A response from Victoria to
the new Aged Care Act: exposure draft – consultation paper no.2

Submission by

SSD Connect Alliance, Bayside City Council SSD & Eastern SSD Partnership

16 February 2024

This submission is the result of 4 roundtables held in late January.

The roundtables were designed & facilitated by Enkindle Consulting.

124 attendees from 75 organisations actively participated in the roundtables, offering a comprehensive representation across metro, regional, rural & remote Victoria.

They include community health, local councils, not-for-profits, health services & Aboriginal community controlled organisations.

About us

The **SSD Connect Alliance** is: City of Darebin, City of Whittlesea, Banyule City Council, Merri-bek City Council, Nillumbik Shire Council, City of Melbourne, Melton City Council, cohealth, Moonee Valley City Council & Sunbury and Cobaw Community Health.

Bayside City Council SSD supports CHSP providers in Southern Metro Melbourne.

The **Eastern SSD Partnership** is EACH, Knox City Council & Yarra Ranges Council.

Acknowledgements

Thank you to the aged care leaders who shared their perspectives in the roundtables.

And thank you Jennene Buckley & Tash Edwards from Enkindle Consulting for your expert design & facilitation of the roundtables and preparing this submission.

We acknowledge the traditional Aboriginal & Torres Strait Islander custodians of Country throughout Victoria. We pay our respects to them, their culture & their Elders past, present & emerging. The regions we work in include people from diverse cultures with diverse beliefs, abilities, bodies, sexualities, genders & ages. We're committed to access, equity, participation & rights for everyone.

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Contents

Background

The Commonwealth Home Support Program (CHSP) currently stands as the largest collective of aged care providers, totalling approximately 1,344[1] organisations. The program serves the most extensive number of older individuals annually, supporting around 871,565[1] older people. Despite the commonly used descriptors like "entry-level" or "basic supports" associated with CHSP, the reality is this program plays a crucial role in supporting the most vulnerable and marginalised groups within our communities. Numerous CHSP providers are dedicated to offering targeted assistance to culturally and linguistically diverse communities, refugees, as well as individuals living with dementia, homelessness, and squalor.

CHSP providers also play a pivotal role in delivering urgent post-hospital support for older individuals with acute or urgent care needs. Community nursing, allied health, personal care, transport, meals on wheels, assistive technologies, and home modification programs rapidly mobilise to provide care and services to at-risk clients who are discharged from the hospital, still waiting for the appropriate aged care assessments and support planning to occur.

The majority of CHSP providers, accounting for almost 70%[2], are small organisations with annual grant funds of less than $1 million per annum from the Department of Health and Aged Care. Many heavily rely on volunteers in both their service delivery workforce and organisational governance through their boards. Due to their size, the accumulative administration component funded through unit pricing provided under CHSP translates to limited administrative and business resources to support service delivery.

The diversity among CHSP operators is noteworthy, with approximately 60% of providers funded for only CHSP. For some of these organisations CHSP serves as their sole source of income. Conversely, there are CHSP providers, such as local councils, Aboriginal community controlled, and community health organisations, where CHSP is a minor program within a broader health, primary care, or community services portfolio. This adds complexity due to various regulatory and compliance frameworks the one organisation is to operate within.

Many CHSP providers play a crucial role in filling critical gaps in thinly populated market locations nationwide. These providers grapple with chronic workforce shortages, workforce fatigue, and service viability – challenges experienced by providers nationally, but exacerbated by rurality and remoteness.

Considering the implementation timelines and the diverse needs of these 1,344 CHSP providers in adapting to the New Aged Care Act, we strongly encourage the government to pay particular attention to the targeted support required for these providers. This is crucial given the diversity in their operations and services, size and capacity, and the fact that, for a majority of these providers, it will be their first time operating within an Aged Care Act.

Voices within submission

The SSD Connect Alliance, Bayside City Council SSD and the Eastern SSD Partnership facilitated 4 roundtables in late January 2024. The primary aim was to collate the collective perspectives of Victorian CHSP providers regarding the exposure draft of the new Aged Care Act. The sessions served as a platform to gather insights on the Act's provisions, assess its alignment with the intent of the Royal Commission, understand the anticipated impacts on older individuals, evaluate the implications for CHSP providers, and outline the necessary support from the government to ensure effective implementation.

1 2022–23 Report on the Operation of the Aged Care Act

2 Financial Report on the Australian Aged Care Sector 2020-2021

A diverse range of providers, with over 124 attendees from 75 organisations actively participated in these roundtables, offering a comprehensive representation across metro, regional, rural, and remote areas of Victoria. The representative organisations include community health, local councils, not-for-profits, health services, and Aboriginal community controlled organisations.

Representative Organisations

Metro

Access Health and Community
AccessCare, City of Kingston
Alfred Health Carer Services
Australian Vietnamese Women's Association
Banyule City Council
Banyule Community Health
Baptcare
Bayside City Council
Better Health Network
Bolton Clarke
Care Connect
City of Casey
City of Whittlesea
cohealth
Dandenong and Districts Aboriginees Co-operative
Darebin City Council
Donwood Community Aged Care Services
EACH
EV Strengthening Communities
Frankston City Council
Fronditha Care
Gateways Support Services
Glen Eira City Council
Great Care
healthAbility
Inspiro
IPC Health
Kooweerup Regional Health Service
Mecwacare
Merri Health
Merri-bek City Council
Monash Health
Nillumbik Shire Council
Northern Health

Metro

Peninsula Health
Serbian Social Services and Support
South East Volunteers
Spectrum
St Vincent's Hospital Melbourne
Star Health
The Haven Day Centre
The Salvation Army Homelessness Services Victoria
Travellers Aid
UNITED – Spanish Latin American Welfare Centre
Uniting AgeWell Chadstone (St Mark's)
Your Community Health

Regional, Rural & Remote

Ballarat Community Health
Ballarat Regional Multicultural Council
Barwon Health
Bellarine Community Health
Central Gippsland Health
Colac Area Health
Dhauwurd-Wurrung Elderly & Community Health Service
Dhelkaya Health
Gippsland Southern Health Service
Grampians Health Edenhope
Hesse Rural Health
Inspiro Health
Kooweerup Regional Health Service
Latrobe Community Health Service
Moe and District Meals on Wheels
Omeo District Health
Sunbury and Cobaw Community Health
Sunraysia Community Health Service
Swan Hill District Health

Executive Summary

The purpose of this submission is to provide constructive feedback in the form of recommendations to the government regarding the Aged Care Act exposure draft, specifically focusing on its practical implementation within home care settings through the Commonwealth Home Support Programme (CHSP).

A fundamental principle underscored in communications from the Department of Health and Aged Care and the Aged Care Quality and Safety Commission has been the commitment to a risk-proportionate approach to regulation. This approach aims to ensure that the regulatory burden on providers aligns with the nature of their services and associated risk profiles. In working through this exposure draft, the obligations, the statutory duties, and the penalties – the very essence of this proportional approach appears to have been lost.

The multitude of changes, obligations, and responsibilities outlined may place CHSP providers in a precarious position, potentially making it financially unviable for some to continue operating. This is a particularly pressing concern in regional, rural, and remote settings where these providers may constitute the primary or one of few sources of aged care support in their communities.

The recommendations presented below respond to the provisions outlined in the Act, with a specific focus on the impacts, risks, and supports necessary to assist CHSP providers, who constitute the majority of providers nationally. Throughout the roundtable discussions, 2 pivotal questions consistently emerged:

1. Will there be an urgent cost impact study to assess the cumulative financial implications for CHSP providers in the implementation of the new Act? Moreover, how will this translate into revised unit pricing and subsidies?
2. What financial support will be injected to assist CHSP providers in acquiring the necessary resources to implement each of the requirements, obligations, and statutory duties imposed under the Act?

The responses to these inquiries will significantly influence the future decisions of numerous CHSP providers, determining whether they can continue offering crucial CHSP/Home Care support to older individuals in their communities. The urgency of addressing these financial considerations cannot be overstated, as they directly impact the viability of essential care services in diverse and often under-served locations.

Summary of Recommendations

Statement of Rights

Rec 1: Inclusion within the Statement of Rights for “timely access to funded care and support”, to ensure older people are not sitting in national queues for extended periods.

Rec 2: The Statement of Rights needs simplification and should be written in plain language, taking into account the English proficiency and literacy levels within our population.

Rec 3: Consider the significant workforce and funding barriers in creating a service delivery environment where older people have the “right to speak in their preferred language”.

Rec 4: Inclusion of a list of responsibilities of service users within the new Aged Care Act or the Rules.

High Quality Care

Rec 5: Provide detailed guidance within the Rules on how each component of the definition of high-quality care will be measured for each service category.

Rec 6: The Independent Health and Aged Care Pricing Authority (IHACPA) to include within their costing study, costing framework and unit pricing recommendations, the cost for providers to deliver high-quality care.

Rec 7: Provide clarification within the rules or guidance material on what the Quality Regulator would define as “timely and responsive” delivery of services.

Rec 8: Include within the definition of high-quality care, the expectation that clinical and care services adhere to evidence-based practice, with the System Governor and Quality Regulator supporting the workforce and service model transformation.

Eligibility for Entry to Aged Care

Rec 9: The exposure draft be amended to provide capacity for the System Governor or their delegates to approve the eligibility of a person under 65 in circumstances where a person is at risk.

Rec 10: Expand the scope of responsibilities of Care Finders and Elder Care Support program to deliver prioritised support to ineligible individuals**.**

Alternative Entry Requirements

Rec 11: Ensure alternative entry requirements are codesigned with primary care, acute care, assessment, and service providers – particularly stakeholders from regional, rural, and remote settings.

Rec 12: Provide extended implementation and transition timeframes due to the significant number of health stakeholders that need to understand new alternative service entry requirements.

Rec 13: Undertake further consultation on the allied health service type with the view of realigning the service type with nursing services under Service Category 5.

Registration Categories

Rec 14: Undertake further consultation on social support type with the view of moving some service lists into Category 1 or 3.

Obligations and Statutory Duties

Rec: 15: Provision of targeted mentoring and support services to CHSP organisations who are not currently approved providers.

Rec 16: Consideration be given to organisations where aged care forms a small part of their operations and the complexity they face in managing and integrating different quality, regulatory and compliance frameworks.

Rec 17: IHACPA to include within their costing study, framework and unit pricing recommendations, the cost for providers to meet the obligations and statutory duties under the new Aged Care Act.

Rec 18: Conduct an in-depth study and impact analysis to understand the short and longer term implications for Governing Boards of CHSP providers.

Fees Payments and Subsidies

Rec 19: Government manage the collection of income-tested fees or its new equivalent. Removing providers as the debt collector for Government.

Rec 20: Consider a change of policy where income-tested fees or its new equivalent are not charged for the first 56 days of service provision. To enable time for financial assessment and any subsequent hardship applications to be processed by Services Australia.

Governance of the Aged Care System

Rec 21: Expand the responsibilities of the Inspector-General of Aged Care to enable complaints to be made about the System Governor, Quality Regulator, and the Pricing Authority.

Regulatory Mechanisms

Rec 22: Gain urgent advice from the insurance industry on the impact of the new Regulatory Mechanisms on the insurance policies of providers. Adjusting the unit pricing and subsidies accordingly based on insights provided.

Rec 23: The System Governor undertake further clarification on the process for responding to a disclosure and how vexatious claims will be managed.

Appointment of Supporters and Representatives

Rec 24: Provide the ability for older people to have the option to nominate both representatives and supporters.

Rec 25: Delay the implementation of the decision-making framework until any conflicts between existing state legal instruments, and the practical impacts are resolved.

Rec 26: Delay implementation of the supported decision-making framework until the System Governor has the ITC and resourcing plan to deliver timely processing of requests and communication of appointments to all stakeholders.

Rec 27: Quality Regulator to implement process enabling stakeholders (including registered providers) to raise concerns about any appointed representative or supporter.

Rec 28: Personnel under the National Aged Care Advocacy Program, Care Finders and Elder Care Support program should fall within the supported decision-making framework.

Reform Readiness and Implementation Support

Rec 29: Provide transition funding to all home care providers to fund the resources and supports needed to implement the new Aged Care Act as a matter of urgency.

Rec 30: Additional targeted support be provided to the 990+ CHSP providers who receive less than $1 million a year in funding to reduce the risk of these organisations transitioning out of Aged Care.

Reform Timelines

Rec 31: Government work with providers to develop a 24+ month transition plan that provides a staged and structured implementation of the new Aged Care Act.

Rec 32: Transition timelines should also ensure adequate time for the System Governor and Quality Regulatory to implement the necessary ITC infrastructure, support personnel and guidance material.

Recommendations

Chapter 1

Statement of Rights

Rec 1: Inclusion within the Statement of Rights for “timely access to funded care and support”, to ensure older people are not sitting in national queues for extended periods.

The Royal Commission has explicitly advocated for the universal right to "timely support and care". The new Aged Care Act must incorporate safeguards to shield older people from enduring prolonged wait times to access funded care and support.

Specifically, the Support at Home program must be structured to avoid replicating the extensive waitlists that older people presently face within the Home Care Package Program and Commonwealth Home Support Programme. The Act should stipulate the obligation for both current and future governments to allocate adequate aged care funding, ensuring that the provision of funded aged care services aligns with the evolving needs of our ageing population.

Rec 2: The Statement of Rights needs simplification and should be written in plain language, taking into account the English proficiency and literacy levels within our population.

While we appreciate the underlying intention of the new Aged Care Act to establish a rights-based legislative framework, there is a notable concern that the Statement of Rights is too lengthy and wordy, spanning 3 pages within the Exposure Draft. It is essential to consider the cultural diversity and varying literacy levels within our population, as well as the practical implementation challenges faced by service providers and stakeholders charged with the responsibility of supporting older people in their care or accessing care, to understand their rights within the new Aged Care Act.

To enhance clarity and accessibility, especially when compared to the current Charter of Aged Care Rights, the new Statement of Rights should be presented in straightforward language—a concise and easily communicable statement that can be readily understood, explained, and applied.

Rec 3: Consider the significant workforce and funding barriers in creating a service delivery environment where older people have the “right to speak in their preferred language”.

While acknowledging the principle and intent of this right, its practical implementation appears challenging and unrealistic, primarily due to ongoing workforce challenges, funding limitations, and the diversity of our population that speak approximately 400 languages nationally.

This becomes especially pronounced when considering the smaller workforce teams in regional, rural, and remote communities, and the ability to provide bilingual workers and/or interpreters at all times.

Rec 4: Inclusion of a list of responsibilities of service users within the new Aged Care Act or the Rules.

The current User Rights Principles 2014 encompass both the rights and responsibilities of care recipients. However, the new Aged Care Act outlines 3 pages of rights for older people receiving aged care services but does not include their responsibilities.

It is imperative for home care providers to establish a secure workplace, ensuring that workers can enter homes feeling safe. This includes situations such as the restraint of dangerous dogs, a smoke-free environment, and the assurance of respectful treatment. Equally important is fostering a clear understanding among older people (service users) regarding their responsibilities in the context of service provision.

This understanding should include adherence to the terms outlined in Home Care Agreements, compliance with fee structures, effective communication, and service changes. To address this critical aspect, the new Aged Care Act or the associated Rules should explicitly incorporate a list of service user responsibilities. This inclusion will contribute to a balanced framework that not only emphasises the rights of older people but also outlines the reciprocal responsibilities essential for fostering a safe and respectful care environment for workers.

High Quality Care

Rec 5: Provide detailed guidance within the Rules on how each component of the definition of high-quality care will be measured for each category.

It will be important for individual CHSP providers to gain clarity on the application of high-quality care across the various service types within home care services. Understanding how the Regulator will assess and gauge high-quality care in the diverse spectrum of services delivered. Specifically, providers need insights into how different services, such as meals on wheels, community nursing, social support transport, or home maintenance and modification, will be evaluated against the definition of high-quality care.

The question arises: How will each element of high-quality care be precisely measured or assessed? Providers seek assurance on how to ascertain whether they have achieved high-quality care in the eyes of the Regulator. A transparent and standardised framework for evaluation will ensure a consistent understanding and application of high-quality care across the diverse services within home care.

Rec 6: IHACPA to include within their costing study, costing framework and unit pricing recommendations, the cost for providers to deliver high-quality care.

While the aspiration for providers nationally is to deliver high-quality care, achieving this level of service involves costs that are presently not considered within current grant funding and pricing mechanisms. The inclusion of high-quality care under the new Aged Care Act will create a gap in service expectations between what is possible to be delivered within current funding and resource restraints and the aspirations included within the definition of high-quality care.

The unit pricing structure within the current CHSP fails to accommodate the costs involved in the delivery of high-quality care, as defined by the new Aged Care Act, or the ability to invest in the necessary service transformation, training and development that would be needed to achieve these aspirations.

To bridge this gap and make high-quality care a reality for all older people in care, IHACPA will need to incorporate the cost of delivering high-quality care into its costing studies, frameworks, and pricing recommendations.

Rec 7: Provide clarification within the Rules or guidance material on what the Regulator would define as "timely and responsive" delivery of services.

Providers will require additional guidance from the Regulator regarding the specific service expectations related to "timely and responsive" service delivery, as it pertains to each service type and category. This becomes especially crucial in the context of CHSP services, where providers are managing high volumes of service users (older people receiving services) across a diverse range of services and programs.

Note that a number of CHSP services are being delivered by a volunteer workforce. The challenge lies in understanding how the principles of timely and responsive service delivery translate across varied services. For instance, what does "timely" mean for garden maintenance services, compared to social transport, personal care, or community transport?

Rec 8: Include within the definition of high-quality care, the anticipation that clinical and care services adhere to evidence-based practice, with the System Governor and Quality Regulator supporting the workforce and service model transformation.

Providers need to support their clinicians to leverage the best available evidence in promoting safe and high-quality care. The System Governor and Quality Regulator will need to play a critical role in supporting the implementation of high-quality care, through the development, monitoring, and evaluation of evidence-based clinical and care pathways, tools, and training that facilitate effective care delivery.

Additionally, to provide financial support to enable a sector-wide skills uplift, ensuring that the aged care workforce has the necessary resources and training to consistently deliver care in line with the latest evidence and best practices.

Chapter 2

Eligibility for Entry to Aged Care

Rec 9: The exposure draft be amended to provide capacity for the System Governor or their delegates to approve the eligibility of a person under 65 in circumstances where a person is at risk.

Providers contributing to this submission have collectively voiced concerns about the potential for individuals to "fall through the gaps" in service access. These gaps are particularly evident for those who may fall outside the eligibility criteria of aged care, state health, or NDIS programs, or when there are no alternative referral pathways available. Specific instances include:

- Older adults under 65 years who require support for chronic diseases, medical issues (such as cancer), chronic pain, hoarding disorder, palliative care, early onset dementia, mental health conditions, and social isolation.
- Instances where state health programs, like HACC PYP, are either unavailable within a locality or lack the capacity to support and accept the person into care.
- Challenges faced in rural and remote locations, where aged care providers may be the only provider who can offer suitable care and support, especially for individuals living with early onset dementia.

Given these challenges, the new Aged Care Act should incorporate clear provisions that empower the System Governor or their delegate to approve eligibility for individuals under 65, both on a short-

term and longer-term basis. This flexibility is essential for those who require care and support but have no other viable options, potentially putting them at risk without aged care support.

Rec 10: Expand the scope of responsibilities of Care Finders and Elder Care Support program to deliver prioritised support to ineligible individuals.

In circumstances where an individual is deemed ineligible for Aged Care, the My Aged Care team may lack the necessary local knowledge of services within specific localities and related service access issues. Additionally, the team may not be equipped to serve as technical experts on the eligibility criteria for the NDIS or on the array of state-based programs. Consequently, they may struggle to provide effective support to individuals deemed ineligible to find alternative care arrangements. The risk in these situations is individuals falling through the gaps of care.

Presently, the new Care Finders and Elder Care Support program are primarily focussed on the support of people to access aged care programs. It is recommended to expand the capacity of these 2 programs to provide dedicated support to individuals deemed ineligible for aged care, supporting them to find alternative care arrangements and preventing gaps in service access.

Alternative entry requirements

Rec 11: Ensure alternative entry requirements are co-designed with primary care, acute care, assessment, and service providers, and particularly stakeholders from regional, rural, and remote settings.

CHSP providers face significant pressure from hospitals discharging older people into the community who require immediate care and assistance. CHSP providers can encounter daily referrals for urgent care and support requests, covering a spectrum of needs including transport, personal care, allied health, home modification, assistive equipment, meals on wheels, domestic assistance, and nursing. Noting that Assessors could take weeks to attend an assessment, particularly in regional, rural, and remote settings.

There are also service environments, such as homeless shelters and First Nation communities, that require immediate care to be wrapped around individuals. This may include services such as meals, transport, podiatry services, and personal care.

To ensure the seamless provision of urgent care, it is important that the System Governor co-designs the new alternative entry processes to safeguard service providers when receiving urgent referrals from GPs, hospital discharge staff, or health professionals.

This should involve creating a framework, clear criteria, and processes to enable providers to confidently support urgent referrals, ensuring they will be funded for these services even before the completion of the assessment. This co-design approach will not only streamline the care delivery process, reducing ambiguity around alternative entry pathways, but also address the time-sensitive nature of urgent care requirements.

Rec 12: Provide extended implementation and transition timeframes due to the significant number of health stakeholders that need to understand new alternative service entry requirements.

CHSP providers receive urgent care and service referrals from a large number of health stakeholders, including primary care, hospitals, and health service providers. Given the large number of stakeholders involved nationally who refer to CHSP providers for urgent service access for older people, it will be important to provide realistic implementation and transition timeframes to

facilitate a comprehensive sector-wide understanding of the new entry criteria and alternative access pathways for emergency access to aged care programs.

Chapter 3

Registration Categories

Rec 13: Undertake further consultation on the allied health service type with the view of realigning the service type with nursing services under Service Category 5.

Allied health providers, contributing to this submission, have jointly expressed concerns about the placement of the allied health service type within Category 4, instead of alongside nursing services in Category 5. This concern arises from the recognition of the complex clinical nature inherent in allied health assessments and service provision. Allied health service providers play a pivotal role in complex care management, addressing diverse aspects of clinical care such as dietetics, wounds, podiatry and falls, occupational therapy and activities of daily living, physiotherapy in mobility and pain management, and speech therapy in swallowing, to name a few. The request is for allied health to move to Category 5 to align with the complexity of the care provided.

Rec 14: Undertake further consultation on social support type with the view of moving some service lists into Category 1 or 3.

In finalising the service list, types and categories, it will be important to gain further insights from CHSP providers and consider the diversity of services provided under the social support service type. Several community transport providers, for example, offer social outings and social transport. This is a service that would align more closely in Category 1 than in its current placement within Category 4. Understanding that centre-based programs can differ quite significantly in nature from social programs operated by other providers such as meals on wheels and community transport organisations. Further refinement of the definition of social support is warranted, as there may be a need to include social support under 2 categories.

Obligations and Statutory Duties

Rec 15: Provision of targeted mentoring and support services to CHSP organisations who are not currently approved providers.

There are over 850 CHSP providers that are not approved providers and thus do not currently fall under the existing Aged Care Act. A number of reform changes implemented over the last 14 months – including the Code of Conduct, quarterly and annual reporting, and provider governance – have not been applied to the majority of CHSP providers. The majority of CHSP organisations are small entities, receiving less than $1 million per annum in CHSP grant funds, operating with limited resources and often governed by volunteer boards. Providing targeted mentoring and support to these CHSP providers is crucial, as the impact of change on these providers is expected to be more significant compared to organisations who are approved as providers of aged care.

Rec 16: Consideration be given to organisations where aged care forms a small part of their operations and the complexity they face in managing and integrating different quality, regulatory and compliance frameworks.

Organisations like community health, Indigenous medical services, and local councils, which offer aged care services as a small component of their overall operations, should be further considered in the development of the Rules and guidance material. The boards and leadership have diverse

responsibilities for a range of services that are not centred around aged care. Including general practice, dental, mental health, disability, family services, and domestic violence. The Quality Regulator should acknowledge the practical challenges for these organisations in implementing the new Aged Care Act and integrating aged care regulations within their broader organisational framework that needs to incorporate various regulatory requirements.

Rec 17: IHACPA to include within their costing study, framework and unit pricing recommendations, the cost for providers to meet the obligations and statutory duties under the new Aged Care Act.

The unit pricing structure within the current CHSP does not account for the costs associated with effectively managing the obligations and statutory duties outlined in the new Aged Care Act, or the ability to fund the necessary service transformation, training, and development required to meet these obligations and duties. Additionally, many CHSP organisations have benefited from volunteer governing boards. However, with the introduction of the new Aged Care Act and its associated responsibilities, there will be a heightened investment of time and increased risk associated with governance.

To address these changes, CHSP organisations may need to start remunerating their board directors to attract and retain qualified individuals. This shift would directly impact the overall cost of service delivery. IHACPA needs to urgently assess the costs associated with implementing the new obligations and duties as part of their costing studies, pricing frameworks, and pricing recommendations. Areas to consider include project and change management resources, remuneration levels for boards and leaders due to increased risk, potential rises in insurance costs, and additional recurrent resourcing to manage these ongoing responsibilities.

Rec 18: Conduct an in-depth study and impact analysis to understand the short and longer-term implications for governing boards of CHSP providers.

The exposure draft of the new Aged Care Act outlines an extensive list of obligations and statutory duties that apply to all providers, including associated penalties. For many CHSP providers, the increased risk and compliance requirements could be the reason for services to exit the aged care sector, creating further gaps, especially in regional, rural, and remote communities.

Consideration must be given to the governing bodies of CHSP providers, where many directors are volunteers. There may be a need for providers to transition to remunerated boards of governance to attract and retain directors, given the increased risks and time requirements to fulfil their obligations and statutory duties. Existing remunerated directors may also expect increased remuneration to align with the increase in the risk profile of their role and the time needed to meet the new obligations and statutory duties. This all comes at a cost to service delivery.

For organisations where aged care is just a minor part of their service scope, (e.g. community health, Aboriginal medical services, and local councils), advice may be to exit aged care, due to the regulatory burden and level of risk, given the diversity of their responsibilities and programs.

The System Governor needs to undertake an insights study and impact analysis on how the new Aged Care Act impacts CHSP providers. The short and long-term implications for governing boards and what may influence organisations' decisions to exit the aged care sector. It should also address the consequences for older people trying to access aged care in their community and what decisions need to be made on the level of support and implementation timeframes to ensure CHSP providers continue to deliver aged care.

Chapter 4

Fees Payments and Subsidies

Rec 19: Government manage the collection of income tested fees or its new equivalent. Removing providers as the debt collector for government.

Home Care Package and residential aged care providers often encounter extended periods (exceeding 3 months) for older people awaiting the outcomes of their income and/or means testing by Services Australia. This delay puts older people at risk, as some are hesitant to commence services until the full cost of care is clarified, while others may commence care and later face a substantial back payment of fees. Service providers find themselves in the challenging role of being the government's debt collectors, with the government reducing their subsidy for income-tested fees and assigning them the responsibility of recovering the debt from the older person. This situation leads to unnecessary tension or even a breakdown in the relationship between the client and the service provider. In cases where the client refuses to pay, there is the sensitive issue of potentially ceasing services and the financial burden of unpaid fees.

If means and income testing is expanded to include all programs, including CHSP, Services Australia should directly manage the collection of any assessed income or means testing fees with the older person. This approach would alleviate the financial risk and administrative burden for small providers who may not be equipped to absorb such financial risks.

A further consideration:

In rural and remote areas due to the structures of farming and family businesses, older people may be holding assets that are integral to their family business. The complexity of these situations in terms of income and means testing needs to be carefully considered. This complexity is already an issue for residential care and these matters may need to be reviewed before introducing any means testing in home care.

Rec 20: Consider a change of policy where income-tested fees or its new equivalent are not charged for the first 56 days of service provision. To enable time for financial assessment and any subsequent hardship applications to be processed by Services Australia.

The delay in financial assessments can often lead to older individuals having to retroactively pay large amounts of income-tested fees, causing stress, complaints, and financial hardship. In home care settings, especially when older people are discharged from the hospital, services need to commence before any income or means testing can be explained or assessed. This may result in situations where older people enter care without being fully informed or certain about the actual cost of care for several weeks or months.

When implementing a new fees and payments structure under the new Aged Care Act, it is advisable to consider a change in policy. Specifically, income-tested fees or their new equivalent should not be charged for the first 56 days of service provision. This grace period allows time for assessment and the processing of any subsequent hardship applications by Services Australia.

Chapter 5

Governance of the Aged Care System

Rec 21: Expand the responsibilities of the Inspector-General of Aged Care to enable complaints to be made about the System Governor, Quality Regulator, and the Pricing Authority.

Providers contributing to this submission have raised 2 collective concerns regarding the governance structure of the new Aged Care System:

- There are concerns that the Complaints Commissioner lacks independence from the Quality Regulator.
- There is no clear pathway for providers or stakeholders to address complaints about the Quality Regulator, including the Complaints Commissioner, the System Governor, or the Pricing Authority.

The Royal Commission had explicitly recommended the establishment of the Inspector-General of Aged Care, outlining their role in handling complaints about the System Governor, Quality Regulator, and the Pricing Authority. However, this responsibility was excluded from the role in the government's subsequent establishment of the Inspector-General of Aged Care.

To ensure direct oversight and provide safeguards for service providers, it is recommended that:

- The responsibilities of the Inspector-General be expanded to directly address complaints relating to the System Governor, Quality Regulator, and the Pricing Authority.
- Clear pathways are established for providers to the Inspector-General to raise concerns or make complaint where they feel the powers of the System Governor and Quality Regulator are being misused.
- The Inspector-General establish mechanisms to closely monitor the implementation of the new regulatory framework, ensuring that the Quality Regulator is effective in adopting a risk-proportionate approach to regulation.

Chapter 6

Regulatory Mechanisms

Rec 22: Gain urgent advice from the insurance industry on the impact of the new regulatory mechanisms on the insurance policies of providers. Adjusting the unit pricing and subsidies accordingly based on insights provided.

Concerns have been raised regarding the potential impact the new regulatory framework, obligations and statutory duties, and associated penalties and compensation pathways may have on insurance premiums and insurance coverage for providers.

Providers face the risk of escalating insurance premiums that have not been factored into the current pricing and funding mechanisms, and there may be certain risks that are deemed uninsurable.

It will be crucial for the System Governor to consult with the insurance industry to assess the impact of the new regulatory mechanisms on the insurance policies of all provider and program types. Additionally, the System Governor should direct the IHACPA to incorporate the impacts into the unit pricing, pricing frameworks and pricing recommendations.

Chapter 7

Whistleblowers Framework

Rec 23: The System Governor undertake further clarification on the process for responding to a disclosure and how vexatious claims will be managed.

Providers contributing to this submission have raised various questions and concerns regarding the new whistleblower provisions:

- The list of authorised individuals to receive a disclosure includes aged care workers, encompassing volunteers, which is deemed inappropriate and impractical. There is a need for a more selective approach, narrowing down the authorised roles within an organisation that can receive a disclosure.
- Uncertainty on handling situations where a disclosure is perceived as vexatious, and how this can be effectively managed to mitigate the reputational risk for providers.
- Ambiguity regarding how organisations running multiple programs can integrate the aged care whistleblower provisions with existing whistleblower protection already applicable to their organisation.
- Lack of clarity on what happens after a person makes a disclosure, including the formal processes for privileged and confidential discussions. Particularly in situations where there are multiple providers involved.
- A need for further explanation of the statement that "disclosures do not need to be made in good faith".

The System Governor should conduct additional consultations on the whistleblower process, specifically focusing on who can receive disclosures, formal response processes, protections against vexatious claims, and their management. This additional consultation will provide greater clarity and guidance that should be incorporated within the new Aged Care Act or through the accompanying Rules.

Chapter 8

Appointment of Supporters and Representatives

Rec 24: Provide the ability for older people to have the option to nominate both representatives and supporters.

Family situations and dynamics are complex, and the nominated decision-makers may not be the informal caregiver. For instance, a husband may be the caregiver for his wife, but their daughter holds the Enduring Power of Attorney (EPOA) for her mother. In this situation, the wife may wish for her husband to be her nominated supporter but, where needed, her daughter would step in as decision-maker as her representative.

In another scenario, a son lives with his mother as her day-to-day support and caregiver, but due to mental health and personal medical conditions, he has limited capacity. The daughter, holding the EPOA, manages health appointments and oversees financial matters, including significant decisions related to the selection of providers, care planning, and services. In this situation the older person may want to nominate her son as a supporter and her daughter as a representative.

A third example involves an older person with 3 daughters. The older person desires all 3 daughters to be nominated as supporters since they actively contribute to his care. While all daughters can

seek information and communicate with providers and My Aged Care about their father's care, only one daughter possesses the EPOA to make decisions when required.

These examples highlight the intricate nature of shared responsibilities and support structures that can exist and the importance of flexibility in the supported decision-making framework for the older person.

Rec 25: Delay the implementation of the decision-making framework until any conflicts between existing legal instruments, and the practical impacts are resolved.

Prior to implementing the decision-making framework, it is crucial to address the interface challenges between the new framework and existing state and territory instruments. Despite the assurance that the System Governor will automatically appoint individuals as representatives if they hold legal instruments such as Enduring Power of Attorney (EPOA) or are appointed guardians, situations may arise where the nominated representative differs from the EPOA, or an alternative decision-maker specified in a signed health directive.

How these situations will be managed, and from whom service providers should take direction, remains uncertain. Additionally, questions arise about how health services and primary care will be informed of an approved representative under aged care.

Given the uncertainties and potential complications in the interface between decision-making frameworks, there is a need to delay the implementation of the supported decision-making framework until clear guidance is provided.

Rec 26: Delay implementation of the supported decision-making framework until the System Governor has the ITC and resourcing plan to deliver timely processing of requests and communication of appointments to all stakeholders.

The key success factor in implementing the supported decision-making framework is ensuring that the System Governor has the necessary resources, processes, information, and communications technology in place to:

- Efficiently and promptly manage requests for the appointment of supporters and representatives, establishing clear timeframes for approvals and providing clarity on interim arrangements while waiting for approvals. Consideration of the dynamic nature of families. Common situations where the older person has changed their representative between assessment and service provision commencing.
- Establish mechanisms for communicating approvals and updates to identified stakeholders, including multiple providers (e.g. transport provider, meals on wheels provider, personal care provider, GP) in a timely manner.
- Provide sufficient helpdesk or advisory resources to support older people and their families during the transition to the new supported decision-making framework, ensuring phone and email communications are available to all stakeholders.
- Establish processes for My Aged Care and single assessment services to manage the nomination of supporters and representatives for older people entering care.
- Develop guidance, support materials, and comprehensive change and communication plans.

It is essential that the System Governor has the resources and infrastructure for a successful implementation to reduce anxiety, confusion, and frustration among older people. Additionally, to prevent disruptions in care or sensitive matters where stakeholders may lose clarity on who can provide support or represent an older person during critical decision-making processes.

Rec 27: Quality Regulator to implement process enabling stakeholders (including registered providers) to raise concerns about any appointed representative or supporter.

While there is agreement that older persons should have the ability to appoint a representative when they prefer someone else to make decisions, the System Governor must establish mechanisms to effectively monitor and identify situations where representatives are not fulfilling their duties as outlined in the new Aged Care Act. These mechanisms should also address instances of breakdowns in family relationships or an increased identified risk of elder abuse.

To address these concerns, a clear process must be in place:

- Allowing stakeholders, including service providers, to raise concerns or lodge complaints regarding an approved supporter or representative, with mechanisms in place to investigate and resolve these issues.
- Establishing processes that enable an urgent change in representative or supporter when there is a high-risk matter reported to the System Governor.
- Ensuring that the process for older people to add or change their representatives and supporters is straightforward and accessible.

Rec 28: Personnel under the National Aged Care Advocacy Program, Care Finders and Elder Care Support program should fall within the supported decision-making framework.

The consultation guidance material lacks clarity on why personnel providing support and advocacy under the National Aged Care Advocacy Program, Care Finders, and Elder Care Support programs do not fall within the supporter and representative provisions of the new Aged Care Act. The workforce within these programs engages with the most vulnerable cohorts in our community and should be subject to the same rules, responsibilities, and associated penalties as other stakeholders. Additionally, the fact that these programs are not subject to worker regulation provisions, complaints, and serious incident frameworks, as required for service providers under the new Aged Care Act, adds additional risk to the older person.

For these reasons, the workforce under these 3 national programs should unequivocally fall within the supported decision-making framework.

Chapter 9

Reform Readiness & Implementation Support

Rec 29: Provide transition funding to all home care providers to fund the resources and supports needed to implement the new Aged Care Act as a matter of urgency.

As the System Governor and Quality Regulator have been funded to acquire resources, expertise, and support in the development of the new Aged Care Act and its implementation, each provider will also require funding to mobilise resources for the implementation of the new Aged Care Act within their organisations. As highlighted multiple times in the recommendations above, the current unit pricing structure and funding mechanism for CHSP and home care programs do not allow providers to allocate funds for additional resources, change, and communication strategies necessary for the service transformation, training, and development required to implement the new Aged Care Act.

It is imperative that transition funding be urgently made available to all CHSP providers.

Rec 30: Additional targeted support be provided to the 990+ CHSP providers who receive less than $1 million a year in funding to reduce the risk of these organisations transitioning out of aged care.

Nearly 70% of CHSP providers are organisations receiving annual grant funds of less than $1 million per annum from the Department of Health and Aged Care.

- Many of these CHSP providers rely heavily on volunteer workforces, with very few paid workers.
- Many CHSP providers are governed by a board of volunteers.
- Many of the CHSP providers are servicing regional, rural, and remote localities.
- Many lack the administrative quality, human resources, and information technology infrastructure required.

Approximately 60% or 850 CHSP providers do not fall under the current Aged Care Act. Despite the intention of a proportionate approach to regulation, the impact of change on these providers is expected to be more significant compared to organisations that are already approved as providers of aged care. These CHSP providers will need hands-on support to strengthen their governance systems and facilitate the service transformation, training, and development necessary to implement the changes, obligations, and duties under the new Aged Care Act.

Targeted support can also take the form of national resources adaptable at an operational level, including policies, procedures, tools, templates, forms, and flowcharts developed and made available to all providers.

The ultimate goal is to ensure CHSP providers continue to deliver much needed care and support to the most vulnerable in our communities.

Reform Timelines

Rec 31: Government work with providers to develop a 24+ month transition plan that provides a staged and structured implementation of the new Aged Care Act.

When making recommendations regarding the timing of the rollout of the new Aged Care Act, it is essential to consider the cumulative impact of every provision with the Act that applies to providers. The date of this submission is 16 February 2024. The proposed go-live date for the new act is July 2024. With only 4 months remaining, the exposure draft of the new Aged Care Act is incomplete, and providers have no visibility into the details held within the Rules. At this point, it seems implausible for providers to be expected to mobilise resources to implement an incomplete exposure draft with minimal detail and no offer of financial support within such a short timeframe. Many CHSP providers simply do not have the resources to achieve this type of change without a realistic timeline, support structure and an injection of funding.

Rec 32: Transition timelines should also ensure adequate time for the System Governor and Quality Regulatory to implement the necessary ITC infrastructure, support personnel and guidance material.

It is essential to note that any implementation timeline should provide sufficient time for the System Governor and Quality Regulator to establish the required information technology and communication infrastructure, support personnel, training, and guidance materials before implementation by providers for each change within the new Aged Care Act.

Recommended Transition Timetable

An attempt has been made below to structure the implementation of the Aged Care Act into 7 tranches over a 24-month period. Two critical actions and their associated timeframes are missing from the outlined transition timelines below:

- The need for IHACPA to urgently conduct a study to determine the financial impact of the new Aged Care Act on unit pricing, pricing frameworks, and revised pricing recommendations.

- The need for the System Governor to develop a comprehensive support strategy for CHSP providers, encompassing funding, to mobilise the necessary project and change resources along with associated implementation costs.

Tranche 1					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
3 months	1/03/2024	1/07/2024	Register Providers	3	• The regulatory framework is central to the new Act, and providers must be registered first for the Act to function. • These will be new requirements for CHSP providers. It is recommended that notification of responsible persons is completed as part of the deeming process. • Bundling these changes together will enable CHSP providers to identify responsible persons, educate them on their responsibilities, obligations and statutory duties as well as put in place systems for managing suitability and change of circumstance matters. • In addition, approved providers have been through similar changes with key personnel and suitability matters. Therefore, an update to the existing guidance materials by the commission should enable CHSP providers to start preparing for these changes. • Feedback was that implementing statutory duties would require more time. In addition to changes to providers' governance systems and education of responsible persons, providers may need to engage legal counsel and insurance brokers to ensure they have adequate insurance in place.

Tranche 2					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
12 months	30/09/2024	30/09/2025	Quality Standards	3	• The Quality Regulator has been preparing the sector for the new Quality Standards for some time and has already started educational activities, providing templates and guidelines. • Providers can start to prepare to implement the standards in the lead-up to 1 July. However, in this proposed approach, we suggest that provider registration takes priority so that it is clear to all parties what standards apply to which provider. • Historically, changes to quality standards have taken some time to implement and embed in an organisation, Therefore a transition period is required to allow time for actions to be taken to strengthen the systems and monitoring practices.

Tranche 3					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
3 months	30/09/2024	31/12/2024	Code of Conduct	3	• This suggested bundling addresses the need to educate and communicate with a broader stakeholder group, primarily older people in care, their representatives, staff, volunteers, and associated providers. The proposed transition timing allows providers to roll these out alongside the Quality Standards (if applicable). • The Statement of Rights is new, and CHSP providers have indicated engagement with new clients would be quicker (say 3 months). With existing clients a more extended period is requested due to the sheer number of older people within CHSP programs and the sporadic nature that some CHSP clients engage with services. • This approach takes into consideration that CHSP providers have not been required to implement the Code of Conduct yet. However, it acknowledges that the Regulator has guidance materials that will require some tweaking (to match new wording).

6 months	30/09/2024	31/03/2025	New Whistleblower Protections	7	• With whistleblowers, providers have feedback that additional time will be needed. Protection policies and processes will need to be established, as well as education.
9 months	1/01/2025	31/06/2025	Alternative Entry Pathway	2	

Tranche 4					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
9 months	1/01/2025	30/06/2025	Eligibility and Entry	2	• Recommended that at least 6 months be provided for transition to the new eligibility and alternative entry pathways, considering the significant number of stakeholders involved. • Ensuring hospitals and primary care nationally know of the new eligibility and alternative entry pathway. • To enable time for the government to ensure there are alternative care pathways in each state, region and locality for people who may fall through the gaps.

Tranche 5					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
12+ months	1/01/2025	31/12/2025	Provider Governance Requirements	3	• This was viewed as similar to the implementation of similar reforms for approved providers. Therefore, feedback for provider governance is to allow a 12 to 15-month transition period for CHSP providers. Allowing for governing body membership changes, constitutional changes, and establishment of required advisory bodies, as well as any new operational reporting requirements. • The consultation paper and exposure draft had limited information for worker registration. Therefore, it was difficult for providers to comment. However, as it referred to NDIS and state offices, CHSP providers who are also NDIS providers were able to comment that this is likely to take the same time to transition.
3-12 months	1/01/2025	31/12/2025	Worker Registration	3	

Tranche 6					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
12 months	30/06/2025	30/06/2026	Information Management	7	• Both changes are likely to involve ITC changes for organisations and government. Therefore, a more extended transition period is suggested. • The timing enables scope for alignment of state and federal legislation in relation to supported decision-making.
12 months	1/01/2025	31/12/2026	Support decision making framework	1 & 8	

Tranche 7					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
12 months	1/07/2026	30/06/2027	Fees and Payments	4	• This was difficult for CHSP providers to give feedback on as the exposure draft was silent on any detail regarding this Chapter. However, it was indicated that depending on the nature of the changes, it will likely require a financial system, ITC system and claiming changes for the organisation. If there is a significant impact on the existing older people in care, the changes may require a lengthy implementation process. • A suggestion for CHSP providers is to align changes to fees, payments, and subsidies with the changes to Support at Home in 2027. • High-quality care has been listed in this tranche to enable providers to focus on implementing and embedding their obligations and duties under the new Act, the new fees and payment arrangements, and the new entry and eligibility provisions. Resources can then be redirected into innovation and aspirational projects.

Contacts

Thank you for the opportunity to submit a response to the consultation on the exposure draft for the new Aged Care Act.

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