# Support At Home Alliance

A group of organisations passionate about the future of the home care system for senior Australians

## SUBMISSION ON *IN-HOME AGED CARE DISCUSSION PAPER*

The Support at Home Alliance is a group of state and national organisations passionate about getting the future of the home care system right, the first time, for senior Australians.

Membership includes:
- Aged and Community Care Providers Association (ACCPA)
- Australian Community Transport Australia (ACTA)
- Community Options Australia (COA)
- Community Transport Organisation (NSW)
- Ethnic Communities' Council of NSW
- Home Modifications Australia
- Local Community Services Association
- Local Government NSW
- Meals on Wheels Australia and Meals on Wheels NSW
- Municipal Association of Victoria (MAV) [in-principle support]
- NSW Neighbour Aid & Social Support Association
- National Sector Support and Development Network

## Summary

The Support at Home Alliance (the SaH Alliance) welcomes the opportunity to respond to the Department of Health and Aged Care (DoHAC) In-Home Aged Care Discussion Paper. The SaH Alliance acknowledges that the Discussion Paper has responded to many of the issues raised since its initial consultation paper was released in January 2022.

Our submission reviews the key features we expect to see in a In-Home Aged Care Program from July 2024 and reports on an analysis of the sector's response to four alternative funding models:
- Status quo mix of HCP individual budgets and CHSP block grants
- Aged Care Royal Commission
- DoHAC *In-Home Aged Care Discussion Paper*
- SaH Alliance activity-based funding model – an Australian National Aged Care Classification (AN-ACC) for home care.

Central to the SaH Alliance is a funding model which is consistent across health and aged care systems, characterised by an activity-based payment based on classification of individual needs alongside a base care tariff to support capacity. Payments to service providers would be structured as an annual price and volume contract. However, older people could choose an individual payment option, which we anticipate would be taken up by around 15% of consumers. As with residential care, a new fit-for-purpose assessment tool will need to be developed in tandem to support the new funding model.

Based on a review of international and Australian examples, our submission identifies how Australia's in-home care system could be designed to maximise equity, efficiency, quality and choice.

## DoHAC *In-Home Aged Care Discussion Paper*

The then Department of Health released a consultation paper on the design of the Support at Home Program in January 2022. Despite initial indications (in the paper itself) that only minor aspects were up for co-design, the SaH Alliance acknowledges that the Department has taken on board sector feedback and adjusted key aspects of its proposed model in the DoHAC *In-Home Aged Care Discussion Paper*[1] released in late October 2022.

Of note, DoHAC has made the following changes:

- Expansion of grants to include transport, meals, group social support, cottage and centre-based respite services as well as thin or niche markets.
- Clarification of availability of care management to include episodic support for people with less complex needs.
- Full flexibility to change services within a quarterly budget, other than:
  - Care management cannot be reduced
  - Caps on monthly cleaning and gardening.
- 25% flexible pool for providers to make temporary service increases when needed.

At its heart, though, the October 2022 DoHAC model still seems to be based on the same core concepts as advanced in the January 2022 paper. Most funding would be delivered through an individual fee-for-service payment via a service list with prices fixed and capped by the government.[2] The expansion of grant funding is not integrated into this system but would run alongside it. There is no commonality of approach with the rest of the aged care system via the AN-ACC or the broader health system.

## SaH Alliance Desired Key Features

In December 2021, the SaH Alliance released a position paper titled *Seamless Aged Care: How to set up Support at Home right, first time*.[3] We argued that home and community care programs are the bedrock of Australia's aged care system, supporting communities through provision of personal care services, meals, transport, community support, amongst others. Our organisations are embedded in every local area across Australia, providing services and support to people regardless of where they live, their culture or their ability to pay. Our aim is simple, to ensure the over 1 million older people we care for, are able to continue to live in their local communities, participate in everyday activities, for as long as possible.

Our December 2021 position paper articulated a vision for the future of Support at Home which:

- Is built on existing network of local services, activities and supports, both formal and informal.
- Provides real choice for older people through provider-managed or self-managed services or mix of both.
- Minimises burden on the older person, e.g. administration, rostering etc (unless it's their choice).
- Involves a localised planning framework and capability development with a strong interface with health services.
- Has at its core a funding model that is equitable and sustainable.

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[1] Department of Health & Aged Care (2022) *In-Home Aged Care Discussion Paper* at https://www.health.gov.au/sites/default/files/documents/2022/10/a-new-program-for-in-home-aged-care-discussion-paper_0.pdf

[2] This is somewhat inaccurately described as 'activity-based funding' in the DoHAC Discussion Paper.

[3] Support at Home Alliance (2021) *Seamless Aged Care: How to set up Support at Home right, first time* at https://acsa.asn.au/ACSA/media/General/Support-at-Home-Alliance-Position-Paper.pdf

In response to the DoHAC *In-Home Aged Care Discussion Paper*, the SaH Alliance and its members identified 10 criteria by which to analyse any new model for Support at Home.

***Criteria to Evaluate Any New In-Home Care Model***

| | |
|---|---|
| 1. | Operational efficiency (including through the transition period) |
| 2. | Transparency |
| 3. | Consistency: one funding model across all aged care |
| 4. | Includes a mechanism to increase funding as needs increase |
| 5. | Funding equity between consumers |
| 6. | Funding equity between providers |
| 7. | Fairly shares financial risk between government, providers and consumers |
| 8. | Does not create perverse incentives |
| 9. | Agility – service provider can flexibly respond to changing needs of consumers |
| 10. | Person-centred care and support |

SaH Alliance members were then invited to rate four models against these criteria on a scale where five stars is best, one star is worst.  The table below synthesises the ratings compiled by member organisations.

With the exception of one organisation, all participating SaH Alliance members rated the SaH activity-based funding AN-ACC model as the best.  One organisation did not assess the AN-ACC model on the basis that it did not feel sufficiently familiar with it.  All participating SaH Alliance members rated the current In-Home Aged Care proposal as the worst.

While the DoHAC proposed model is (in some aspects) an advance on the current system, it falls far short of the advantages of the SaH Alliance's activity-based funding model.

***Support at Home Alliance Ranking of Potential In-Home Aged Care Program Models***

Worst * ** *** **** Best *****

| Criteria | Status quo | Royal Commission model | DoHAC October discussion paper | AN-ACC |
|---|---|---|---|---|
| 1.Operational efficiency (including transition) | ** | *** | *** | *** |
| 2.Transparency | ** | ** | **** | **** |
| 3. Consistency across all aged care | * | ** | ** | ***** |
| 4.Includes a mechanism to increase funding as needs increase | *** | **** | *** | **** |
| 5.Funding equity between consumers | * | **** | **** | **** |
| 6.Funding equity between providers | ** | *** | ** | ***** |
| 7.Fairly shares financial risk between government, providers and consumers | ** | *** | ** | *** |
| 8. Does not create perverse incentives | * | ** | * | *** |
| 9. Agility – service provider can flexibly respond to changing needs of consumers | ** | ** | *** | ***** |
| 10. Person-centred care & support | ** | **** | *** | **** |

## An Alternative Model for In-Home Aged Care

The DoHAC discussion paper starts with an assumption that aged care should be built around a competitive market model in which providers compete for customers and are paid fee for service. We are concerned this is a model which has proved ineffective in other human services sectors. The SaH Alliance believes that an alternative model should be adopted for Australia's in-home aged care system.

***Australian Comparison: Medicare***
The core of the In-Home Aged Care program as currently proposed is that applicants will be assessed and approved for specified hours for each item on a schedule of services. Just like Medicare, each item on the list has a predetermined price and providers bill retrospectively for services delivered.

The limits of fee for service are well understood in the health sector. On the primary care side of the system, considerable work is underway to test and potentially introduce funding models that better deal with people with chronic and complex care needs.

***Australian Comparison: NDIS***
The individualised NDIS market model is failing, with significant cost overruns due to higher-than-expected demand and increasing costs per plan. Both of these cost drivers include elements of supplier-induced demand. It is perplexing that these significant overruns (now estimated to be in the billions) were not expected as they are the inevitable consequence of the design of the NDIS itself.

The DoHAC discussion paper sets out a proposed In-Home Aged Care program that is essentially an NDIS for older Australians. The major difference is that individual plans will be specified as items of service rather than a quantum of dollars, alongside greater contribution from grant funding (but at an unspecified level). But the net effect will be the same.

The reality is that the NDIS model is not a practical option for widespread adoption across the aged care sector. With only about a third as many participants as the aged care sector and with most adult participants having stable care needs, the NDIS has taken many years to roll out its model based on 'necessary and reasonable supports'. Even now, nearly a decade since its inception, the NDIS model is not fully implemented and there are real questions about its sustainability.

The aged care sector has more than a million consumers at any one time, has a significant number of consumers with unstable and progressively increasing needs and has many thousands of people who come and go each year. The model adopted by the NDIS is simply not practical for the aged care sector. If implemented across all of community aged care, even more people would die waiting.

The implications at the system level are significant. The implementation of an NDIS model in the aged care sector can be anticipated to blow out aged care costs in the same proportions and for the same reasons as the NDIS. As Sir Humphrey would say, it would be a 'courageous' decision for a new government to repeat the design errors of the NDIS when significant cost blow outs are inevitable and at a time when the budget has no capacity to accommodate them.

***International Comparison: Netherlands***
This is consistent with the Dutch aged care experience, where, given the choice, about 85% of people elect not-for-profit grant funded services over an individualised voucher model. The experience of the Dutch should be used to inform the design of a future model for Australia.[4]

## SAH Alliance Recommended Model

Working with the Australian Health Services Research Institute, the SaH Alliance has been testing whether the new residential aged care funding model (the AN-ACC) would also work in community aged care. Key features of the SaH Alliance model are as follows:

- *Support at Home Program* with similar funding model to residential care, allowing *seamless integration*.

[4] See, for example, the evidence of Professor Jos Schols of Maastricht University at the 31 August 2020 hearing of the Aged Care Royal Commission https://agedcare.royalcommission.gov.au/media/28360

- *Activity-based funding model* with mix of a base care tariff to ensure *capacity* to provide services and an individual care payment based on care delivered or *activity*.
- Assessments for Support at Home Program would be *calibrated to level of need and align with AN-ACC for residential care*.
- *Activity-based funding model* would determine allocation to funding class. Services could be variable within funding allocation.
- Care management would be *integrated within the funding model*, either via the base care tariff or the casemix component.
- *Base care tariff* would be paid at different levels according to the real costs incurred to ensure capacity to deliver services to particular communities, such as rural and remote areas.
- *An option for self management* would be available to consumers (see Appendix 1).

Proof of concept has been established so far in Meals on Wheels and in Community Transport services in NSW and there is widespread agreement that it will work equally well for other community aged care. The result of this work is very clear. The AN-ACC is a fit-for-purpose funding model that works equally well in residential and community aged care.

Adoption of the one funding model across residential and community aged care has significant policy and operational advantages and the AN-ACC must thus be considered as a serious alternative to the proposals set out in the DoHAC discussion paper.

However, building on the Dutch aged care and the Australian NDIS experience, some care recipients would prefer a voucher-style model. The SaH Alliance supports introducing a policy that gives care recipients a real choice between an AN-ACC funded service or an individualised funding arrangement. The care recipient would get the same hours of care, same access to care coordination and case management, etc. irrespective of whether they elect the AN-ACC funded service or an individualised funding arrangement.

Given the choice, the Dutch experience is that 85% elect services from a block-funded not-for-profit aged care provider. Only 15% elect individualised funding via a voucher style system. The government could anticipate the same proportions in Australia if the same range of services and same entitlements were available in both streams. The only difference is the delivery model. This is real consumer choice.

In relation to implementation costs and complexity, the AN-ACC model is certainly no more costly or complex than the current In-Home Aged Care proposal. It is likely to be significantly cheaper and administratively more efficient. This is because the cost of implementing the AN-ACC model is substantially cheaper than implementing individualised funding for more than a million people per annum. On that note, it is important to distinguish between conceptual and administrative complexity. The In-Home Aged Care proposal is conceptually simple but administratively complex. The AN-ACC model is conceptually more complex but administratively much simpler.

Appendix 2 outlines a few key operational issues and Appendix 3 outlines a potential integrated model for aged care, prepared by Prof Kathy Eagar.

## APPENDIX 1

## ROLE OF SELF MANAGEMENT

Contrary to popular perceptions, the majority of older people accessing care and support in their home do not want Consumer Directed Care (also described as 'choice and control'). The significant majority of older people want **person-centred**, not consumer-directed, care. They want **relationship-based care**, not transaction-based care. Yet transaction-based care is the inevitable consequence of a competitive market model.

People receiving care and support at home want to trust the people coming into their homes and they want to have an authentic relationship with them. They do not want to be treated as a financial transaction nor a commercial customer.

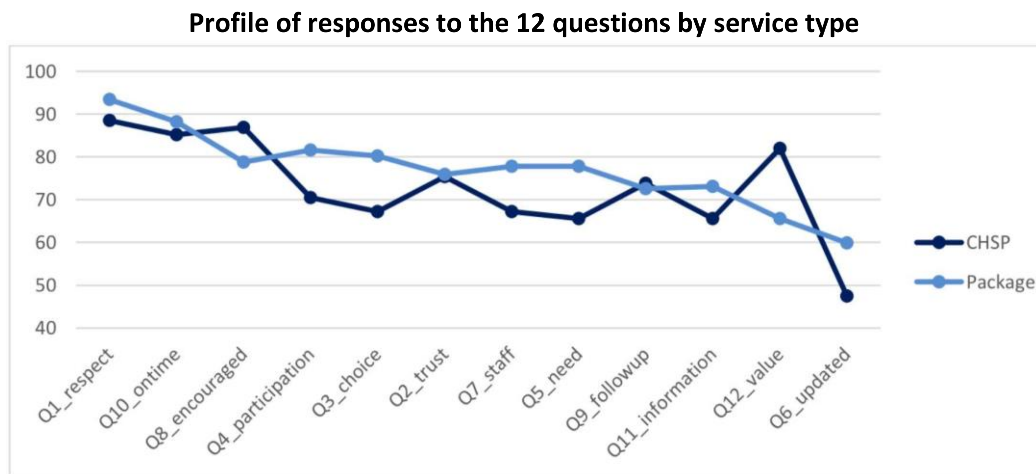
Also contrary to popular perceptions, we do not have any evidence that people with a Home Care Package (HCP) have better experiences than people in receipt of Commonwealth Home Support Program (CHSP) services.

To the best of our knowledge the only piece of work that has been done comparing CHSP and HCP consumer experiences head to head is the CERHC survey[5]. This survey asked people in receipt of both service types to rate their experiences using twelve questions:

| Question |
|---|
| |
| Q1: Do staff treat you with respect? |
| Q2: Do you trust your service provider? |
| Q3: Do you have a choice in what services you get? |
| Q4: Do you participate in making decisions about what services you get? |
| Q5: Do you get the services you need? |
| Q6: How often are your services updated? |
| Q7: Do the staff know what they are doing? |
| Q8: Are you encouraged to do as much as possible for yourself? |
| Q9: Do staff follow up when you raise things with them? |
| Q10: How often do the staff come on time? |
| Q11: Do you understand the information you are given about your services? |
| Q12: Do you get value for money? |

The summary results are as follows:

[5] Wells, Y., & Fetherstonhaugh, D. (2019). *CERCH pilot Phase 2: Report to the Aged Care Quality and Safety Commission*. Melbourne: La Trobe University

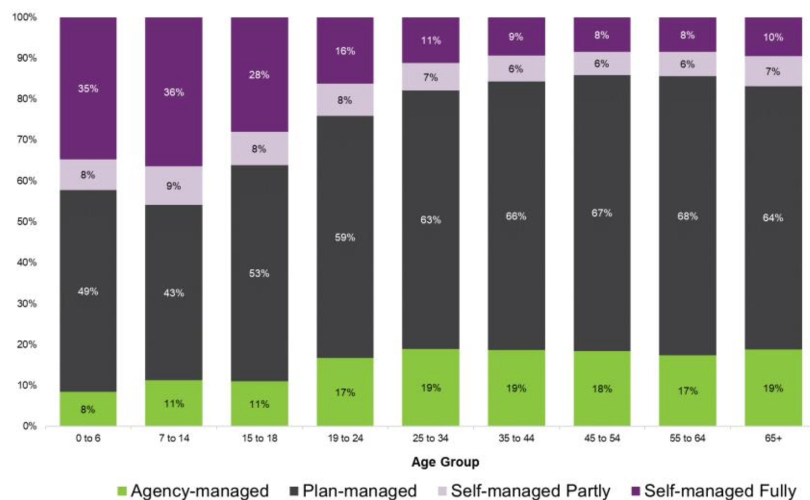



While there were small differences on most items, differences were significant for only two questions:

- Packaged care participants gave significant more positive responses than CHSP participants to "Q3: Do you have a choice in the services you get?"
- CHSP participants gave significantly more positive responses than packaged care participants to "Q12: Do you get value for money?"

Despite what some people have claimed, no one can claim that we have any actual evidence that consumers have a better experience with the HCP individualised funding model.

The other available measure we have on what care and support recipients actually want comes from the NDIS. A core feature of the NDIS is self-management but participants are given the option in relation to the management of their package. The results for the most recent quarter (Q4 2021/22) are[6] shown below. Only about 15% of older people in the Australian NDIS elect full or partial self-management.




[6] https://www.ndis.gov.au/about-us/publications/quarterly-reports

## APPENDIX 2

## OPERATIONAL ISSUES

The purpose of this appendix is not to describe in detail how the AN-ACC price and volume would work or how the AN-ACC and the individualised funding options can be efficiently run in parallel. It is simply to identify a small number of key issues that would need to be addressed, some in the design phase and some in business rules.

The purpose of this attachment is also to make the point that the two approaches can be run in parallel without the system being too complicated or too expensive to administer.

On that note, it is important to reiterate a previous comment. There is an important difference between conceptual and administrative complexity. The In-Home Aged Care proposal is conceptually simple but will prove to be administratively complex. It will be very expensive to implement. The AN-ACC model is conceptually more sophisticated but administratively much simpler. It will be much less expensive to administer, both for the Department and for providers.

***How would the system work for a care recipient?***

A person needing an aged care service, or needing a different service to their current one, would be referred or would self-refer for a needs-based **assessment**. The assessment, which may be either face to face or by phone or by videoconferencing, is scaled for the circumstances of each person.

The second step is that, working with the person (and their family/carer), the assessment agency develops an initial **service plan.** This service plan lists the services that the person needs and identifies those services that can be funded through the Commonwealth aged care program.

The next step is that the person is **approved** for an agreed list of services. Approvals are no longer framed as a quantum of dollars.

The next step is that every care recipient is offered two delivery options – a no-profit AN-ACC funded service or an individualised funding arrangement. This is the point where this proposal differs completely from the current In-Home Aged Care proposals.

People from CALD backgrounds would need access to interpreters at every step to ensure the voice of the person needing the aged car service, or their carer, family member or advocate is front and centre in any decision making.

The important difference is that AN-ACC funding and individualised funding become **delivery options** and the care recipient elects the delivery option of their choice. AN-ACC and individualised funding models are not services or programs in their own right.

Each person elects the delivery option of their choice. This is real choice. This is an overarching decision for all of their care, not service by service.

Each care recipient can change this election as their circumstances change or if they are unhappy about the services that they are receiving. They do so by returning to the assessment agency for a new referral and plan.

Based on the delivery option elected, each person is given a list of local providers that offer the delivery option that they have elected and they select the provider/s of their choice. A new 5 star rating system will help with this.

***How would an AN-ACC classification and funding model for care at home be developed?***

Proof of concept of the AN-ACC model has already been established for community transport services in NSW and for delivered meals services and this has resulted in a set of Base Care Tariffs, activity classes and AN-ACC client classes for each. Using a similar methodology, Base Care Tariffs, activity classes and AN-ACC client classes would be developed for other service types and combination classes would then be created for care recipients needing more than one service. Computerised information and reporting systems makes this a relatively straightforward process.

The calibrated assessment tool that the Department already has under development would then need to be refined. Its task is to allocate each care recipient to one or more AN-ACC classes. As with residential care, the assessment tool cannot be developed in isolation from the funding model.

This development process could be undertaken as one major project (as occurred in residential care). Alternatively, it could be undertaken progressively over several years with both care recipients and service organisations progressively transitioning to the new arrangements.

***How could the existing system transition to the AN-ACC classification and funding model?***

The answer to this question is an extension to the answer above. If the AN-ACC model for community aged care is developed in one large project, it could be implemented nationally from a specified date. This was the approach taken in residential aged care.

If the AN-ACC model for community aged care is developed progressively over time, implementation could also be incremental. Implementation would logically start with organisations that deliver only one type of service and be progressively extended to include multiservice agencies.

Either way, an AN-ACC Transition Fund would need to be established in the same way as the AN-ACC Transition Fund for residential care. The residential care AN-ACC Transition Fund ensures that no residential aged care facility will receive less funding under AN-ACC in the first two years of transition.[7]

***What is a price and volume contract and how does it differ from the residential aged care model?***

The AN-ACC funding model we are advocating for has the same building blocks (Base Care Tariffs and AN-ACC casemix classes) as the AN-ACC funding model in residential care. This brings with it significant policy and operational advantages.

However, there is one important difference in how the AN-ACC is implemented in the two sectors. The AN-ACC residential funding model is a per diem model. The AN-ACC community funding model is a per annum price and volume model.

Under a price and volume contract, the Department enters into an annual contract that specifies the total price and the total volume of activity to be delivered over the whole year. There are two line items as shown below.

[7] For more about the AN-ACC Transition Fund, see https://www.health.gov.au/resources/publications/what-is-the-an-acc-transition-fund

**An illustration of a price and volume contract**

| Funding agreement | Total RVU per annum | Minimum activity | Maximum activity | $ per RVU | Total |
|---|---|---|---|---|---|
| Base Care Tariff Level 1 | | | | | $300,000 |
| Total AN-ACC RVUs (+/- 10%) | 20,000 | 18,000 | 22,000 | $10 | $200,000 |
| **Total** | | | | | **$500,000** |

The first is a Base Care Tariff. This is an annual allocation that is approved at the beginning of the financial year. This covers the organisation's capacity costs in the year ahead, thus allowing organisations to plan ahead and to offer secure employment to their staff. This will help reduce workforce shortages.

The second is activity, specified as total weighted activity units per annum. The total quantum of activity is also approved at the beginning of the financial year based on expected activity in the next year.[8]

It can be seen in the illustrative example above that the price and volume contract is for 20,000 RVUs (units of activity) plus or minus 10%. In this example, plus or minus 10% is set as the 'tolerance band'. If the provider delivers between 18,000 and 22,000 units of activity, they have met the contract. There are no variations in funding for activity that is within the tolerance band.

Each care recipient referred to a service brings with them an approved quantum of RVUs. This quantum is determined by their assessment. Providers pool these RVUs and can use the total pool of RVUs to best meet the needs of all of the people they provide services to. An example of an individual care recipient plan and the total RVU they bring to the service provider is shown below.

| Service plan | RVU | Per year | RVUs | Detail |
|---|---|---|---|---|
| 1. Meal service needs assessment or reassessment | 4.00 | 4 | 16.00 | Quarterly assessment |
| 2. Delivery of standard meal/s, excl meal costs (per delivery, not per meal) | 0.50 | | 0.00 | |
| 3. Preparation and delivery of a standard meal | 1.00 | 312 | 312.00 | Six days a week, 52 weeks a year |
| 4. Preparation of standard meal (client or representative picks up) | 0.50 | | 0.00 | |
| 5. Preparation and/or delivery of special meal: dietary or culturally-specific | 1.20 | | 0.00 | |
| 6. Preparation and delivery of special meal: texturally modified meal | 2.00 | | 0.00 | |
| 7. Preparation & delivery of standard meal plus extra social support & wellbeing monitoring | 1.20 | | 0.00 | |
| 8. Preparation and/or delivery of special meal: dietary or culturally-specific plus extra social support & wellbeing monitoring | 1.40 | | 0.00 | |
| 9. Preparation and delivery of special meal: texturally modified meal plus extra social support & wellbeing monitoring | 2.20 | | 0.00 | |
| 10. Centre-based meal (incl any necessary transport) | 0.80 | 52 | 41.60 | Once a week, 52 weeks a year |
| 11. Preparation and/or delivery of a meal and supervision of the consumption of the meal | 3.20 | | 0.00 | |
| RVU per year | | 368 | 369.60 | Average RVU=1.00 |
| AN-ACC class | High needs | | | |

[8] When activity is weighted within any specific service type, it is expressed in Relative Value Units or RVUs. Thus there is one set of RVUs for community transport services and another for delivered meals. When activity is weighted or calibrated across both residential and home care, it is expressed in National Weighted Activity Units or NWAU.

It will be seen in this example that the outcome of the assessment is that the person is assessed as high need for meals services. In this illustrative example, this person's service provider will be allocated 400 RVU toward their pool of total RVU. This is because there are four AN-ACC client classes for food services, one of which is for high need consumers (defined as people who need more than 365 RVUs per annum). Allocating RVUs per class makes the model more efficient than allocating RVUs per person[9].

The 20,000 of RVUs in the price and volume contract in this illustrative example has been built up as shown below.

| Client classes | Definition | Class RVU | Number of clients | Total RVU |
|---|---|---|---|---|
| Class 1: Casual needs | Person needs up to 50 RVU per annum | 40 | 15 | 600 |
| Class 2: Low needs | Person needs between 50 and 150 RVU per annum | 100 | 31 | 3,100 |
| Class 3: Medium needs | Person needs between 150 and 365 RVU per annum | 250 | 30 | 7,500 |
| Class 4: High needs | Person needs more than 365 RVU per annum | 400 | 22 | 8,800 |
| **Total** | | | **98** | **20,000** |

A core feature of a price and volume contract is that the provider has discretion to cross-subsidise within the pool of total activity and to surge services for individual care recipients up and down in response to changing needs. Such surges may be required on a daily, weekly or intermittent basis, with the provider being held accountable for meeting the needs of the individual consumer. The only requirement is that, in order to meet the contract, total activity across all care recipients must be within the tolerance band specified in the contract.

The AN-ACC is not an individualised funding model and individual care recipients do not 'own' the RVUs they bring with them. Instead, these RVUs are contributed to the total funding pool of the provider and form part of the build-up of the total volume specified in the contract.

Indeed, care recipients do not even need to know what an RVU is or how many RVUs they are bringing with them. From the perspective of the care recipient, these technical matters are unimportant. What matters is that the person receives the care and support they need.

This is no different to a person being admitted to a public hospital. The patient neither knows nor cares about the technical details of the hospital funding model. What matters to the patient is that they receive the care they need when they need it. The same applies to the introduction of the AN-ACC in residential aged care. What matters to residents and families is not the technical aspects of the residential aged care funding model. What matters to residents and families is the adequacy of the funding (and by extension staffing) to meet their care needs.

[9] A further benefit of building a small number of classes into the funding model is that they help to define the threshold for reassessment. A person would be eligible for reassessment if their needs have changed sufficient for them to change AN-ACC class.

The pooling of RVU is a key advantage of the AN-ACC model over the proposed In-Home Aged Care model. The AN-ACC model for community aged care is agile – service providers can flexibly respond to the changing needs of consumers without any need for the consumer to be constantly reassessed or for the provider to manage a 'high-cost outlier pool', the technical term for what is proposed in the discussion paper. Experience in the health system suggests that a high-cost outlier pool ends up being unwieldly, inefficient and inequitable. They are no longer included in health funding models.

The volume tolerance band is a key mechanism to fairly share financial risk between government and providers. A key policy question to be resolved is thus how to deal with volume variations that are outside the tolerance band. Continuing with the above example, the policy question is how to deal with an organisation that delivers only, say, 16,000 activity units or a provider who delivers 24,000 activity units.

The funding principle is straightforward – the same policy must apply in both cases. There are two options. One is that payments for this aspect of the contract are adjusted throughout the year, typically on a quarterly basis. The other is that there are no adjustments within a financial year. Instead, actual activity in any one year informs or forms the starting point for the contracted volume of activity for the following year.

***How would an AN-ACC funding model ensure equity for disadvantaged communities?***

A key role for any new In-Home Aged Care program must be to ensure equity between older people and between providers operating across all communities (on a geographic and population basis). The AN-ACC model has the capacity to be tailored to meet the needs of culturally and linguistically diverse people, disadvantaged communities and other groups with special needs in three different ways.

The first is that the AN-ACC can be designed to ensure the viability of small specialist services. The AN-ACC capacity payment (the Base Care Tariff) is ideal for specialist services that are tailored to the needs of small groups of care recipients. An example is ethno-specific day programs. These typically have proportionally high fixed costs and low variable costs. The AN-ACC can accommodate these by the inclusion of proportionally more funding in the Base Care Tariff.

In the residential care version of AN-ACC, the Base Care Tariff payments are varied according to rurality and target population (Aboriginal & Torres Strait Islander or homelessness). The payment for a standard metropolitan service is 0.49 NWAU. For a rural service this can vary from 0.55 to 0.68 NWAU. For a rural Aboriginal service this can vary from 0.78 to 1.80. The NWAU for a homelessness service it is set at 0.92.[10]

The levels of the Base Care Tariff are established after a costing study so they reflect actual levels of difference in costs of delivery to respective communities. In home care, cost differentials for other communities, such as CALD communities, would also be measured to see if they warrant variable Base Care Tariff payments.

The second design element is that, if costs for specific activities are higher for some groups, this can be accommodated in the design of the activity classes. An example is the inclusion of culturally specific meals in the AN-ACC Version 1 classification for delivered meals services.

[10] Department of Health & Aged Care (2022) *AN-ACC Funding Guide* at https://www.health.gov.au/sites/default/files/documents/2022/10/the-australian-national-aged-care-classification-an-acc-funding-guide_1.pdf

The third design element is that it is possible to inflate the RVUs for communities with special needs. An example is the national hospital funding model which includes NWAU loadings for three special patient populations - Indigenous patients; paediatric patients and patients who live in remote locations. Rather than create separate funding classes for these patient groups, every NWAU is automatically increased if the patient falls into one or more of these subpopulations. This ‘vertical equity’ approach increases funding for populations with special needs but in a more efficient way than a standard payment model.

***Should the AN-ACC model be used to set consumer co-payments?***

No, the AN-ACC should not be used to set consumer contributions. The AN-ACC is a funding model to determine the government subsidy that an aged care provider receives. How consumers contribute toward the cost of the services they receive is a completely separate issue. The SaH Alliance will welcome engagement with government and consumer representatives on the design of a future fit-for-purpose consumer contribution system.

***What is the role of the Independent Health and Aged Care Pricing Authority (IHACPA) in an AN-ACC funding model for care at home?***

The role of the IHACPA is to undertake regular costing studies and to use the results of the costing study to recommend the price for a NWAU of 1.00. This is critical for the future of care at home as it introduces for the first time a direct relationship between cost and price. A major failing over the last decade or more has been the lack of an explicit policy on the relationship between cost and price. This can be addressed by IHACPA.

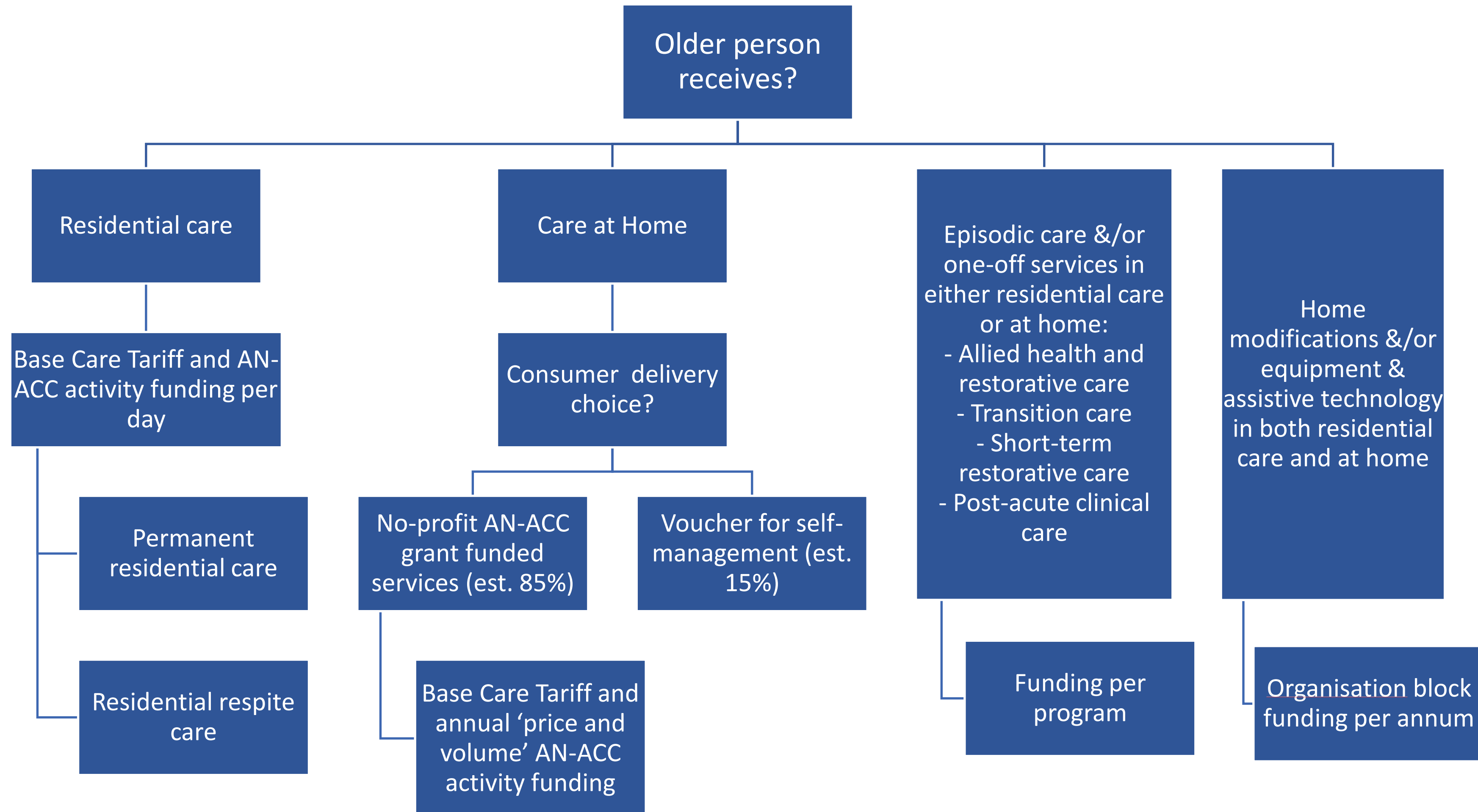
The AN-ACC model is a ‘no-profit’ model in which providers are funded to deliver high quality care and support services, with all of the funding spent on the direct and indirect costs of service delivery[11]. Providers cannot make a profit on these services. Nor can they operate at a loss. This requires that the funding covers all costs associated with the provision of high quality, efficient services including all overhead costs. The application of the IHACPA concept of the ‘National Efficient Price’ will be critical to the provision of sustainable community aged care going forward.

It would need to be determined whether the price of an NWAU of 1.00 is the same in both residential and community care or whether the IHACPA recommends a separate price for each.

[11] Note that the concept of ‘no-profit’ refers to the funding model, not to the status of the organisation delivering the services. The AN-ACC model of community aged care funding is agnostic about the nature of the organisation delivering the service. Both ‘for-profit’ and ‘not-for-profit’ organisations could provide AN-ACC funded services if those services are delivered on a no-profit basis.

## APPENDIX 3

## POTENTIAL AGED CARE SYSTEM MODEL

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