Silverchain submission

Aged Care Rules 2024: Draft Chapter 4: Funding

6 December 2024

silverchain

Acknowledgement of Country

Silverchain respectfully acknowledges the Traditional Custodians of the lands on which we work and live. We acknowledge Elders both past and present, whose ongoing effort to protect and promote Aboriginal and Torres Strait Islander cultures will leave a lasting legacy for future leaders and reconciliation within Australia.

Our Innovate Reconciliation Action Plan artwork was created by artist, Charmaine Mumbulla from Mumbulla Creative. The artwork is crafted from many individual pieces and is layered to tell the Silverchain story, including our increased commitment and efforts towards healing, reconciliation, and social justice.

Contents

Contacts

For more information, please contact:

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Executive Summary

As pioneers and innovators of community and home-based care for more than a century, Silverchain Group welcomes the opportunity to provide comment on the Draft Rules: Service List for the Aged Care Bill 2024 (Bill). We provide a range of health and aged care services to 140,000 people each year. Many of our 5,900 employees provide care to 33,000 older people through Home Care Packages (HCPs) and the Commonwealth Home Support Program (CHSP).

We have provided comment on the Draft Rules in respect to how the Department expects these to be implemented in practice.

The structure of the funding sets the foundations for a more financially sustainable aged care system in Australia

We welcome the detail released in the subordinate legislation for the Aged Care Act 2024. Efforts to prepare to transform services have been hamstrung by a lack of information to date, and providers have been waiting for sufficient detail to begin reforming services in earnest. As such, the publication of the Rules: Service List and Chapter 4 is welcomed and we encourage the Department to finalise and release other subordinate legislation as soon as possible lest the Department becomes subject to caretaker conventions in early 2025. The resulting significant delay of the information we need to transform services both to meet the legislation but also to align with the new Strengthened Standards and Support at Home program will prevent providers being ready for a 1 July 2025 implementation.

We have read the Draft Rules in conjunction with the Support at Home Handbook to form a view about whether the Rules are sufficient to enable a successful transition of services to Support at Home (SaH) for older people to remain independent in their own homes and communities.

We note with disappointment that the Draft still does not release the information in full, with significant content not drafted as yet (namely parts 8, 9 and 10 and Chapter 8 and 197B Fee Reduction Subsidy outstanding).

There remain equity issues that need to be considered

We acknowledge the attempts made to address equity issues in the Aged Care Act 2024 and the subordinate Rules: Funding. This includes, for example, rural/remote and First Nations subsidies, but there are other aspects of individuals' lives that make it challenging to access and/or provide high quality care to them.

We note that in section 196A that there are a range of person centred and provider supplements. We were disappointed to see that there is no longer a Dementia supplement. Providing care to a person living at home with Dementia is more costly than providing to someone without Dementia, and this should be recognised in the funding if one of the aims of the Act is to ensure people can age at home if they want to.

Funding mechanisms need to reflect the evidence base around intersectional disadvantage

The Rules require clarification about the subsidy and loading that will be provided to an individual regardless of the number of subsidy classifications they may be eligible for. It is important that the funding structures recognise the importance of intersectional disadvantage for an older person where their challenges or discrimination are not just about their age but are compounded by other factors, like their location, trauma experiences, ethnicity etc. Providing services to an older person who experiences multiple forms of disadvantage or discrimination is far more complex than for an older person without these experiences. As such, the Rules need to ensure that any relevant loading is applied to the efficient unit price for all of the classifications a person is eligible for.

Care Management funding caps

We are concerned about the reported reduction in care management fees to 10% under Support at Home. This is a material reduction in fees for this type of care and for some people,

this will be inadequate to meet their needs. Our experience is that care management requirements increase with the clinical complexity of presenting issues for older people, but it is also more complex for people who have challenging family, housing and other social situations. These challenges are not likely to be reflected in their SaH classification level (and associated budget). This will disadvantage providers who are known to be able to provide end-to-end care, including clinical care and care involving complexity, as the care management cap of 10% across clients is unlikely to balance out across the cohort for these types of providers; this includes Silverchain.

Co-contributions on efficient price only (and not loadings)

It is not clear in the draft Rules if the co-contributions older people need to make for their independence and everyday living services are proportioned to the efficient price cap or to that cap plus the loadings.

Co-payments may influence people's decisions about the non-clinical supports they wish to receive – leading to an increase in the need for clinical supports

We predict that the Service List and associated contributions regime embedded in the Rules will drive choices by consumers based on financial factors rather than evidence-based needs. Section 314AA indicates that full pensioners will be required to pay 17.5% contribution to the cost of their everyday living services and 5% for independence services. We believe this will have unintended consequences and drive consumer-decision making in ways that do not support the best possible outcomes, high quality clinical care and will lead to inefficient use of aged care resources.

For example, personal care is in a category that attracts a co-contribution however clinical care will not attract a co-contribution. We can foresee a client choosing to reduce the number of hours of personal care they receive (in order to reduce the amount they need to pay out of pocket) which will have flow on impacts to the use of clinical resources. Personal care workers play an important role in monitoring the health and wellbeing of people living in their own homes and escalating concerns to clinical colleagues. It is commonplace that a personal care worker will identify a skin integrity issue for an older person first and then escalate to ensure that a nurse can provide wound care. Consideration should be given to the risk that individuals will forego needed and beneficial services to minimise any co-contribution.

We have serious concerns about co-payments associated with continence related services and products. Silverchain has expertise and extensive experience in continence management not just within an aged care context, but also provides some state-funded services for continence care as well. While the clinical care provided by nursing staff with continence expertise will not attract a co-payment under Support at Home, products to support that care will. For example, we already see 'rationing' of continence products by some of our clients – a 'making do' with 3 rather than 4 continence pads a day or the reuse of single use products like catheters (against clinical advice). For some older people, the choices they will need to make are undignified – either have the dignity of bladder and bowel control or eat, or heat/cool themselves or pay for medications. There are major clinical risks associated with inadequate continence management including the risk of urinary tract infections and subsequent increased risks of delirium and falls and urosepsis for people with catheters. Similarly, infrequent changing of continence pads and products may lead to compromised skin integrity requiring increased use of clinical care services to treat skin damage.

There are aspects of the Rules that require amendments to consider people who begin with a provider during a quarter

There are aspects of the Rules that require amendments to consider people who exit from a provider's service during a quarter. In a rights-based and multi-provider model for home care supports, it is likely that clients will change to different providers mid-way through a quarter – this presents challenges to the way in which provider-based subsidies can be calculated.

For example, in Subdivision B (203B) the amount to be credited to the provider needs to be written in such a way as to ensure that the amounts are pro rata for the number of days in the quarter that the client was with the provider. We note that the Department is actively addressing how to operationalise this issue at the time of this submission.

Ceasing an account

Section 193D indicates that the circumstances in which an individual's ongoing home support account ceases are that more than 60 days have passed since the individual died. Similarly, 211A indicates that the account period for a client ceases at the end of the day the client dies. These timeframes will be problematic to implement and is likely to lead to unnecessary burden on providers. Currently the timeframe is 70 days for cessation of an account and this is already problematic for providers.

For example, in a circumstance where a person has died at home but has been leasing high-cost equipment such as a hospital height adjustable bed, it may take some time for the equipment to be returned to the supplier and invoiced to the home care provider. Similarly, there are often some 'tasks' that remain after a person has died that are required of the provider within the first weeks of death (for example, safe disposal of unused medicines). Similarly, if part of the supports were provided through a brokered third-party service, it may take some time for invoices to be generated and paid across the system of providers involved in the care that may take some weeks after the passing of the client.

There are a range of areas in the Rules where we believe the drafting could be improved to minimise or prevent unintended consequences during policy implementation.

Disincentive for people to exit from the NDIS and join the aged care system

We acknowledge that the Aged Care Act 2024 aims to reform the system to allow for a financially sustainable aged care system, and in doing so, co-payments are an important component of the policy reform.

However, for clients who have lifelong disability and who have previously been supported through the National Disability Insurance Scheme (NDIS) there is an inherent disincentive in the structure of the aged care system to have them shift from a no co-contribution NDIS to a co-contribution aged care system. Added to this, the caps on consumable and limited budgets for assistive technology and guide dogs, there is a disincentive for people to shift from the NDIS to the aged care system. The number of people aged over 65 in the NDIS and numbers transferring to the aged care system needs to be closely monitored by both the Department and the National Disability Insurance Agency. Ideally, co-contributions of anyone transferring from the NDIS to the aged care system should be waived to eliminate the disincentive.

Assistive Technology accounts

We are concerned about unintended consequences associated with the way this section of the Rules is drafted.

- Section 211A indicates that the account ceases at the end of the day on the day the person dies (or enters residential aged care). As discussed previously, this is problematic as there are services that need to be provided in the days and weeks after this relating to the return and invoicing of equipment (particularly high-cost equipment).
- 211B (subsection 2) prescribes a list of conditions for which a medical practitioner certifies a diagnosis which would warrant use of assistive technology. The experience of the NDIS has shown that listing in legislation (even subordinate legislation) what appears to be an exhaustive list of conditions will ultimately lead to exceptions being needed and will incentivise the seeking of medical diagnosis merely in order to access equipment and services. The NDIS is now moving (sensibly) to a functional based eligibility. The test in the aged care system should not be a diagnosis but it should be a functional need regardless of what the underlying medical or age-related cause of the need is.

- There is a $1000 cap on continence products outlined in 212A. We assume that this will reflect a replacement of the funding currently available through the federally funded Continence Aids Payment Scheme. For some clients particularly those with Dementia or who require internal catheters, this allowance will be insufficient to meet their needs (even with co-payments). It also provides an advantage to larger providers who can exert their buying power to purchase continence consumables at lower per unit prices for their clients. The Current DVA process offers a more appropriate mechanism to ensure efficient use of funds but allows people to access the continence products according to the severity of their needs by making an evidence-based application for increased funding for products, after a specific threshold is reached.
- Section 212B indicates that assistive technology will be categorised into low, medium and high. Without detail of the types of assistive technology and equipment that falls into these categories, we are unable to comment on the feasibility of the funding amounts listed. We welcome the inclusion of a low AT category to fast-track access to low cost but high impact equipment and technology.

Home modification subsidies

Section 221(2) describes a cap of $15,000 be provided to a client for the purposes of home modifications to allow them to remain independent and safe in their own homes. For some clients, this amount will be inadequate to meet their needs to have their home safe to remain and age in place. We appreciate that it is fiscally responsible to put a limit on the amount of subsidy provided for modifications to privately owned dwellings, but we wish to draw attention to the cost differential between modifications that allow someone to remain at home and the cost associated with the Government supporting someone to live 24/7 in a residential aged care facility for the remainder of their life. We recommend there is a process in place where applications can be made for the increase of the subsidy for home modifications if evidence can be provided that the modifications are value for money in allowing the person to remain living independently at home.

Clarity is needed in section 273A on the proportion of the costs of home modification costs (and other products and services in including self-care) that a client will be required to co-contribute to. If this proportion is set high (e.g. 66%), then some older people (many of whom are on fixed and low incomes) will forego necessary changes to their dwellings that would otherwise enable them to remain living at home. We acknowledge that the Act aims to ensure that the government subsidised aged care system is financially sustainable in the context of an impending tsunami of demand with the aging of our population, however we wish to draw attention again to the cost differential between modifications that allow someone to remain at home and the cost associated with the Government supporting someone to live 24/7 in a residential aged care facility for the remainder of their life.

The way this section 273A is worded indicates that only the cost of home modifications can be passed on to the client. If this is the case, it does not recognise the significant administrative burden and cost incurred by the provider in arranging for and overseeing the home modifications. The Act enshrines our responsibilities to oversee the quality and safety of all third-party providers, and as such, the administrative requirements and oversight costs needs to be fairly compensated for providers.

We hope that the Department finds our feedback of assistance in refining the Draft Rules. We would be pleased to provide further detail if you would find elaboration on our commentary or recommendations of value.

We recommend:

- That the Department release a full draft of these Rules including content relating to:
  - Part 8: Subsidy for certain specialist aged care programs
  - Part 9: Subsidy claims and payment
  - Part 10: Grants
  - Chapter 8: Funding of aged care services—individual fees and contributions
  - 197B Fee Reduction Subsidy calculation method.
- That a subsidy be provided to Support at Home services delivered to any person living with dementia.
- That the Service List includes an item for the development of dementia and cognition management plans for people receiving care in their homes.
- That loadings be provided on the efficient unit price for services for each and every subsidy a person is eligible for.
- That clarity is provided as to whether people are expected to pay co-contributions on the efficient price of a service only or the efficient price plus any loadings that apply.
- That clarification is needed in the Rules about the definition and requirements around Interim Budgets.
- That co-contributions be removed or reduced significantly for services and products with a direct evidentiary link to increased clinical risks.
- That the Rules are clearer as to the requirements for provider-based subsidies in the circumstances where clients change providers mid-way through the quarter.
- That the Rules provide up to 90 days from the date of death before the person's account is ceased to allow appropriate acquittal of payments for all services delivered by the aged care provider and third-party contractors.
- 211A to be rewritten to allow for services to be provided for up to one week from the date of the person's death.
- That anyone 65 or over transferring from the NDIS to the aged care system to receive supports be 'grandfathered' and not required to pay co-contributions for their supports.
- That the number of participants in the NDIS 65 years or older be monitored to determine any barriers to transferring to being supported under the aged care system.
- That the list of conditions listed in 211B (subsection 2) be removed and eligibility based on assessed need rather than diagnosis.
- That a process be developed (similar to the Department of Veteran's Affairs) for approval for access to necessary continence products beyond the capped amount of funding in 212A.
- That a list of low, medium and high assistive technology be released to the sector urgently to support transition planning.

1. About Silverchain and this submission

For 130 years Silverchain has provided high-quality, in-home health and aged care services to multiple generations of Australians. As a not for profit, we employ more than 5,900 people, including nurses, doctors, allied health, care experts, and a dedicated research and innovation division, operating as Silverchain, RDNS Silverchain and KinCare.

Our ambition is to create a better home-care system for all Australians.

Our team provides a range of health and aged care services to more than 140,000 people each year. We specialise in home and community-based care because we believe that people should have, and prefer to have, their care in or close to their homes. Our services comprise complex and acute nursing; hospital in the home; specialist community palliative care; independence services and support at home, allied health services; digital enabled care and remote monitoring; and chronic and complex disease management.

We are accredited against both health and aged care standards nationally. We are recognised as a rural and remote aged care provider through the Department of Health and Aged Care specialist verification for aged care framework.

We currently provide home aged care services to 33,000 people across Australia through Home Care Packages and the Commonwealth Home Support Program.

We have a productive and positive relationship with the Commonwealth departments and agencies. We currently serve on the Department of Health and Age Care's Support at Home Sector Reference Group and Data and Digital Reference Group to advise on the implementation of the Support at Home program reforms and on the Australian Commission for Quality and Safety in Health Care's Aged Care Advisory Group.

2. The funding structure

The structure of the funding sets the foundations for a more financially sustainable aged care system in Australia

The sector has welcomed the detail released of the subordinate legislation for the Aged Care Act 2024. Efforts to transform services have been hamstrung by a lack of information to date, and providers have been waiting for sufficient detail to begin reforming services in earnest. As such, the publication of the Rules: Service List and Chapter 4 is very welcomed and we encourage the Department to finalise and publicly release other subordinate legislation as soon as possible lest the Department becomes subject to caretaker conventions in early 2025, resulting in a significant delay of the information we need to transform services both to meet the legislation but also to align with the new Strengthened Standards and SaH program.

We have read the Draft Rules in conjunction with the SaH Handbook to form a view about if the Rules are sufficient to enable a successful transition of services to SaH for older people to remain independent in their own homes and communities.

We note with disappointment that the Draft still does not release the information in full – with significant content not drafted as yet (namely parts 8, 9 and 10 and Chapter 8 and 197B Fee Reduction Subsidy outstanding).

There remain equity issues that need to be considered

We acknowledge the attempts made to address equity issues in the Aged Care Act 2024 and this subordinate Rules: Funding, including rural/remote and First Nations subsidies for example, but there are other aspects of individuals' lives that make it challenging to access and/or provide high quality care to them.

We note that in section 196A that there are a range of supplements. We were disappointed to see that there is no longer a Dementia supplement.

We also note that the Rules: Service List has a provision for services specific to residential aged care homes that relates to dementia and cognition management and includes the development of an individual therapy and support program. It is estimated that by 2050, there will be a doubling of the number of people living with dementia. Most of these people will want and need to live in their own homes as their condition progresses. The Strengthened Standards also have a strong focus on providers identifying and appropriately responding to the needs of older people living with dementia and as such, it is expected that home care providers will support the older person and their families in developing

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- That clarity is provided as to whether people are expected to pay co-contributions on the efficient price of a service only or the efficient price plus any loadings that apply.
- Clarification is needed in the Rules about the definition and requirements around Interim Budgets.
- That co-contributions be removed or reduced significantly for services and products with a direct evidentiary link to increased clinical risks.

plans for management of any behavioural and psychological symptoms of dementia while the person remains living at home and in the community. The addition of a relevant item for dementia and cognitive management for the SaH program offers older people and providers the reassurance that living with dementia in the community is not only 'accepted' but can be encouraged and managed safely with the right plans in place.

Providing care to a person living at home with dementia is more costly. There are often increased costs in terms of training of staff and additional care management activities needed to ensure care is provided in an appropriate way for them (e.g. multiple calls to remind them who is visiting and on what day, behavioural support planning with informal carers). There is also often significantly more engagement with family members to ensure the person remains safe at home and emergency planning activities.

Funding mechanisms need to reflect the evidence base around intersectional disadvantage

The Rules require clarification about the subsidy and loading that will be provided to an individual regardless of the number of subsidy classifications they may be eligible for. It is important that the funding structures recognise the importance of intersectional disadvantage for an older person where their challenges or discrimination are not just about their age but are compounded by other factors, like their location, trauma experiences, ethnicity etc. Providing services to an older person who has experienced multiple forms of disadvantage or discrimination is far more complex than for an older person without these experiences. As such, the Rules need to ensure that any relevant loading is applied to the efficient unit price for all of the classifications a person is eligible for.

Care management funding caps

We are concerned about the reported reduction in care management fees that can be used in a person's classification level for Support at Home to 10%. This is a material reduction in fees for this type of care and for some people, this will be inadequate to meet their needs. Our experience is that care management requirements increase with the clinical complexity of presenting issues for older people, but it is also more complex for people who have complex family, housing and other social situations. For example, for a client who has multiple adult children who are involved in their care – to arrange a home visit, there might be three phone conversations needed to ensure that the older person plus two carers are aware and agree to the arrangements – this becomes even more complicated in the situation of family conflict or if the older person has behaviours associated with Dementia and there are safety concerns (e.g. wandering).

Co-contributions on efficient price only (and not loadings)

It is not clear in the draft Rules if the co-contributions older people need to make for their independence and every day living services are proportioned to the efficient price cap or to that cap plus the loadings.

Interim budgets

Further clarification is needed in the Rules as to what is, and how the Interim Budget referred to in 194A will be operationalised.

Co-payments may influence people's decisions about the non-clinical supports they wish to receive – leading to an increase in the need for clinical supports.

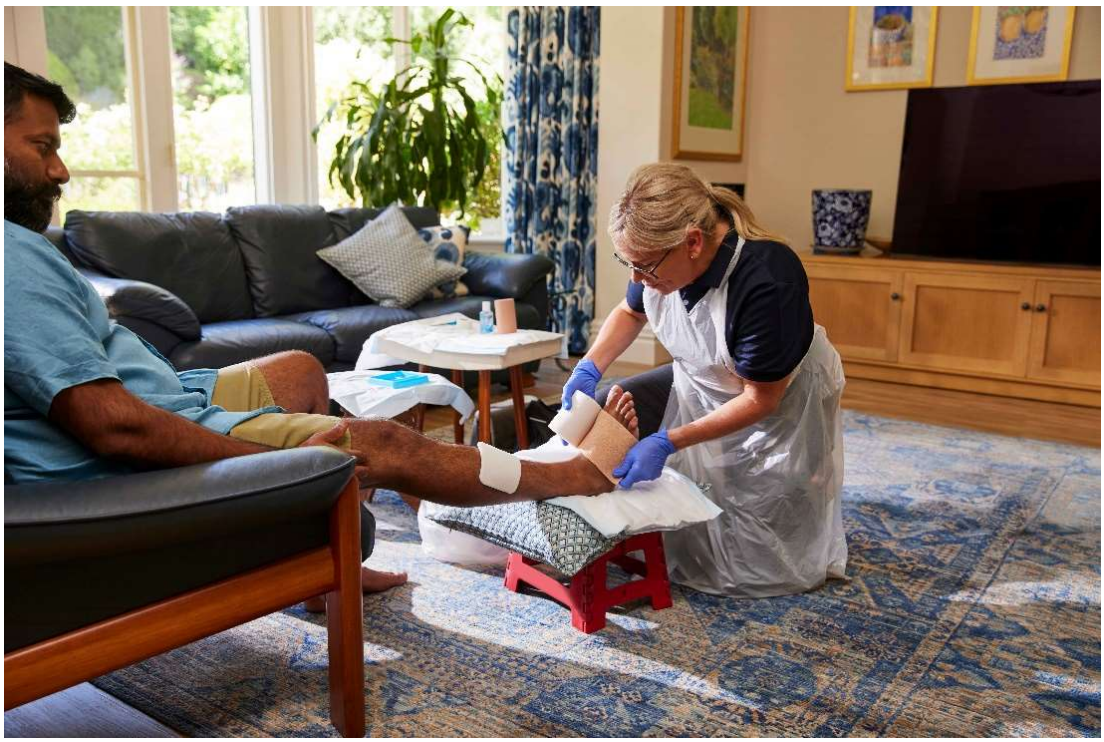
We predict that the Service List and associated contributions regime embedded in the Rules will drive choices by consumers based on financial factors rather than evidence-based needs. Section 314AA indicates that full pensioners will be required to pay 17.5% contribution to the cost of their everyday living services and 5% for independence services. We believe this will have unintended consequences and drive consumer-decision making in ways that do not support the best possible outcomes, high quality clinical care and will lead to inefficient use of aged care resources.

For example, personal care in a category that attracts a co-contribution however clinical care will not attract a co-contribution. We can foresee a client choosing to reduce the number of hours of personal care they receive (in order to reduce the amount they need to pay out of pocket) which will have flow on impacts to the use of clinical resources. Personal care workers play an important role in monitoring the health and wellbeing of people living in their own homes and escalating concerns to clinical colleagues. It is commonplace that a personal care worker will identify a skin integrity issue for an older person first and then escalate to ensure that a nurse can provide wound care.

We can reasonably predict that some older people will not prioritise having domestic assistance to clean their living environment (due to a co-payment), but the reality is that when our nurses attend their home, they may need to do some initial spot cleaning in order to have a hygienic and clear space in which to do their work (unpack wound dressings or catheters etc). This will lead to a waste of clinical resources (which the client does not co-contribute to) at a time when Australia has an existing clinical workforce shortage.

We have serious concerns about co-payments associated with continence related services and products. While the clinical care provided by nursing staff with continence expertise will not attract a co-payment, products to support that care will. For example, we already see 'rationing' of continence products by some of our clients – a 'making do' with 3 rather than 4 continence pads a day or the reuse of single use products like catheters. For some older people, the choices they will need to make are undignified – either have the dignity of bladder and bowel control or eat, or heat/cool themselves or pay for medications.

There are major clinical risks associated with inadequate continence management including the risk of urinary tract infections and subsequent increased risks of delirium and falls and urosepsis for people with catheters. Similarly, infrequent changing of continence pads and products may lead to compromised skin integrity requiring increased use of clinical care services to treat skin damage. We are concerned that the cap of $1000 per year for continence products will be insufficient for many people and we refer to the Department of Veteran's Affairs continence aids program where people are able to make an evidence-supported application for access to all the continence products needed annually.



3. Enabling variation in entry/exit points for the system

There are some aspects of the Rules that require improvements in order for successful implementation.

There are aspects of the Rules that require amendments to consider people who begin with a provider during a quarter.

There are aspects of the Rules that require amendments to consider people who exit from a provider's service during a quarter. In a rights-based and multi-provider model for home care supports, it is likely that clients will change to different providers mid-way through a quarter; this presents challenges to the way in which provider-based subsidies can be calculated.

For example, in Subdivision B (203B) the amount to be credited to the provider needs to be written in such a way as to ensure that the amounts are pro rata for the number of days in the quarter that the client was with the provider.

We recommend:

- That the Rules are clearer as to the requirements for provider-based subsidies in the circumstances where clients change providers mid-way through the quarter.
- That the Rules provide up to 90 days from the date of death before the person's account is ceased to allow appropriate acquittal of payments for all services delivered by the aged care provider and third-party contractors.
- 211A to be rewritten to allow for services to be provided for up to one week from the date of the person's death.

Ceasing an account

Section 193D indicates that the circumstances in which an individual's ongoing home support account ceases are that more than 60 days have passed since the individual died. Similarly, 211A indicates that the account period for a client ceases at the end of the day the client dies. These timeframes will be problematic to implement and is likely to lead to unnecessary burden on providers. Currently the timeframe is 70 days for cessation of an account and this is already problematic for providers, particularly in the context of the end of life pathway.

For example, in a circumstance where a person has died at home but has been leasing high-cost equipment such as a hospital height adjustable bed, it may take some time for the equipment to be returned to the supplier and invoiced to the home care provider. Similarly, there are often some 'tasks' that remain after a person has died that are required of the provider within the first week of death (for example, safe disposal of unused medicines). Similarly, if part of the supports were provided through a brokered third-party service, it may take some time for invoices to be generated and paid across the 'system' of providers involved in the care that may take some weeks after the passing of the client.

4. Unintended consequences

We would like to draw your attention to a range of areas in the Rules where we believe the drafting could be improved to minimise or prevent unintended consequences during policy implementation.

Disincentive for people to exit the NDIS and join the aged care system

We acknowledge that the Aged Care Act 2024 aims to reform the system to allow for a financially sustainable aged care system, and in doing so, co-payments are an important component of the policy reform.

However, for clients who have lifelong disability and who have previously been supported through the National Disability Insurance Scheme (NDIS) there is an inherent disincentive in the structure of the aged care funding system to encourage them shift from a no co-contribution NDIS to a co-contribution aged care system. Added to this, the caps on consumable and limited budgets for assistive technology and guide dogs, there is a disincentive for people to shift from the NDIS to the aged care system. The number of people aged over 65 in the NDIS and numbers transferring to the aged care system needs to be closely monitored by both the Department and the National Disability Insurance Agency. Ideally, co-contributions of anyone transferring from the NDIS to the aged care system would be waived to eliminate the disincentive.

We recommend:

- That anyone 65 or over transferring from the NDIS to the aged care system to receive supports be 'grandfathered' and not required to pay co-contributions for their supports.
- That the number of participants in the NDIS 65 years or older be monitored to determine any barriers to transferring to being supported under the aged care system.
- That the list of conditions listed in 211B (subsection 2) be removed and eligibility based on assessed need rather than diagnosis.
- That a process be developed (similar to DVA) for approval for access to necessary continence products beyond the capped amount of funding in 212A.
- That a list of low, medium and high assistive technology be released to the sector urgently to support transition planning.

Assistive Technology accounts

We are concerned about unintended consequences associated with the way this section of the Rules is drafted.

- Section 211A indicates that the account ceases at the end of the day of the day the person dies. As discussed previously, this is problematic as there are services that need to be provided in the days and weeks after the client passes relating to the return and invoicing of equipment (particularly high-cost equipment). This is particularly important for services provided through the Support at Home End of Life pathway.
- 211B (subsection 2) prescribes a list of conditions for which a medical practitioner certifies a diagnosis which would warrant use of assistive technology. The experience of the NDIS has shown us that listing in legislation (even subordinate legislation) what looks like an exhaustive list of conditions will ultimately lead to exceptions being needed and the incentivisation of the seeking of medical diagnosis in order to access equipment and services. The NDIS is now moving (sensibly) to a functional based assessment. The test in the aged care system should not be a diagnosis but it should be a functional need regardless of what the underlying medical cause of the need is.
- There is a $1000 cap on continence products outlined in 212A. We assume that this will reflect a replacement of the funding currently available through the federally funded Continence Aids Payment Scheme. For some clients particularly those with Dementia or who require internal catheters, this allowance will be insufficient to meet their needs (even with co-payments). It also provides an advantage to larger providers who can exert their buying power to purchase continence consumables at lower per unit prices for their clients.

The Current DVA process offers a more appropriate mechanism to ensure efficient use of funds but allows people to access the continence products they need according to the severity of their need by making an evidence-based application for increased funding for products.

- Section 212B indicates that assistive technology will be categorised into low, medium and high. Without detail of the types of assistive technology and equipment that falls into these categories, we are unable to comment on the feasibility of the funding amounts listed. We welcome the inclusion of a low AT category to fast-track access to low cost but high impact equipment and technology.

Home modification subsidies

Section 221(2) describes a cap of $15,000 be provided to a client for the purposes of home modifications to allow them to remain independent and safe in their own homes. For some clients, this amount will be inadequate to meet their needs to have their home safe to remain and age in place. We appreciate that it is fiscally responsible to put a limit on the amount of subsidy provided for modifications to privately owned dwellings, but we do need to draw attention to the cost differential between modifications that allow someone to remain at home and the cost associated with the Government supporting someone to live 24/7 in a residential aged care facility for the remainder of their life. We recommend there is a process in place where applications can be made for the increase of the subsidy for home modifications if evidence can be provided that the modifications are value for money in allowing the person to remain living independently at home.

Clarity is needed in section 273A on the proportion of the costs of home modification costs (and other products and services in including self-care) that a client will be required to co-contribute to. If this proportion is set high (e.g. 66%), then most clients (many of whom are on fixed and low incomes) will forego necessary changes to their dwellings that would otherwise enable them to remain living at home. We acknowledge that the Act aims to ensure that the government subsidised aged care system is financially sustainable in the context of an impending tsunami of demand with the ageing of our population, however we do need to draw attention again to the cost differential between modifications that allow someone to remain at home and the cost associated with the Government supporting someone to live 24/7 in a residential aged care facility for the remainder of their life. The way this section is worded indicates that only the cost of home modifications can be passed on to the client. If this is the case, it does not recognise the significant administrative burden and cost incurred by the provider in arranging for and overseeing the home modifications. The Act enshrines our responsibilities to oversee the quality and safety of all third-party providers, and as such, the administrative requirements and oversight costs needs to be fairly compensated for providers.

5. Conclusion

We hope that the Department finds our feedback of assistance in refining the Draft Rules. We would be pleased to provide further detail if you would find elaboration on our commentary or recommendations of value.

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