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

Submission by

[redacted]

Background

The Commonwealth Home Support Program (CHSP) currently stands as the largest collective of aged care providers, totalling over 1300 organisations. The program serves the most extensive number of older individuals annually, supporting around 800,000 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. Personal care, transport, meals on wheels 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 diversity among CHSP operators is noteworthy, with approximately 60% of providers funded only for CHSP. For some of these organisations CHSP serves as their sole source of income. Conversely, there are CHSP providers, such as [redacted] as a local council, 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 already in our organisation that we 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 1,300 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.

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. Two pivotal questions need to be addressed:

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 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

We recommend:

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. 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.

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 the responsibilities of service users within the new Aged Care Act or the Rules.

Rec 5: The legislation is further strengthened by focusing on well-being, reablement and quality of life and pivoting from the current approach that leans towards a deficit approach and a medical model of care and support extending beyond the default of ‘clinical care’ needs to activities of daily living.

Rec 6: Terminology regarding care must include access to disability supports where required.

Rec 7: Early access to aged care should extend beyond the cohorts currently identified to include support for people with age-related conditions, such as early-onset dementia. There is an absence of other formal supports available (such a condition is very unlikely to meet eligibility requirements for the NDIS).

Rec 8: The Act includes details on how the rights of older people will be upheld as standard practice and not merely through an aspirational series of statements that can only be upheld when there is a breach in another section of the legislation.

Rec 9: Choice and control be strengthened throughout the Act to uphold the rights of the older person, including through the co-design of support plans.

Rec 10: The interdependence in care relationships is acknowledged and the needs and rights of carers and the care relationship are considered in addition to those of the older person.

Rec 11: Defines informal carers, the essential supports they provide and how they interact with the system regarding rights.

Rec 12: Defines professional advocacy services and the responsibilities they have to interact with the various stakeholders: providers, supporters and representatives, System Governor, Regulator, Commissioners or delegates and providers.

Rec 13: Responsibilities of older people accessing aged care should be embedded in the Act, alongside their rights.

Rec 14: Flexibility is embedded within the Service List to enable older people to exercise choice and control to make informed decisions.

High Quality Care

We recommend:

Rec 1: 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 2: The Independent Health and Aged Care Pricing Authority (IHACPA) to also include within their costing study, costing framework and unit pricing recommendations: the cost for providers to deliver high-quality care.

Rec 3: Provide clarification within the Rules or guidance material on what the Quality Regulator would define as “timely and responsive” delivery of services.

Rec 4: 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. 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.

Rec 5: Providers be voluntarily audited against high-quality care systems and outcome measures by the Aged Care Quality Commission to achieve a status of a provider of ‘high quality’ care that can be promoted.

Rec 6: Measurable high-quality care needs to be funded to be delivered sustainably, so a financial incentive will be required.

Eligibility for Entry to Aged Care

We recommend:

Rec 1: 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 2: The Care Finder model is continued, with a process of continuous improvements to the model.

Rec 3: Expand the scope of responsibilities of Care Finders and Elder Care Support program to deliver prioritised support to ineligible individuals**.**

Rec: 4: Providing funded training, communications toolkits and claimable funding for aged care workers and other community organisations to build individual capacity to understand the system and the older person's options to exercise choice and control or refer the person to a Care Finder.

Rec 5: The timeframe from application for an aged care assessment to commencement of service access should be measured as a process outcome for an older person. Regional stewardship, including local government, should be considered to ensure systemwide responses.

Rec 6: The flowchart: *Who will be able to access Commonwealth funded Aged Care* (p 32) and the Act be updated to put the older person at the centre of the entry, review and reassessment processes. The older person appears to be a passive recipient of the process, with others making decisions about their support needs and service levels. Assessment needs to be a co-designed process for developing support plans and should be supported by an appropriately skilled and qualified workforce.

Alternative Entry Requirements

We recommend:

Rec 1: Ensure alternative entry requirements are codesigned with primary care, acute care, assessment and service providers – particularly stakeholders from regional, rural and remote settings.

Rec 2: Provide extended implementation and transition timeframes due to the significant number of health stakeholders that need to understand new alternative service entry requirements.

Rec 3: A clause is included in the Act that defines exceptional circumstances and the process to fast-tracking access to service supports across all programs/services, assurance of funding and the follow-up process to retrospectively comply with the complete entry requirements. Exceptional Circumstances could be situations of fire or floods.

Registration Categories

We recommend:

Rec 1: Undertake further consultation on social support type with the view of moving some service lists into Category 1 or 3. Social support group services be realigned to Category 3.

Rec 2: Aged care financial literacy activities should be supported and resourced as a part of the service list.

Rec 3: Undertake further consultation on the allied health service type with the view of realigning the service type with nursing services under Service Category 5. They 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 and Social Work.

Rec 4: The aged care worker screening is moved to a national register and away from State and Territory registers to support safeguarding.

Rec 5: A separate definition of volunteers and separation of responsibilities, registrations, screening, etc in the corresponding relevant documents.

Obligations and Statutory Duties

We recommend:

Rec: 1: Provision of targeted mentoring and support services to CHSP organisations who are not currently approved providers.

Rec 2: 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 3: 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 4: Conduct an in-depth study and impact analysis to understand the short and longer-term implications for Governing Boards of CHSP providers.

Rec 5: The exemption under s 100(1)(b) regarding membership of governing bodies be replicated in s 101 to exempt local government authorities from advisory body requirements.

Fees Payments and Subsidies

We recommend:

Rec 1: The Government manage the collection of income-tested fees or its new equivalent. Removing providers as the debt collector for Government.

Rec 2: The System Governor has responsibility to improve aged care financial literacy of older people accessing the system.

Rec 3: With the absence of the recommendations of the Aged Care Taskforce at the time of this submission. We recommend future engagement opportunities to provide feedback on a proposed payment schedule and a contributions framework for older people accessing the Support at Home program.

Rec 4: Grant funding for Support at Home service activities of transport, meals and social support groups as a funding stream.

Rec 5: The department release a draft pricing schedule for consultation and as final release in 2024 to enable providers to understand the viability of continuing, entering or exiting as a registered service provider of Support at Home.

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

Governance of the Aged Care System

We recommend:

Rec 1: 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.

Rec 2: The Aged Care Complaints Commissioner is an independent appointment reporting directly to the Minister and not to the Aged Care Quality and Safety Commissioner as currently proposed.

Regulatory Mechanisms

We recommend:

Rec 1: 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 the insights provided.

Rec 2: The System Governor undertake further clarification on the process for responding to a disclosure and how vexatious claims will be managed.

Rec 3: Twelve months from the date the Act is gazetted into law be allowed for providers to transform their businesses to achieve compliance.

Rec 4: The Commission provides clear guidance on interim expectations regarding the transition phase.

Rec 5: Clarity is improved regarding the obligations of CHSP providers between the passing of the new Act and the full rollout of Support at Home.

Rec 6: Sector Support and Development is continued through and beyond the implementation period of Support at Home.

Appointment of Supporters and Representatives

We recommend:

Rec 1: Provide the ability for older people to have the option to nominate both representatives and supporters.

Rec 2: Delay the implementation of the decision-making framework until any conflicts between existing state legal instruments and the practical impacts are resolved. 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 there is an alternative decision-maker specified in a signed health directive.

Rec 3: Clarification around how these decision making conflicts will be managed, and from whom service providers should take direction.

Rec 26: Delay implementation of the supported decision-making framework until the System Governor has the Information Technology and Communication Plan to deliver timely processing of requests and communication of appointments to all stakeholders.

Rec 27: Quality Regulator to implement a 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

We recommend:

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.

Broader themes of the Legislation

We recommend:

Rec 1: The System Governor (delegate) should develop local partnership arrangements with local governments to support regional stewardship of aged care markets and workforces.

Rec 2: The legislation should be written for accessibility by older people, their supporters and the aged care workforce. Guidance documentation should accompany the legislation for improved access to empower people to understand their rights and responsibilities across the service system.

Rec 3: The legislation needs to reflect the shared definitions, concepts, registrations, regulations and pathways for complaints or appeals, where appropriate, with legislation that governs interfacing systems such as the National Disability and Insurance Scheme (NDIS) and health.

Rec 4: The department or the Minister prioritise solutions that resolve existing service issues, including waiting lists for CHSP services and assessment before the integration of CHSP into Support at Home.

Rec 5: Workforce strategies are aligned across jurisdictions and the care sector.

Rec 6: Funding parity is sought through new contractual agreements with providers for CHSP to extend until at least end June 2027. The (yet to be released) recommendations from the Aged Care Taskforce should also be considered with regard to funding subsidies for specialisations, geographic remoteness and providers of last resort.

Rec 7: 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.

Rec 8: 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.

Reform Timelines

We recommend:

Rec 31: Government work with CHSP 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 Information Technology infrastructure, support personnel and guidance material.

Recommended Transition Timetable

An attempt has been made below to structure the implementation of the Aged Care Act into 7 timeframes 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.

Recommendation A

Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
6 months	1/04/2024	1/10/2024	To Register CHSP Providers	3	• The regulatory framework is central to the new Act, and providers must be registered first for the Act to function. • There 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 already 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.

Recommendation B					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
12 months	30/09/2024	30/09/2025	Strengthened Quality Standards implemented	3	• The Quality Regulator has been preparing the sector for the Strengthened 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.

Recommendation C					
Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
6 months	30/06/2024	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).

9 months	30/06/2024	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.

Recommendation D

Length of Time to Implement	Suggested Start	Suggested End	Major Change	Chapter	Rationale
12 months	1/07/2024	30/06/2025	Alternative Entry Pathway	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 all referring agencies including 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.
12 months	1/07/2024	30/06/2025	Eligibility and Entry	2	

Recommendation E

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.
12 months	1/01/2025	31/12/2025	Worker Registration	3	

Recommendation F

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 Information Technology and Communication Plan 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	

Recommendation G

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, Information Technology system and claiming changes for the organisation. If there is a significant impact on the existing older people with 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 section 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.