ageing Grants (ACSIHAG) Fund resulting in savings of $20.1 million over four years.

The DACS Fund will provide programmes that promote high quality and more appropriate care to older people with dementia. Funding will also be provided to support specific measures for Indigenous Australians and ensure people from diverse backgrounds receive the same quality of care as other older Australians.

Programme guidelines outlining how funding will be delivered will be finalised later in 2015.

Key stakeholders, including the CALD and LGBTI Strategy Working Groups, the Aged Care Sector Committee, and the National Aged Care Alliance, will be consulted on this measure.

CHAPTER 12

12. REGULATION AND COMPLIANCE

Australians expect high standards of care and accommodation in aged care services. The Government's approach to quality and regulation emphasises providers' responsibility for providing, maintaining and improving services.

The Government regulates the quality of aged care service by controlling who is able to provide aged care services and the number and location of places to manage unmet needs and ensure equitable access.

Once funded to deliver aged care services, the provider must continue to meet legislative and funding agreements or contract responsibilities, including:

- participating in regular assessments against quality standards by the Australian Aged Care Quality Agency (Quality Agency);
- retaining accreditation if a residential home; and
- mandatory reporting requirements.

If a provider is not meeting its obligations under the Act or contract, the Department may take regulatory action. This action is aimed at protecting current and future care recipients' health, welfare and interests as well as returning the provider to compliance.

12.1. APPROVED PROVIDER REGULATION

To receive Australian Government subsidies under the *Aged Care Act 1997* for providing aged care, an aged care service must be operated by an organisation that has been approved under the provisions of the Act, and hold an allocation of places in respect of care recipients occupying those places in a service. In 2014–15, the Department received 135 applications from entities seeking approval as providers. Of the assessed applications 65 per cent were approved. At 30 June 2015, there were 1,237 operational approved providers of residential and home care services (excluding providers of flexible aged care services).

An approved provider and the provider's key personnel must continue to be suitable under the legislative provisions. One of the obligations of an approved provider is to notify any changes in key personnel within 28 days. In 2014–15, approved providers notified 7,087 changes.

Approved providers of Australian Government funded aged care must comply with the legislative obligations as set out in the Act and the *Quality Agency Principles 2013*. The Department monitors compliance by approved providers with their responsibilities and, should the approved provider cease to be suitable, the Department is required to revoke approved provider status under the provisions set out in the Act.

Section 10-3 of the Act allows the Department to revoke an approved provider's approval when they are no longer suitable to provide care. In 2014–15, no approvals were revoked.

12.2. QUALITY AGENCY

The Quality Agency is an independent statutory agency responsible for quality monitoring of aged care providers subsidised or under contract to Commonwealth. The Quality Agency's responsibilities include:

- conducting quality reviews of community care services (home care packages, the National Respite for Carers Programme (NRCP) and Commonwealth HACC services) and services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme;
- managing the accreditation of aged care homes, including undertaking review audits, and assessment contacts, including unannounced visits;
- promoting innovation in quality management and continuous improvement and providing information, education and training to industry; and
- liaising with the Department about aged care services that do not comply with the quality standards.

Quality reviews and accreditation processes are undertaken in accordance with the Quality Agency Principles established under the *Australian Aged Care Quality Agency Act 2013*.

12.3. COMMUNITY AGED CARE

Providers of home care packages, NRCP and Commonwealth HACC services must meet the Home Care Standards that set expectations for effective management, access and service delivery, and service user rights and responsibilities. A quality review is conducted by the Quality Agency at least once during a three year cycle to assess and monitor services' performance. In 2014–15, quality reviews were conducted on 389 out of a total of 1,104 (35 per cent) home care and NRCP outlets[27]. Quality reviews were conducted on a total of 289 Commonwealth HACC services.

12.4. NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER FLEXIBLE AGED CARE PROGRAMME QUALITY FRAMEWORK

Services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Programme must meet culturally appropriate standards that set expectations for care delivery, information, governance, management and accountability. A quality review is conducted by the Quality Agency at least once every two years to assess and monitor services' performance. Of the 31 services operating during 2014–15, 17 quality reviews were conducted.

[27] Quality reviews of home care and NRCP services are undertaken at the service outlet level.

12.5. RESIDENTIAL CARE ACCREDITATION

Accreditation

The Act requires aged care homes to be accredited in order to receive Australian Government subsidies. The accreditation process managed by the Quality Agency assesses the performance of homes against the 44 expected outcomes of the four Accreditation Standards:

- management systems, staffing and organisational development;
- health and personal care;
- resident lifestyle; and
- physical environment and safe systems.

As part of the re-accreditation process, the Quality Agency undertakes:

- a site audit usually conduced every three years; and
- an unannounced assessment contact each year.

An assessment contact is a visit by aged care quality assessors to an aged care home for the purpose of assessing performance against the Accreditation Standards. Assessment contacts may involve an overview of the home's performance against all the Accreditation Standards, may be focused on certain aspects of care or services, or cover one or more of the 'assessment modules'. In particular, any matters previously identified as requiring improvement will be reviewed. Assessment contacts are usually conducted over a full day by a team of assessors.

In 2014–15, 1,425 re-accreditation site audits were undertaken and all homes received one unannounced visit.

As at 30 June 2015, 2,597 of the 2,682 accredited homes (96.8 per cent) were accredited for three or five years[28].

Responding to risks

In addition to the unannounced visit undertaken as part of accreditation, the Quality Agency also undertakes unannounced assessment contacts and review audits in response to identified risk, including from referrals from the Department. There were a total of 2,888 unannounced visits (including the one unannounced visit per home undertaken as part of the accreditation process) comprising 2,878 unannounced assessment contacts and ten unannounced review audits.

Review audits occur when there are concerns about a home's performance against the Accreditation Standards. A review audit is an assessment of the quality of care provided by a home against all 44 expected outcomes of the Accreditation Standards. Review audits are carried out on-site by an assessment team made up of at least two quality assessors and generally take two to four days. During 2014–15, the Quality Agency undertook 23 review audits, of which 10 were unannounced.

[28] A total of 47 homes (46 homes in South Australia and one home in the Northern Territory) were accredited for five years. These homes belong to the ten providers who participated in the South Australia Innovation Hub (Hub) 12 month trial which commenced on 10 October 2014. Hub providers who met performance criteria for participation in the Hub were granted an extended period of accreditation of up to five years following a decision to re-accredit each service.

During 2014–15, the Quality Agency identified 78 homes (2.9 per cent) as not having met one or more of the 44 expected outcomes of the Accreditation Standards. Homes found to have not met the Accreditation Standards were placed on a timetable for improvement, providing them with an opportunity to meet the Accreditation Standards.

During 2014–15, 24 review audit decisions were made, as follows:

- 15 homes were the subject of a decision not to revoke or vary the period of accreditation;
- nine homes were the subject of a decision to vary accreditation; and
- no requests for reconsideration on review audit decisions.

Information about a home's accreditation status, including copies of the most recent accreditation and review audit reports, is published on the Quality Agency's website[29]. The Quality Agency's annual report provides further details about its operations.

12.6. RESIDENTIAL CARE CERTIFICATION, PRIVACY AND SPACE REQUIREMENTS

Prior to 17 October 2015 residential aged care buildings were assessed against the Department's Certification Assessment Instrument, which was based on the Building Code of Australia. The requirements of the Instrument did not override the building regulations within each state and territory. Through the Building Code, the state and territory building regulations set the minimum community standard for safety, health and amenity of buildings.

On 17 October 2014, as part of the *Omnibus Repeal Day (Autumn 2014) Act*, certification was removed from the Act. This means that providers do not need to apply to the Department for certification in respect of new services and there is no provision for a review of certification for existing services. Further, certification is no longer relevant for eligibility for supplements and the ability to charge accommodation payments. The Accreditation Standards still require that residential aged care services comply with all relevant Commonwealth, state or territory regulations and requirements, including building, privacy and space, fire, and work, health and safety regulations.

12.7. INDUSTRY EDUCATION AND LEARNING

During 2014–15, the Quality Agency conducted industry education and learning activities including:

- Better Practice conferences, attended by a total of 1,567 delegates;
- a series of other educational activities, seminars and courses were attended by 1,846 participants, about *Making the most of complaints, Foundations for managing risk*, and *Information systems – keys to delivering quality care*;
- Quality Education on the Standards (QUEST) sessions, delivered to 8,863 aged care staff, in topics including privacy and dignity, accreditation overview, assessing the Standards, accreditation for consumers - your role in aged care, continuous improvement for residential aged care, turning data into results and using resident feedback; and
- various presentations at industry conferences made by Quality Agency executives.

[29] Australian Aged Care Quality Agency, http://www.aacqa.gov.au

The Quality Agency has developed an e-learning strategy for aged care managers and staff to have improved access to its industry education programmes.

Details of other activities undertaken by the Department to build the capacity of aged care services to deliver high quality care are provided in Chapter 10.

12.8. COMPLIANCE/SANCTIONS

Approved providers of Australian Government subsidised aged care services must comply with responsibilities specified in the Act and the Aged Care Principles. These responsibilities encompass quality of care, user rights, accountability and allocation of places. The responsibilities of approved providers are set out in Appendix C.

The accreditation system for residential care and the quality reporting system for home care, the Commonwealth Home Support Programme, and the National Aboriginal Torres Strait Islander Flexible Aged Care Programme requires providers to accept responsibility for providing, maintaining and improving service. The regulatory process provides assurance that providers are meeting their responsibilities and where there is non-compliance take appropriate action to return the provider to compliance.

Both the Quality Agency and the Department have a role in monitoring aged care services. In broad terms, the Quality Agency manages the accreditation process and assesses performance against the Accreditation Standards for residential care, assessing performance against the Home Care Standards for home care, and Home and Community Care (HACC) providers as well as performance against the National Aboriginal Torres Strait Islander Flexible Aged Care Quality Framework for National Aboriginal Torres Strait Islander Flexible Aged Care Programme providers.

The Department assesses the performance of approved providers against their responsibilities under the Act, taking into account the assessments of the Quality Agency. The Department is also responsible for taking regulatory action when approved providers fail to comply with their responsibilities, including failing to implement improvements required by the Quality Agency or the Department.

12.9. PROTECTING RESIDENTS' SAFETY

Allegations and suspicions of assault

To help protect residents, the Act has compulsory reporting provisions. Services must report suspicions or allegations of assaults to local police and the Department.

This legal requirement ensures that those affected receive timely help and support and that operational and organisational strategies are put in place to prevent the situation from occurring again. Such strategies help maintain a safe and secure environment for residents. The police have the responsibility for substantiating the allegations.

Reportable assaults

A reportable assault is:

- unreasonable use of force on a resident, ranging from deliberate and violent physical attacks on residents to the use of unwarranted physical force;
- unlawful sexual contact, meaning any sexual contact with residents where there has been no consent.

Services make a report based on a suspicion or allegation. This means services must make a report if someone suspects that an assault may have occurred or if someone has witnessed or been informed of a reportable assault.

Unlawful sexual contact

Unlawful sexual contact refers to non-consensual sexual activity involving residents in aged care homes. Reporting requirements under the Act are designed to protect vulnerable residents, not to restrict their sexual freedoms.

When aged care staff first have a suspicion of a reportable assault or become aware of an allegation of a reportable assault, they should report it immediately to the most senior member of staff on duty. Within 24 hours, a service must report the incident to local police and the Department.

There are limited circumstances where the requirement for service providers to report alleged or suspected assaults does not apply. These relate to incidents:

- that have already been reported to police and the Department (for example, where multiple staff members report an assault to the service provider); and
- where the alleged assault was perpetrated by a resident with a previously diagnosed cognitive or mental impairment.

Where the incident involves a resident with a previously diagnosed cognitive or mental impairment, the requirement to report does not apply when the following conditions are met:

- the resident alleged or suspected of committing an assault had a documented clinical assessment of mental or cognitive impairment prior to the alleged assault taking place; and
- the service provider develops, documents and implements strategies to manage the behaviour of the resident within 24 hours of suspecting or receiving an allegation of assault.

In 2014–15, the Department received 2,625 notifications of reportable assaults. Of those, 2,199 were recorded as alleged or suspected unreasonable use of force, 379 as alleged or suspected unlawful sexual contact, and 47 as both. With 231,555 people receiving permanent residential care in 2014–15, the incidence of reports of suspected or alleged assaults was 1.1 per cent.

People can make a report directly to local police or the Department and staff of aged care homes can do so without fear of reprisal from their employer. The Act provides certain protections for service staff who report, in good faith, suspicions or allegations of assault.

Missing residents

A resident is considered missing when they are absent and the service is unaware of any reasons for the absence.

The Department must be informed within 24 hours by service providers about missing residents in circumstances where:

- a resident is absent from a residential care service;
- the absence is unexplained; and
- the absence has been reported to police.

The Department must also be notified where the provider was unaware that a resident was missing and the police returned the resident to the service before the service provider had the opportunity to lodge a report. In 2014–15, there were 1,127 notifications of unexplained absences of care recipients.

Sanctions

In 2014–15, the Department issued two Notices of Decision to Impose Sanctions to two approved providers. On 30 June 2015, none of these sanctions remained in place. Details of sanctions imposed in 2014–15 are included in Appendix D.

In 2014–15, the Department also issued 18 Notices of Non-Compliance against aged care services in relation to quality of care matters and two Notices of NonCompliance were issued in relation to prudential matters.

In all cases of identified non-compliance, the Department assesses the risk to care recipients and determines if regulatory action will be initiated in order to return the approved provider to compliance with its responsibilities. During 2014–15, the main areas of non-compliance related to approved providers not meeting the Accreditation Standards, particularly in relation to Standard 2: Health and personal care.

Compliance/sanction information

Information is available on the My Aged Care website in relation to compliance action taken by the Department against providers of residential aged care. This information is published so that consumers can make informed decisions about their care needs and having these needs met.

The information includes residential aged care services that have been issued a sanction, are currently the subject of a Notice of Non-Compliance or have received a Notice of Non-Compliance in the previous two years.

Compliance action(s) taken by the Department can be found against the service on the My Aged Care website.

The information published about a Notice of Non-Compliance or sanction includes the status of the Notice/sanction (current/archived), the date of issue (a sanction will include the date of expiry), the reason(s) for the Notice/sanction and the outcome of the compliance action. Information is moved to the archived list when either the provider has resolved the non-compliance or has a sanction imposed on it, or the sanction has expired.

Risk management for emergency events

The Act, the Accreditation Standards and the Home Care Standards require that all aged care services have emergency management plans and protocols in place to protect the health, safety and wellbeing of care recipients.

The Department works with the aged care sector, state, territory and local governments and emergency planning authorities to support emergency preparedness of Australian Government subsidised residential aged care homes, and aged care services in the community.

12.10. PRUDENTIAL

On 1 July 2014, the Prudential Standards moved from the *User Rights Principles 1997* (User Rights Principals) to the *Fees and Payments Principles 2014 (No.2)* (Fees and Payments Principles).

Approved providers of residential and flexible aged care services that hold refundable deposits, accommodation bonds and/or entry contributions (refundable accommodation payments) must comply with the prudential requirements stated in the Act and the Fees and Payments Principles. The prudential requirements aim to protect refundable accommodation payment balances paid to approved providers by residents of aged care homes.

Approved providers holding refundable accommodation payment balances must comply with four Prudential Standards: the Liquidity Standard, the Records Standard, the Disclosure Standard, and the Governance Standard. The Prudential Standards seek to reduce the risk that approved providers default on their refundable accommodation payment refund obligations to residents by:

- requiring providers to systematically assess their future obligations with refundable accommodation payments and the associated funding implications to ensure that they are able to meet their refund obligations as they fall due;
- requiring providers to establish and maintain a register that records information about refundable accommodation payments and the residents who pay them;
- requiring providers to establish and document governance arrangements for the management and expenditure of refundable accommodation payments; and
- promoting the transparency of approved providers' management of refundable accommodation payment funds by requiring disclosure to residents, prospective residents, and the Department, of information on the approved provider's prudential compliance and their financial position.

The Prudential Standards require aged care providers that have charged refundable accommodation payments to complete and submit an Annual Prudential Compliance Statement (APCS) within four months of the end of their financial year, disclosing accommodation deposit holdings and compliance with charging, managing and refunding accommodation payments against the prudential requirements. In 2013–14, 1037 approved providers were asked to complete and lodge an APCS by 31 October 2014. The APCS outcomes for 2012–13 and 2013–14 are in Table 36.

Table 36: Annual Prudential Compliance Statement outcomes, 2012–13 and 2013–14[30]

ANNUAL PRUDENTIAL COMPLIANCE STATEMENT REPORTED NONCOMPLIANCE	2012–13	2013–14
Reported instances of non-compliance with the Records Standard	16	5
Reported instances of non-compliance with the Disclosure Standard	28	12
Reported instances of non-compliance with the Liquidity Standard	6	5
Reported instances of non-compliance with the Governance Standard	17	5
Reported instances of non-compliance with refunding responsibilities[31]	64	106

[30] 2014–15 data is unavailable at the time of publication.

[31] 2012–13 figures only reflect reported instances of non-compliance with late refunds. 2013–14 figures include reported instances of non-compliance with late refunds and applicable interest.

The 872 approved providers that held accommodation bonds at 30 June 2014 reported through their APCS that they held 68,656 accommodation bonds and entry contributions with a total bond balance value of almost $15.6 billion. These figures include the bonds held by the four providers that reported on a financial year ending 30 December 2013 (these providers have different reporting requirements and must submit an APCS by 30 April). This is an increase of $2.2 billion in accommodation bonds held on 30 June 2013. The average holding per approved provider that held accommodation bonds was $18 million.

Accommodation Payment Guarantee Scheme

The prudential requirements are supplemented by the Accommodation Payment Guarantee Scheme (Guarantee Scheme) established under the *Aged Care (Accommodation Payment Security) Act 2006.*

In the event that an approved provider becomes insolvent and defaults on the refund of refundable accommodation payments, the Guarantee Scheme enables the Government to refund all refundable accommodation payment balances owed to residents by their approved provider. In return for the payment, the rights that each resident had to recover the amount from their approved provider are transferred to the Commonwealth so it can pursue the approved provider for the funds. The Guarantee Scheme is triggered if the approved provider has been placed into bankruptcy or liquidation and there is at least one outstanding refundable accommodation payment balance. The Secretary must then make and publish a default event declaration in order to enable payments to be made under the scheme.

The Guarantee Scheme was triggered three times in 2013–14; the Department paid almost $8.6 million during the 2014–15 financial year as a result of those triggers. The Guarantee Scheme was not triggered in 2014–15.

Validation of providers' appraisals under the Aged Care Funding Instrument

Approved providers are accountable for the subsidies they receive based on the Aged Care Funding Instrument (ACFI) appraisals for funding classifications they complete to show the assessed care needs of their residents. The Department checks the accuracy of the appraisals to ensure that homes are correctly funded according to the care needs of their residents and that public expenditure is protected.

In 2014–15, 20,587 reviews of funding classifications under the ACFI were completed. Of these reviews, 2,372 (11.5 per cent) resulted in reductions in funding and 190 (one per cent) resulted in increased funding classifications. The Department analysed the cause of the 11.5 per cent funding reductions and found that questions relating to the Activities of Daily Living domain had the highest level of downgrade followed by the Complex Health Care domain. The Department has continued to use its ACFI compliance powers to address cases of significant failures to correctly apply the ACFI.

If an approved provider is dissatisfied with a change to a funding classification made by a Departmental review officer, the provider can request a reconsideration of that decision. Decisions were reconsidered for 214 residents or nine per cent of the 2,372 downgraded classifications involved 313 ACFI question decisions. Of the 214 cases the Department reconsidered, 80 (37 per cent) of Departmental review officer decisions were confirmed. In 103 cases (48 per cent), the original classification by the approved provider was reinstated. New decisions were determined for 31 (14 per cent) of the cases. In the majority of these cases, the decision was changed because the approved provider was able to supply evidence that was unavailable at the time of the review visit.

12.11. QUALITY INDICATORS

The Productivity Commission report, *Caring for Older Australians*, and the Australian National Audit Office report, *Monitoring and Compliance Arrangements Supporting Quality of Care in Residential Aged Care Homes*, recommended the development of quality indicators for aged care.

Quality Indicators are defined measures that relate to the outcomes of care and services. They measure aspects of service provision which contribute to the quality of care and services given by the care providers. Quality indicators will assist consumers to make decisions about their care options and drive continuous improvement.

A pilot of Quality Indicators for residential care commenced in May 2015. The pilot involved two pilot data collections of three clinical indicators (pressure injuries, unplanned weight loss and the use of physical restraint). Work is continuing to identify consumer experience and quality of life measures that can be piloted during 2016. It is expected that the National Aged Care Quality Indicators Programme will commence in 2016. Work has also commenced on identifying Quality Indicators for home care services.

12.12. LOOKING FORWARD

The Australian Government will consult with the aged care sector regarding the establishment of a single quality framework for all aged care services. A single quality framework will deliver a consistent approach to quality across residential care and care at home for consumers while reducing complexity and red tape for providers who deliver both types of care.

The Australian Government will also introduce full cost recovery for accreditation services as a first step in moving towards a private market for these services. Cost recovery arrangements for accreditation services have been in place, in some form, since 1999. This initiative will align charges with the actual cost of providing residential care accreditation services. The changes will improve equity and accountability by ensuring that residential service providers that use Australian Government services bear the associated cost.

Safeguards will be introduced to ensure that the increased cost to providers does not compromise their financial viability. A 50 per cent cost recovery discount will apply to small residential care facilities with fewer than 25 places, as well as those who receive the viability supplement (including homes in rural and remote areas, and services for people who are homeless or at risk of homelessness). Residential care facilities with fewer than 25 places that also receive the viability supplement will not pay anything under the new arrangements.

The Government will work with the aged care sector to develop private market options for the delivery of accreditation services. Competition in accreditation services will help put downward pressure on these costs for providers while improving the overall quality for older Australians.

CHAPTER 13

13. AGED CARE COMPLAINTS SCHEME

The Aged Care Complaints Scheme (the Scheme) seeks to achieve quality outcomes for recipients of aged care services.

The Scheme has facilitated proportionate and timely resolution of complaints since the new options for complaints resolution and risk assessment tools began in September 2011. Early resolution is used, where appropriate, to improve timeliness of resolution for the complainant and the service provider. More complaints are now being resolved through non-investigative techniques.

13.1. OVERVIEW OF CONTACTS WITH THE SCHEME

The Scheme responds to complaints about Australian Government subsidised aged care services such as residential care, home care and the Commonwealth HACC programme. Complaints relating to the Commonwealth Home Support Programme are now also included in the remit of the Scheme.

The Scheme received 10,924 contacts in 2014–15. A total of 7,537 contacts were in-scope for the Scheme, representing 69.0 per cent of all contacts. In 2014–15, a contact was in-scope when it related to an approved provider's responsibilities under the Act or a Commonwealth HACC provider's responsibilities under the Commonwealth HACC Funding Agreement, including complaints, inquiries and notifications.

Of the in-scope contacts, 74.8 per cent were open, that is, the person disclosed their name and contact details to the Scheme.

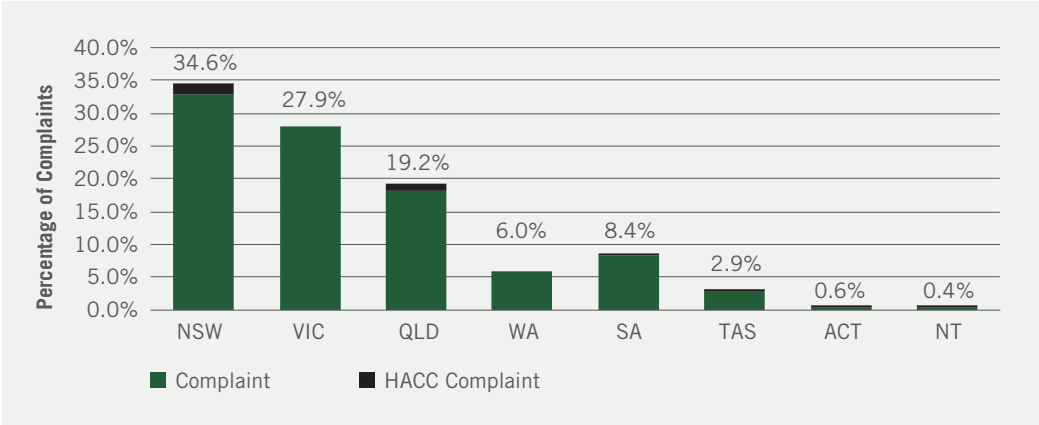
Of the in-scope contacts, 17.6 per cent were from an approved provider, 37.3 per cent were from a representative or family member of a care recipient and 9.2 per cent were from the care recipient themselves. The remainder of contacts were received from external agencies, other areas of the Department or from persons who wished to remain anonymous.

A total of 3,387 contacts were out-of-scope, representing 31 per cent of all contacts. A contact is out-of-scope when it is not related to an approved provider or an approved provider's responsibilities under the Act or a Commonwealth HACC provider's responsibilities under the Commonwealth HACC Funding Agreement. Where possible, the Scheme will provide the person making the contact with information about their options or they may be referred to an appropriate alternative organisation. Examples of out-of-scope contacts include complaints about retirement villages (which are regulated by the states and territories), questions about industrial matters and requests for legal or clinical advice.

Complaints to the Scheme

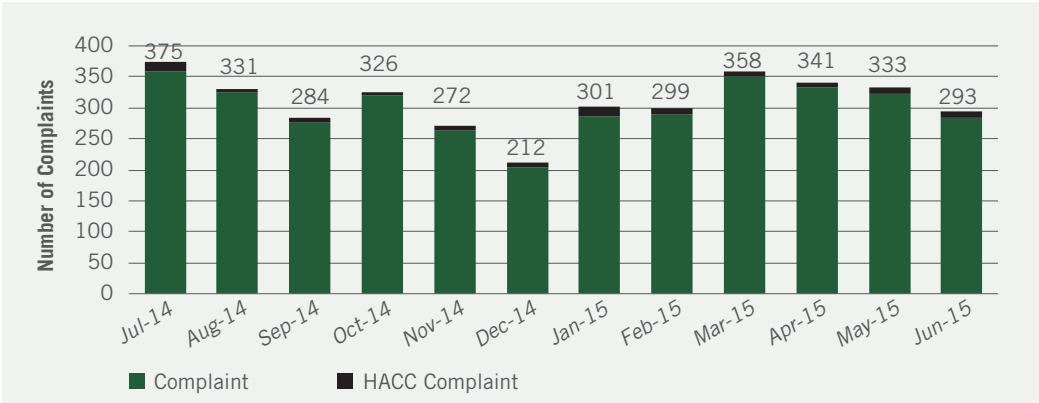
Of the 7,537 in-scope contacts, the Scheme received 3,725 complaints relating to Australian Government subsidised residential care, home care and home support; on average 310 complaints were received each month. A breakdown of national complaints by state and territory can be seen in Figure 4.

Figure 4: Percentage of total national complaints received in 2014–15, by state and territory



The fewest number of complaints were recorded in December 2014, with the highest number of complaints recorded in July 2014 (Figure 5).

Figure 5: Number of complaints received each month in 2014–15



13.2. AVERAGE NUMBER OF COMPLAINTS PER CARE TYPE

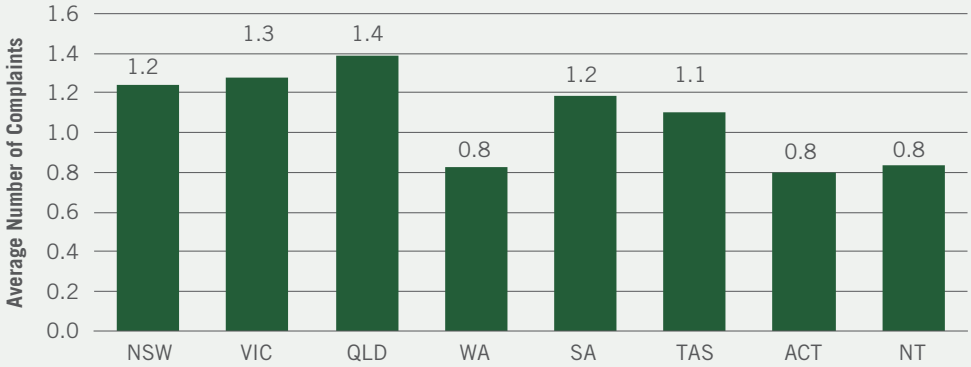
Of the 3,725 complaints received in 2014–15:

- 88.1 per cent (3,281) related to residential aged care services;
- 8.5 per cent (316) related to home care services;
- 2.4 per cent (91) related to Commonwealth HACC services; and
- 1.0 per cent of complaints (37) were not linked to a corresponding care type.

The national average was 1.1 complaints per residential care service (compared with 0.1 complaints per home care service and 0.003 complaints per Commonwealth HACC service) provider. These figures are based on those residential care services that were operational during 2014–15.

State by state, the average number of complaints per residential care service ranged from 0.8 in the Western Australia, Australia Capital Territory and Northern Territory to 1.4 in Queensland (Figure 6). The numbers of complaints for home care services and Commonwealth HACC services are too small to be usefully reported by state and territory.

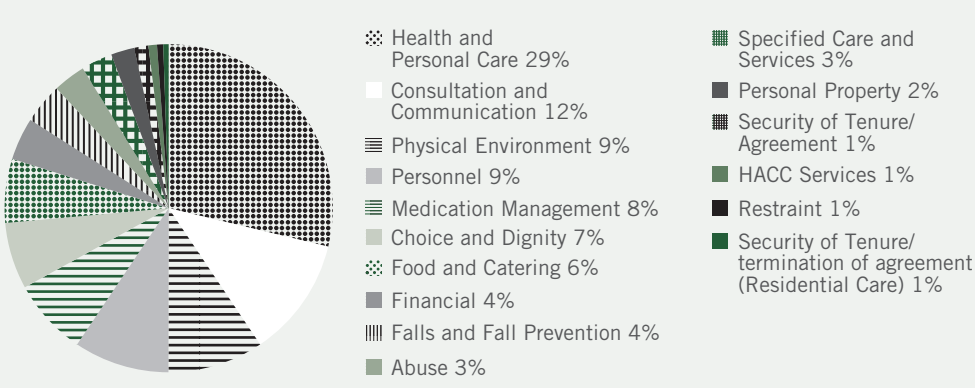
Figure 6: Average number of complaints per residential aged care service in 2014–15, by state and territory



13.3. MOST COMMONLY REPORTED COMPLAINT ISSUES

Complaints examined by the Scheme often incorporate more than one issue. In 2014–15, there were 8,888 individual issues identified within a total of 3,725 complaints. Figure 7 identifies the top five issue keywords identified in complaints to the Scheme in 2014–15.

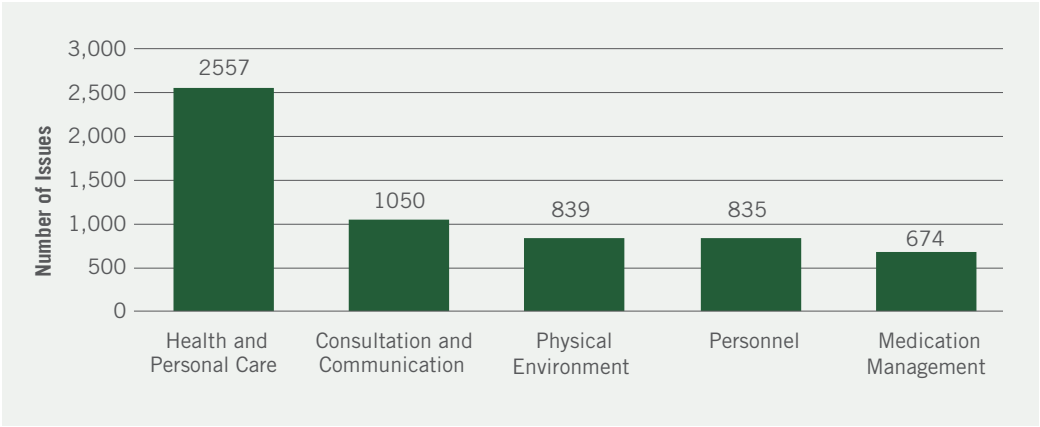
Figure 7: Issues recorded in complaints to the Scheme in 2014–15



The top five (67 per cent) issues were (Figure 8):

1. Health and personal care, including for example, issues associated with infections, infection control, infectious diseases, clinical care, continence management, behaviour management and personal hygiene (28.8 per cent);
2. Consultation and communication, including for example, issues associated with internal complaints process, information, family consultation and failing to advise enduring powers of attorney or guardians (11.8 per cent);
3. Physical environment, including for example, issues associated with call bells, cleaning, equipment, safety and temperature (9.4 per cent);
4. Personnel, including for example, issues associated with number of staff and training/skills/qualifications (9.4 per cent); and
5. Medication management, including for example, issues associated with access and administration (7.6 per cent).

Figure 8: Top five issues recorded in complaints to the Scheme in 2014–15

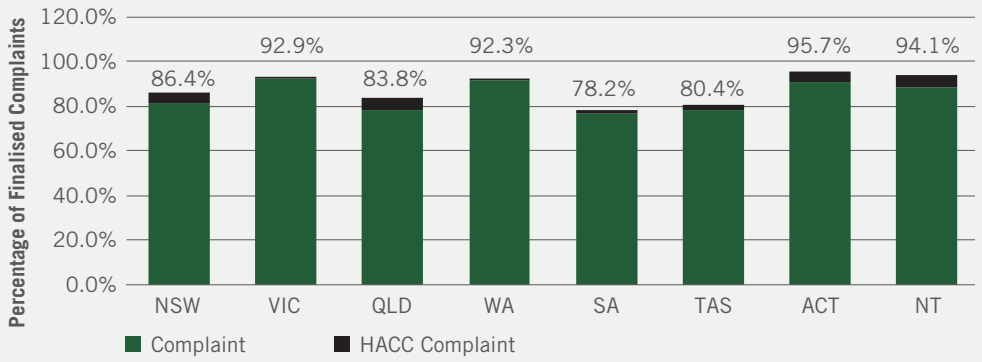


13.4. COMPLAINTS FINALISED

During 2014–15, the Scheme finalised 3,674 complaints, an average of 306 complaints finalised per month, nationally. This number includes some complaints which were received in 2013–14.

The Scheme released its Service Charter to the public in 2011. In this charter, the Scheme committed to resolve complaints within a benchmark timeframe of 90 days wherever possible. In 2014–15, the Scheme resolved 87.3 per cent of complaints within 90 days. A breakdown by state and territory can be seen in Figure 9. On average, cases were resolved within 37 days.

Figure 9: Percentage of complaints finalised in 90 days in 2014–15, by state and territory

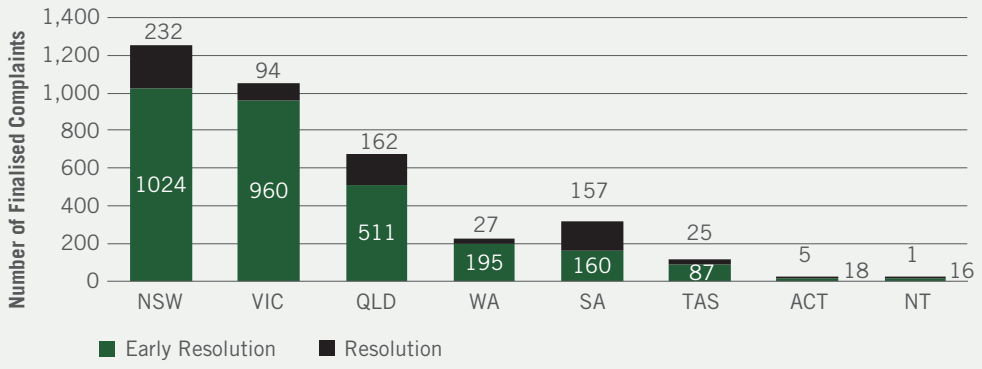


13.5. EARLY RESOLUTION VS. OTHER RESOLUTION APPROACHES

The Scheme aims to resolve concerns as soon as possible to achieve quality and timely outcomes for care recipients. In the Scheme this is known as early resolution. This may involve helping the complainant clarify their issues, assisting communication between complainants and the service provider and providing information.

During 2014–15, 80.9 per cent of complaints were finalised in early resolution, the remaining 19.1 per cent of complaints progressed to the resolution stage of the complaints process. The stages of complaints resolution for each state and territory can be seen in Figure 10.

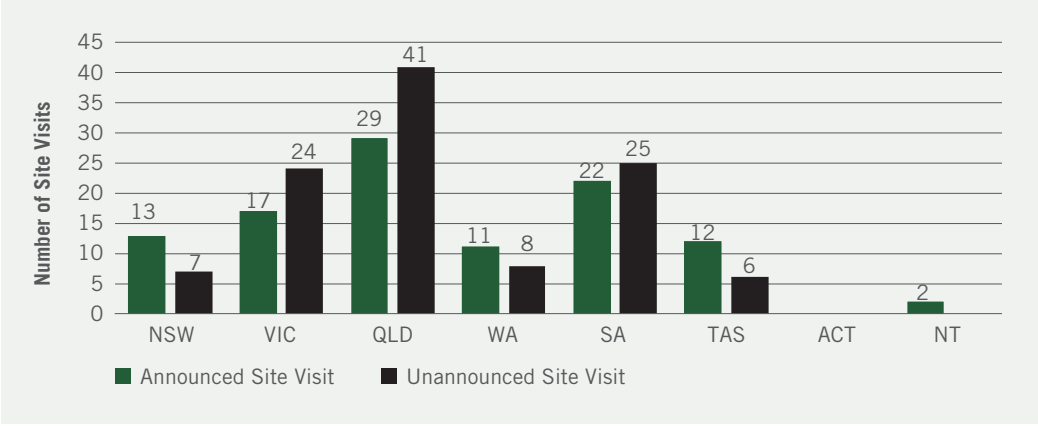
Figure 10: Stage of complaints resolution in 2014–15, by state and territory



13.6. SITE VISITS

Scheme officers may visit either the approved provider's premises or the aged care service during the course of resolving a complaint. Visits may be announced or unannounced depending on the nature of the issue being examined. Officers conducted 217 visits in 2014–15, comprising 106 announced and 111 unannounced site visits. A breakdown of announced and unannounced visits can be seen in Figure 11.

Figure 11: Announced and unannounced site visits conducted by the Scheme in 2014–15, by state and territory



13.7. DIRECTIONS (INCLUDING NOTICES OF INTENTION)

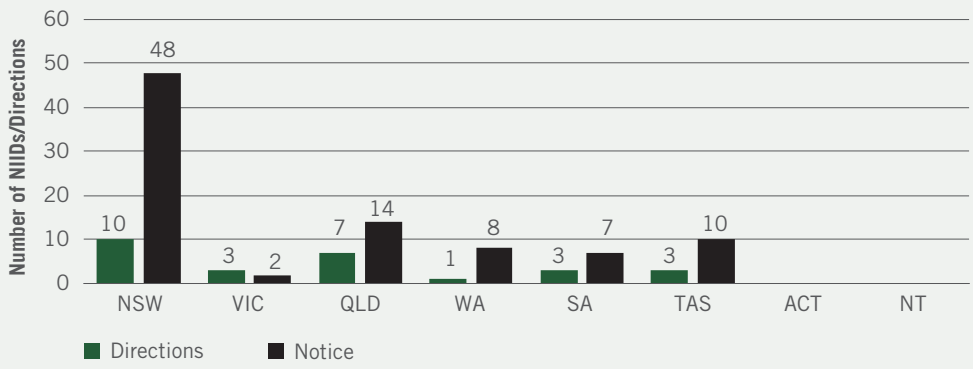
The Department can issue a Direction if it is not satisfied that a service provider is meeting its responsibilities under the Act or its Commonwealth funding agreement, in regards to a complainant's concerns.

A Direction is issued in writing and outlines what the service provider must do, in what timeframes, to address the issues of the complainant and meet its responsibilities.

Before issuing Directions, the Scheme will typically give a provider a Notice of Intention to Issue Directions (NIID). The NIID gives the approved provider the opportunity to demonstrate to the Scheme how they have, or will solve the issues. Depending on the approved provider's response to the NIID, the Scheme may or may not issue Directions.

Figure 12 indicates that in 2014–15, 89 complaints resulted in a NIID being issued. Of these, 11 ultimately resulted in Directions. In addition, there were 16 complaints where the Scheme decided to proceed straight to issuing Directions without a NIID. As a result there were a total of 27 Directions issued in 2014–15.

Figure 12: Notices of Intention to Issue Directions and Directions issued by the Scheme in 2014–15



13.8. REFERRALS TO EXTERNAL ORGANISATIONS

At any time, the Scheme might refer issues to an external agency more appropriately placed to deal with the matters raised. For example, criminal matters are referred to the relevant state or territory police service, while concerns regarding the conduct of a health professional are referred to the relevant health professional regulatory body, such as the Australian Health Practitioner Regulation Agency. Depending on the matters being referred, the Scheme may continue to manage the complaint.

In 2014–15, the Scheme made 827 referrals to external agencies. Of these, 97.8 per cent (809) were made to the Australian Aged Care Quality Agency (Quality Agency).

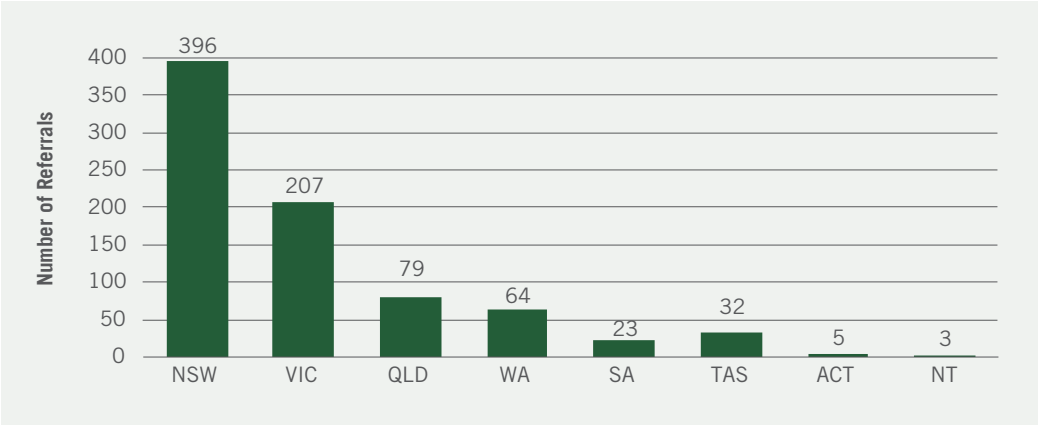
If the Scheme finds a problem that may be related to systemic issues within a residential aged care service, it may refer the matter to the Quality Agency while continuing to examine the original complaint. The Quality Agency will consider this information in its case management of residential aged care services. It may bring forward a visit already scheduled, change the scope of the planned visit or hold the information for the next planned visit.

Of the 809 referrals to the Quality Agency, the Scheme:

- asked the Quality Agency to consider information at the next assessment contact in 83.4 per cent of referrals;
- provided the Quality Agency with information about matters considered to be non-urgent in 6.9 per cent of referrals;
- requested an accreditation assessment contact in 9.3 per cent of referrals; and
- requested the Quality Agency conduct a review audit in 0.4 per cent of referrals.

A breakdown of referrals to the Quality Agency by state and territory is provided in Figure 13 below.

Figure 13: Referrals to the Quality Agency in 2014–15, by state and territory



The remaining 2.2 per cent of external referrals were to other agencies, such as health care complaints commissions, coroners or relevant health professional regulatory bodies.

13.9. INTERNAL RECONSIDERATION

In line with good administrative practice and the *Complaints Principles 2011*, if either party to a complaint is dissatisfied with certain decisions made by the Scheme in the complaints process, they can seek reconsideration of these decisions by the Scheme. During 2014–15, 17 applications were received for internal reconsiderations (Table 37).

Table 37: Applications for internal reconsideration received in 2014–15

STATE/TERRITORY	NSW	Vic.	QLD	WA	SA	Tas.	ACT	NT	TOTAL
Internal Reconsideration	10	3	2	0	1	0	1	0	17

13.10. EXTERNAL REVIEW

The Aged Care Commissioner (the Commissioner) is a statutory office created under the Act. Amongst other functions, the Commissioner has the capacity to conduct a review of decisions made by the Scheme, when service providers or complainants appeal against such decisions. The Commissioner also has the capacity to undertake reviews of Scheme processes at the request of service providers or complainants or on their own initiative.

Reviews of Scheme decisions

The Commissioner completed 21 reviews of the Scheme's decisions representing less than one per cent of finalised complaints.

Of the 21 reviews conducted, seven directions were for the Scheme to undertake a new resolution process (33 per cent) and 14 recommendations were for the Scheme not to undertake a new resolution process (67 per cent). The Scheme completed seven new processes.

Reviews of Scheme processes

The Commissioner provided 18 final reports to the Scheme, resulting from reviews of Scheme processes. As at 30 June 2015, the Scheme had responded to 15 reports. The remaining three reports were received on 30 June 2015 and will be responded to in the 2015–16 financial year.

The Scheme accepted 21 of the 23 recommendations made by the Commissioner. The remaining two recommendations will be responded to in the 2015–16 financial year.

Recommendations arising from these reviews were used to refine and improve the Scheme and its processes.

Whilst the Commissioner can examine complaints made to her about Scheme processes, she can also decide to initiate her own review of Scheme processes.

In addition to investigating individual complaints, under 95A-1(c) of the Act, the Commissioner may investigate Scheme or Quality Agency process matters within her jurisdiction on her own initiative. The 'own initiative' power allows the Commissioner to act on concerns such as those arising from trends identified by her Office, media reports or information provided or requested by the Minister. The Commissioner finalised one 'own initiative' review during 2014–15.

13.11. INDEPENDENT COMPLAINTS SCHEME FROM 1 JANUARY 2016

As announced in the 2015–16 Budget, the Australian Government will increase the independence of aged care complaints handling arrangements by transferring the complaints powers of the Secretary of the Department to the existing Aged Care Commissioner from 1 January 2016.

The changes improve the confidence in aged care complaints handling processes by separating the role of complaints management from the funding and regulation of aged care services. The Department will retain policy and compliance functions, and the Quality Agency will continue to manage the accreditation system.

The independence of the complaints scheme was recommended in the 2009 Walton Review, and the Productivity Commission's 2011 *Caring for Older Australians* report.

APPENDICES

APPENDIX A: AGED CARE LEGISLATION

LEGISLATIVE FRAMEWORK FOR AGED CARE

The *Aged Care Act 1997* (the Act) and delegated legislation – Aged Care Principles and Determinations – provide the regulatory framework for Australian Government funded aged care providers, and provide protection for aged care recipients.

The legislative framework sets out the requirements to be an approved provider of Australian Government funded aged care, for the allocation of aged care places, the approval and classification of care recipients, the accreditation of services, and the subsidies paid by the Australian Government. The framework also sets out the responsibilities of providers in relation to aged care quality and compliance.

Aged Care Principles

Aged Care Principles are made under subsection 96-1 (1) of the Act. The Act enables the Minister to make Principles that are required or permitted under the Act, or that the Minister considers necessary or convenient to carry out or give effect to a Part or section of the Act.

There are currently 16 sets of Principles made under the Act. In addition, the *Aged Care (Transitional Provisions) Principles 2014* was made under the *Aged Care (Transitional Provisions) Act 1997*. These Principles may be amended at any time.

Table 38: Principles made under the *Aged Care Act 1997*

PRINCIPLES	PURPOSE / DESCRIPTION OF PRINCIPLE
Accountability Principles 2014	These principles describe the arrangements for access to residential aged care services and home care services by the CEO of the Quality Agency, quality assessors for residential care and quality reviewers for home care and the Aged Care Commissioner, the responsibilities of an approved provider in giving certain information to the Secretary or the Minister, the responsibilities of approved providers in relation to financial reporting, the responsibility of an approved provider to participate in the aged care workforce census, the responsibilities of an approved provider in relation to staff members and volunteers requiring police certificates, and the circumstances in which the requirement to report allegations or suspicions of reportable assaults does not apply.
Aged Care (Transitional Provisions) Principles 2014	These principles only describe matters relating to residential care subsidy, home care subsidy and payments for entry to residential care for care recipients who are continuing care recipients.
Allocation Principles 2014	These principles describe matters relating to planning for the location and distribution of aged care places, the allocation process and assessment of applications, the transfer of places, variations of conditions of allocation and the relinquishment of places and the revocation of unused allocations.
Approval of Care Recipients Principles 2014	These principles deal with eligibility requirements for a person to receive residential, home or flexible care, the circumstances in which approvals of a care recipient for one or more types of aged care may be limited, when an approval to receive care will come into effect, the lapsing of approvals, and transitional arrangements to ensure the appropriate treatment of care recipients who commenced receiving residential care before 1 July 2014 but who did not receive an approval until after 1 July 2014.
Approved Provider Principles 2014	These principles describe the matters that the Secretary must consider (or have regard to) in deciding whether a person who has applied to be approved as a provider of aged care is suitable to provide aged care. The principles also describe the circumstances in which the Secretary may specify a shorter period of time in which an applicant may give further information in support of an application to become an approved provider.

PRINCIPLES	PURPOSE / DESCRIPTION OF PRINCIPLE
Classification Principles 2014	These principles deal with the classification of care recipients, specifically the procedures for determining classification levels for care recipients receiving residential care or residential care provided as respite care, care recipients that do not require classification (care recipients in a Multi-Purpose Service), the classification levels for care recipients being provided with residential care or respite care, appraisals of the level of care needed for care recipients, how if an approved provider has been suspended from undertaking appraisals the provider may make an application for the lifting of the suspension, and the date of effect, expiry and renewal of classifications.
Committee Principles 2014	These principles describe the functions, constitution and certain operational arrangements for the Aged Care Financing Authority.
Complaints Principles 2014	These principles describe a scheme for the management and resolution of complaints and other concerns about aged care services provided by approved providers.
Extra Service Principles 2014	These principles describe the criteria that needs to be met for a grant of extra service status, describe some of the conditions of a grant of extra service status including the matters that the Secretary must take into account if varying the conditions of a grant of extra service status and describe matters relating to the content of extra service agreements including provisions that must be included in extra service agreements between an approved provider and a care recipient.
Fees and Payments Principles 2014 (No. 2)	These principles outline the arrangements for fees for both home care and residential care services (for care recipients who enter care on or after 1 July 2014), the requirements in relation to accommodation payments, whether they are made as a daily accommodation payment or a refundable accommodation deposit, the requirements in relation to accommodation contributions whether they are made as a daily accommodation contribution or a refundable accommodation contribution, the rules around refunds of refundable deposits (including accommodation bonds), and the prudential obligations of providers holding accommodation bonds or refundable deposits.
Grants Principles 2014	These principles provide for residential care grants, the criteria for allocations, the criteria for determining priority between allocations, and the means for working out the amount to be allocated. For advocacy grants, the criteria to be used by the Secretary for deciding whether to make a grant and the way that applicants must be notified of a decision on an application for an advocacy grant. For community visitors grants, the bodies eligible to apply for a community visitors grant, the criteria to be used by the Secretary in deciding whether to make a grant, the way that applicants must be notified of a decision on an application for a community visitors grant, and the conditions of community visitors grants.

PRINCIPLES	PURPOSE / DESCRIPTION OF PRINCIPLE
Information Principles 2014	These principles specify the people to whom the Secretary may disclose protected information and for what purposes the information can be disclosed.
Quality of Care Principles 2014	These principles set out the responsibilities of approved providers in providing care and services for residential and home care. The principles specify the care and services that an approved provider of residential care is to provide, set out the Accreditation Standards that must be met by a residential care service to achieve accreditation, specify the care and services that an approved provider of home care is to provide, and set out the Home Care Standards that a home care provider is expected to meet as a part of quality review.
Quality of Care Reporting Principles 2013	These principles provide for the reporting requirements for the Australian Aged Care Quality Agency.
Records Principles 2014	These principles specify the records that must be kept and retained by approved providers. This includes records relating to care recipients, records about allegations or suspicions of reportable assaults and records about the police certificates of staff members and volunteers.
Sanctions Principles 2014	These principles specify steps that an approved provider must take to ensure that none of its key personnel is a disqualified individual, specify requirements in relation to the appointment of advisers and administrators to assist approved providers to comply with their responsibilities in relation to sanctions, and specify the matters to which the Secretary must have regard in deciding on the length of a sanction period where a sanction has been imposed on an approved provider for non-compliance with its responsibilities.
Subsidy Principles 2014	These principles deal with the eligibility requirements for the payment of subsidies and supplements in respect of care recipients in residential care and home care, the reductions to subsidy that may be made for care recipients in residential or home care, and eligibility for flexible care subsidy and the basis on which flexible care subsidy is paid.
User Rights Principles 2014	These principles set out the responsibilities of approved providers in providing residential or home care services. The principles deal with security of tenure for care recipients, access for persons acting for care recipients, and the information the provider must give care recipients in particular situations. The principles also describe the rights and responsibilities of recipients of both residential care and home care and the requirements for all home care packages to be delivered on a Consumer Directed Care basis from 1 July 2015.

Aged Care Determinations

The Act provides for the regulation and funding of aged care services. Persons who are approved under the Act to provide residential, community or flexible care services (approved providers) can be eligible to receive subsidy payments in respect of the care they provide to approved care recipients.

Chapter 3 of the Act empowers the Minister to determine, in writing (by legislative instruments or 'Determinations'), the daily amounts of residential care, home care and flexible care subsidies that are payable to aged care providers. Accommodation-related supplements and charges are indexed on 20 March and 20 September each year, in line with the Government's pension indexation arrangements. Other care-related subsidies and supplements are indexed annually in July each year.

The Act empowers the Minister and/or the Secretary to determine the amount of Australian Government subsidies as well as matters including the conditions on the allocation of aged care places.

APPENDIX B: LEGISLATIVE AMENDMENTS MADE IN THE REPORTING PERIOD

AMENDMENTS TO AGED CARE LEGISLATION

The following table lists changes to the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997* that were made and came into effect during 2014–15.

Table 39: Legislative Amendments

AMENDMENTS TO THE AGED CARE ACT	DESCRIPTION OF AMENDMENT
Omnibus Repeal Day (Autumn 2014) Act	17 October 2014 This Act amended the *Aged Care Act 1997* by repealing references to certification from the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*.
Aged Care and Other Legislation Amendment Act 2014	9 December 2014 This Act amended the *Aged Care Act 1997* to remove the workforce supplement from the list of primary supplements provided for by the *Subsidy Principles* and the *Aged Care (Transitional Provisions) Act 1997* to make consequential amendments.
Norfolk Island Legislation Amendment Act 2015	28 May 2015 This Act made amendments to ensure Norfolk Island is included in and subject to the *Aged Care Act 1997.*

AMENDMENTS TO AGED CARE PRINCIPLES

The following table lists changes to the Aged Care Principles that were made and came into effect in 2014–15.

Table 40: Amendments to Aged Care Principles

AMENDMENTS TO THE AGED CARE PRINCIPLES	DESCRIPTION OF AMENDMENT
Accountability Amendment Principle 2014 (No. 1)	16 January 2015 This instrument amends the *Accountability Principles 2014* by replacing references to paragraph 63-1(1)(m) of the *Aged Care Act 1997* with references to paragraph 63-1(1)(l) in section 9 and paragraphs 10(2)(b) and (c).

AMENDMENTS TO THE AGED CARE PRINCIPLES	DESCRIPTION OF AMENDMENT
Aged Care Legislation Amendment (Removal of Certification and Other Measures) Principles 2015	30 June 2015 This instrument addresses consequential changes required to *Accountability Principles 2014, Allocation Principles 2014* and *Fees and Payments Principles 2014 (No.2)* as a result of the repeal of certification from the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997* and unrelated unintended drafting errors made in the *Subsidy Principles 2014*.
Aged Care (Transitional Provisions) Amendment (March 2015 Indexation) Principles 2015	19 March 2015 This instrument amends the *Aged Care (Transitional Provisions) Principles 2014* to update the specified amount of maximum accommodation charge for a post 2008-reform resident as a result of routine indexation.
Aged Care (Transitional Provisions) Amendment (Removal of Certification and Other Measures) Principles 2015	30 June 2015 This instrument amends the *Aged Care (Transitional Provisions) Principles 2014* as a result of the repeal of certification from the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*, and unrelated unintended drafting errors made in the *Aged Care (Transitional Provisions) Principles 2014*.
Aged Care (Transitional Provisions) Amendment (September 2014 Indexation) Principles 2014	18 September 2014 This instrument amends the *Aged Care (Transitional Provisions) Principles 2014* to update the specified amount of maximum accommodation charge for a post 2008-reform resident as a result of routine indexation.
Fees and Payments Amendment Principles 2014 (No 1)	16 January 2015 These Principles amend the *Fees and Payments Principles 2014 (No 2)* to remove subsection 41(2), section 42A, subsection 61(2) and section 61A, being requirements for approved providers to comply with Part 3A.3 of the *Aged Care Act 1997* in relation to managing refundable deposits, accommodation bonds and entry contributions. These requirements were instead included in the *Aged Care Act 1997* by legislative amendment.
Quality of Care Amendment Principle 2014 (No. 1)	8 January 2015 This instrument amended the *Quality of Care Principles 2014* to repeal the requirement for a fire safety exception notice, for a given residential care service, to be provided to the Secretary if an approved provider is notified by a State, Territory or local government authority that the approved provider is not complying with any applicable State or Territory laws relating to fire safety in relation to the service.
User Rights Amendment (Consumer Directed Care) Principles 2015	30 June 2015 This instrument amends the *User Rights Principles 2014* to ensure that the requirements of Consumer Directed Care apply consistently to all consumers and approved providers of home care from 1 July 2015.

AMENDMENTS TO AGED CARE DETERMINATIONS

Determinations that commenced in 2014–15 are listed below. Unless they had been rescinded, Determinations made in previous years were also in effect during 2014–15.

Table 41: Amendments to Aged Care Determinations

AMENDMENTS TO AGED CARE DETERMINATIONS	DESCRIPTION OF AMENDMENTS
A New Tax System (Goods and Services Tax) (GST-free Supply—Residential Care—Government Funded Supplier) Determination 2015	4 February 2015 This determination is made under the *A New Tax System (Goods and Services Tax) Act 1999* and ensures that aged or disabled residents of non-Commonwealth government funded residential aged care services will receive GST-free all the residential care services that are GST-free to aged or disabled residents of Commonwealth funded residential aged care services under the *Aged Care Act 1997*.
A New Tax System (Goods and Services Tax) (GST-free Supply—Residential Care—Non-government Funded Supplier) Determination 2015	4 February 2015 This determination is made under the *A New Tax System (Goods and Services Tax) Act 1999* and ensures that aged or disabled residents of non-Commonwealth government funded residential aged care services will receive GST-free all the residential care services that are GST-free to aged or disabled residents of Commonwealth funded residential aged care services under the *Aged Care Act 1997*.
Australian Aged Care Quality Agency (Other Functions) Specification 2014	15 January 2015 This specification authorises the Quality Agency CEO to undertake quality reviews of Commonwealth Home and Community Care and National Respite for Carers Programme services and to conduct assessments of National Aboriginal and Torres Strait Islander Flexible Aged Care Programme services.
Australian Aged Care Quality Agency (Other Functions) Specification 2015	30 June 2015 This instrument provides authority for the Quality Agency CEO to undertake quality reviews of both the Commonwealth Home Support Programme and National Aboriginal and the Torres Strait Islander Flexible Aged Care Programme service.
Aged Care (Subsidy, Fees and Payments) Amendment (Removal of Certification and Other Measures) Determination 2015	30 June 2015 This determination amends the *Aged Care (Subsidy, Fees and Payments) Determination 2014* required as a result of the repeal of certification from the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997* and clarifies existing calculations made under the *Aged Care (Subsidy, Fees and Payments) Determination 2014*.

AMENDMENTS TO AGED CARE DETERMINATIONS	DESCRIPTION OF AMENDMENTS
Aged Care (Subsidy, Fees and Payments) Amendment (March 2015 Indexation) Determination 2015	18 March 2015 This determination amends the *Aged Care (Subsidy, Fees and Payments) Determination 2014* to increase the amount of supplements payable to approved providers of aged care services in respect of a day from 20 March 2015 in line with the changes to the consumer price index, in addition to increasing the value of the caps and thresholds in line with the aged pension.
Aged Care (Subsidy, Fees and Payments) Amendment (Indexation, Pre-Entry Leave and Other Measures) Determination 2015	30 June 2015 This instrument amends the *Aged Care (Subsidy, Fees and Payments) Determination 2014* to increase the amount of subsidies and supplements payable to approved providers of aged care services from 1 July 2015 and remove reference to the pre-entry leave subsidy.
Aged Care (Subsidy, Fees and Payments) Amendment (September 2014 Indexation) Determination 2014	18 September 2014 This determination amends the *Aged Care (Subsidy, Fees and Payments) Determination 2014* to increase the amount of supplements payable to approved providers of aged care services in respect of a day from 20 September 2014 in line with the changes to the consumer price index, in addition to increasing the value of the caps and thresholds in line with the age pension.
Aged Care (Transitional Provisions) (Subsidy and Other Measures) Amendment (March 2015 Indexation) Determination 2015	18 March 2015 This determination amends the *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* to increase the amount of supplements payable to approved providers in aged care services in line with the changes to the consumer price index.
Aged Care (Transitional Provisions) (Subsidy and Other Measures) Amendment (Indexation, Pre-Entry Leave and Other Measures) Determination 2015	30 June 2015 This determination amends the *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* to increase the amount of subsidies and supplements payable to approved providers of aged care services from 1 July 2015, remove reference to the pre-entry leave subsidy and make consequential changes as a result of the operation of the *Aged Care and Other Legislation Amendment Act 2014*.
Aged Care (Transitional Provisions) (Subsidy and Other Measures) Amendment (Removal of Certification and Other Measures) Determination 2015	30 June 2015 This instrument amends the *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* as a result of the repeal of certification from the *Aged Care Act 1997* and the *Aged Care (Transitional Provisions) Act 1997*, and unrelated unintended drafting errors made in the *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014*.

AMENDMENTS TO AGED CARE DETERMINATIONS	DESCRIPTION OF AMENDMENTS
Aged Care (Transitional Provisions) (Subsidy and Other Measures) Amendment (September 2014 Indexation) Determination 2014	18 September 2014 This determination amends the *Aged Care (Transitional Provisions) (Subsidy and Other Measures) Determination 2014* to increase the amount of supplements payable to approved providers of aged care services in line with the changes to the consumer price index.
Continence Aids Payment Scheme Amendment 2015	30 June 2015 This scheme amends the Continence Aids Payment Scheme 2010 to increase the contribution (payment) in line with agreed indexation arrangements for this payment.
GST-free Supply (National Disability Insurance Scheme Supports) Amendment Determination 2015	4 February 2015 This determination is made under the *A New Tax System (Goods and Services Tax) Act 1999* and specifies 22 kinds of supplies of supports which are GST-free where the supplier receives government funding for the supplies. This ensures that people receiving support under the National Disability Insurance Scheme receive the same GST treatment they would receive if they were in Commonwealth funded residential aged care services under the *Aged Care Act 1997*.

APPENDIX C: RESPONSIBILITIES OF APPROVED PROVIDERS UNDER THE *AGED CARE ACT 1997*, AS AT 30 JUNE 2015

Approved providers were required to comply with their responsibilities under the Act. These included meeting their responsibilities in relation to:

QUALITY OF CARE

- complying with the *Quality of Care Principles 2014* in relation to the type and level of aged care that is provided by the service; and
- complying with the Accreditation Standards, Home Care Standards and/or Standards for Flexible Care (that is, National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Standards and/or Transition Care Standards).

USER RIGHTS

Charter of Care Recipients' Rights and Responsibilities – Residential Care

Aged Care Act 1997, Schedule 1 User Rights Principles 2014

1. Care recipients' rights – residential care

Each care recipient has the following rights:

a) to full and effective use of his or her personal, civil, legal and consumer rights;
b) to quality care appropriate to his or her needs;
c) to full information about his or her own state of health and about available treatments;
d) to be treated with dignity and respect, and to live without exploitation, abuse or neglect;
e) to live without discrimination or victimisation, and without being obliged to feel grateful to those providing his or her care and accommodation;
f) to personal privacy;
g) to live in a safe, secure and homelike environment, and to move freely both within and outside the residential care service without undue restriction;
h) to be treated and accepted as an individual, and to have his or her individual preferences taken into account and treated with respect;
i) to continue his or her cultural and religious practices, and to keep the language of his or her choice, without discrimination;
j) to select and maintain social and personal relationships with anyone else without fear, criticism or restriction;

k) to freedom of speech;

l) to maintain his or her personal independence;

m) to accept personal responsibility for his or her own actions and choices, even though these may involve an element of risk, because the care recipient has the right to accept the risk and not to have the risk used as a ground for preventing or restricting his or her actions and choices;

n) to maintain control over, and to continue making decisions about, the personal aspects of his or her daily life, financial affairs and possessions;

o) to be involved in the activities, associations and friendships of his or her choice, both within and outside the residential care service;

p) to have access to services and activities available generally in the community;

q) to be consulted on, and to choose to have input into, decisions about the living arrangements of the residential care service;

r) to have access to information about his or her rights, care, accommodation and any other information that relates to the care recipient personally;

s) to complain and to take action to resolve disputes;

t) to have access to advocates and other avenues of redress;

u) to be free from reprisal, or a well founded fear of reprisal, in any form for taking action to enforce his or her rights.

2. Care recipients' responsibilities – residential care

Each care recipient has the following responsibilities:

a) to respect the rights and needs of other people within the residential care service, and to respect the needs of the residential care service community as a whole;

b) to respect the rights of staff to work in an environment free from harassment;

c) to care for his or her own health and well being, as far as he or she is capable;

d) to inform his or her medical practitioner, as far as he or she is able, about his or her relevant medical history and current state of health.

ACCOUNTABILITY REQUIREMENTS

Each provider has a responsibility to:

- keep and maintain records that enable claims for payments of residential care subsidy to be verified;
- cooperate with any person who is exercising the powers of an authorised officer under the Act;
- notify the Department of any change of circumstances that materially affects the approved provider's suitability to be a provider of aged care;
- notify the Department of any change to the approved provider's key personnel;
- ensure that none of the approved provider's key personnel is a disqualified individual;
- comply with any conditions that apply to the allocation of any places included in the service;
- provide records to another approved provider relating to any places transferred to that provider;
- comply with the requirements in relation to the relinquishment of places;
- conducting in a proper manner, appraisals or reappraisals of the care required by residents;

- comply with any undertaking given to the Secretary to remedy non compliance with the provider's responsibilities;
- provide audited yearly financial reports;
- comply with the prudential requirement relating to accommodation bonds;
- allowing people acting for an accreditation body to access the service for the purpose of accrediting the service;
- comply with the requirement to report allegations or suspicions of assaults on residents of aged care homes; and
- ensure that staff and volunteers who have access to care recipients, undertake a national criminal history record check to determine their suitability to provide aged care services.

APPENDIX D: SANCTIONS IMPOSED UNDER THE *AGED CARE ACT 1997* – 1 JULY 2014 TO 30 JUNE 2015

Table 42: Sanctions imposed under the *Aged Care Act 1997* – 1 July 2014 to 30 June 2015

STATE AND SERVICE	APPROVED PROVIDER	SANCTIONS IMPOSED	DATE IMPOSED	REASON FOR SANCTION	OUTCOMES
South Australia Andrewartha Aged Care	Stirling District Hospital Inc	Revocation of approved provider status, unless the approved provider agrees to provide relevant training within 6 months, at its expense, for its staff to support them in meeting the needs of care recipients. Revocation of approved provider status, unless an adviser, approved by the Commonwealth, with the appropriate skills, qualifications and background to assist the approved provider to comply with their responsibilities in relation to care and services, is appointed by the approved provider for a period of six months. The approved provider is not eligible to receive Australian Government subsidies for any new care recipients for a period of six months.	20 September 2014	Evidence of serious risk posed an immediate and severe risk to care recipients' safety, health or well-being, specifically: • residents are not receiving appropriate clinical care; • identified clinical issues are not consistently addressed; • residents' care plans are not current or accurate; and • residents' care needs are not appropriately reassessed as their needs change.	Subsidy sanction lifted on 16 March 2015 Adviser and training sanction expired 19 March 2015

STATE AND SERVICE	APPROVED PROVIDER	SANCTIONS IMPOSED	DATE IMPOSED	REASON FOR SANCTION	OUTCOMES
Western Australia Braemar Village	Commissioner of the Presbyterian Church	1. Revocation of approved provider status, unless the approved provider agrees to provide relevant training within 6 months, at its expense, for its staff to support them in meeting the needs of care recipients. 2. Revocation of approved provider status, unless an adviser, approved by the Commonwealth, with the appropriate skills, qualifications and background to assist the approved provider to comply with their responsibilities in relation to care and services, is appointed by the approved provider for a period of six months. 3. The approved provider is not eligible to receive Australian Government subsidies for any new care recipients for a period of six months.	5 December 2014	Evidence of serious risk posed an immediate and severe risk to care recipients' safety, health or well-being, specifically: • staff have not received adequate orientation to their roles or sufficient training to ensure that care and services are delivered in line with care recipients' needs; • care recipients have not been re-assessed to ensure that care plans reflect care recipients' current clinical needs; • care recipients' medications are not being managed safely and correctly, placing care recipients at risk of not receiving medications as prescribed; and • care recipients' nutrition and hydration needs are not being met.	All sanctions expired 4 June 2015

GLOSSARY

GLOSSARY

TERM	DEFINITION
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Programme
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
ACETI	The Aged Care Education and Training Incentives Programme
ACFA	Aged Care Financing Authority
ACFI	Aged Care Funding Instrument
ACHA	Assistance with Care and Housing for the Aged
ACNS	The Aged Care Nursing Scholarships
ACSC	Aged Care Sector Committee
ACSIHAG	Aged Care Service Improvement and Healthy Ageing Grants
Act, the	The *Aged Care Act 1997*
ACWVET	The Aged Care Workforce Vocational Education and Training
ADL	Activities of Daily Living
APCS	Annual Prudential Compliance Statement
BEH	Behaviour
CALD	Culturally and Linguistically Diverse
CDC	Consumer Directed Care
CHC	Complex Health Care
CHSP	Commonwealth Home Support Programme
Commissioner, the	The Aged Care Commissioner
CRCCs	Commonwealth Respite and Carelink Centres
CVS	Community Visitors Scheme
DACS	Dementia and Aged Care Services
DBMAS	Dementia Behaviour Management Advisory Services

TERM	DEFINITION
Department, the	The Department of Social Services (Date Reference to MOG for future activities)
DHS	Department of Human Services
DSBS	Dementia and Severe Behaviours Supplement
DTC	Day Therapy Centre
DTSC	Dementia Training Study Centres
DVA	Department of Veterans' Affairs
EACH-D	Extended Aged Care at Home
EBPAC	The Encouraging Better Practice in Aged Care
FIS	Financial Information Service
Fund, the	Aged Care Workforce Development Fund
GPs	General Practitioners
HACC	Home and Community Care
LGBTI	Lesbian, Gay, Bisexual, Transgender and Intersex
Minister, the	In 2014–15, this referred to the Assistant Minister for Social Services, Senator the Hon Mitch Fifield. Between 21 and 30 September 2015, this referred to the Minister for Social Services, the Hon Christian Porter MP. From 30 September 2015, this referred to the Minister for Aged Care, the Hon Sussan Ley MP
MPS	Multi-Purpose Service(s)
NACAP	National Aged Care Advocacy Programme
NATSIFlex	National Aboriginal and Torres Strait Islander Flexible Aged Care Programme
NDIS	National Disability Insurance Scheme
NIID	Notice of Intention to Issue Directions
NRCP	National Respite for Carers Programme
NSAF	National Screening and Assessment Form
PHNs	Primary Health Network
PICAC	Partners in Culturally Appropriate Care
Principles, the	Aged Care Principles, which are subordinate legislation made by the Minister under subsection 96 1(1) of the Act
Quality Agency	The Australian Aged Care Quality Agency

TERM	DEFINITION
QUEST	Quality Education on the Standards Sessions
RAS	My Aged Care Regional Assessment Service
ROACA	Report on the Operation of the *Aged Care Act 1997*
RTOs	Registered Training Organisations
SBRTs	Severe Behaviour Response Teams
Scheme, the	The Aged Care Complaints Scheme
Secretary	the Secretary responsible for the Administration of aged care; in 2014–15, this referred to the Secretary of the Department of Social Services. Following Machinery of Government changes in September 2015, this referred to the Secretary of the Department of Health.
STRC	Short-Term Restorative Care Programme
TRACS	Teaching and research aged care services
Transitional Provisions Act	the *Aged Care (Transitional Provisions) Act 1997*
2014–15	2014–15 refers to the financial year between 1 July 2014 to 30 June 2015

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