UTS Ageing Research Collaborative (UARC)

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SUPPORT AT HOME:

Response to the Department of Health and Aged Care discussion paper (October 2022)

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Executive Summary

The Australian Government is developing a new in-home aged care program, to commence on 1 July 2024. As part of the design process, the (then) Department of Health issued an initial Overview paper in January 2022, to which UARC responded with its *Support at Home: a commentary on the design of the new unified program* (UARC Commentary). In October 2022 the Department issued a second discussion paper. This UARC Response addresses the further development of the program design and specific questions raised by the Department.

The Department has been responsive to many matters raised in the consultations to date. Nonetheless, there remain some difficult design challenges which require further consideration, including the sustainability of the program and the nature and levels of client contributions.

The Department's inclusion of program objectives in its discussion paper addresses one of UARC's key concerns. There is considerable alignment between the Department's objectives and those proposed in the UARC Commentary. One of the remaining omissions is explicit recognition of the need for providers to have incentives to deliver efficient and effective services that reflect consumer needs and preferences. Support for competitive market-based delivery has been a consistent theme over the last decade of reforms, noting that thin markets require alternative funding and incentive structures.

Governance arrangements remain under-developed. Many features of the new program can be expected to amplify the challenges of clarifying issues of responsibility, controllability and accountability for assessors, care partners and providers. With no new discussion of governance arrangements in the discussion paper, these issues require further elaboration.

A self-managing, multi-provider, fee-for-service model has unresolved coordination and accountability challenges. Older Australians who elect to manage their own services will need clear and timely information on their eligibility, entitlements and obligations to be able to effectively exercise of choice and control within this model. There will also be a need for reliable information sharing with providers and the broader health system, appropriate technology services and safeguard mechanisms such as care partner support.

Publicly funded care partners should be accountable to the older Australians they support. There are sound rationales for the public funding of care partner roles to support older Australians to achieve the best outcomes from the aged care services for which they are eligible. The care partner role applies equally for single provider and multi-provider models and all levels of care. The functions and required skill sets of the partners will be different depending on the needs and preferences of older Australians and the models of care they choose, but continuity of support within established, trusted relationships should be prioritised. Care partners' primary accountability to the older Australians that they support suggest this role needs organisational independence from providers, but could be aligned with assessor organisations provided there were strictly separated lines of authority.

A publicly funded fee-for-service model for care partners could produce incentives for inefficient over-servicing at the public's expense. An alternative could be capitation-based funding, with the payment rate normalised for the characteristics of the client population.

A mixed funding model for services is appropriate to support the viability of those services in thin markets and those with high fixed costs. For thin markets, activity-based funding should have an evidence-based loading to compensate for the higher variable costs of delivery, with supplementary grant funding to serve as an availability payment for the higher fixed costs. The Department's preference for a time-based competitive process, with five-year funding agreements, is appropriate.

Grant funding of centre-based day care and social support, delivered meals and transport would facilitate continuity of these important services that have been regularly provided by local government, community organisations and other business. Nonetheless, appropriate incentives for efficiency and effectiveness, together with performance transparency for provider accountability, will still be required.

The flexible pool proposal needs considerable refinement. The proposed 25% margin for flexible top ups of services is excessive and risks undermining the important resource allocative role of the assessment process. Alternative means of mitigating the need for a large flexibility pool should be considered, including ongoing refinement of assessment processes and a timelier matching of the older person's assessed needs with their support plans. The Department's view that the delivery of some service types such as clinical support should be protected through a quarantining mechanism is supported.

Innovation may be suppressed by inappropriate regulation. Many aged care rules have specified the type and quantum of inputs and even specific outputs rather than outcomes, but some have been wound back and this should continue. Meaningful sector-based innovation, which fundamentally transforms the efficiency and effectiveness of care provision, is likely to be beyond the financial capacity of any one organisation. Open innovation approaches require clarity and agreement on which aspects of care provision require improvement, together with good governance and translation processes.

Section 1 Background

The Australian Government is developing a new in-home aged care program which will commence on 1 July 2024. The program will bring together three existing community-based programs: Commonwealth Home Support Programme (CHSP), Home Care Packages (HCP) and Short-term Restorative Care (STRC), as well as residential respite in aged care homes.

On 6 January 2022, the Department of Health and Aged Care (the Department, DoHAC) released an initial consultation paper – *Support at Home Program Overview*.[1] A wide range of responses were received from stakeholders, including UARC's *Support at Home: A Commentary on the Design of the Proposed Unified Program* ("UARC Commentary").[2]

On 18 October 2022, the Department released a second discussion paper – *A New In-Home Program for Aged Care*.[3] In this paper, the Department concluded that there are four areas of broad agreement: the need for independent and consistent assessments of aged care needs; a new scheme for goods, equipment and assistive technology and home modifications; explicit funding of care partners to monitor older Australians' clinical needs and support them as needed; and the introduction of a list of available services.

On that basis, the DoHAC discussion paper focusses on five key areas: direct service management by older Australians; implementation of the care partner concept; achieving value for money while fully funding the cost of care; ensuring flexibility of care; and fostering innovation and investment.

In this Response by the University of Technology Sydney Ageing Research Collaborative (UARC), the authors have addressed the following issues:

- Assessment of any remaining substantive issues within those areas of broad agreement, as assessed by the Department
- Responses to the matters raised and questions asked by the Department on each of the five focus areas
- Commentary on additional matters not raised by the Department which remain fundamental to the design of an effective, efficient, equitable and sustainable in-home aged care program

Areas of broad agreement as assessed by DoHAC

Improving the consistency of assessment of aged care needs by independent assessment organisations

A unified independent assessment system has long been advocated for by stakeholders as being an important step in creating a continuum of care across aged care, as well as in removing system complexity and confusion for older Australians. Consistency of assessment is necessary to ensure that the care needs of older Australians are met, that the distribution of subsidised services is equitable according to need, and that there is a basis for accountability for client outcomes.

Consistency and independence are key concepts for the design and operation of an assessment process, but there are others: the appropriateness and clarity of eligibility assessment criteria, and recognition that assessors themselves have a measure of accountability for client care outcomes. The Government is primarily responsible for the efficient and effective allocation of public resources (service subsidies) by

determining the eligibility criteria, but assessors are responsible for appropriately applying the criteria to ensure that those subsidies are only allocated in accordance with government policy and procedures.

Introducing a new scheme for goods, equipment and assistive technology and home modifications that supports older Australians to remain independent

The characteristics of these activities support the establishment of a separate scheme.

Explicitly funding care partners to monitor older Australians' clinical needs and support them when they need help

This matter raises several complex issues, as will be discussed in Section 5 of this UARC Response. However, one of the conclusions from Section 5 is to support the explicit funding of care partners.

Introducing a service list that provides more clarity around the services available in the home

The previous UARC Commentary noted the benefits of a Service List: "The concept of a Service List has merit in that it can aid the development and ongoing transparent review of the efficient, equitable and sustainable funding of subsidies for specified in-home care services."[4] However, the Commentary also drew attention to the risks of over-specification.[5] These matters, and the associated issue of ensuring some measure of service flexibility within an Individualised Support Plan, are analysed in Section 7 of this UARC Response.

In concluding this Background, it is appropriate to recognise the Department's responsiveness to the many matters raised in consultations to date. Their second discussion paper is less tied to the disability care model that was put forward in their first paper and appears more open to a wider conversation as evident by the range of questions it asks.

Nonetheless, there remain some difficult challenges to be faced in designing a new unified in-home care program, of which the nature and levels of client contributions are of particular importance.

Section 2 The Objectives of the New Program

In UARC's Commentary, the point was made that DoHAC's first discussion paper did not set out the proposed objectives for the new unified in-home program. Thus, it was not possible to assess whether the proposed design features would result in a program that met its intended objectives and contribute to the desired outcomes. As summed up in the UARC Commentary: "The design of the Support at Home program should be guided by principles that are consistent with the broader reform agenda and centred on the independence and wellness of senior Australians."[6]

The Department is to be commended for correcting this initial omission. Its October paper includes a set of objectives which underpin the final design of the new in-home aged care program. This section of the UARC Response undertakes a comparative analysis of the DoHAC objectives and those proposed by UARC (see Figure 1) and offers guidance on further refinement of the Department's proposals.

Figure 1 Objectives for Reform to In-Home Aged Care: Comparison between UARC and DoHAC

DoHAC objectives which broadly align with UARC principles:

- Older Australians should have timely access to a full range of services that meet their assessed aged care needs.
- People who can afford to contribute to the cost of their care should do so.
- Older Australians should have choice and control over services that meet their assessed aged care needs.
- Funding and quality assurance arrangements should ensure that older Australians receive services that are safe and high quality.
- Aged care expenditure over time should be predictable and fiscally sustainable.

DoHAC objectives not included in the UARC principles:

- Services should be underpinned by a robust evidence base on how to meet a person's assessed needs and support independence.
- Reform to in-home aged care should simplify current arrangements for older Australians by consolidating assessment arrangements and programs that are currently cumbersome for older Australians to navigate.

UARC principles not explicitly represented in the DoHAC objectives:

- Services to be delivered within a competitive, market-based framework
- The allocation, management, delivery and outcomes of subsidised services to be transparent and have clear lines of accountability.

As Figure 1 demonstrates, there is substantial alignment between many of the proposed objectives, even though the specific wordings have some differences. In some instances, DoHAC have progressed the objectives to include more fulsome descriptors. For example, the UARC Commentary proposed that: "Subsidised services to be funded sustainably and equitably between taxpayers and clients."[7] DoHAC have taken this further and proposed the following two inter-related objectives, both of which are supported:

- People who can afford to contribute to the cost of their care should do so.
- Aged care expenditure over time should be predictable and fiscally sustainable.[8]

DoHAC has addressed the issue of simplifying program processes and structures and making the new program easier to navigate. These are important considerations in designing the new program and have been put forward in previous reviews. The Department has proposed the following formulation: "Reform to in-home aged care should simplify current arrangements for older Australians by consolidating assessment arrangements and programs that are currently cumbersome for older Australians to navigate."[9]

The underlying intention of this proposed objective is strongly supported, but its current wording is focussed on the inadequacy of current arrangements and is inappropriate for a forward-looking set of objectives. Accordingly, DoHAC may wish to consider rephrasing this objective along the following lines:

Older Australians and their carers should be able to easily understand the eligibility requirements for access to the subsidised services and their own obligations and to readily navigate the program's processes including assessment, care partnership, selection of provider/s and complaints resolution.

Competitive market-based frameworks

UARC's Commentary advocated for a greater emphasis on both the effectiveness of the services being delivered and the efficiency of that delivery. DoHAC has included an objective that promotes the effectiveness of the taxpayer subsidised services: "Services should be underpinned by a robust evidence base on how to meet a person's assessed needs and support independence."[10] Again, this is supported.

In relation to the efficiency of service delivery, the UARC Commentary argued that providers need operational incentives to deliver services that reflect consumer needs and preferences and support delivery at the lowest viable price. This latter point was particularly relevant given that there is no direct market pricing discipline on direct care costs in aged care (while noting that in a residential care context, the supply of accommodation does have exposure to market pricing for non-supported residents in aged care homes).

Support for a market-based delivery environment and the harnessing of competitive dynamics has been a consistent theme over the last decade of reforms. The 2016 *Aged Care Roadmap*,[11] for instance, specified the goal of having responsive providers and increased competition. Market-based competition was also central to the Home Care Package reforms of 2017 and the abolition of ACAR, which formally takes effect in 2024. A market-based environment also supports the further core objective that older Australians are to have both choice and control over the services they are eligible to receive. Nonetheless, there are also many thin market situations that require a different approach, as discussed in Section 6 of this Response, ranging from rural and remote service delivery to meeting the special needs of particular groups of older Australians.

Accordingly, the following objective could be added to those proposed by the Department:

Services should be delivered within a competitive, market-based framework where appropriate, noting the existence of thin markets where alternative funding and incentive structures need to apply.

Section 3 Governance: Responsibilities, Transparency and Accountability

Reference to program governance is a surprising omission from the set of proposed objectives in DoHAC's October discussion paper. As the UARC Commentary articulated, good governance design is fundamental to the success of the program and needs to consider how roles and responsibilities for processes and outcomes align with the control and accountability of involved parties. The UARC Commentary proposed that this be acknowledged as an explicit objective of the program, along the lines of: "The allocation, management, delivery and outcomes of subsidised services [should] be transparent and have clear lines of accountability."[12]

The lack of further discussion of governance arrangements in the latest DoHAC discussion paper leaves unanswered a number of overarching concerns for each of the five key areas of reform discussed in the sections to follow.

As articulated in the UARC Commentary, controllability is the basis for accountability and refers to the extent to which an employee or manager has influence over activity for which she or he is responsible. Controllability is required for the effective design of accountability systems.

Control in the absence of accountability (in such forms as being monitored, evaluated, and/or sanctioned) reduces the incentives for the party with control to fulfil the task or outcome adequately. In the case of home care services, accountability is essential to ensure that subsidised services meet the assessed needs of older Australians, and that subsidised services represent efficient use of public funds and "value for money".

Conversely, accountability in the absence of sufficient control can drive different types of dysfunctional behaviour and governance practices. Where parties are held accountable for tasks or outcomes that they cannot meaningfully influence, efforts to incentivise process and performance improvements may lead to the discouragement rather than motivation of the accountable party. This raises issues of fairness and procedural justice from the perspective of the accountable party, and a persistent inability to raise and resolve issues with them from the perspective of the client and governing body.

While the proposed new program is intended to clarify and simplify access to, and navigation of, the in-home care system, many of its features can be expected to amplify the challenges of aligning responsibility, controllability and accountability. For example, the separation of care planning from service delivery, the introduction of a new care partner role, and the ability of older Australians to engage multiple service providers, will each increase the interdependence of tasks and the need for information sharing and cooperation between the involved parties. This more complex service delivery model, while simplifying access from an older person's perspective, will nonetheless create more opportunities for overlapping responsibilities, limits on controllability and misalignment of accountabilities.

The governance structure of the program, including its transparency, needs to apply to all the various parties in the system, including care recipients, assessors, care partners, providers, regulators and administrators. In the following section (Section 4), we discuss the specific circumstance of clients electing to engage multiple service providers independently of a primary provider.

Section 4 Managing Services Across Multiple Providers

The Department is proposing that older Australians should have the ability to appoint different providers to deliver the various services that are included in Individualised Support Plans. This will provide the older person with more choice and control over the support that they receive and aligns with one of the objectives discussed in Section 2 above. However, there is a need to balance simplicity of the proposed arrangements with the potential additional complexity that comes with increasing the degree of choice and control within this system. As noted by both the UARC Commentary and the DoHAC discussion paper, the introduction of a multi-provider fee for service model presents a set of new coordination and accountability challenges which have yet to be resolved.

Many of the older Australians who currently receive in home aged care services only receive a single service. Approximately 51% of CHSP participants in 2020-21 received a single service (equating to more than 40% of those who benefit from all three existing community care programs).[13] A further 50.2% of HCP consumers were in a Level 1 or Level 2 package in 2020-21, from which we can infer a comparatively simple service mix for the majority.[14] Many of these clients may not choose to have multiple providers or to manage their own services.

However, some older Australians with complex needs may elect to self-manage their own care by appointing multiple providers, while others will still choose to have their services delivered and managed by a single primary provider. Similarly, some older Australians will require ongoing support from a care partner while others will have minimal need for that support (see Section 5).

Accountability for undertaking the monitoring of outcomes and changes in clinical and care needs will necessarily work differently depending on which model of engagement an older Australian adopts. In all circumstances, providers must be accountable in the first instance for the delivery of agreed services (under the Quality of Care Principles). However, additional functions that are currently the responsibility of Approved Providers (within HCP) may need to be redistributed given the role of care partners and where multiple providers are involved in the delivery of the Individualised Support Plan.

Those functions include taking full responsibility for the coordination of care professionals, integration of services to the benefit of the consumer, and the exercise of professional judgement as to the appropriate service mix within the Individualised Support Plan. Importantly, these functions currently remain the responsibility of the approved provider even where services are brokered or subcontracted to another provider, and where the client elects to self-manage their package.

Under a self-management model within in-home care, coordination and integration of care will likely be the responsibility of the client; while responsibility for the appropriateness of the service mix will continue to be held by the assessor and client in terms of the Support Plan and be held by the client with the support of the care partner for more granular service mix decisions.

Responsibility for managing quarterly budgets

As raised above, the principle of improving the scope of an older Australian's choice and control over their services should extend to having choice over the extent to which they want to manage their services, provider relationships, and quarterly budget. In terms of budget control, older Australians who elect to manage their own services should assume responsibility for ensuring that they stay within their funding entitlements. It may be appropriate for those who prefer not to assume this function should have the option of allowing a primary provider to take it on. This raises the question of how the financial management currently delivered by providers, separate to the safeguarding and clinical oversight function to be performed by care partners, will be funded. While providers within HCP currently can charge separate package management fees (to be capped from January 2023), this service is not specifically funded within CHSP and would need to be built into the service price as part of overhead recovery.

For older Australians who elect to manage their own services, clear communication of their eligibility, entitlements and obligations will be essential to support the exercise of choice and control. DoHAC proposes that this function could be fulfilled via a new central payment platform, intended to help older Australians to manage their funds.[15] Convenient access to timely information about their expenditure and remaining funds will be important to prevent over- or under-spending. Other potential checks that could be designed into the system and in supporting technology platforms could include periodic monitoring by care partners (where relevant) as part of regular check-ins and review of care outcomes, or automated monitoring by Services Australia to identify and alert clients to overspending.

Clear processes should be developed that will be triggered by instances of overspending. For example, such an event could trigger a care partner review and/or reassessment, an accrual to the following quarter, or an option to pay out-of-pocket for additional services once a quarterly budget is fully acquitted.

Potential additional challenges of multi-provider model

One of the potential challenges arising under a multiple provider model of service delivery is that there is an increased risk of service fragmentation that undermines the provision of integrated care. Evidence on integrated care indicates that the provision of comprehensive, holistic, person-centred and tailored care that is continuous, carefully coordinated and involves clients and carers in shared decision-making increases positive outcomes for older people living in the community.[16]

Under a multiple provider model, additional coordination is required to prevent the fragmentation which could occur. For example, individual providers responsible for delivering certain services may become less aware of a care recipient's other needs, particularly if they no longer have the same information about or familiarity with a client as they would under a single-provider model. Fragmentation may create service gaps, communication breakdowns and blind spots that prevent early detection and attention to an individual's changing needs and circumstances. Conversely, having multiple providers may well lead to a duplication or overlap of services.

Thus, a multi-provider model is likely to create additional responsibilities for clients to coordinate services. This may come with additional administrative tasks such as initiating multiple service contracts, sharing duplicate or similar information and communicating with the various providers. Furthermore, if an older

person's capacity to self-manage declines, these additional coordination tasks may fall to informal carers, which in turn could lead to increased risk of carer burden and burn-out.

From a provider's perspective, operating within a multiple provider environment risks undermining their knowledge and understanding of their clients, which may lead to problems in delivering quality, coordinated, continuous care. It could also create further complexities in managing costs, as it may create additional costs of coordination, administration, communication and scheduling, particularly if multiple providers offer services with interdependencies between them.

To address some of these challenges and ensure appropriate coordination of services within a multiple provider model, forthcoming research by UARC[17] suggests that performance indicators should focus on:

- Efficient and effective information sharing between clients, providers and other health care services
- Clear information flow (e.g. from DoHAC, or Services Australia) to clients and their carers about their rights and responsibilities to coordinate and self-manage services
- Clarity about the governance requirements for approved providers to ensure the quality and safety of services and to meet obligations under the *Aged Care Act*
- Safeguard mechanisms (e.g., routine check-ins by care partners) to ensure clients are receiving appropriate care services to meet their needs, particularly as their needs or circumstances change over time
- Technology to support the efficient scheduling of services.

Section 5 Care Partners for Older Australians

The following response to the DoHAC discussion paper on the issue of care partners is structured into the three topics below. This represents a reordering of the DoHAC discussion questions, as the answer to one affects the subsequent answers to others.

The starting point is a focus on what older Australians need by way of a partnership to assist with the care management of their aged care services in its broadest sense. From there, it is possible to determine the role and accountabilities of a care partner and how their functions differ from those of assessors and providers. The location of care partners within the in-home care system can then be determined. Consideration of more operational issues, such as information flows and the use of IT, can then follow.

The role and accountability of care partners within the context of care management

The broad scope of services that currently constitute care management are defined in the *Quality of Care Principles 2014* of the *Aged Care Act 1997* under Schedule 3 – Care and services for home care services:

> *Care management: Includes reviewing the care recipient's home care agreement and care plan, coordinating and scheduling care and services, ensuring care and services are aligned with other supports, liaising with the care recipient and the care recipient's representatives, ensuring that care and services are culturally appropriate, and identifying and addressing risks to the care recipient's safety.*[18]

This definition sets out a range of care management services that approved providers may currently deliver. As the data presented in the UARC Commentary demonstrated, care management services are not exclusively directed to those on the highest home care packages but are delivered across all levels of care.[19]

To an extent, this broader definition serves as a basis for considering the more specific role and functions of a care partner, while observing that care management has a less clinical scope than recent literature suggests could be within the remit of such a role.[20]

The Department summarises its assessment of what older Australians have identified as their needs for care as: "Older Australians emphasised that care management should be a partnership between themselves and an appropriately trained person – or care partner – who can support them to achieve the best outcomes from aged care services."[21]

A concern with the DoHAC paper is the interchanging of the terms 'care management' and 'care partner' given their potential differences in scope. However, it is evident in some phrasing that the Department is proposing that the care partner functions would focus on clinical oversight, monitoring and safeguarding the safety of the older person. This role is distinguished from that of more administrative functions of care management such as scheduling care workers, which would remain in the domain of care providers.

The DoHAC interpretation of the needs of older Australians in terms of care partnership is consistent with the first of three alternative roles put forward in the UARC Commentary: "To act on behalf of the client, to ensure that their care needs are met, and the best possible outcomes are achieved."[22]

A conclusion is drawn below about the role and accountability of a care partner, but it first needs to be defined in the context of two other roles: needs assessments and the provision of care.

The primary accountability of all three roles is to the older Australian, although there are secondary effectiveness and efficiency accountabilities to the Government (and taxpayers) as a consequence of their receipt and/or stewardship of public funds. Figure 2 discusses this further in relation to assessors and providers, drawing on the governance considerations in Section 3.

Figure 2 The roles and accountabilities of assessors and care providers

Assessor role

At a general level, the primary role of the assessor is to determine the needs of the older person and their eligibility for specific subsidised aged care services, and to develop an Individualised Support Plan with the older person that delivers the best outcome for them within the limits of the eligible services. Assessors are also paid from the public purse and are allocating public funding (the subsidies for the services) according to criteria specified by the Government.

Provider role

The role of the provider, again in generalised form, is to deliver the services in a manner that achieves the best outcomes for the older Australian within the limits of the plan approved by the assessor and to do so effectively and efficiently. There has been a great deal of focus on the accountabilities of providers and their staff for delivering care, and the quality and safety regulatory regime has been upgraded as a consequence.

Accountability of assessors

A criticism that could be levied on the DoHAC paper is that it pays insufficient attention to the important role played by assessors in determining an older Australian's eligibility for subsidised services and their accountability for the outcomes from the care that the assessor approves. Equally, there is little accountability of assessors for the effective and efficient allocation of subsidised services, including potential over-allocation that is not supported by assessed current needs. The very high level of unspent HCP funds may in part be a consequence of over-allocation of subsidised services by some assessors, although there is evidence that many older Australians show reluctance in taking up services to meet needs that the assessment process may have properly identified. These matters need to be more rigorously developed as part of the single assessment service.

Accountability of Government

The Government shares some responsibility for assessment outcomes by ensuring that the eligibility criteria are clear under the Integrated Assessment Tool currently under development and that assessors and plan outcomes are effectively monitored. The services to be subsidised should also be supported by evidence of their effectiveness, consistent with a program objective to this effect which was discussed in Section 2. Further, the rates of those subsidies should achieve a balance between the public benefits and the personal benefits to older Australians.

Following from a broad understanding of the roles and accountabilities of assessors and providers as set out in Figure 2, the role of a care partner should embody concepts such as safeguarding the older Australian while they are recipients of subsidised aged care services and enhancing the effectiveness of the aged care system by ensuring the best outcomes are achieved at the individual older person level. Hence the following conclusion could be drawn in respect of care partners:

A care partner is primarily accountable to the older Australian. Their role is to support that person to achieve the best outcomes from the aged care services for which they are eligible.

Care partners, in common with assessors, are also accountable to the Government as they are paid from the public purse to perform their role efficiently and effectively.

The role applies equally to situations where an older Australian has a single provider as to where they choose the option of self-managing and directly engaging two or more providers under a multi-provider model, although there will be differences in the conduct of the role's functions. Similarly, the role also applies to whatever level of care the older Australian has been assessed as needing by the assessor and is receiving from the provider/s of that care, but there will be functional differences.

Importantly, none of the three roles (of assessor, provider, and care partner) is accountable to either of the other two, and their accountabilities for the care outcomes for the older person are limited to their specific roles and functions. On this basis, care partners should demonstrate more than 'a degree of impartiality' as envisaged by the Department and should instead operate independently of the other two roles. This would assure the older Australian that their care partner is working for their best outcomes and does not have conflicts of interest.

Given the support role of a care partner, it would not be appropriate for them to be an independent source of data for the purpose of scaling quality indicators, but they could assist the older person to respond to client experience interviews when asked.

The governance aspects of this independence were explored in greater depth in Section 3 and the organisational consequences of where the care partner should 'sit' are addressed later.

Functions of a care partner and their organisational location

A care partner, to effectively support an older Australian in their receipt of aged care services, must have sufficient knowledge, skills and attributes to understand the care recipient's needs, undertake clinical oversight and monitor the extent to which a range of services could assist the person to meet those needs, including the subset of subsidised services for which they could be eligible.

Before proceeding, a relevant issue to consider is the scope of matters for which a care partner would be responsible and the extent to which it is bound by the limits of subsidised aged care services and the performance of assessors and providers. Even extending the remit to health more generally would require the care partner to support the person in their dealings with GP's, hospital discharge processes, non-subsidised allied health service, pharmacists and others. A convincing case could be made that all such services have real and immediate impacts on a person achieving the best outcomes from aged care services. Further, the older person is living a whole life and needing support across all aspects thereof, rather than being siloed for the purpose of administrative conveniences. Nonetheless, this response currently adopts the narrow interpretation of the role set out earlier.

A possible outline of the functions of a care partner that are consistent with their role could be:

- Make initial contact with a person who has been assessed and has agreed to and accepted their Individualised Support Plan – to introduce themselves and explain that their role is to support the older person with their receipt of services and reassessments as necessary.
    - It will be equally important to clarify that they are not care coordinators or managers, including where a person has decided to self-manage their care and/or employ multiple providers.
    - This model has some similarity to that of the NDIS, where provider organisations deliver this service across geographical boundaries.
- Form an independent view of the relevance of the Plan to the needs of the older person and report that view to the person. As appropriate, and with the person, raise any concerns with the assessor through the channels available to the older person.
- Support the older person to engage one or more providers, as required.
- Conduct a follow up meeting with the older person once services are being received (say within three months).
- Conduct routine meetings with clients as a clinical oversight and safeguard mechanism.
    - The frequency by which these routine meetings occur could be set to vary, depending on the scope and frequency of the individual services being received, the number and complexity of those services, and the capability of the older person and/or their informal carers to manage their own service mix.

Given the role and functions of the care partner as proposed above, their scope of responsibility could include the following:

- Consideration of whether there are any significant changes in the older person's needs for subsidised care services
- Support in raising a request for reassessment by the assessor if that is appropriate
- Consideration of the effectiveness of the services being delivered in meeting the Support Plan
- Consideration of whether there are any underutilised services that are provided for in the Support Plan and support the older person to assess and reconsider the reasons for the underutilisation
- Support in identifying, raising and resolving any issues with the provider/s
- Support in adjusting to any transitions in care services to meet changed needs
- Support in raising any relevant matters with the Aged Care Quality and Safety Commission
- Pro-active support in preventing, mitigating or managing crises
- Response to any other concerns held by the person.

These responsibilities could form the basis for developing a small number of performance indicators. The primary indicators could assess clients' experience of their care partner's support and be collected through appropriate questions in an independently administered client experience survey. In addition, the care partner, as with assessors, would be engaged through a service provision contract with the Department and would be subject to contractually agreed performance measures. For care partners these could include several procedural measures such as those below, although development of effectiveness measures would also be very desirable:

- Timeliness of initial contact (e.g., proportion of new clients met within a certain time period from entry to program)
- Completeness of follow-up and routine meetings (e.g., proportion of follow-up and routine meetings conducted, according to assigned schedule)
- Timeliness of responding to as-needed requests (e.g., average time to respond to clients)

Neither care partners nor assessors would be subject to assessment by the Aged Care Quality and Safety Commission.

The organisational consequences of the independent care partner model are difficult to resolve. In part, it involves a trade-off between the purist but more expensive option of care partners residing within independent organisations compared to a second option of care partners operating in separated parts of an organisation that undertakes another role and thereby achieving economies of scale for many overhead functions.

In examining this latter option, and remaining within the aged care system, the alternatives are either being in assessor organisations or provider businesses or another host organisation – possibly an established not-for-profit body that is not a provider. The care partner, with the particular focus on supporting the older person to ensure that the services are meeting their needs, is likely to have a greater range of conflicts of interest with providers than assessors. The clinical orientation of the role would have an alignment with the assessor function. Such an arrangement would require clear separation of duties and reporting, however, so that a care partner could assist an older person to challenge an assessment, free from any conflict of interest.

Positioning the care partner role outside of provider organisations, where responsibility for the care management function currently rests, also requires that care partners have sufficient regular contact with their clients to be able to identify when needs have changed, given that this can occur rapidly. Identification of need is an issue that requires skill and access to sufficient information, as well as the ability to develop a trusted relationship with the older Australian who may find it challenging to discuss their need for support and care services.

Efficiently funding care partners

The rationale for publicly funding a care partner program could be based on at least three grounds: the potential cost savings arising from achieving a more effective alignment between an older Australian's needs and the subsidised services delivered to them; the timelier reassessment of changing needs; and the more efficient management and use of care recipient entitlements.

The DoHAC paper noted that there are challenges in implementing a care management (partner) model that achieves coverage across all levels of care, "while ensuring scarce expertise is targeted to those who need it most."[23] These challenges are compounded if the care partner is not nested within an organisation that is already being supported to provide management and administrative overheads for aged care.

Nonetheless, good design requires that both challenges be addressed. The funding model that is adopted will be instrumental in creating the right incentives for the efficient, effective and universal delivery of care support. There also needs to be transparency of the care partner's performance to all stakeholders and accountability to the Government.

A second consideration, as raised by the Department, is to ensure that scarce workforce expertise is allocated efficiently by being directed to those most in need, and a related consideration applies to the allocation of scarce public funding.

As noted in Section 4, the initial needs of many older Australians may be addressed by only one or two services and the beneficial input from a care partner may be quite limited. A greater level of clinical knowledge and skills will be called upon for older Australians who have complex needs. Nonetheless, the universal provision of initial meetings and some regularity of check-ins, regardless of care complexity, is an important safeguard to assess the appropriateness of the care assessment and identify any issues in service delivery.

A model may emerge to respond to these varying resourcing needs by adjusting the frequency of meetings and requisite skill set of the care partners. For example, older people with low complexity of needs may have less frequent check-ins after the initial meeting, with a care partner that does not have higher order clinical skills.

However, if a client's complexity of needs extends beyond that care partner's scope of practice, either a clinical consultant could be called upon to assist or, in some cases, there may be a need for a personalised hand-over to a relevantly qualified care partner. Nonetheless, continuity of care partner support by someone who has built a trusted relationship with the older person should be prioritised whenever possible.

In terms of a funding model that has incentives for the efficient and effective delivery of services, one end of the funding spectrum would be a fee for service model. Such a model would be conceptually simple and consistent with the DoHAC proposed design of the new in-home care program. However, the form and quantum of care support to be delivered will be highly variable and depend on the range of factors identified earlier.

A concern with a fee for service model is that in a publicly funded environment which is not subject to market forces, there can be an incentive for inefficient over-servicing at the public's expense. This could be moderated by contractual specification of service delivery but that presents considerable risk of over- or under-servicing for each older person. Unlike care management that is undertaken by provider organisations, a lack of market forces means that there is no incentive from within the organisation to "keep the client". Careful attention to performance indicators, as discussed above, will be important for accountability within this model.

An alternative model would be capitation-based funding, with the payment rate normalised for the characteristics of the client population. The model could have fixed grant funding and variable activity-based funding components, reflective of the nature of the service delivery model. For the variable component, the numbers of clients could be an average over a defined payment period and the factors used in the normalisation process could, in part, reflect those outlined above.

The care partnering organisation could then allocate the resources more flexibly according to relative need. This strength, however, is at the same time a cause for concern – the non-transparent rationing of care partner support amongst the client population. To an extent, the current CHSP service model suffers the same limitation.

Further consideration of in-home care funding, which would apply also to care partners, is dealt with next in Section 6.

Section 6 A Funding Model That Supports Provider Viability And Offers Value For Money

In its discussion paper, the Department prefaces its funding section with an outline of its proposal for a mix of grants and activity-based funding that is tailored to the specific characteristics of the individual services. At a high level, the Department's proposed model has considerable merit.

Further, the Department identifies three broad topics worth closer examination: setting 'prices' which reflect the full cost of service delivery; the additional delivery costs in thin markets; and service types which need a degree of funding certainty. Again, these topics identify some of the more significant issues and reflect a desire by the Department to come to satisfactory resolutions. The Department has also recognised the particular situations facing Indigenous service providers and has committed to further consultation with Indigenous stakeholders.

Before proceeding, however, it is important to note that this Section is focussed on how aged care funding can be applied to enhance the effectiveness of the service outcomes and the efficiency of the resource allocations, but it says nothing about how the revenue will be sourced from Australian taxpayers and home care clients. This is despite one of the objectives for the new program being: "People who can afford to contribute to the cost of their care should do so." Another is: "Aged care expenditure over time should be predictable and fiscally sustainable." Short term predictability issues are discussed by the Department, but longer-term fiscal sustainability is not. At some stage the Department, with the support of Ministers, needs to issue a discussion paper on the longer-term challenges of sustainably funding in-home aged care.

Although the specific questions raised by the Department in its October paper centre around thin markets and funding certainty, the paper does recognise that adequate funding is needed to ensure that efficient providers can operate and invest viably over the longer term to deliver high quality and safe care services to a range of older people in a range of cost environments. The Department's commitment to "work with the Independent Health and Aged Care Pricing Authority (IHACPA) to develop a set of efficient prices to form the basis for the activity-based service payments"[24] is important and supported. The determination of an efficient level of grant funding is of equal importance and must also be evidence-based and transparent.

Additional delivery costs in thin markets

Issues relating to thin markets were the second broad funding topic raised by the Department. There are several features of these markets that have a bearing on the need for loadings on activity-based funding and for supplementary grant funding, both of which have been acknowledged by the Department. Those features raise associated challenges of embedding appropriate incentives into funding arrangements to facilitate the efficient and effective supply of services in the absence of market-based competition.

The costs of service delivery in thin markets have been documented in other reports and will not be repeated here. See, for example, ACFA's 2016 *Financial Issues Affecting Rural and Remote Aged Care Providers*.[25]

Importantly, the challenges of delivering services to small numbers of clients distributed across significant areas apply not only to rural and remote providers but to providers of services to the homeless, to some CALD communities and to others, even where they live in metropolitan areas. In all these situations, providers face the added complexity of creating specialised services and engaging staff with specialist knowledge, skills and attributes. Similarly, there can be additional costs in attracting a workforce to locations that are underserviced, such as the need to offset a lack of affordable housing in some regional areas. The older persons themselves incur travel and other costs (money, time, convenience) as they try to access the services, as do their informal carers, family and friends.

Hence the funding model needs to recognise that the variable costs should have an evidence-based loading to compensate for the higher costs of delivery, in recognition of the needs of the client base and the locations of delivery. In addition, there are sound reasons to provide supplementary grant funding which serves as an availability payment that addresses the higher fixed costs of delivery as well as, in many cases, the higher variability in the number of older persons being cared for.

Supplementary grant funding can enable a provider to be the community's access point for services over at least the medium term irrespective of the actual level of services funded and delivered in any one period. A similar argument has been mounted elsewhere in relation to base funding for a community's access to health care and aged care through multipurpose services.[26] The Royal Commission into Aged Care Quality and Safety drew on many of the issues raised in that report. Similarly, the AN-ACC model for residential care has adopted this same long-recognised approach to funding variable and fixed costs.

There are various methods by which the need for activity-based loadings and/or access availability grants can be identified, but above all, the most important characteristic is that there are clear, transparent and quantifiable criteria that are applied by accountable administrators. One of the aims is to reduce the incidence of political involvement in the allocation of public funds and the delivery of the attendant services and infrastructure. Recent history demonstrates that it is insufficient to rely on Section 71 of the *Public Governance, Performance and Accountability Act 2013*, which provides: "A Minister must not approve a proposed expenditure of relevant money unless the Minister is satisfied, after making reasonable inquiries, that the expenditure would be a proper use of relevant money."[27] The Act defines proper as follows: "***proper***, when used in relation to the use or management of public resources, means efficient, effective, economical and ethical."

The literature provides a guide to various forms of criteria for assessing need, but they should be chosen according to their best fit with the particular circumstances. This may include, as an example, evidence of client coverage falling below a certain acceptable threshold. In terms of determining the level of funding for loadings on activity-based payments and the value of access availability supplements to grants, costing studies of current service delivery could be undertaken by IHACPA. However, as the studies underpinning the AN-ACC process demonstrated, such studies are based on the 'what and how' of current service delivery models, rather than address the more fundamental questions of what services should be delivered and what would be the more efficient and effective means of delivering the services to achieve the desired outcomes. This issue will be raised again in Section 8 on innovation and investment. Another option, although with similar limitations, could be to undertake transparent benchmarking of costs and outcomes across multiple providers, client groups and locations to serve as a guide to efficient funding levels.

In relation to the grants component specifically, and given the absence of market-based competition as noted above, the Department has signalled its preference for a temporally based competitive process, with five-

year funding agreements. A variation would be a competitive negative auction to ascertain the level of funding required to enable an efficient provider of high quality and safe services to deliver those services for the medium term. The five-year period suggested by DoHAC is an appropriate balance between funding certainty for providers and their staff and associated service supply certainty for clients, and retaining competitive tension to maintain the incentives for efficient and effective service delivery. The Department also proposed that providers be subject to minimal reporting requirements for the supplementary grants, noting that these would be additional to activity-based payments reports that enable automatic capture of service provision data. This is supported.

Funding certainty for some service types

Funding certainty is the third broad funding topic flagged by the Department. The discussion paper noted the importance of the ongoing availability of episodic support for services such as dementia support, continence advisory services and vision support. This is supported and is not dealt with further.

The Department also raised questions about the relevance of activity-based payments for some services that have fixed costs that are well above average, as well as fluctuating numbers of clients. It specifically identifies three services that have on other occasions been termed 'social supports' or 'entry level services' – transport, meals delivery and group social support services. All have long antecedents with local government and with community based, volunteer-supported organisations and as well with grant funding such as currently though CHSP.

Two issues are discussed in this response: how to ensure older Australians in need have access to an ongoing and trusted service; and how to ensure that the service is efficient and is delivering value for money.

The access issue is discussed first. An appropriate funding model which aims to ensure the ongoing availability of subsidised services that have very high fixed costs (including but not limited to whether their services are provided in rural and remote areas), would expect to have a high weighting to ensure the ongoing presence of the service and a reduced weighting for the variable costs of service delivery. For some services a grant only model would be appropriate, though the quantum of that grant should be reviewed periodically based on any material growth or contraction in the number of clients or changes in the cost of service delivery. An important additional consideration is the facilitation of reliable delivery through the selection of providers who have the trust of this older and more vulnerable cohort of citizens.

There appears to be widely based agreement that a fee for service model for group-based social support services does not respond to the evidence on either count. As UARC stated in its earlier Commentary: "Including such services within a fee-for-service model, as in the implementation of the NDIS, risks loss of service reliability and a reduction in social connectedness."[28]

The Royal Commission also addressed this issue, and its Recommendation 33 is as follows:

> **Social supports category**
>
> **From 1 July 2022, the Australian Government should implement a social supports category within the aged care program that:**
>
> **a. provides supports that reduce and prevent social isolation and loneliness among older people**
>
> **b. can be coordinated to the greatest practicable extent in each location with services and activities provided by local government, community organisations and business designed to enhance the wellbeing of older people**
>
> **c. includes centre-based day care and the social support, delivered meals and transport service types from the Commonwealth Home Support Programme**
>
> **d. is grant funded.**[29]

UARC supports the full adoption of the Royal Commission's Recommendation 33 (other than in respect of its implementation date which should now be 1 July 2024) and notes that the previous Government accepted this recommendation and advised that it is responding through the measure Home Care - Future design and funding.[30]

The second issue deals with the challenge of ensuring that these subsidised services are delivered efficiently. In large urban areas, market-based competition can create incentives for providers to both be responsive to client needs and offer value for money. Nonetheless, even there, the selection of providers for highly essential and personalised aged care service for this vulnerable group of people requires that the approval process for providers must take into account many factors beyond the cost, and there must be proportionate regulation of quality and safety.

In thin markets across all regions, as discussed earlier, contemporaneous competition between providers is an even less valid construct. However, regular monitoring of quality, quantity and costs is essential. While the ability to roll over funding into the following period can avoid wasteful end-of-period expenditure, providers should submit requests that exceed a certain threshold (perhaps no more than 10% of the period total) and supporting evidence. Funding reviews would take these requests and justifications into account. Given the special circumstances in which these grants are provided, transferring any excess funding to other essential services would not be appropriate. Better analysis of the costs of service delivery, especially in regard to the allocation of indirect costs, will be necessary for setting prices under these contracts. The periodic opening of provider funding to competition can be an appropriate proxy to market competition in many circumstances.

The particular circumstances of Social Support Services

The preceding sub-section supported the proposition that social support services be grant funded. In this respect it recognises the somewhat unique characteristics of these services, as did the Royal Commission. Other parts of this response by UARC have also drawn attention to the unique circumstances of these social support services.

For instance, a challenge in designing the care partner role is to balance universal coverage with the efficient allocation of scarce resources. Many recipients of only one or perhaps two social support services may well benefit from an initial meeting to confirm that the assessment reflected the older Australian's needs, but that

further care partner support may be significantly less unless the complexity of needs increases. Another consideration in relation to the assessment process is that many older Australians who newly access subsidised aged care and who, at that stage, only need one of these social support services should have a simple assessment process that is easy to follow and to comply with. Nonetheless, it also needs to be recognised that what may appear to be a simple request for transport, meal delivery or group social support may result from a more complex set of needs which should not go unaddressed. To an extent, an initial visit from the care partner would provide an opportunity for a second opinion.

Finally, if in-home care funding is to rely on the calculation of a national efficient price, the inclusion of pricing for social support services could prove very distortionary. This in itself is sufficient reason to leave these services out of the broader in-home care funding arrangements and retain some form of grant-based funding with appropriate incentives for efficiency and effectiveness and transparency for provider accountability.

Section 7 Support That Meets Assessed Needs But Is Responsive To Changes Over Time

The need for the type, volume, timing of services being delivered to have some flexibility was emphasised previously in UARC's Commentary. It is consistent with one of the Department's proposed program's objectives, which is: "Older Australians should have timely access to a full range of services that meet their assessed aged care needs."[31] Implicit in this objective is that, as peoples' assessed needs change, they should have timely access to services that meet those changed needs. This responsiveness to change and associated requirement for program flexibility has been recognised and accepted by the Department.[32]

The Departmental paper includes new detail on how the program's flexibility will be operationalised and it puts forward two mechanisms. First, it is proposed that older Australians would be able to adjust their service mix at any time according to their needs through discussion with their provider(s) and subject to the constraints of a quarterly budget and some quarantining of services. Second, additional short-term support (in excess of an individual budget) could be sought without reassessment and be funded through a provider-held flexible pool.

DoHAC's discussion questions relate to the second mechanism concerning the operation of a flexibility pool. However, there are also some unanswered questions that remain about how the first flexibility mechanism will function, especially in the context of the newly articulated program objectives.

Flexibility through service swaps and quarterly budgets

In principle, flexibility provisions support the objective that 'Older Australians should have choice and control over services that meet their assessed aged care needs' and aim to make it easier for them to access a full range of relevant services in a timely and responsive manner. Yet, the combination of having a prescriptive initial Individualised Support Plan and a set of complicated flexibility provisions may result in a complex and challenging experience of system navigation for older Australians.

For older people to be able to make informed choices about the services that they receive, it is essential that they have access to clear, simple and transparent communication about which services are 'quarantined' and which services may be adjusted in order to better meet their needs. In this respect, however, the Department's view that the delivery of clinical support should be prioritised through this quarantining mechanism is strongly supported.

The implementation of quarterly budgets, within which older Australians are permitted to manage their service mix, will necessarily look different depending on the extent to which the person chooses to manage their own services or if their service mix is managed by a preferred provider. However, in both cases, quarterly budgets should be stated either by service category or 'net' of quarantined funding that cannot be swapped for other services. Older Australians should be supported to understand their budgets, the services that can be changed/adjusted and those which cannot, and how they can request additional short-term

services. This support should either be provided by a preferred provider, if there is one, or by the care partner (see Section 5).

Flexibility through use of a provider flexible pool

The Department frames the concept of a flexible pool of funding in the following terms: "an additional pool of funds on top of an individual's budget to facilitate minor tops ups without needing a reassessment (set at around 25% of the total cost of their clients' budgets each quarter). It would be up to the provider how this pool is spent across their clients, based on guidance about how to prioritize needs. Funds would be paid on an activity basis."[33] Additional funding of care through a flexible pool should be used to meet short-term support needs, and to be an interim arrangement while reassessment for increased ongoing need is being undertaken.

It should be noted that one factor which relates to the changing support needs of older Australians is the availability and capacity of informal carers. Many older Australians who are supported by family, friends or other informal carers may have limited ongoing need for publicly subsidised in-home aged care services. However, they may have a need for additional short-term support during periods where the informal carer is not available. Flexible funding will provide an essential mechanism for providers to scale up care during such periods and provide stability and peace of mind for both the older Australian and those who care for them.

For older Australians with more complex needs, access to respite on a flexible or emergency basis is important and can often be driven by carer availability. The comparatively unpredictable nature of demand for some services, including cottage and centre-based respite, may mean that a flexible pool which is set at a proportion of total (ongoing) client budgets will not be an appropriate or sufficient funding mechanism. As discussed in the previous section, DoHAC's proposal that long-term grants be part of the ongoing funding for some providers who provide these forms of respite, will be important to support the viability of these services.

A potential unintended consequence of the use of a flexible pool (especially if it is of the magnitude as proposed by the Department) is that it might undermine the important resource allocative role required of the assessment process. This would occur if the perception were that the provider can readily determine that the older person has significant additional needs that are not being met and can allocate substantial additional resources to providing the associated services. In addition, there is a question about accounting for the services provided – how are services which are accessed through a flexible pool reconciled with those that are included in the older Australian's quarterly budget?

As discussed in Section 5, care partners will play an essential role both in identifying increased need, and in supporting older Australians to access additional services for which they would be eligible, to meet those needs.

Considerations in determining the size of the flexible pool

In the October discussion paper, DoHAC suggested that each provider would have an additional quarterly funding pool that would be equivalent to 25% of the total value of their clients' quarterly budgets. In the context of the above discussion of the role of such a pool in managing short-term needs, and as an interim

measure prior to reassessment, 25% is likely to be a significant overestimation of the actual additional temporary requirements of providers and their clients.

To put this figure into a still broader context, in 2020-21, the Government contributed $2.7 billion to home support,[34] $4.2 billion to home care (p78),[35] $458 million to residential respite care,[36] and a further $67.3 million to the STRC program for a total annual expenditure of approximately $7.5 billion. A further $1.7 billion in unspent funds was held by HCP providers as at 30 June 2021, which represents current underutilisation of funds of at least 10% and which is not included in these expenditure figures.

On this basis, a rate of 25% of total clients' budgets would create a potential aggregate annual flexible pool value of over $1.8 billion across the sector. This represents an extraordinary amount of funding for which there is currently very limited guidance or accountability for its use.

Before committing such large sums of expenditure, consideration should be given to ways of mitigating the underlying need. The starting point, as acknowledged by the Department, is the development of an assessment tool and classification system "to better align older Australians' aged care assessment service recommendations and funding intensity with their support needs."[37] This would be followed by the ongoing refinement of assessment and reassessment processes to ensure timely matching of the older person's contemporary assessed needs and the services/funding available within their Plans/quarterly budgets.

Mitigation can also be achieved through the design of alternative flexibility measures, including the separate (partial) grant funding of services commonly used to support short-term or unpredictable support needs (such as respite and restorative/reablement care).

Determination of the appropriate level of funding for a flexible pool should be made through analysis of the frequency, duration and cost of short-term and interim care arrangements within the scope of the existing programs, taking into account the effectiveness of the mitigation measures discussed above. The recent implementation of Improved Payment Arrangements for HCP and the resulting payment in arrears for the provision of home care services provides a potential source of data that could be used to facilitate this analysis. To reiterate our argument in Section 6, all advice received by DoHAC on appropriate funding levels (including the value of the flexible pool) should be evidence-based and oriented toward achieving an efficient, effective and transparent allocation of funding.

Section 8 Encouraging Innovation and Investment

The ability to incentivise innovation rests upon the capacity of organisations to direct innovation towards two key areas. The first is in relation to how value is created for care consumers (typically referred to as the quality of care, a point returned to later). The second is to increase the financial viability of the organisation through the generation of additional revenues and reducing the costs incurred. Revenue growth can come from increases in price due to innovation driving product/service differentiation and increases in the quantity sold/delivered. As explained in the Departmental paper, given the prices are set by government a revenue-focussed strategy would not seem to be applicable. A second approach is to reduce costs and thereby increase margins as a result of the efficiencies gained from the innovation process.

The context in which innovation is encouraged is significant, as it can be suppressed by inappropriate regulation, particularly where the rules specify the type and quantum of particular inputs or even specific outputs rather than outcomes. The input approach can require all providers to produce services in the same or similar manner and the output approach requires providers to produce the same services. Innovation which achieves the intended outcomes with different resource mixes or different services is not only discouraged but is in fact prohibited. Specifying staffing numbers at certain skill levels are an example of input controls and many service specifications are examples of output controls.

It may not even be necessary for the regulation to be so specific for it to suppress innovation. A consequence of the Aged Care Approvals Rounds has been for applicants to put forward 'safe' models of residential aged care so as to improve their chance of being awarded additional bed licences. In addition, there has been a bias to selecting known providers rather than new entrants who may think differently and have different business models and/or have different accommodation offerings. The solution was to remove the regulatory barriers to innovation and thereby enhance the incentives to innovate through more flexible competition.[38] In considering innovation processes, key questions are: who is undertaking the innovation, what is the focus of the innovation, who gains the benefit of the innovation, and who is funding the innovation?

In respect of the question of 'who', innovation can occur at the provider level and can improve that provider's profitability and market share (sometimes as a disruptor). For this to occur, however, the regulatory framework needs to be permissive of such an approach, and the sector-level impact can be slow to achieve. Any meaningful sector-based innovation which fundamentally transforms the efficiency and effectiveness of care provision, and thereby also improving providers' financial returns through lowering costs, is likely to be beyond the financial capacity of any one organisation.

The Department's discussion paper suggests an annual innovating grants program which has a focus on individual providers. This has some merit, with those providers acting as 'innovation labs'. However, careful consideration would need to be given to how the innovative practices are broadly disseminated and the benefits shared across the sector, given the incentive for providers to privatise and maximise individual competitive benefit.

Broader scale innovation requires a more 'open innovation' approach where innovation occurs in a more distributed form between and within providers rather than limited to a siloed organisation-specific approach. In this instance the innovation process would need government support or larger pooled funding

arrangements. Research and development corporations are one such model. Open innovation approaches require clarity and agreement on which aspects of care provision require improvement through innovation, together with good governance and a translation processes. This will enable the innovation to be adopted and implemented across providers, thereby increasing the effectiveness and efficiency of care at a sector level.

Innovation can be undertaken in a number of key areas. One is an orientation towards providers being able to meet consistent and high-quality outcomes. A second is to increase the efficiency and effectiveness of care provision. This can be focused on the models of care and the use of technology. Related to this is innovation in platform development and integration (online and apps) to better service the needs of clients and providers.

On the question of encouraging investment in the aged care sector, the DoHAC paper addresses the 'right conditions for investment' and asserts (not without reason) that capital investment is hindered by uncertainty in the sector about reforms and regulatory requirements along with the workforce challenges (albeit a risk that is more directly manageable).

While these points have merit, the key issue - which is unaddressed - is that investors are not confident of their ability to gain sufficient returns from the sector relative to other competing investment opportunities. As argued in the UARC Sustainability report,[39] capital investment follows potential returns that have a higher and more predicable level of certainty. This argues for government to be clear in signalling its reform intentions, in consulting widely and in adopting evidence-based reforms which benefit the community as a whole. Returns are also dependent on the setting of prices, with sufficient margin over the direct and indirect cost of service delivery required to encourage investment.

The two issues of innovation and investment can also be brought together. If investors see investment in innovation as being able to sufficiently increase market share and/or reduce costs to viable levels (given the risks present – including regulatory and reform uncertainty) then capital will flow into the sector. As discussed above, there may be an argument for government investment in the innovation processes where the addition of industry R&D expenditure and subsequent investment is likely to produce a net public benefit.

A final point on the question of 'Competition on quality' is that the focus of all providers should be on offering high quality care, as a baseline expectation for participation in the sector. Innovation in relation to quality should be implemented across all providers and can provide a point of difference and ability to compete in the market. Competition should reflect productive activity focusing on the responsiveness to consumer needs and preferences, on the types of services and supports offered and on economies of scale and scope and other efficiencies.

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References

[1] Department of Health. (2022). *Support at Home Program Overview*. https://www.health.gov.au/resources/publications/support-at-home-program-overview.

[2] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[3] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[4] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 20. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[5] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 21. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[6] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 11. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[7] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 11. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[8] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 15. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[9] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 15. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[10] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 15. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[11] Aged Care Sector Committee. (2016). *Aged Care Roadmap*. https://www.health.gov.au/resources/publications/aged-care-roadmap.

[12] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 11. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[13] Department of Health and Aged Care (2022). *Financial Report on the Australian Aged Care Sector 2020-21* https://www.health.gov.au/sites/default/files/documents/2022/11/financial-report-on-the-australian-aged-care-sector-2020-21-financial-report-on-the-australian-aged-care-sector-2020-21.pdf.

[14] Department of Health and Aged Care (2022). *Financial Report on the Australian Aged Care Sector 2020-21* https://www.health.gov.au/sites/default/files/documents/2022/11/financial-report-on-the-australian-aged-care-sector-2020-21-financial-report-on-the-australian-aged-care-sector-2020-21.pdf.

[15] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 25. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[16] Mathew, J., & Patel, H. P. (2021). Integrated care for older adults living with frailty. *Clinics in Integrated Care*, 9, 100078; Bird, S.R., Kurowski, W., Dickman, G. K., et al. (2007). Integrated care facilitation for older patients with complex health care needs reduces hospital demand. *Australian Health Review*, 31(3), 451-461.

[17] Parker, D., Rawlings-Way, O., Brown, D., Sutton, N., McAllister, G., Lewis, R., & McEwen, C. (forthcoming). *The Structures, Processes and Outcomes of Integrated Care for Older Adults across Care Settings: An Umbrella Review*. UTS Ageing Research Collaborative. University of Technology Sydney.

[18] *Quality of Care Principles 2014* (Cth), Schedule 3, Part 1, Section 2. https://www.legislation.gov.au/Details/F2020C00096.

[19] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 16. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[20] Kelly, K. J., Doucet, S., & Luke, A. Exploring the roles, functions, and background of patient navigators and case managers: A scoping review. *International Journal of Nursing Studies*, 98, 27-47.

[21] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 20. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[22] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 17. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[23] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 20. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[24] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 23. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[25] Aged Care Financing Authority. (2016). *Financial Issues Affecting Rural and Remote Aged Care Providers*. https://www.dss.gov.au/sites/default/files/documents/02_2016/11415_acfa_financial_report.pdf.

[26] Woods, M., Edwards, K., Nejad, M. N., Haywood, P., & Wise, S. (2019). Aged Care in MPS: Response to the Australian Government Terms of Reference. Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney. https://www.health.gov.au/health-topics/aged-care/aged-care-reforms-and-reviews/review-of-the-multi-purpose-services-program.

[27] *Public Governance, Performance and Accountability Act 2013* (Cth), Section 71. https://www.legislation.gov.au/Details/C2017C00269.

[28] Lewis, R., Woods, M., Brown, D., Parker, D., Sutton, N., McAllister, G., & Sinclair, D. (2022). *Support at Home: A Commentary on the Design of the Proposed Unified Program*, p. 19. UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/162149.

[29] Royal Commission into Aged Care Quality and Safety. (2021). *Final Report: Care, Dignity and Respect*. *Volume 1, Summary and Recommendations*, p. 232. https://agedcare.royalcommission.gov.au/publications/final-report-volume-1.

[30] Department of Health. (2021). *Australian Government Response to the Final Report of the Royal Commission into Aged Care Quality and Safety*, p. 26. https://www.health.gov.au/resources/publications/australian-government-response-to-the-final-report-of-the-royal-commission-into-aged-care-quality-and-safety.

[31] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 15. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[32] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 28. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[33] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 23. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[34] Department of Health and Aged Care. (2021). *Financial Report on the Australian Aged Care Sector 2020–21*, p. 63. https://www.health.gov.au/sites/default/files/documents/2022/11/financial-report-on-the-australian-aged-care-sector-2020-21-financial-report-on-the-australian-aged-care-sector-2020-21.pdf.

[35] Department of Health and Aged Care. (2021). *Financial Report on the Australian Aged Care Sector 2020–21*, p. 78. https://www.health.gov.au/sites/default/files/documents/2022/11/financial-report-on-the-australian-aged-care-sector-2020-21-financial-report-on-the-australian-aged-care-sector-2020-21.pdf.

[36] Department of Health and Aged Care. (2021). *Financial Report on the Australian Aged Care Sector 2020–21*, p. 105. https://www.health.gov.au/sites/default/files/documents/2022/11/financial-report-on-the-

australian-aged-care-sector-2020-21-financial-report-on-the-australian-aged-care-sector-2020-21.pdf.

[37] Department of Health and Aged Care. (2022). *A New Program for In-Home Aged Care – Discussion Paper*, p. 28. https://www.health.gov.au/resources/publications/a-new-program-for-in-home-aged-care-discussion-paper.

[38] Woods, M., & Corderoy, G. (2020). *Impact Analysis: Alternative Models for Allocating Residential Aged Care Places. Final Report.* Centre for Health Economics Research and Evaluation (CHERE), University of Technology Sydney. https://www.health.gov.au/sites/default/files/documents/2020/09/final-report-impact-analysis-alternative-models-for-allocating-residential-aged-care-places-report.pdf.

[39] Woods, M., Sutton, N., McAllister, G., Brown, D., & Parker, D. (2022). *Sustainability of the Aged Care Sector: Discussion Paper.* UTS Ageing Research Collaborative. University of Technology Sydney. https://opus.lib.uts.edu.au/handle/10453/158194.