The Auditor-General
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Performance Audit

Administration of the Community Aged Care Packages Program

Department of Health and Ageing

Australian National Audit Office

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Australian National
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Canberra ACT
23 May 2007

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken a performance audit in the Department of Health and Ageing in accordance with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit and the accompanying brochure to the Parliament. The report is titled *Administration of the Community Aged Care Packages Program.*

Following its tabling in Parliament, the report will be placed on the Australian National Audit Office's Homepage—http://www.anao.gov.au.

Yours sincerely

Ian McPhee
Auditor-General

The Honourable the President of the Senate
The Honourable the Speaker of the House of Representatives
Parliament House
Canberra ACT

AUDITING FOR AUSTRALIA

The Auditor-General is head of the Australian National Audit Office. The ANAO assists the Auditor-General to carry out his duties under the *Auditor-General Act 1997* to undertake performance audits and financial statement audits of Commonwealth public sector bodies and to provide independent reports and advice for the Parliament, the Government and the community. The aim is to improve Commonwealth public sector administration and accountability.

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Abbreviations

AACD	Ageing and Aged Care Division (of DoHA)
ABS	Australian Bureau of Statistics
ACAP	Aged Care Assessment Program
ACAR	Aged Care Approvals Round
ACAT	Aged Care Assessment Team
ACPACs	Aged Care Planning Advisory Committees
AIHW	Australian Institute of Health and Welfare
BPA	Business Practice Agreement
CACP(s)	Community Aged Care Package(s)
CALD	People of culturally and linguistically diverse backgrounds
CCCs	Commonwealth Carelink Centres
CCRCs	Commonwealth Carer Respite Centres
COAG	Council of Australian Governments
CPP	Community Partners Program
DoHA	Department of Health and Ageing
DVA	Department of Veterans' Affairs
EACH	Extended Aged Care at Home
EACH–Dementia	Extended Aged Care at Home – Dementia
FSD	financially and socially disadvantaged

HACC	Home and Community Care
OATSIH	Office of Aboriginal and Torres Strait Islander Health
PBS	Portfolio Budget Statements
PICAC	Partners in Culturally Appropriate Care
QR	Quality Reporting
STOs	State and Territory Offices (of DoHA)
VHC	Veterans' Home Care

Summary and Recommendations

Summary

Background

1. ANAO conducted this audit to provide assurance to Parliament that the Department of Health and Ageing (DoHA) was fulfilling its responsibilities in administering the Community Aged Care Packages (CACPs) program.

2. The audit objective was to assess the effectiveness of DoHA's management of CACPs in fulfilling the legislated objectives of the program.

3. The CACPs program is a community care program designed to help frail older people with complex daily care needs stay in their own homes, as an alternative to residential types of care.

4. Unlike many other types of community care provided to Australians who are ageing or disabled, the subsidies paid under it are fully funded by the Australian Government.

5. Alongside the Australian Government's very much larger residential care program, it is one of three types of care regulated by the *Aged Care Act 1997* and the Aged Care Principles promulgated under it.

6. Though still relatively small, the program has grown steadily, especially since the Australian Government's 'Staying at Home' policy initiative in 1998, which increased the emphasis on community-based options for aged care. The Government has increased the number of CACPs from 10 000 in that year to 35 574 in 2006. This reflects a planning ratio of 20 community care places for every thousand people aged 70 years and over as at 30 June 2006. In February 2007, this planning ratio was increased to 25 places for every thousand people aged 70 years and over, to be achieved in the next four years.

7. The CACP, as well as facilitating the wishes of individuals to remain in their own homes, is a cost-effective policy option in that the subsidy for such a package is only approximately a third of that of a residential care subsidy. Funding for community care provided under the Act in 2006–07 is $414 million. CACPs now account for some 5 per cent of total Australian Government aged care expenditure.

8. The program works by DoHA funding a network of service providers which deliver the actual packages of care to people residing in the Aged Care Planning Regions across Australia. The packages are tailored to the individual needs of recipients.

9. The distribution of the number of new packages created under the Government's planning framework each year is made through a three-level process, the Aged Care Approvals Round, the final level of which is where providers in the aged care planning regions are allocated specific numbers of new places. The providers then receive funds from the Government as a *per diem* subsidy for the number of occupied places that they hold. Medicare Australia makes the actual payments of the subsidies to providers. Once allocated to providers, the places are held indefinitely.

10. To obtain entry to a place held by a provider, the potential CACP recipient must be assessed as eligible for a CACP by an Aged Care Assessment Team, a network of which operate under State and Territory management in a joint Commonwealth/State program. Providers which hold vacant or prospectively vacant operational CACP places may then take the eligible potential care recipients into their care.

Legislation

11. The CACPs program is administered by DoHA under the *Aged Care Act 1997* and the 'Principles' made under it. This Act governs all aspects of the provision to older Australians of:

- residential care;
- community care; and
- 'flexible care'.

12. The Act sets out procedures for planning the services, the approval of service providers and care recipients, payment of subsidies to providers, and responsibilities of service providers. Many of the administrative procedures specified in the legislation are common to all three subsidy types.

13. The legislation specifies 'special needs groups' such as Indigenous Australians and people of non English-speaking backgrounds as requiring specific attention in the programs funded under it, to ensure their access needs are met.

14. The legislation also provides for DoHA to allocate limited grant funding (Community Care Grants) to providers, to help promote services in new areas or areas hard to service.

Service delivery environment

15. Starting 15 years ago as a pilot program, CACPs are now an established part of aged care service provision. They are a valued component of the much larger community care sector, other parts of which draw extensive funding from other spheres of government as well as the Australian Government.

16. Among the product offerings of the aged care industry, CACPs provide an alternative care option to residential care and are attracting increasing attention as they are much less costly to provide, and they offer value for users as well as providers. They allow the people who can access them, whatever their means, to continue to live independently, despite their having complex care needs.

17. Providers of CACP services are required by the aged care legislation to perform care planning, care coordination and case management on an individual basis, as well as arranging direct service delivery to them such as personal assistance with showering and travelling to appointments. Recipients of the packages are not means tested but providers may charge fees, adding to the commercial value of the packages in the industry environment.

18. CACP service providers typically deliver other programs as well as CACPs. They operate in a large, diversifying and increasingly sophisticated service industry sector that encourages sound business practices. Because the scheme of the legislation makes CACPs very similar to residential care beds, providers receive funding through subsidies that are determined by occupied place numbers, not services actually delivered.

19. DoHA manages its legislative responsibilities for CACPs in this complex service delivery environment. On one hand the CACPs program comprises one small component of a wide spectrum of care provision in an ageing and disability sector that, in the community care area, is populated by many funding agencies, including other Commonwealth agencies and programs as well as State and Territory ones. This environment generates boundary problems and issues for administrative staff in provider organisations, among aged care professionals and among government agencies and staff. Community care recipients can also be faced with having to

understand the many pathways to care places, and navigate multiple entry points and eligibility requirements.

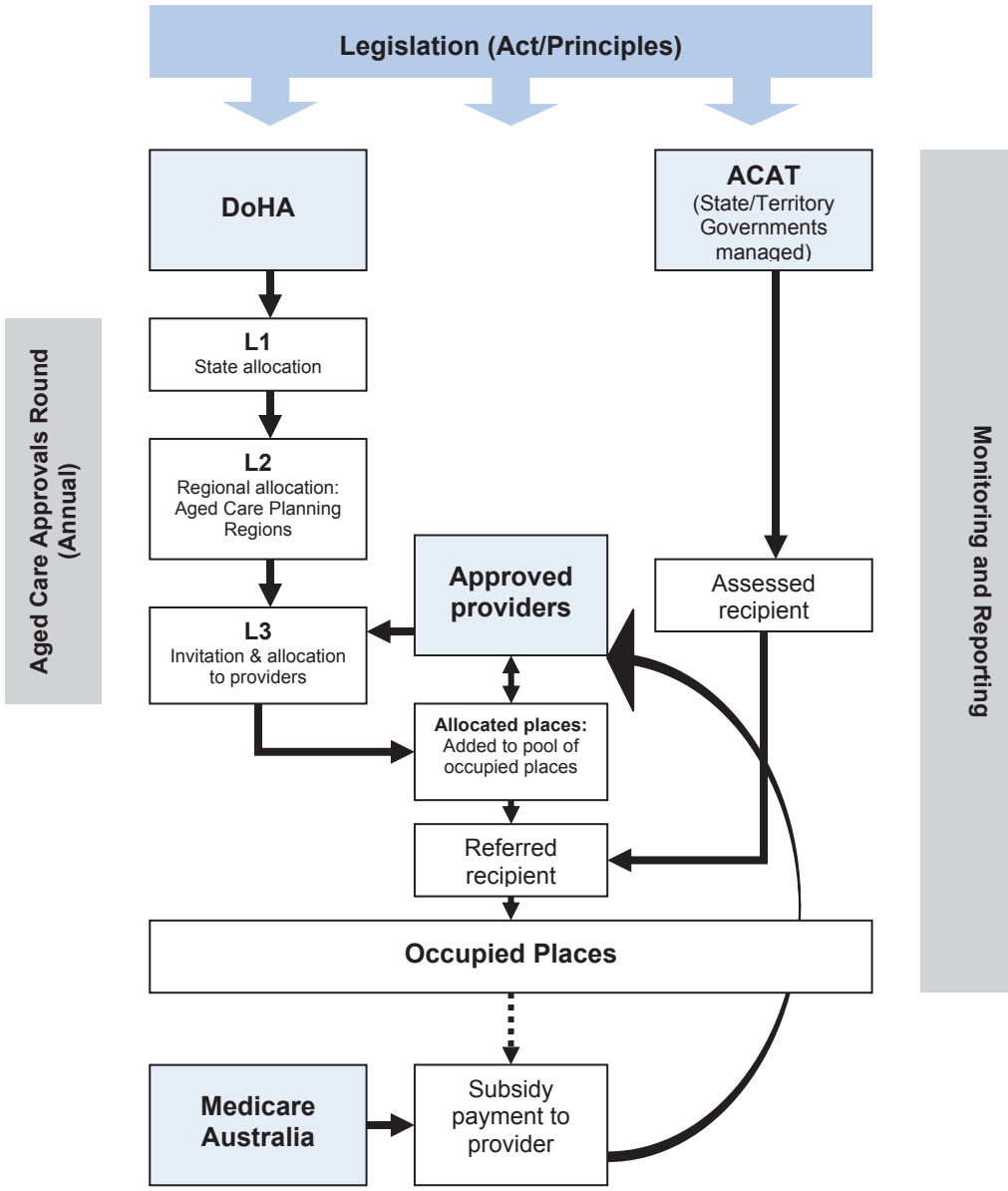
20. On the other hand, the CACP is delivered through the Australian Government passing funding to providers to deliver the actual services. Circumstances created by this 'arms' length' relationship with the delivery mechanism, and by the ways the aged care service provision industry actually works in its 'market place', requires DoHA to maximise use of the limited monitoring mechanisms available to it if the department is to ensure that the legislated objectives of the CACPs program are achieved.

21. The Australian Government, in partnership with the States and Territories, is undertaking a major review of community care (including CACPs) to establish a simplified, streamlined, more accessible and better coordinated community care system. The review is outlined in the Australian Government's planning document *The Way Forward: A New Strategy for Community Care* issued in 2004. This strategy is shaping intergovernmental reform efforts which were under way during the audit. The Australian Government has initiated a separate review of its own community care programs – the *Review of Subsidies and Services*.

22. The CACPs program can be represented diagrammatically as follows.

Figure 1

CACPs program



Source: ANAO

Overall audit conclusion

23. The Department of Health and Ageing (DoHA) manages the Community Aged Care Packages (CACPs) program integrally with the other subsidy schemes covered by the *Aged Care Act 1997*. The program assists ageing people, regardless of their financial circumstances, to continue living independently at home rather than needing to enter aged care homes and hostels to obtain care. It has grown considerably in the numbers of people it supports and the amounts of funds allocated to it since it was introduced as a pilot in the early 1990s. It is now an important component of aged care service provision in the community care sector.

24. The ANAO considers that DoHA has performed effectively, within developing Australian Government policy, in enhancing the number of new CACP places in ways that balance complex resource constraints, interfaces of CACPs with other Aged Care Act-funded places, and varying regional needs for services.

25. DoHA's ongoing management of CACPs would be strengthened by improvements in the following areas:

- greater consistency in the practices in DoHA's State and Territory Offices (STOs) with regard to their regional planning and assessment roles in the Aged Care Approvals Round, as well as in the areas of program management and approaches to monitoring outcomes;
- the use and administration of Community Care Grants to stimulate the extension of CACP services to areas where there is unmet or poorly served need;
- improved monitoring of service provider performance including their focus on special needs groups over time; and
- improved reporting to Parliament about the extent of unmet need and provider fulfilment of responsibilities, as required by the legislation.

26. DoHA's State and Territory Offices (STOs) assess relative need for new CACP places at the regional level using a range of relevant though variable data and sources. While core requirements are being met, individual STOs would benefit from sharing better practice.

27. Decisions on the assessment of individuals by Aged Care Assessment Teams and the role of providers in deciding whether to accept people into places are specified in the legislation. While DoHA is not directly involved in

decisions on admitting people to CACP places, it requires more information from its STOs and CACP providers to satisfy itself that the arrangements operate fairly and consistently across Australian regions. Such information would, for example, allow DoHA to assess whether hard-to-place people are falling through the gaps.

28. The legislation under which CACPs are administered provides a funding mechanism which DoHA could use in a more proactive and consistent way to stimulate the extension of CACP services to areas where there is unmet need or groups that are poorly served. Uptake of these grants is very small and highly uneven. DoHA could make improvements in how it administers the grants and encourages providers to use the opportunities they present.

29. DoHA's effectiveness in monitoring the performance of the program has not kept pace with the growing importance of the program in terms of its claims on Australian Government funding and the weight it is now carrying in service provision for ageing Australians. Because the program is run at arms length, through the payment of subsidies and grants to approved providers, DoHA and the service providers are in an interdependent relationship in regard to performance management. How providers understand and discharge their responsibilities determines the quality of the program outcomes. However, DoHA's systems for collecting information about provider performance capture only a part of the relevant material required.

30. While the Australian Government, with DoHA advice, is participating in intergovernmental efforts to review and reform community care and has introduced a major review of its own community aged care programs, DoHA has not given priority to the introduction of effective and comprehensive information and reporting systems to ensure that the objects of the legislation are being met by the operation of the program. This has meant that, while issues of duplication, overlap, and lack of coordination with other community care services are being addressed, some key questions about program outcomes and the results of activities of service providers are difficult for DoHA to answer at present. For example, while the legislation provides for 'special needs groups' to receive particular attention in allocation of places, and the ANAO does not disagree with the department that this was generally achieved in the allocation process, how far providers continue to adhere to conditions of grants of places relating to special needs groups year-upon-year is not monitored in an ongoing way.

31. The aged care legislation imposes particular requirements for reporting on the program to the Parliament on an annual basis. DoHA could improve the content and focus of its reporting in line with legislative requirements. In particular, the department could prepare material for the report that is presented by the Minister for Ageing annually on the operation of the *Aged Care Act 1997* which more closely addressed the minimum requirements of the legislation. Such material could be generated by clearer tasking of STO's in the work performed in the annual acquittal of payments to providers, so that, for example, provider performance in their case management roles, and in their implementation of any obligations they have for delivering services to 'special needs' groups, could be quantified and centrally reported.

32. Opportunities also exist for the department to use existing data collection arrangements, such as through its annual subsidy acquittal activities, the monthly payments claim processing system and, in the future, DoHA's Quality Reporting initiative, to assemble a fuller picture of how the CACPs program is performing across a wider range of performance characteristics than is being undertaken at present.

Key Findings

CACPs in their service delivery environment (Chapter 2)

33. Features of the service delivery environment of CACPs in which DoHA must perform its management responsibilities for the program are the extensive and complex nature of the community care sector, and the business circumstances of service providers in the aged care industry.

Case management requirement

34. The *Aged Care Act 1997* requires the effective delivery of case-managed packages of aged care services to people with complex care needs who are not being provided with residential care – the case-management being at an individual care recipient level, undertaken by CACP service providers to whom packages are allocated.

35. The legislation also requires that CACP recipients are approved against clear assessment that all approved individuals have complex care needs and require coordination services from the provider. Co-ordination of care services is consequently interpreted as a requirement of case management.

36. As the scheme of the legislation makes CACPs very similar to residential care beds, providers receive funding through subsidies determined by occupied place numbers, not services actually delivered. Providers consider the resulting revenue stream, which may also include the proceeds of any fees levied on recipients, important in their overall operations. This place-based funding contributes to shaping the way providers offer the CACP services. How providers deliver their services in fulfilment of their business strategies determines how well the program works to deliver its legislated objectives.

37. Despite the pivotal role of providers, DoHA has limited means of obtaining data on service delivery by providers. In particular, it has very limited information on how providers deliver case management services, services that are a significant legislated feature of CACPs and which give CACPs special value to recipients of care.

Overlap with other programs

38. The *Aged Care Act 1997* requires service providers to avoid duplication of services in delivering case-managed packages of aged care services to individual care recipients.

39. DoHA's Guidelines do not address the boundary between the CACPs program and Veterans' Home Care (VHC). Consequently, the ANAO noted considerable variations amongst providers, community organisations and DoHA's State and Territory Offices (STOs) in their understanding as to whether a care recipient who is a VHC recipient could also be held against a CACP place, and vice versa.

40. As well as VHC, CACPs have many overlapping characteristics with other community care programs, which make them difficult to distinguish from each other and, in many respects, make them difficult for DoHA to manage. The department is involved in major reform efforts that are under way both inter-governmentally and within the Australian Government to simplify the various community care programs, delineate their boundaries more clearly and make them mutually consistent and more accessible to users.

Planning and allocating new places (Chapter 3)

41. DoHA's activities in planning and allocating new CACP places are undertaken in a policy planning framework determined by the Government from time to time, in accordance with its assessment of the need for places across the various aged care types, and estimates of available budget resources. A major challenge to CACPs program administration is the maintenance of balanced growth of CACPs in the overall aged care program to achieve government-set targets, within the capacity of the community care industry.

42. The quantitative targets of the policy are determined periodically by the Australian Government as ratios expressed in terms of places per thousand of the population aged 70 years and over, to be achieved by a particular year. The legislation also identifies 'special needs groups' such as Indigenous Australians and people of non-English-speaking backgrounds as requiring specific attention in the program.

43. DoHA's role in assembling demographic planning data and industry information is crucial to this policy decision-making by the Government. DoHA directs substantial efforts towards ensuring that the Government receives advice based on accurate and up-to-date data, and that its control, monitoring and reporting arrangements for the creation and distribution of new places at aggregate levels reflect sound practice.

44. The legislation specifies in some detail how the distribution of new CACP places should be undertaken through three successive 'levels' of the annual Aged Care Approvals Rounds, where the newly-created places are distributed among:

- the States and Territories; then to
- Aged Care Planning Regions within each State and Territory; and finally
- allocated to interested service providers in response to submissions from them.

45. DoHA's STOs perform the main assessment roles in the later two of these three processes. While the legislation's core requirements are generally met, the procedures employed by STOs vary more widely than different circumstance in States would suggest is appropriate. Identification of requirements of some of the 'special needs' groups specified in the legislation is conducted with varying degrees of rigour and effectiveness. There would be significant benefits for the overall consistency and quality of delivery if DoHA was to disseminate better practices from a review of the different methodologies used in each STO to brief Aged Care Planning Advisory Committees.

46. As DoHA is required by the legislation to ensure that aged care services are targeted towards people with the greatest need for those services, and that access to them is facilitated regardless of race, culture, language, gender, economic circumstances or geographic location, the end result of each Aged Care Approvals Round should be that the distribution of places numbers and places allocation to providers is optimum in regard to these objectives. The ANAO found that the systems used by the department to ensure that this happens at the regional and provider level could be improved. How the department intends to address gaps and shortfalls in CACP places at these levels could also be made more explicit in decision-making.

Community Care Grants

47. The Aged Care legislation also provides for DoHA to allocate limited grant funding (Community Care Grants) to providers, to help promote services in new areas or areas hard to service. However, the department has not established sound procedures nationally to support the important function of meeting unmet or poorly served needs which can occur in regional Australia.

Providing places to people (Chapter 4)

48. The aged care legislation requires decisions to be made about a person's access to a CACP place at two key points:

- the professional assessment of the person's needs by an Aged Care Assessment Team (ACAT), which determines whether a person is eligible for a place; and then
- the decision of a service provider to admit the eligible person to a care place in the provider's possession.

49. Neither of these decision points is under the direct control of DoHA. However, they both have formal status under the Australian Government's aged care legislation administered by DoHA. Legislation requires ACAT approvals for CACPs to be made against clear assessment that all approved individuals have complex care needs and require coordination services from the provider.

ACAT assessments

50. The ACATs operate in a joint Commonwealth/ State/ Territory funding framework and are administered by the States. They function as delegates of DoHA when making their eligibility decisions, using guidelines and employing training provided by DoHA. The Australian Government, and DoHA at departmental level, are engaged in extensive reform efforts to improve the operation of the ACAT system.

51. Notwithstanding the departmental guidelines and the training provided by DoHA, the ANAO found considerable variations between ACAT practices on a State/Territory basis and among ACATs individually. While the reform processes under way were intended to address these and other concerns, the operation of the ACATs in their roles as departmental delegates could be improved, so as to achieve better national consistency in regard to:

- the ACAT focus on what it is that makes a CACP appropriate for a person (as distinct from other aged care types, or nothing); and
- in the ACATs' practices in referral of eligible people to providers.

Monitoring providers' decisions on acceptance of people into CACPs

52. DoHA has very limited information about providers' decisions on the placement of people assessed as eligible for a CACP, into CACP places. Relevant database material cannot produce fit-for-purpose data about waiting times and waiting numbers to provide information about:

- demand or supply;
- the queues of people awaiting assessment who want immediate placement; or
- those assessed waiting for placement.

53. Without at least some of this information, and acknowledging that at aggregate level there will continue to be an excess of demand over supply of places so long as resources are constrained, DoHA cannot assure itself about the effectiveness of arrangements for this final step in the pathway to a CACP place.

Monitoring and reporting program outcomes (Chapter 5)

54. The key objectives of the CACPs program are to provide:

- coordinated aged care packages tailored to meet the complex care needs of people, delivered where care recipients live; and
- an effective alternative to residential aged care for people who wish to stay at home.

55. The aged care legislation also requires that in deciding the allocation of places, DoHA give particular attention to the requirements of groups with special needs. Furthermore, the legislation specifies minimum content for the annual report that the responsible Minister must cause to be laid before each House of the Parliament on the operation of the *Aged Care Act 1997*. Those matters that are directly relevant to CACPs include:

- the extent of unmet demand for places; and
- the extent to which providers are complying with their responsibilities under the Act.

56. The aged care legislation points towards a wide range of performance characteristics that would be suitable for the CACPs program and for assessing and reporting on its improvement, including at the aggregate, State, regional and provider levels. However, DoHA's performance indicators focus on the creation of new places at the aggregate level, especially meeting the Government's target ratio of service provision. The department's performance indicators do not address the quality of CACPs program outcomes. In particular, they do not take into account the specified content of the annual reports required to be prepared annually on the operation of the *Aged Care Act 1997*, which address the assessment of unmet need and the extent to which providers are complying with their responsibilities under the Act.

Monitoring providers' performance in program delivery

57. The ANAO found that DoHA's acquittal system does not capture the performance of providers in regard to their fulfilment of all conditions of allocation of places to them, especially case management requirements and the targeting of people with special needs:

- a common gap in DoHA's STOs' monitoring of service provision was measuring the time providers spent in providing case management and/or care coordination services, as opposed to individual services; and
- while all deeds of agreement reviewed by the ANAO had a requirement for a minimum ratio of financially and socially disadvantaged people in the care places occupied, providers are not required to report specifically on their performance in meeting these conditions of allocation.

58. The ANAO also found that, in its present form, DoHA's Quality Reporting initiative is not intended to be used to capture quantitative data that could be used nationally to report on providers' performance of their responsibilities.

59. Overall, DoHA is constrained in its ability to provide comprehensive quantitative reporting on many aspects of program delivery, especially the phase of it that is the responsibility of providers. The constraints mainly arise from the complexity of interfaces between the CACPs program and the other aged care programs including those in the community care sector, and the limited information that DoHA has on the performance of CACP service providers.

Recommendations

60. The ANAO has made eight recommendations to assist DoHA improve its administration of the Community Aged Care Packages Program. DoHA has agreed to all recommendations, one with qualification. The second recommendation involves consultation between DoHA and DVA. Both agencies have agreed to that recommendation.

DoHA's response

61. The Department welcomes the audit findings and will develop a program of work to meet the objectives identified in the response to the audit recommendations, noting that some aspects will involve a stepped process

over several years. Funding provided though the *Securing the Future of Aged Care for Australians* measure will provide resources to improve monitoring of service provider performance as part of a broader quality initiative. The Department will develop better practice guidelines and improve consistency in the practices of its State and Territory Offices and has already commenced action to address particular issues, including clearer Aged Care Approvals Round documentation and guidelines for the process of assessing applications. The Department is working with state and territory governments, through the 2006 Council of Australian Governments initiative to improve the Aged Care Assessment Program including the implementation of a national training strategy for Aged Care Assessment Teams. The Department will undertake to provide additional information in annual reporting on the operation of the *Aged Care Act 1997*, as required under Section 63-2 of the Act.

DVA's response

62. The Veterans' Home Care (VHC) program is a Department of Veterans' Affairs (DVA) program to help eligible veterans and war widows/widowers with low-level needs remain living independently in their homes for longer. The VHC program is not designed to meet the needs of veterans or war widows/widowers with complex or high-level needs. If such cases are identified by the VHC assessment agency, they are referred to more appropriate programs of care, such as the Community Aged Care Packages (CACP) program.

63. Where VHC clients are referred to other higher care programs, the VHC program Guidelines (Section 5.9) provide specific guidance to VHC assessment agencies on:

- what DVA services and under what circumstances these services may continue to be provided;
- the management of VHC clients receiving CACPs and other packages; and
- the necessary interactions with case managers of other programs.

64. DVA welcomes the recommendation by ANAO for DoHA to promulgate guidelines for its CACP Program to ensure a consistent approach to veterans as a special needs group in their access to CACPs. The introduction of clear guidelines in this area will significantly assist in the understanding by CACPs managers and providers of how the VHC program should interact with the CACP program to the benefit of veterans.

Recommendations

Recommendation No.1

Para 2.14

The ANAO recommends that DoHA, in consultation with the aged care provider industry, promulgate 'better practice' guidelines in the delivery of case management services to care recipients, for issue to providers.

DoHA's response: *Agreed.*

Recommendation No.2

Para 2.40

To clarify the relationship between CACPs and Veterans' Home Care services, and in consultation with the Department of Veterans' Affairs, DoHA should promulgate guidelines in its CACP Program Guidelines publication on the relationship so as to ensure a consistent approach to veterans as a special needs group in their access to CACPs.

DoHA's response: *Agreed.*

DVA's response: *Agreed.*

Recommendation No.3

Para 3.63

The ANAO recommends that DoHA improve administrative effectiveness in the arrangements it makes for the allocation of new CACP places in the Aged Care Approvals Rounds (ACAR) at the State and Territory level by:

(a) issuing guidelines on 'better practice' procedures for State and Territory Offices to use in their collection and assessment of information to assist the Aged Care Planning Advisory Committees in their preparation of advice, so as to promote consistent quality levels of advice across all States and Territories to the departmental officer delegated to make the allocation decisions;

(b) requiring its State and Territory Offices to include in their annual submissions on proposed allocation of places in Level 3 of the ACAR, information on gaps in service provision, including for special needs groups, that would remain following approval of the proposed allocations; and

(c) requiring its State and Territory Offices to include in their annual submissions to DoHA's Central Office on the proposed allocation of places to providers, information on avenues or opportunities to address the gaps identified in (b) above.

DoHA's response: *Agreed.*

Recommendation No.4

Para 3.75

The ANAO recommends that DoHA increase the transparency of its decisions on the allocation of places to providers by requiring State and Territory Offices to:

(a) assemble in written form material that could be provided as debriefing to providers on the basis for allocation decisions made by DoHA on provider applications for places; and

(b) seek comment from providers on the quality of the supporting information provided in the running of the ACAR and on the quality of feedback on the allocation of places.

DoHA's response: *Agreed with qualification.*

Recommendation No.5

Para 3.97

The ANAO recommends that DoHA implement administrative procedures to enable Community Care Grants to be deployed with greater consistency to improve the management and delivery of the CACPs program to all areas of need for CACP places. In particular, DoHA should:

(a) determine the basis of allocation of Community Care Grants provision to States and Territories, depending on their needs;

(b) issue guidelines for its State and Territory Offices to promote the use of Community Care Grants by providers to assist the provider industry to meet unmet or poorly served needs;

(c) collect information through State and Territory Offices, as part of their submission of recommendations for allocation of CACP places to providers in ACAR Level 3, on the need for, and use of, Community Care Grants to meet gaps in service provision; and

(d) use information on the performance of providers in their utilisation of any Community Care Grants successfully won by providers to enhance departmental reporting on gaps in service provision for CACPs.

DoHA's response: *Agreed.*

Recommendation No.6

Para 4.37

The ANAO recommends that DoHA consult with the States and Territories to:

(a) improve aged care assessment procedures for CACPs so that the approval of people as CACP care recipients effectively targets people with complex care needs requiring active case management by service providers; and

(b) increase consistency across Australia's regions in the procedures by which people are referred to CACP care, from the point of their aged care assessment to the point of their accessing the CACP services of a provider.

DoHA's response: *Agreed.*

Recommendation No.7

Para 4.60

To enable it to ensure more effectively that the CACPs program is operating equitably and that any gaps in service delivery are identified and minimised, the ANAO recommends that DoHA take steps to obtain systematic information about provider decisions on acceptance of people into CACP places, by utilising referral networks which it funds. Such information would enable DoHA through its State and Territory Offices to:

(a) assess whether people with special needs or who are difficult to place are being adequately served by the program;

(b) assure itself that people assessed as CACP recipients do not fall through market gaps in service provision and stay unplaced indefinitely or for excessive periods;

(c) better report on the patterns of supply and demand for CACP services; and

(d) in conjunction with the measures proposed in other recommendations in this audit, through better matching of the numbers of places allocated to providers to actual demand for the places, alleviate access difficulties for people to CACP places and distribute limitations on access on an equitable basis.

DoHA's response: *Agreed.*

Recommendation No.8

Para 5.67

ANAO recommends that DoHA utilise the legislated objectives of the CACPs program, and specifically the minimum content requirements for annual reporting on the operation of the *Aged Care Act 1997* set out in the Act, to improve the performance information it provides to the Parliament about community care. To do this, DoHA should improve the effectiveness of its program management and reporting by:

(a) introducing administrative arrangements enabling it to generate, assemble and collate information about areas of unmet need for CACPs in a systematic way, which would also permit it to implement mitigating strategies;

(b) enhancing its ability to monitor the performance of providers in regard to:

- providers' fulfilment of all the conditions of allocation of their CACP places, especially in regard to special needs groups; and
- providers' performance of their case management responsibilities;

(c) introducing arrangements for the periodic review of the appropriateness of conditions of allocation of places, to ensure that the conditions continue to be relevant to demographic needs; and

(d) so as to facilitate DoHA's assessment and reporting to the Parliament of program performance improvement over time, implementing procedures in the Quality Reporting system to capture, at a national level, aggregated quantitative information about providers' performance of their legislated responsibilities.

DoHA's response: *Agreed.*

Audit Findings and Conclusions

1. Introduction

This chapter provides a background to the audit, including a brief description of the CACPs program, its growth and status in legislation, and an outline of the audit objective, scope, criteria and methodology.

Background

1.1 The Australian Government introduced the Community Aged Care Packages (CACPs) program in 1992–93 as a pilot program to help frail older people with complex daily care needs who nevertheless wish to remain living in their own homes. These people would otherwise be eligible for low level residential care and the program was designed to give them a home alternative to this, while delivering a coordinated care service that enabled care to be planned to meet the changing needs of the individual care recipients continuing to live independently.

1.2 By the late 1990's the CACPs program had grown beyond pilot status. Significant increases in funding have been directed to it over the years since then, as governments have opted to increase the amounts and proportions of aged care payments directed at care types other than residential care.

1.3 When new aged care legislation was developed in 1997, the CACPs program was included in the coverage of this legislation as 'community care'. The *Aged Care Act 1997* was directed principally at the codification of the Australian Government's residential care program activities, following a review of that sector, but it also gave legislative foundation to other care types including innovative care arrangements. The inclusion of the CACPs program in the new Act brought with it the application of many of the features of the administrative scheme for residential care to the community care type.

1.4 Inclusion of the CACPs program within the *Aged Care Act 1997* gave legislative mandate and authority for most aspects of the management of the CACPs program. The scope and direction of the audit proceeded from the starting point of the legislation.

1.5 The *Aged Care Act 1997* provides a statement of the objects of the Act including the desired results of the funding provided under it. These objects relate to all the care types funded under it, not specifically the CACPs. An extract from the Act containing the Objects provisions is at Appendix 1.

1.6 As legislated, key features of the CACPs program in regard to the administration of the program are:

- use of a network of providers specifically approved to deliver CACPs in various areas across Australia, so that providers have responsibility for service delivery of the CACPs while operating at arms length from the Australian Government and subject to regulation by the Australian Government;[1]
- allocation of CACP 'places' to providers in such a way as to seek to ensure that priority needs are met within planning benchmarks set by the Australian Government, regardless of where recipients live;
- distribution of Australian Government funds appropriated to the CACPs program through a system of subsidy payments to these providers, which hold and account for the specified number of 'packages' from time to time allocated to them;
- specification of 'special needs groups' such as Indigenous Australians and people of non English-speaking backgrounds as requiring specific attention by the department when packages are allocated, and in assessment of individuals for eligibility for them, to ensure their access needs are met.
- use of the jointly-funded Commonwealth/State aged care assessment system, administered by the States/Territories, to assess whether people are eligible under the law to receive one of these packages; and
- provision for payments of one-off grants to approved providers to assist providers to meet the costs of providing new services, for example to isolated or remote communities or an Aboriginal and Torres Strait Islander community.

1.7 Key features of the CACPs program as legislated in regard to the output of the program are:

- provision by providers of individually tailored packages of care services planned, coordinated and case-managed to meet the care needs of the people they accept into the lists of those in their care; and
- reporting annually to the Parliament on unmet needs and implementation of provider responsibilities.

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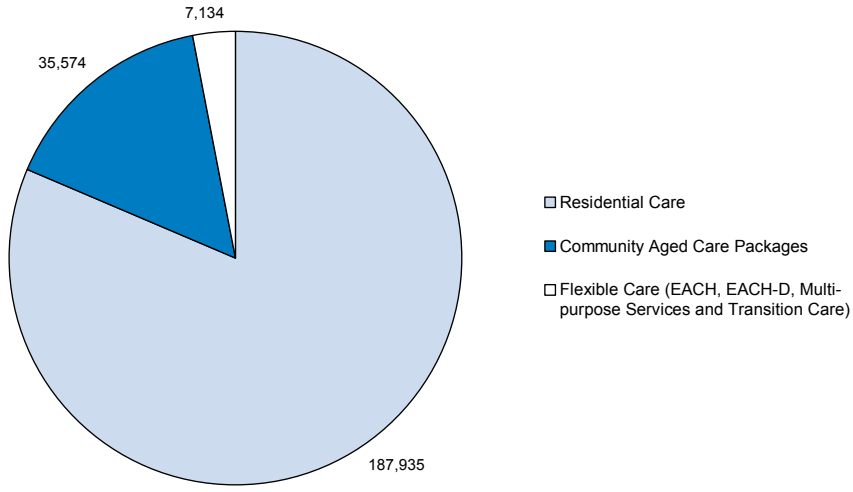
[1] Service providers include not-for-profit, commercial and government organisations.

1.8 The Act applies many common mechanisms and administrative procedures to all the subsidies/care types funded under it, including residential care. The subsidy types include a 'flexible care' care type which enables funding of places where higher levels of care are delivered in the home than CACPs (e.g. Extended Aged Care at Home (EACH) places and EACH-Dementia places). These places typically deliver more service and carry much higher costs. The Act does not prescribe numbers of places, nor ratios of numbers of places in individual care types to total places. These are policy decisions of the Government.

1.9 In line with the specifications in the Act, the CACPs and residential care programs are administered integrally with all the *Aged Care Act 1997* places. DoHA does not consider the CACPs program to be an isolated program. Though growing, it is also relatively small within the Act's coverage. Even when CACP and flexible care places are combined, the numbers of places provided under the residential program is much larger, as the following Figure 1.1 shows.

Figure 1.1

Allocated aged care places by subsidy group funded by the Australian Government under the *Aged Care Act 1997* at 30 June 2006



Source: *Report on the Operation of the Aged Care Act 1997 1 July 2005 to 30 June 2006*, DoHA.

1.10 Furthermore, as the average cost per place of residential care is much more than the subsidy cost per place of community care, the allocation of resources to CACPs is much smaller as a proportion of total costs of the Australian Government's aged care programs.

1.11 Though the CACPs program services a relatively small component of the aged population receiving the benefit of *Aged Care Act 1997* subsidies, there is interest in channelling increased aged care resources through community care rather than through residential care options. The growth in the numbers of places provided as community care types under the Act has been particularly strong in the period after the Government increased its emphasis on community care options for aged care with its 'Staying at Home' policy initiative in 1998. In that year the number of CACPs was 10 000 compared to 35 574 at 30 June 2006. Moreover, decisions taken by the Australian Government after a review directed at residential care pricing arrangements in 2004,[2] and again in February 2007, have increased the proportion of Australian Government-funded aged care places represented by CACPs and flexible care in the growth of new *Aged Care Act 1997* places.[3]

Community Aged Care Package snapshot

- There were 19.9 operational community care places (either a CACP or an EACH place) per 1 000 people aged 70 and over, as at 30 June 2006.
- 35 574 Community Aged Care Packages places were allocated to approved providers as at 30 June 2006. A further 1 926 packages were announced in the Aged Care Approvals Round on 1 May 2006 to be made available in 2006–07.
- Funding for community care provided under the *Aged Care Act 1997* in 2006–07 is estimated to be $414 million.
- The rate of subsidy for CACPs at 1 July 2006 was $33.30 per day per package, equivalent to $12 155 per annum.
- At 30 June 2006 there were 1 007 approved service outlets.[4]

[2] The *Review of Pricing Arrangements for Residential Care, 2004,* conducted by Professor Warren Hogan.

[3] In response to the Hogan Review's immediate recommendations, in 2004 the Government increased the planning target ratio for community care/flexible care places from 10 out of 100 overall aged care places to 20 places out of 108 places. In further implementation of the Hogan recommendations, in February 2007, the Government again increased the ratio of community care/flexible care places to 25 places out of 113 overall aged care places. Media Release by the Minister for Ageing, 'Reforms Secure the Future for Aged Care', SS13/07 11 February 2007.

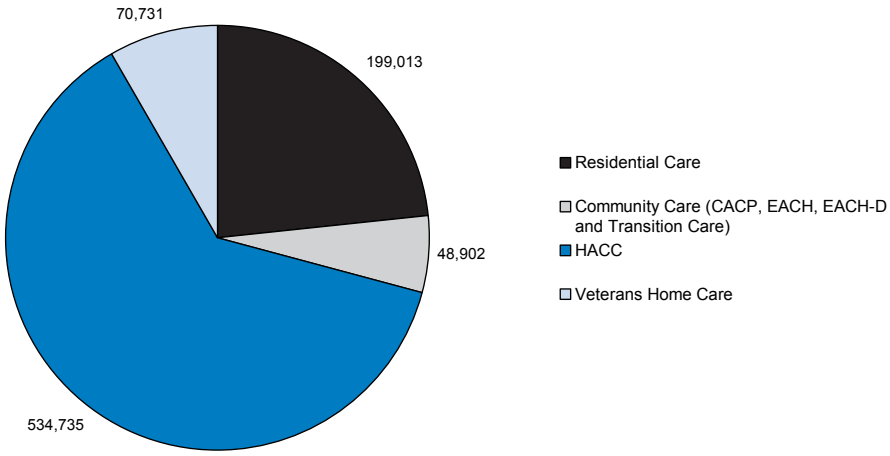
[4] Data provided by DoHA, to be published in the next AIHW CACP statistical overview.

Community care

1.12 The CACPs program accounts for only a part of community care in Australia. By far the largest number of recipients of aged care services in Australia receive what is called community care assistance of various types, at home, and from a range of programs other than the CACPs program. As shown in Figure 1.2, most aged care recipients in Australia receive their services under Home and Community Care (HACC).[5] Smaller aged population sectors receive services from other Australian Government programs, such as those for veterans and war widows (in particular, Veterans' Home Care (VHC) administered by the Department of Veterans' Affairs). A number of recipients under these programs also receive services under the CACPs program.

Figure 1.2

Recipients of aged care services in Australia in 2005–06



Source: *Report on the Operation of the Aged Care Act 1997 1 July 2005 to 30 June 2006,* DoHA*; VHC Annual Statistical Summary 2005–06*, DVA.

Note: Total HACC recipients in 2005–06 were 792 200, of which 67.5 per cent were aged 70 and over (i.e. 534 735 recipients of HACC services in 2005–06 were aged 70 and over).

[5] The HACC program is an Australian Government/State/Territory program jointly funded but State-managed under Specific Purpose payments from the Australian Government.

Program administration

1.13 The Department of Health and Ageing (DoHA) administers the CACPs program through its Ageing and Aged Care Division (AACD) on behalf of the Australian Government. DoHA's Central Office conducts program planning, policy and reporting activities, while the department's State and Territory Offices (STOs) perform program administration including liaison with providers.

1.14 In 2006–07, CACPs will be delivered under DoHA's Outcome 4: *Aged Care and Population Ageing* which provides support for older Australians to enjoy independence, good health and wellbeing; high quality, cost-effective care is accessible to frail older people, and their carers are supported.

Program structure and appropriations

1.15 The CACPs program represents DoHA's second largest outlay on community care after the HACC program.

1.16 Subsidies paid under the CACPs program are wholly funded by the Australian Government. Means testing is not required for CACP recipients. However, as well as receiving Australian Government subsidies, providers are entitled to charge fees to care recipients for their services as CACP providers, depending on clients' capacity to contribute to the cost of their care. Where levied, these co-payments are subject to legislative caps[6] and the policy objective is that no recipient who needs a package will be deprived of access on grounds of incapacity to pay. Fees charged to recipients of CACPs may be higher than in other programs such as some HACC services where State/Territory pricing arrangements usually prevail.

1.17 The legislation provides authority for DoHA to use CACPs program funds provided by Commonwealth Appropriations in two main ways:

- to make recurrent payments of subsidies to providers–*per diem* subsidies are paid to providers to assist them to deliver packages of services to individuals (the total subsidy payments to providers are calculated on the basis of the actual number of people occupying community care places within the allocation of places held by approved providers at any one time and who are not 'on leave' from their places); and

[6] The fees that can be charged are limited to specified percentages of the maximum basic rate of pension as varied (17.5 per cent) or of the person's other income (50 per cent) if their income exceeds the maximum basic rate of pension. This is legislatively regulated.

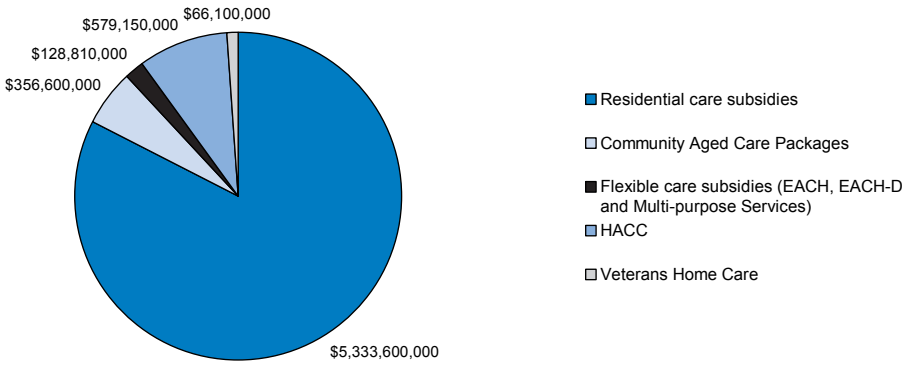
- to make one-off payments of Community Care Grants to approved providers to help them in extending services.

The legislation does not specify any particular formula for the allocation of funds between subsidy payments and grants payments.

1.18 The CACPs program now accounts for some 5 per cent of total Australian Government aged care expenditure. Figure 1.3 below provides detailed appropriation information for 2006.

Figure 1.3

Australian Government aged care expenditure 30 June 2006



Source: *Report on the Operation of the Aged Care Act 1997 1 July 2005 to 30 June 2006*, DoHA; DVA Annual Report 2005–06.

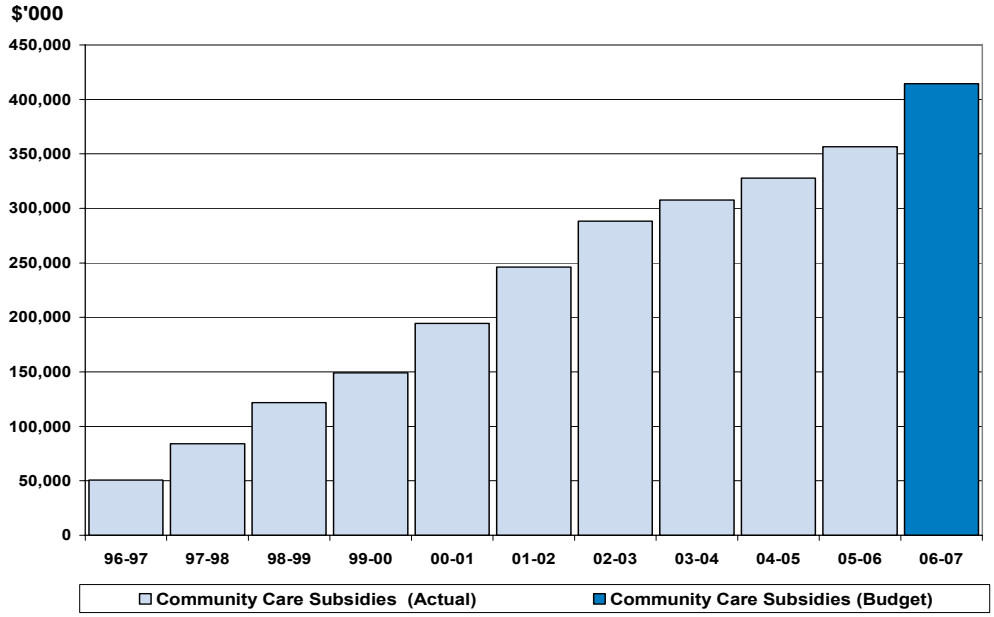
Note: Australian Government HACC funding in 2005–06 totalled $858 million. Of this, $579 million is attributed to those aged 70 years and over (67.5 per cent of HACC recipients). The Australian Government contributed approximately 60 per cent of total HACC funding.

1.19 In line with the growth in the importance of home-based care, provision of funding for CACP subsidies has been growing steadily. Figure 1.4 below shows the year-by-year funding for community care subsidies[7] by DoHA from 1996–97 to 30 June 2006, with the budget of $414 million for 2006–07. By comparison, the budget allocation to HACC in that year was $928 million.

[7] DoHA frequently includes EACH and EACH-Dementia places in published information on community care. The data in Figure 1.4 includes these flexible care allocations in some years.

Figure 1.4

Community care subsidies



Source: DoHA Annual Reports; DoHA Portfolio Budget Statements 2006–07.

Audit approach

1.20 ANAO conducted the audit to provide assurance to Parliament that DoHA was managing the CACPs program consistently with the provisions of legislation, within the Australian Government's ageing and aged care programs. In addition, the audit identified possible improvements in DoHA's administration of CACPs.

Audit objective

1.21 The audit objective was to assess the effectiveness of DoHA's management of CACPs in fulfilling the legislated objectives of the program.

Criteria

1.22 The audit criteria focused on:

- the role and functioning of the CACPs program within the community care sector – to ensure alignment of the program with its objectives (Ensuring Integrity);

- the allocation of new CACP places and places to providers and people – to ensure that aged care services were targeted towards the people with the greatest needs and were shaped to meet their needs as individuals (Planning and Delivery); and
- monitoring and reporting – to ensure continuous improvement in service planning and delivery and the achievement of the legislated objectives of the program (Achieving Improvement).

Scope

1.23 The audit focussed on DoHA's administration of CACPs and addressed its interfaces with other aged care program activity by the Ageing and Aged Care Division. This included the Aged Care Assessment Program, the Commonwealth Carelink information system and the department's information line, and coordination of CACPs with other programs including HACC. It addressed DoHA's arrangements with Medicare Australia for the delivery of payments. However, the scope did not include review of the residential aged care program, nor review of the activities of other departments such as the Department of Families, Community Services and Indigenous Affairs, the Department of Veterans' Affairs, the Department of Human Services or Centrelink in delivering the Australian Government's ageing and aged care programs.

Audit methodology

1.24 In order to form an opinion against the audit objective, ANAO:

- studied general information about the provision of public health services; including statistics and research available in Australian Institute of Health and Welfare (AIHW) and Australian Bureau of Statistics (ABS) publications, and information available from State and Territory Government websites and media reports;
- reviewed the legislation;
- tested in fieldwork the expectations included in the above criteria;
- interviewed staff in DoHA, particularly staff in the Ageing and Aged Care Division with responsibility for managing CACPs, including staff in New South Wales (NSW), Queensland, South Australia and Tasmania State Offices;
- reviewed DoHA's operational documents, files and publications;

- reviewed relevant reports and literature;
- interviewed key stakeholders, including:
  - staff of State Government Health or Human Services Departments in NSW, Queensland, South Australia and Tasmania responsible for the monitoring and evaluation of Aged Care Assessment Teams and other responsible officers;
  - independent chairs and/or members of Aged Care Planning Advisory Committees in three States;
  - Aged Care Assessment Team personnel in the four states visited;
  - service provider personnel in the four states visited;
  - personnel of Commonwealth Carelink Centres and Commonwealth Carer Respite Centres
  - staff of the Aged Care Unit in the AIHW;
  - staff of the Australian Bureau of Statistics;
  - representatives of care recipients and their carers;
  - representatives of peak bodies for the aged care provider industry.

Use of consultants

1.25 The consultancy firm Chris Conybeare and Associates was contracted by the ANAO to provide assistance in all aspects of the audit.

Other relevant audits

1.26 The ANAO has not previously audited the Community Aged Care Packages Program. However, it has completed the following related audits in recent years:

Helping Carers: the National Respite for Carers Program, Department of Health and Ageing, Audit Report No.58 2004–05;

Veterans' Home Care, Department of Veterans' Affairs, Audit Report No.43 2004–05;

Managing Residential Aged Care Accreditation, Department of Health and Ageing, Audit Report No.42 2002–03;

Home and Community Care Follow-up Audit, Department of Health and Ageing, Audit Report No.32 2001–02;

Home and Community Care, Department of Health and Aged Care, Audit Report No.36 1999–2000; and

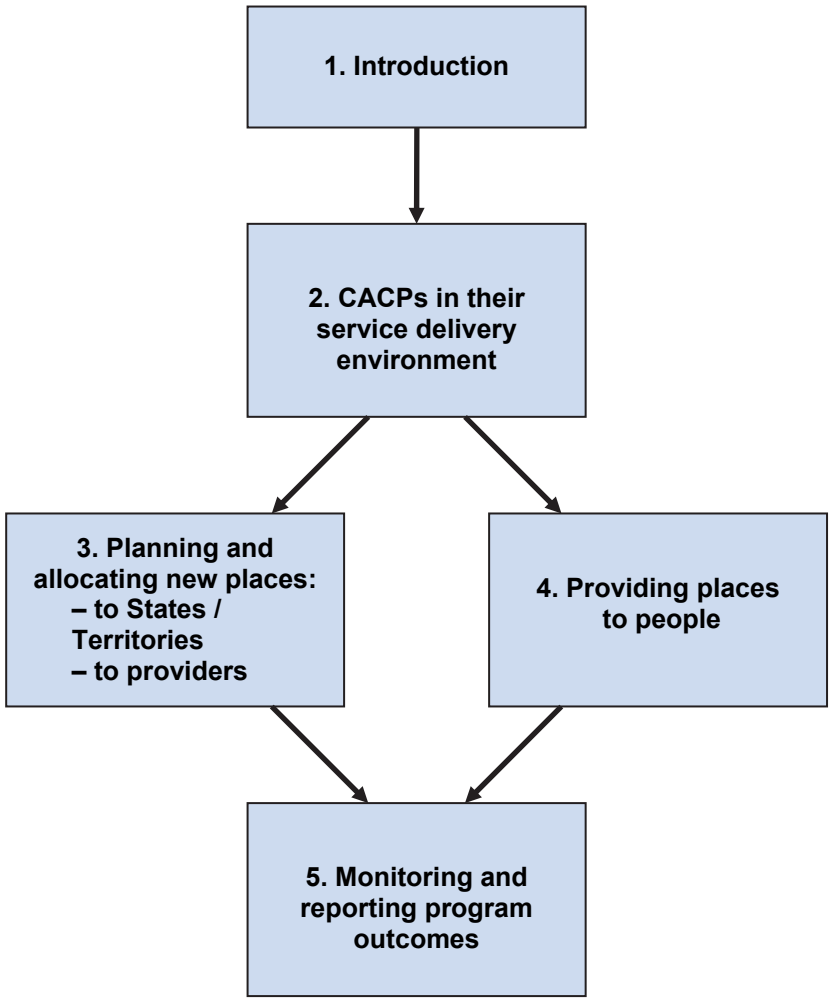
The Planning of Aged Care, Department of Health and Aged Care, Audit Report No.19 1998–99.

Report structure

1.27 This report presents the audit's findings, conclusions and recommendations in five chapters as follows:

- Chapter 1 provides background to the audit, a brief outline of the growth and development of the Community Aged Care Packages Program and its position in legislation, and summary details of the audit objective, scope, criteria and methodology;
- Chapter 2 examines the role and functioning of CACPs within the aged care service delivery environment to deliver services to aged care recipients (addressing audit criterion: Ensuring Integrity);
- Chapter 3 analyses the methods used by DoHA to plan the program, allocate new places and administer Community Care Grants (addressing audit criterion: Planning and Delivery);
- Chapter 4 examines the processes utilised to decide who accesses places once they have been allocated to providers (addressing audit criterion: Planning and Delivery); and
- Chapter 5 assesses how DoHA monitors its State and Territory Offices and CACP providers, obtains and uses information to assess program performance, reports to Parliament, and seeks to improve the quality of program outcomes (addressing audit criterion: Achieving Improvement).

The report structure is represented diagrammatically in the following figure.


1. Introduction
2. CACPs in their service delivery environment
3. Planning and allocating new places:
– to States / Territories
– to providers
4. Providing places to people
5. Monitoring and reporting program outcomes

2. CACPs in their Service Delivery Environment

How CACPs work to deliver services to aged care recipients is examined in this chapter, including: the attributes of CACPs that derive from legislative provisions; their role in the complex community care spectrum of services; the functions and practices of aged care service providers in actually delivering the scheme in the context of aged care industry activities; and how the program design specified in the legislation gives providers heavy responsibility in achieving the purpose of the program.

What are CACPs

2.1 The Community Aged Care Packages (CACPs) program was introduced in 1992–1993 as a 'community' alternative for older people with complex care needs who wish to remain living in their own homes with care and support arrangements that are supervised and coordinated. The program specifically targets frail older people living in the community who require management of care services because of their complex care needs. These people would otherwise be eligible for at least low level residential care.

2.2 The program brought together and developed a number of earlier activities that focussed on care of the aged and disabled in the community setting. It reflected increased interest in the development of lower cost and more appropriate care facilities for aged people alongside those available in residential schemes.

2.3 The principal activity of the program is the payment of subsidies to approved service providers to assist them to coordinate and provide individually planned packages of care services to people occupying 'places' in the scheme. The services are designed to meet certain daily care needs of people living in their own residences, including in retirement villages.

2.4 Packages are planned and coordinated by an approved service provider. They are specified in a Community Care Agreement negotiated between a service provider and a service recipient. Service providers use a case management approach to develop and monitor care delivery to those service recipients. The range of services that can be provided is specified in the *Community Care Subsidy Principles 1997* made by the Minister for Ageing

under the *Aged Care Act 1997*.[8] Individual services within a package may be provided by several organisations and personnel in the local area but are always coordinated by the approved provider who must meet and maintain standards laid down in the *Community Care Subsidy Principles 1997.*

2.5 The program also includes a component of grant payments to approved providers to assist these organisations either to establish new services, or to extend existing services to cover additional areas. These payments are one-off and to a maximum of $50 000. The legislation provides for these grants to meet areas of need for community care service(s).

2.6 As CACPs are tailored to the individual needs of care recipients, the individual packages vary widely in what they supply and how they are delivered. A typical rural-located CACP could be that described in the following case study.

Mr E – a CACP case study

Mr E commenced a CACP aged 91. He is currently 94. He lives alone with his dog on his farm, where he has lived since he was 4 years old, in an isolated rural area approximately 18 km from the nearest town. The only time that Mr E has left his family farm was for a period of 4 years during World War ll. His wife died approximately 4 years ago. He has no children but has a very caring niece who lives on a neighbouring property, with her husband and they farm the property on Mr E's behalf. Mr E uses a walking frame to assist with mobility.

Under the CACP, Mr E receives a total of 10 hours service per week. Carers attend to Mr E's needs each day, travelling 18 km each way, and services consist of:

- assisting with showering and dressing;
- emptying commode;
- supervising medication;
- preparing breakfast, lunch and placing evening meal in bowl ready to heat in microwave oven supplied by the service provider;
- making Mr E's bed each day and changing linen weekly;
- washing and house cleaning;
- assisting Mr E with breathing and physiotherapy exercises;
- transport to doctors and other appointments as needed, including Social Days arranged by the service provider;
- driving Mr E around his property to view stock and crops when requested.

The farmhouse was built over a century ago and remains in its original state of corrugated iron and pressed tin. The house was found to be infested with white-ants in all doorframes and

[8] *Community Care Subsidy Principles* Section 12-5. The primary listed services are: bathing, showering or personal hygiene, toileting, dressing and undressing, mobility, transfer, preparing and eating meals, sensory communication or fitting sensory communication aids, laundry, home help, gardening, and short term illness, but do not cover expenses for certain services such as nursing. Other services that may be provided 'in conjunction with these services' include 'other services required to maintain the person at home'. Section 2.2 *Program Guidelines,* Department of Health and Ageing, 2004.

floors, and had vermin and snakes in the overgrown garden. The service provider carried out work to reduce a number of hazards for both Mr E and the carers, including modifications to the showering environment. The service provider installed a personal safety alarm phone.

Mr E has shared with his carers that he is quite lonely and looks forward to them coming in each day as they are the only people he sees, apart from his niece who tries to visit each week. Due to his poor eyesight Mr E is unable to read papers and has no interest in watching television or listening to the radio. He is content to sit on a chair at his kitchen table all day apart from venturing to his back porch area now and again to look out at his property. Whilst there are significant Occupational Health and Safety problems for carers, this is the way Mr E has always lived (by choice) and the service provider would not wish to force Mr E to make changes, due to his frailty and the stress he would endure as a result.

The provider has been very fortunate to have the services of carers who are committed to Mr. E and who are prepared to work around the problems that the house poses. The carers have become family to Mr. E and without his CACP Mr. E undoubtedly would not be able to continue living at home.

Source: A service provider

Case management and care coordination as a prescribed requirement of CACPs

2.7 The intent of the legislation is that all CACPs include care coordination.[9] The care needs of individuals, for them to be approved as CACP recipients, must be 'complex' and require coordination. Moreover, since the occupant of a CACP place is generally not in a position readily to transfer to another service provider of their own volition once they are admitted to a place by a provider, the coordination function is critical in assisting vulnerable people occupying a CACP place to receive assistance and counselling over the whole of this part of their lives. The case coordination function could entail having their care service provision escalate in quality (and cost) at various times, as their ageing may introduce health complexities and more intensive care needs. It could entail their needing to be moved to a provider which had an allocation of the higher level EACH or EACH-Dementia places, for example.

[9] The *Community Care Standards*, in particular, establish the requirement of coordination. They include a specific standard for initial assessment of needs of an incoming care recipient, and on-going monitoring 'that takes all of his or her support needs into account and identifies any changes in the needs'. Schedule 4 Part 2. The *Community Care Standards* do not provide additional particulars of what would constitute adequate service levels for this function. DoHA has clarified the requirement further in promulgating in the *Aged Care Assessment Guidelines* that case management is 'the factor common to all packages'.

2.8 While all providers know that coordination is necessary for all CACPs, what providers actually deliver in 'care coordination' or 'case management' or 'care planning'[10] varied widely from provider to provider. Furthermore, what some providers do and do not do under 'care coordination' is a matter of concern within the industry.

2.9 The legislation does not prescribe specific standards for care coordination and it is not subject to administrative guidelines. Data on the coordination component of the service delivery activity for individual care recipients is not included in the regular information that providers of CACPs are required to submit to support their monthly payment claims or to acquit their funding annually (see Chapter 5). The ANAO found that DoHA has not developed administrative guidelines specifically addressing this issue.

2.10 The ANAO considers that in the absence of particularised and prescribed standards for the case management function, it would be difficult for DoHA to achieve adequate consistency across providers in the ways coordination and case management of care services are undertaken by them and delivered to Australian care recipients.

2.11 The ANAO concluded that, to fulfil its legislative obligations, DoHA should make case management a more prominent feature in its management of CACPs by formulating 'better practice' guidelines for case management and by systematically assessing its delivery in their assessments of provider performance.[11]

2.12 The ANAO examines DoHA's monitoring and reporting of the case management requirement in Chapter 5. The ANAO notes that the procedures in place for Quality Reporting by providers, undertaken every three years,

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[10] The language used by providers and aged care specialists to describe the coordination role required of providers sometimes includes 'case management' as well as care coordination. Specialists in the field note that there are important differences between the meanings of the various terms, with some terms embracing a wider range of services than others. In its analysis of the issues involved in the care coordination function of CACPs under the legislation, the ANAO did not examine these differences.

[11] A later Chapter in this report (Chapter 4) also identifies the need for a sharper focus on care coordination in the decision-making by the aged care assessment process.

include looking at coordination and planning, but do not address the levels of effort applied by providers in their case management role.[12]

2.13 Chapter 5 also assesses DoHA's monitoring of CACP providers. A finding is that, as DoHA has not developed monitoring mechanisms for provider activity levels in their coordination function, the department has little means of monitoring whether, and if so in what way, providers are performing the coordination function in their service delivery performance.

Recommendation No.1

2.14 The ANAO recommends that DoHA, in consultation with the aged care provider industry, promulgate 'better practice' guidelines in the delivery of case management services to care recipients, for issue to providers.

DoHA's response

2.15 The Department agrees with this recommendation.

2.16 The Department of Health and Ageing agrees that `better practice' guidelines on the delivery of case management services to care recipients would promote better and more consistent delivery of this service within CACPs. Guidelines will be developed in the context of implementation of the 2007 *Securing the future of aged care for Australians initiative*.

2.17 Under this initiative funding has been provided to develop a range of activities to improve the quality of community care. These include a focus on best practice and care planning, and provision for better data collection across the range of services provided through the CACP program. This will provide information on the full range of service activity, including the level of case management and care coordination delivered by providers.

The CACPs program in the community care sector

2.18 Many community care programs provided by the various spheres of government provide home-based care. The CACPs are one such program. Overlap, duplication and difficulty for potential care recipients and their carers

[12] As stated in *Quality of Care Principles 1997* Part 5 'Community Care Standards', the third Community Care Standard is 'coordinated, planned and reliable service delivery' and is a requisite reporting item for Quality Reporting by providers of CACPs. DoHA's assessment form states that 'The intent of this Standard is to ensure that services are appropriately planned, coordinated and tailored to cater for individual needs, and that service recipients (and/or their representatives) are able to participate in this process'. The specific questions on this Standard asked of providers relate to the approach used by providers to meet this standard, inviting narrative, rather than quantitative responses.

to understand and navigate entry points, eligibility limitations and pathways to care places have come to characterise the community care landscape. Even in the more restricted category of 'packaged care', where intensive users of some community care types enjoy the benefits of 'care coordination' by professionally trained people, similar to those provided under CACPs, boundary and definitional issues remain among the numerous programs.

2.19 The growth of funding for CACPs since the late 1990s, following successive Australian Government decisions, has led to the development of CACPs out of pilot program status and has added it to the provision of 'packaged care' services available in other aged care programs. The funding growth has not of itself led to improvements in boundary definitions nor better coordinated program design and coherent service provision across the various schemes.

2.20 In recognition of the need for clarification and new directions, the Australian Government, in partnership with the States and Territories, commenced a major review of community care in 2002. The review, the results of which were outlined in the Australian Government's planning document *The Way Forward: A New Strategy for Community Care* issued in 2004,[13] includes CACPs.

2.21 The strategy embodied in the Community Care Review of establishing a simplified, streamlined, more accessible and better coordinated community care system[14] is shaping current intergovernmental reform efforts across a number of operational areas. These activities were under way during the audit[15] and some directions were already becoming evident. Where relevant, the audit took these activities into account in reaching its conclusions, acknowledging that they are ongoing.

2.22 In September 2006, during the field work for the audit, the Australian Government announced a *Review of Subsidies and Services in Australian*

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[13] *The Way Forward*, op. cit., p. 4. The strategy includes establishment of a consistent approach towards program administration in the following areas: assessment for need and eligibility; access to services; eligibility criteria; a common approach to determining consumer fees; accountability; quality assurance; information management and data collection; and planning.

[14] The *Community Care Review* identified some 34 community care programs in operation, 17 of which are funded through DoHA. *The Way Forward – a New Strategy for Community Care,* Minister for Ageing, Department of Health and Ageing, 2004.

[15] A key objective of the 2002 Community Care Review is to streamline and simplify arrangements in the community care sector, providing easier access to it for ageing people and their carers and making it easier for users to understand.

Government Community Care Programs.[16] DoHA advised the ANAO that this review, focussing on the Commonwealth's own programs and operating in conjunction with *The Way Forward*, is examining many issues relevant to the operation of CACPs.[17] It is due to be completed in January 2008. Findings of this review were not available at the time of the audit.

Overlap between the CACPs program and other community care programs

2.23 The CACPs program forms part of a broader framework of community and health services. Programs that overlap with the CACPs program include:

- Home and Community Care (HACC) program, administered by DoHA; and
- Veterans' Home Care (VHC), administered by the Department of Veterans' Affairs (DVA).

2.24 Table 2.1 details the similar services provided by these programs.

[16] Media Release by the Minister for Ageing, SS84/06 18 September 2006.

[17] DoHA advised the ANAO that the review is specifically examining the service needs of frail older Australians, particularly those with complex care needs; the needs of carers; identifying gaps and overlaps in services; examining the structure of subsidy and fee arrangements with particular regard to equity and choice; examining quality and accountability requirements; and assessing the requirement for service into the future, taking account of changes in consumer preferences, demographic changes and the capacity for private provision.

Table 2.1

Overlap between HACC, CACPs and VHC

Program	Home and Community Care (HACC)	Community Aged Care Packages (CACPs)	Veterans' Home Care (VHC) Services
Funding Source	Joint Commonwealth/ State and Territory.	Fully-funded by the Australian Government.	Fully-funded by the Australian Government.
Objective	The aim of HACC is to provide services for frail aged people, people with a disability and their carers to support them to be more independent at home and in the community – thereby, preventing their inappropriate admission to long term residential care.	CACPs were designed to help frail older people with complex daily care needs who wish to remain living in their own homes. These people would otherwise be eligible for low level residential care and the program was designed to give them an alternative.	VHC program is a DVA program to help eligible veterans and war widows/widowers with low-level needs remain living independently in their homes for longer.
Target Groups	HACC target groups include: • people from Aboriginal and Torres Strait Islander communities; • people from non-English speaking backgrounds; • people who live in rural or remote areas; • people who are financially or socially disadvantaged.	CACPs have similar target groups to HACC. However, Veterans are included as a special needs group in the CACPs legislation.	All qualifying veterans.
Services provided	HACC services supplied or purchased include: • personal care, including dressing and grooming; • preparing meals; • house-cleaning; • home maintenance; • special transport; and • nursing at home.	With the exception of nursing services at home, most HACC services are also provided under CACPs.	VHC services provided are: • domestic assistance; • personal assistance; • home and garden services; and • respite. Nursing is available through DVA's Community Nursing program.
Individual or packaged services?	HACC services were initially provided individually, not as a package. Community Options Projects were added to HACC in the early 1990s and these arrange packages of community care services for HACC recipients with complex needs.	CACP services are case managed services, provided at the individual recipient level. The common factor for such packages is that they provide a coordinated package of services to address complex needs.	VHC services are not packaged but are individually provided based on the veteran's ongoing assessed needs. However, the VHC assessment agency considers the veteran's needs when developing service plans.

Program	Home and Community Care (HACC)	Community Aged Care Packages (CACPs)	Veterans' Home Care (VHC) Services
Delivery mechanism	HACC service providers include not-for-profit, commercial and government organisations. A number of recipients of HACC also receive services under CACPs.	Service providers can be providing the same service to some recipients under HACC, and other recipients under CACPs.	Service providers can be providing the same service under HACC, CACPs and VHC. A number of recipients of VHC also receive services under CACPs.
Fees	As well as receiving a government subsidy, HACC service providers may charge fees for HACC services.	As well as receiving a government subsidy, CACP service providers may charge fees for CACP services.	A co-payment applies to most VHC services excluding respite services.

Source: ANAO

2.25 Previous ANAO reports covering these programs[18] identified and commented on the need to avoid unnecessary duplication.

2.26 During this audit aged care professionals and industry members continued to express confusion about the CACP and how it should be distinguished from other programs and community care types. The experts consulted often noted the complexity and possible inconsistencies of relevant guidelines.

2.27 One consequence of this complexity is that the CACPs program is often seen among providers as just another Australian Government funding stream being injected into a growing and diversifying aged care industry – though a very important one. This perception is directly relevant to the circumstances in which providers operate within the aged care industry and the way that Commonwealth payments are channelled to providers. These matters are discussed later in this Chapter (see 'CACPs in the industry context' below).

2.28 The arrangements that have evolved impose on DoHA the need to ensure that the legislated attributes of CACPs are sufficiently prominent in the ways in which CACPs are managed, by which potential care recipients are assessed for them and how providers are held accountable for them. In its monitoring arrangements for the program's results, DoHA needs to have knowledge of how providers are performing their CACP service delivery in the actual market place of aged care services. This requires well-designed monitoring arrangements and systems to ensure that adequate mechanisms exist and that they are operating at full effectiveness.

[18] ANAO Audit Report No.36 1999–2000 *Home and Community Car*e, DoHA.
ANAO Audit Report No.32 2001–02 *Home and Community Care Follow-up Audit*, DoHA.

2.29 The key way in which CACPs differ from the other main forms of community care is that the CACPs are created, and their nature defined in detail by, Australian Government legislation – the *Aged Care Act 1997*[19] and the accompanying Aged Care Principles.[20] This legislation specifies the various forms of assistance to ageing people living in their own homes that may be provided by the packages. It specifies assessment arrangements that need to be satisfied by would-be care recipients, for them to access a CACP place. The Act provides many regulatory specifications for the providers, how they are 'approved', the responsibilities imposed on them and the ways they must operate.

2.30 DoHA has developed a manual of guidelines - the *Program Guidelines for CACPs 2004* - which seek to summarise the statutory requirements for CACPs.

2.31 DoHA's Program Guidelines describe CACPs as individually planned and coordinated packages of community aged care services designed to meet older peoples' daily care needs in the community. The packages are targeted at frail older people living in the community (meaning at home) who require management of services because of their complex care needs. These people would otherwise be eligible for low level residential care under the current classification system for aged care service delivery.

2.32 Nursing services provided in the home are not included in the specified services under CACPs,[21] nor are allied health services. Occupants of CACP places may access other programs for these sorts of services but whether they do or not may depend on the initiative and enterprise of the staff of the CACP service provider and how they regard their performance of the coordination or

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[19] References to the *Aged Care Act 1997* include also the sets of Principles promulgated under it, which are akin to regulations.

[20] The legislation provides for a body of subordinate legislation. This takes the form of 'Principles'. The Principles are akin to Regulations and are disallowable by the Parliament. The Principles lay down standards to be achieved in program delivery and specify detailed administrative requirements. Twenty-one different groups of Principles have been introduced. Of those, nine groups of Principles relate to Community Care. These Principles are: Approved Provider Principles; Quality of Care Principles; Community Care Subsidy Principles; Community Care Grant Principles; Allocation Principles; Approval of Care Recipients Principles; User Rights Principles; Records Principles; and Committee Principles.

[21] The origins of the CACP program are the main reason for this characteristic of the CACP. The program origins of the CACP were the aged person hostels or low-level residential care facilities available until the descriptors in the aged care service structure were changed in the 1990s to 'high' (nursing home) and 'low' (hostel) level residential care. Community Aged Care Packages grew out of the effort to identify better service provision for people wanting to stay at home, who might otherwise be placed in hostel-type care. Nursing homes were where nursing services were provided to residents. Nursing was not provided in hostels.

case management function as regards individual care recipients. The ANAO found that this is a highly variable attribute of providers.

2.33 Given that numerous individual services provided by CACPs are similar or identical to those provided under other services such as HACC, boundary issues in distinguishing CACPs from other services arise in day-to-day administration, which is largely carried out in DoHA's STOs.

2.34 The ANAO noted that the STOs direct considerable effort towards minimising problems of delineation and demarcation of programs in community care at the government-to-government level. Some of DoHA's STOs engage in continuing dialogues with their State Government partner agencies in defining the character of CACP services. Competition for restricted resources, such as equipment, appear to underlie a number of these issues. For example, a provider which also delivers HACC services may seek to cross-leverage services provided under one program against those provided under another, through deploying an item of equipment bought under one program in another, and seeking to charge a fee for this second episode of use.

2.35 DoHA's Program Guidelines for CACPs set out a number of principles for determining boundary issues, which take into account some of the causes of disputes and disagreements. They enunciate Australian Government policy as being '…aimed at maintaining equity of access to community care by preventing double dipping, that is, being funded by two different programs for the same service'.[22]

Relationship of CACPs with Veterans' Home Care

2.36 Veterans are included as a 'special needs group' in the CACPs legislation.[23] The ANAO examined whether DoHA provided adequate guidance on the boundary between CACPs and another wholly Australian Government-funded program which is directed at veterans, Veterans' Home Care (VHC). While the VHC Guidelines provide guidance on the services an eligible veteran is entitled to receive when also receiving services under a CACP or similar package, the ANAO found that DoHA's guidelines do not address the boundary between the CACPs and VHC. The VHC program provides a number of services that are similar to those provided under the CACPs. DVA also provides clinical services that are not available under a

[22] *CACP Program Guidelines*, 2.6.1.

[23] Veterans' Home Care was introduced in the same year as the designation of veterans as a special needs group for the CACP, 2001

CACP, specifically, through its Community Nursing and Allied Health programs. On the basis of the principle set out in the CACP Guidelines a person holding a CACP should be able to access a DVA service that is beyond the scope of the CACP, for example nursing. On the other hand, there may be questions of duplication in the case of some individuals.

2.37 The ANAO noted considerable variations among providers, community organisations and STOs in their understanding as to whether a care recipient who is a VHC recipient could also be held against a CACP place, and *vice versa*. Practices appeared often to be different among providers, with the result that people in like circumstances might receive different levels and quantities of services, or none from one or the other program.-

2.38 The ANAO considers that, because the CACP and VHC are fully funded Australian Government programs, the boundaries between them should be clear, and be set out in the operating guidelines of both agencies. These guidelines should be mutually consistent, so as to avoid dissimilar practices prevailing in the administration of CACPs across Australia, and inequities in access by Australians to Commonwealth programs.

2.39 In consultation with the Department of Veterans' Affairs, DoHA should promulgate administrative guidelines for inclusion in its CACP Program Guidelines so as to ensure consistency of approach to veterans in their access to CACPs.

Recommendation No.2

2.40 To clarify the relationship between CACPs and Veterans' Home Care services, and in consultation with the Department of Veterans' Affairs, DoHA should promulgate guidelines in its CACP Program Guidelines publication on the relationship so as to ensure a consistent approach to veterans as a special needs group in their access to CACPs.

DoHA's response

2.41 The Department agrees with this recommendation.

2.42 The Department of Health and Ageing agrees that there will be benefit in revising the CACP guidelines to make the relationship between CACPs and Veterans' Home Care more explicit and to increase provider awareness. Liaison with DVA over this recommendation has commenced and the next version of the CACP Guidelines will incorporate updated advice to ensure the relationship is managed in a consistent way across service providers.

DVA response

2.43 Agreed. The Veterans' Home Care Guidelines Section 5.9 *Veterans receiving a Community Aged Care Package (CACP) or Community Options Projects (COPs or Linkages)* provides guidance on the services an eligible veteran is entitled to when receiving services under a CACP or similar package to ensure that services are not duplicated with VHC.

2.44 Specifically, the introductory paragraph of this section states that:

> In most cases, a veteran receiving a CACP may not require extra services from VHC. Services such as respite care and home and garden maintenance may be approved if the package of care under the CACP is insufficient to meet the veteran's needs. The veteran's CACP case manager should be consulted prior to allocating any service to ensure a coordinated and holistic management of the veteran's care is maintained and that no duplication of services occur.

2.45 In more general detail, where VHC clients are referred to other higher care programs, this VHC program Guidelines section provides specific guidance to VHC assessment agencies on:

- what DVA services and under what circumstances these services may continue to be provided;
- the management of VHC clients receiving CACPs and other packages; and
- the necessary interactions with case managers of other programs.

2.46 DVA is happy to work in partnership with DoHA to ensure guidelines in both programs are consistent.

CACPs in the industry context

2.47 CACPs program design, as provided for in the legislation, relies on the activities of organisations operating in the care provider sector to deliver the purposes of the program.

2.48 Even when they are not-for-profit, providers operate on a business basis and must take full account of cost factors and developments in the commercial market place to keep their operations viable. Like any business they need to balance revenues against costs.

2.49 In response to market growth, provider entities are typically growing in their business sophistication and in the quality and the range of services and products they are providing. The business and turnover size of many provider

and provider groups are deliberately being increased as their managements seek to achieve efficiencies through economies of scale, and to lower costs in other ways. They also seek to offer wider care choices to consumers in the framework of government policy to encourage diversity and choice.[24]

2.50 Some CACP providers focus wholly on CACP service delivery. There is no requirement, however, for service providers to operate exclusively as CACP providers and few appear to do so. Service providers of CACPs are likely also to be active as providers of other aged care services such as respite care and/or Veterans' Home Care. They are likely to be active providers under a range of community care programs funded by State and local governments, including HACC. They may be providers of services to other approved providers under brokerage (sub-contracting) arrangements.

2.51 The result is that CACPs operate in a complex network of intersecting community, industry and health-care service provision. In that environment, providers engage in often complex financing and business management strategies.

Place-based funding

2.52 All providers consulted by the ANAO regard the CACPs program as a program that is important in supporting their service delivery aspirations. They generally consider that the CACP is a stable source of funding for their operations.

2.53 The Aged Care Act provides funding of providers for their service delivery using a place-based model. Funding is not dependent on actual levels of service provided to individual care recipients by providers.

2.54 Providers receive their payments of the flat *per diem* Commonwealth subsidy (as varied from year to year by a COL-linked index), multiplied by the number of occupied places for which they have approval, regardless of the level of service cost for each individual care recipient.

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[24] Diversity and choice in regard to aged care services funded under the *Aged Care Act 1997* is specifically encouraged by the legislation, as its Object clause (2-1) states:
'The objects of this Act are as follows: …

(g) to encourage diverse, flexible and responsive aged care services that:
(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and
(ii) facilitate the independence of, and choice available to , those recipients and carers; …'

2.55 This amount constitutes a gross monthly Australian Government payment to the provider.[25] In addition to this revenue, the fee stream generated from any co-payments made by care recipients held against the allocated places, may also be significant as a revenue source.

2.56 As the Commonwealth's subsidies are not subject to time limitation, once places are allocated, and provided they are kept occupied, access to the funding is indefinite in duration. This, coupled with the possibility of obtaining fee payments from some care recipients, gives allocated CACP places substantial market place value.

2.57 The ANAO was advised by many of the providers consulted that CACP providers use the funding they receive from the CACPs program across their various service activities in ways that do not specifically tie the revenue from CACP subsidies and fees to provision of services under CACPs. It was noted that the business models employed vary widely from provider to provider. Providers may run the CACP activity on a deficit-generating or surplus-generating basis. They may 'top up' their CACPs with resources from other quarters, e.g. philanthropic sources or rentals from retirement villages if they own and run such facilities. Equally, providers may use surpluses that may accrue from CACPs activities for other activities performed by the service outlet, or even by other service outlets of the same approved provider if it is a network, as many are.

2.58 The funding basis of CACPs also has the effect of compelling providers to exercise care in the way in which they tailor services to meet the needs of individuals once they are 'enrolled' in their service.

2.59 The revenue stream resulting from the Australian Government payments, and any fee revenue collected, is able to be used in any ways the provider considers appropriate for its business purposes, provided that the standards prescribed for CACPs are fulfilled. As these standards do not prescribe service levels such as hours of service, whether services are to be provided over weekends, nor do they articulate any particular standards for care coordination activities, actual service delivery to individuals is highly variable. Accordingly, even for those providers whose business model entails using all revenue from CACPs for CACPs, providers may deliver one or at

[25] From 1999–2000, the place-based funding approach was further strengthened when the Government allowed providers to apply to convert residential aged care places to community aged care places as part of the annual new places approvals round (Department of Health and Ageing Annual Report 1999–2000, p. 300). Costs of providing residential places are relatively fixed, compared to community care places.

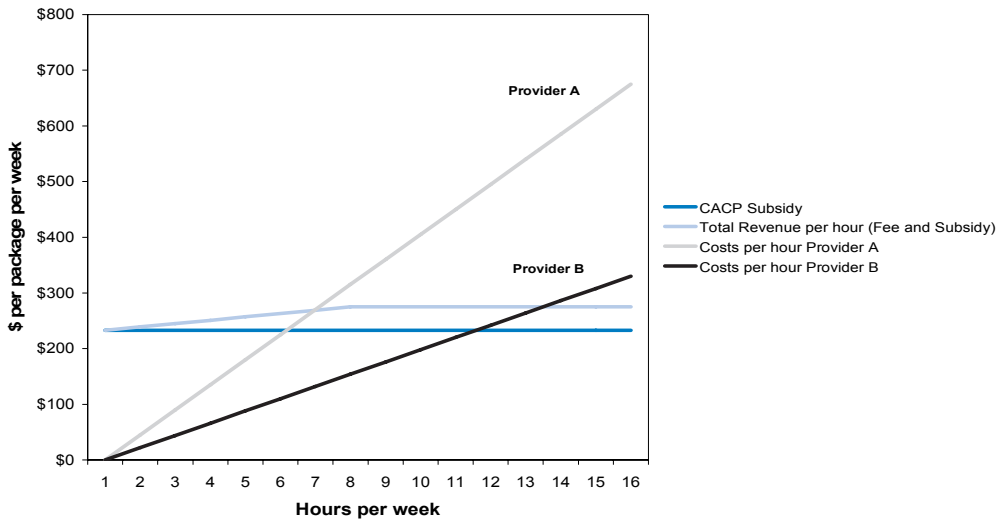
most two services for a few hours a week to a large number of their care recipients, while providing higher service levels to a small number of needy individuals.

2.60 Major variations in service delivery are also generated by the market size and product range of the provider. For example, CACP providers that also run residential facilities appear well-positioned to provide 7-day week service and emergency nursing, for 365 days of the year.

2.61 Noting these factors operating in the aged care industry, the ANAO undertook a broadly-based theoretical analysis of how commercial factors in the industry interact with the Government payments stream to impact on the care levels (expressed as hours of service) which providers may be able to deliver to care recipients. The results of this analysis are summarised in the following figure, which presents the theoretical break-even point for two different types of provider operating different service profiles.

Figure 2.1

Break-even points for different levels of service provision



Source: ANAO, from advice conveyed by providers.

This figure illustrates the relationship between revenue and costs for providers under various assumptions. The CACP subsidy is a fixed amount regardless of the hours spent in service provision, whilst the fee component of revenue is capped at $42 per week. Recipients' ability to make co-payments from their private income above this amount has not been considered. Provider A represents an organisation providing a relatively sophisticated level of care with higher costs (assumed to be $45 per hour) reflecting such aspects as the use of registered nurses for case management. Provider B represents an organisation providing a basic level of care at low cost to the organisation (assumed to be $22 per hour). With the revenue received from subsidies and fees relatively fixed, Provider B should be able to provide CACP recipients on average with a higher number of hours of care per week than Provider A, before starting to operate at a loss.

2.62 In practice, individual providers, regardless of whether they are operating base-level services or more sophisticated service levels, may use some of the proceeds of the CACP subsidy to support other activities outside the CACP proper, especially if they have a relatively large number of low-care care recipients in their CACP places. Also, providers may, for business reasons, seek to generate cash reserves to cover other expense contingencies and so meet care recipient expectations for continuity of service, or use the cash flow for other purposes. As a result, hours of service typically available to their care recipients may be significantly less than the break-even points shown in this figure.

2.63 These issues of program design and coverage are under discussion in the intergovernmental framework of the Community Care Review (*The Way Forward*) and the Australian Government review (the *Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs*) referred to earlier in this Chapter. A number of provider submissions to this review, displayed on the DoHA website in February 2007, align with the ANAO's observations from its field work.

2.64 These submissions indicate that the broad direction of the industry development appeared to be towards a 'drift' of the CACPs program towards providing lower levels of service (expressed in terms of hours per week), as providers seek to apply the subsidy proceeds to caseloads selected so that the recipients require less care. In consequence:

(a) providers have some incentive to favour referrals from the aged care assessment mechanisms – the Aged Care Assessment Teams (ACAT) examined in Chapter 4 – that will (at least initially) entail lower costs for the provider. In the industry this process is known as 'cherry-picking', with the result that some individuals may face difficulties in being placed and others face lengthening delays in obtaining placement; and

(b) a gap appears to be opening between the hours-per-week profile of service provision under CACPs and the higher-level care pathways represented by the Extended Aged Care at Home (EACH) and EACH-Dementia care packages also funded under the *Aged Care Act 1997*.

2.65 The ANAO notes that DoHA actively pursues information through research to determine the extent to which these developments have occurred. The issues are among those subject to study by the Australian Institute of Health and Welfare and a 2002 'Census' on the CACPs program. Another census is planned for 2007.

2.66 The ANAO considers that the use of the place-based funding model, through the flexibility it offers to providers, facilitates the achievement of intended program outcomes, but only if providers operate effectively, according to the legislative expectation, and professionally. Accordingly, whether the outcomes intended for the CACPs are achieved or not depend on providers' performance of their responsibilities.

2.67 Reporting on an annual basis to the Parliament on how providers meet their responsibilities is required in the *Aged Care Act 1997* in the Part of the Act dealing with 'Accountability etc'.[26] The legislation indicates that there would be a counterpart obligation on CACP service providers, via DoHA reporting to the Parliament on provider responsibilities, in return for the benefits of the relative flexibility in the funding formula that they enjoy.

2.68 How DoHA collects and reports information about provider performance, including examination of the limitations imposed by legacy systems, is examined in detail in Chapter 5.

[26] *Aged Care Act 1997*, Part 4.3, Division 63, 63-2 'Annual Report on the Operations of the Act'.

3. Planning and Allocating New Places

This chapter analyses the methods used by DoHA to plan the CACPs program and allocate new places, in particular the sequence of steps and procedures employed in the Aged Care Approvals Round to ensure that new places created by the annual increases in funding decided by the Government are allocated according to relative needs of populations and special needs groups in all Australia's regions equitably. Also analysed is DoHA's administration of Community Care Grants.

The aged care planning framework

Government policy setting

3.1 The number of CACP places planned for Australia is decided within the Australian Government's overall aged care planning framework. A key object of the planning framework is to promote the financial security needed by the aged care industry in Australia to ensure it is able to grow and meet the demands of the ageing population.[27] Policy decisions taken by the Australian Government within the framework determine the speed of creation of new aged care places across the three aged care types (residential, community and flexible) directly funded under the aged care legislation. New place creation is the main driver for investment in the industry.

3.2 The planning framework downstream from this policy-setting process enables the Government to create and allocate aged care places in response to identified community needs, particularly those of people who have special needs.[28] Creation of new places is constrained by the availability of financial resources, but other factors, especially in the case of residential care, include assessments of industry resources, lead times necessary to achieve the creation of new places, and the industry's capability to bring new places into operation.

3.3 The quantitative targets of the policy are determined periodically by the Australian Government as ratios expressed in terms of places per thousand of the population aged 70 years and over, to be achieved by a particular year.

3.4 The present target ratios of 113 places per thousand (made up of 88 residential places and 25 community care places) were determined by the

[27] Media Release by the Minister for Ageing, SS13/07 'Reforms Secure the Future for Aged Care', 11 February 2007.

[28] *Aged Care Act 1997*, s 12-2.

Government and announced in February 2007. The ratios are specified to be achieved by 2011.

3.5 Earlier, as part of the 2004–05 Budget package, *Investing in Australia's Aged Care: More Places, Better Care*, the Australian Government had increased the overall target ratio from 100 places per thousand to 108 per thousand of the ageing population. It also re-weighted the components for residential and community care respectively, by reducing residential places per thousand from 90 to 88[1] and increasing community care places from 10 to 20 per thousand. The revised approach was intended *inter alia* to recognise the preference of older Australians to live in their own homes for as long as possible. The 2004 increase was the first increase in aged care provision ratio since it was introduced in 1985.[29]

3.6 The target ratios create planning 'benchmarks' for the lower levels of planning which are undertaken by the Minister for Ageing and the department. Planning benchmarks are used extensively in the several steps set out in the *Aged Care Act 1997* for:

- the Minister to determine, on departmental advice and taking account of annual Budget allocations, total aged care place numbers and then their distribution each year for each State and Territory; and
- DoHA to decide each year the distribution within each State and Territory of the newly-created aged care places, using regions defined in the legislation, 'Aged Care Planning Regions'.

3.7 A key statutory provision that links the policy and planning processes with funding is the specification in the *Act* that subsidies for all aged care types can only be paid in respect of places formally determined by the Government.

3.8 This 'downstream' planning and decision-making in respect of new places, conducted by DoHA annually within the Government-determined policy framework, is the subject of this chapter.

3.9 Because of the complexity of the issues of planning in aged care, DoHA is required to direct considerable effort to ongoing policy assessment, industry monitoring and policy advice that these planning processes, and the Government's strategies, mandate. The number of new places created must relate to updated demographic projections, data about industry capability and planning; the lead times needed to bring new places on stream; the

[29] *Investing in Australia's Aged Care: More Places, Better Care*, DoHA, May 2004 pp 16, 17.

interrelationships and interactions of the various care types and, in the case of community care, the activities of numerous other agencies and those in other spheres of government which are delivering similar services under other programs – to name but a few of the factors.

3.10 DoHA has achieved substantial success in ensuring that Government policy targets for new numbers growth in the CACPs are achieved. Processes are being implemented, or planned, to improve the national 'tracking' of places. Six-monthly stocktakes prepared by the department to monitor place numbers growth in all care types provide useful and comprehensive information about DoHA's management of program growth.

Scope of the legislation

3.11 The *Aged Care Act 1997* provides for two main ways in which community care providers, or would-be providers, may access Australian Government funding to provide CACPs. The first is through their obtaining 'approved provider' status and then receiving payments of subsidies for occupied places that have been allocated to them. The second is through their application for Community Care Grants to assist with the establishment of new service projects. Their applications for such grants would be made as part of the annual round of allocation of new places.

3.12 The ANAO noted that the provisions relating to Community Care Grants are the only elements of the legislation which expressly address the possibility that the market alone may not always operate effectively to provide places where they are needed. The Grants provisions in the legislation are directed at community care providers which may not have set up, or without assistance could not reasonably be expected to set up, services to ensure that the needs of ageing Australians, wherever they are resident, or of particular vulnerable groups, are serviced. The legislation mentions several vulnerable groups in this context. These provisions provide a means to facilitate extension of CACP services and contributing to the growth needs of the program.

3.13 The remaining parts of this chapter examine how DoHA implements its responsibilities for these two funding components: the Aged Care Approvals Round (ACAR) under which the allocation of CACP places is effected; and the allocation of Community Care Grants. Community Care Grants are administered integrally as part of the ACAR.

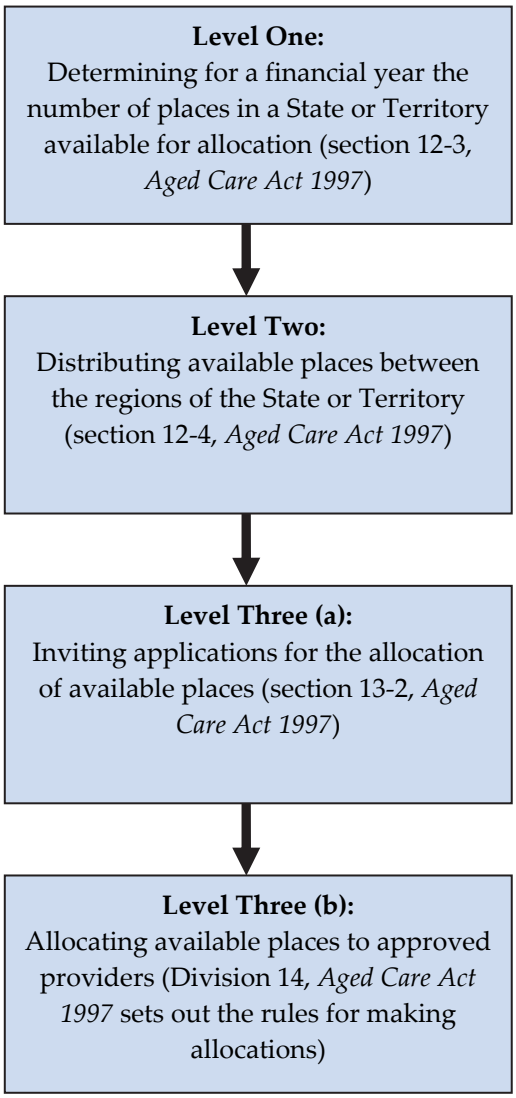
Allocating new places – the Aged Care Approvals Round

3.14 The aged care legislation prescribes the ways decisions should be made upon how the numbers of new places available nationally in any one year should be allocated across Australia's States and Territories, and within the States and Territories. Figure 3.1 below depicts the three main stages or 'Levels' of the ACAR and the ways they relate to the legislative scheme. The ACAR comprises the levels of:

1. allocation of places to States and Territories;
2. allocation of places across Aged Care Planning Regions; and
3. allocation of places to approved service providers servicing those regions.

Figure 3.1

CACPs allocation process



Advice may be sought from an Aged Care Planning Advisory Committee (see section 12-7, Aged Care Act 1997)

Division 13, Aged Care Act 1997 sets out the requirements for a valid application

Allocations take effect immediately, or are provisional allocations having effect as provided for in Division 15, Aged Care Act 1997

Allocated places can be transferred (Division 16, Aged Care Act 1997), varied (Division 17, Aged Care Act 1997) or relinquished (Division 18, Aged Care Act 1997)

Source: *Aged Care Act 1997.*

Allocation of places to States and Territories – ACAR Level 1

3.15 In its advice to the Minister on the determination for the prospective financial year of the number of CACP places to be available for allocation to each State and Territory, DoHA draws on detailed population projection data relating to age cohorts from the Australian Bureau of Statistics (ABS) and other sources, and its own analysis of this material.[30] Analysis involves *inter alia* comparison of the planning benchmarks with the number of target people in the general population.

3.16 Since 2004–05, the Minister has also announced planning numbers for two later years, in the form of 'indicative releases' for two outyears. In 2006, indicative releases were announced for 2007–08 and 2008–09. The indicative releases for later years are not binding but they flow through to the second stage of decision-making on allocations. They are designed to give the aged care industry an understanding of what is in the Government's mind for future place-creation, to assist potential applicant providers to plan the relevant investment in new facilities. The information is aimed particularly at the needs of providers of residential care places.

3.17 Table 3.1 shows the number of both types of aged care places per 1 000 persons aged 70 and over achieved in each State and Territory and nationally, at 30 June 2006, as reported in DoHA's Annual Report 2005–06.

[30] The information used by DoHA is derived from AIHW and ABS sources, such as Australian Standard Geographical Classification population figures and ABS estimated resident population figures.

Table 3.1

Aged Care Places per 1 000 persons aged 70 and over, 30 June 2006

	Allocated*		Operational**	
	Community Care (Note 1)	Total (with Residential)	Community Care (Note 1)	Total (with Residential)
NSW	19.5	117.4	19.2	103.8
Victoria	20.1	118.8	20.0	106.2
Queensland	19.0	116.0	18.9	104.7
SA	19.9	118.0	19.9	112.3
WA	20.6	116.8	19.8	104.7
Tasmania	21.3	117.6	20.6	108.5
NT	135.1	244.8	135.1	238.9
ACT	24.3	125.7	23.9	95.9
Australia	20.1	117.9	19.9	105.8

Source: DoHA's Annual Report, 2005–06, pp. 71–73.

* Allocated places are places allocated to providers through the Aged Care Approvals Round.

** Operational places are places notified to DoHA by providers as being available to fill, or filled

Note 1: In this table, Community Care includes Community Aged Care Packages, EACH and EACH Dementia places, and Transition Care places.

3.18 All States and Territories are close to the community care benchmark, with the exception of the Northern Territory which, because of the high proportion of Aboriginal and Torres Strait Islander care recipients in the 50 to 69 year age group, exceeds the benchmark considerably.[31] ANAO suggests that such Aboriginal and Torres Strait Islander recipients be included in the reported ratio denominator in future, so that statistics are comparable across all STOs. A measure used in one State/Territory, the 'Total Target Aged Population', is a measure that would provide this consistency.

3.19 In his Determination, the Minister distributes the new places in accordance with a number of factors, one of which is the gap of aged care provision in individual States and Territories with the national benchmark. Legacy factors account for different sized gaps. As is evident from Table 3.1

[31] For planning purposes, all decisions on the creation of places are based on the number of people aged 70 years and over in the population. However, administrative decisions by DoHA about the allocation of places to individuals do take into account the Aboriginal and Torres Strait Islander population aged 50 years and over.

above, shortfalls that occur against the *overall* benchmark in any State or Territory are mainly due to lower levels of operational residential places rather than lower community care places levels.

3.20 The ANAO reviewed the data sources used in DoHA's assessments and discussed these with the ABS. It found that the analysis undertaken by DoHA soundly reflected the availability of statistical data. DoHA also maintains close contact with the ABS to ensure that new statistical products being created by ABS can be put to use in aged care planning and allocation.

Allocation of available places within States/Territories – ACAR Level 2

3.21 The specified objective of the planning process is to identify community needs, particularly in respect of people with special needs, and allocate new CACP places in a way that best meets these identified needs.

3.22 The ANAO reviewed the systems DoHA uses to carry out the ACAR Level 2 process, to determine the extent to which DoHA's arrangements met the legislative objective. It noted that the arrangements made necessarily affect only a small margin of overall supply of places in the community. As subsidies are of indefinite duration and are not renewed through any form of re-tendering process, there is a large and growing legacy of places from previous rounds. Changes in demographic patterns and associated needs would only be reflected in the shape of the program over a long period of time.

Needs identification and analysis

3.23 The decision of DoHA on the allocations to the Aged Care Planning Regions within States and Territories is taken as the final step in series of analyses performed at various levels in the department. DoHA advised the ANAO that the role of decision-making at this level of ACAR is to identify and try to fill gaps.[32]

3.24 To assist the STOs to identify community needs the Act provides for Aged Care Planning Advisory Committees (ACPACs) to be set up in States and Territories, and committees have been set up in each State and Territory. Appendix 2 provides details on the role of the ACPACs as specified in the aged care legislation.

[32] DoHA response to Issues Papers, Attachment 1, p. 40.

3.25 The main analysis is undertaken by the department's STOs, which assemble data from a range of sources. Data from the ABS on population projections disaggregated to Aged Care Planning Region level is also utilised. STOs present to their respective ACPACs selected material and analyses, and make recommendations to them. The ACPACs conduct their deliberations on the basis of this material and individual members are able to inject their comments and suggestions.

3.26 The results of the STO work, including ACPAC advice, are collated and further analysed by the DoHA Central Office[33]. A submission is presented to the departmental delegate who takes the final decision on the Level 2 allocations.

3.27 As the STO work in identifying and assembling material for ACPACs was found to be an important function in the ACAR Level 2 stage, and for all States and Territories some documentation for this can be reviewed, the ANAO examined in some detail the sources of information used by STOs, how they analyse it and use it to suggest ways of identifying needs. The STOs' documentation provided to their ACPACs was the main material examined. The ANAO also reviewed the records of selected ACPAC meetings in three STOs and supplemented this documentary review with discussions with non-departmental chairpersons or senior members of three ACPACs. The ANAO reviewed how STOs assembled this material and presented it to AACD in DoHA's Central Office.[34]

3.28 Table 3.2 summarises the result of the examination of ACPAC documentation, as analysed by the ANAO. It identifies the main categories of information taken into account by the different STOs and ACPACs in considering the allocations of places at the regional level. In all cases, the allocation process considered all *Aged Care Act* care types, consistently with the integrated way that DoHA manages the CACPs program with the Residential Care Program and Flexible Care places.

3.29 It should be noted that the listing of information material in the table is not exhaustive of all information provided to the departmental delegate to enable final allocation decisions to be made. Most briefing material provided to

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[33] This collation and analysis is undertaken in the Residential Program Management Branch of the AACD.

[34] Documentation examined was the ACPAC briefing for the most recent planning year in the relevant State available at the time of field work (the audit field work was conducted over the 2005–2006 and the 2006–2007 planning periods). The ANAO examined other ACPAC material and submissions presented to the AACD from NSW, Queensland, Tasmania and South Australia. Discussions were held with ACPAC independent members in Queensland, Tasmania and South Australia. Discussions were held with relevant STO managers in NSW, Queensland, Tasmania and South Australia.

ACPACs includes extensive narrative and documented analysis by departmental officers. The table assembled by the ANAO does, however, provide a summary of all major information types used by DoHA to help ACPACs produce their advice and to analyse the needs for CACPs.

Table 3.2

ANAO analysis of the planning information provided by STOs for ACPAC consideration in 2006

	NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT
Population/Demographic data								
Current populations of people aged 70+ by region	●	●	●	●	●	●	●	●
Forward projections of people aged 70+ by region	●	●	●	●	●	●	●	●
Aboriginal & Torres Strait Islander 50+ current		●	●	●	●	●	●	●
Aboriginal & Torres Strait Islander (50+) projections				●	●		●	●
Special needs groups			●	●			●	●
Identification of Needs by Region & Sub-region								
Current allocation of places by region (including 2005 ACAR)	●	●	●	●	●	●	●	●
2005 ACAR - allocations to providers by name	●	●	●		●	●		
Current ratios by region	●	●	●	●	●	●	●	
Current need (benchmark surplus/shortfall)	●		●	●	●	●	●	
Projected allocations	●	●	●		●			
Projected ratios	●	●	●	●	●			
Projected need (benchmark surplus/ shortfall)	●		●	●				
Special needs analysis by region:								
Aboriginal & Torres Strait Islander	●	●	●	●	P	●	●	●
Rural and remote residents	●	●	●	●	P	●		●
Cultural and linguistic diversity	●	●	●	●	P	●	●	●
Veterans	●	●	●	●	P	●	●	●
Financial/social disadvantage	●	●		●	P	●		
Health profiles by region		●						

	NSW	Vic.	Qld	WA	SA	Tas.	ACT	NT
HACC provider and nature of HACC services by region			●					●
Existence of service providers – previous application outcomes	●				●			
Allocated places v operational	●				●			
Vacancy/occupancy data	●		●	●				
Waiting times (entry period) - days between ACAT approval and entry to a service						●		
Submissions from interested parties	●	●	●	●	●	●	●	
Aged Care Needs Based Planning Information Questionnaire				●				
ACAT input		●	●			●	●	●

Source: ANAO, from DoHA STO ACPAC Information Papers.

Note: ● = Information available. P = Information partially available (not on a regional basis).

3.30 The ANAO found that, generally, all the STOs' briefing provided to the ACPACs addressed the core matters specified by the legislation as matters that the ACPACs should consider in their work. However, the table above shows that STOs have adopted a variety of approaches in selecting and presenting material to their committees.

3.31 The ANAO examined the degree of variability in approaches used by STOs to assess the allocation of CACP places to regions. Some STOs' practices offer more scope than others to assist ACPACs to form balanced judgments on needs. For example, some STOs:

- follow consistent approaches across planning regions in regard to identification of needs of special needs groups;
- include information about other care types, for example, Home and Community Care (HACC) Program provider information and the nature of HACC services by region, to assist in developing a more rounded understanding of existing community aged care alternatives (the ANAO noted that this practice is endorsed in DoHA's CACPs Program Guidelines);
- provide information about the patterns of service by CACP service providers within a region, together with previous application outcomes;

- attempt to identify vacancy and occupancy data within a region; and
- include information about waiting times or 'entry period' – the number of days between ACAT approval and a recipient's entry to a service.

3.32 All ACPAC members consulted by the ANAO endorsed the procedures each STO used and considered they were well served by STO staff.

3.33 The ANAO also identified instances where there was an unclear and confused demarcation with other services (for example, HACC, Veterans' services) that made it difficult to identify unmet need in a planning region.

3.34 In addition, planning regions and sub-regions do not correspond with regions for data sources or some State/ACAT feeder regions, creating confusion and poor accountability for matching places to relative need.

3.35 The ANAO concluded that, while core requirements are being met, individual STOs would benefit from sharing better practice. DoHA could review the different methodologies used in each STO to brief ACPACs and identify good practices adopted by particular STOs, in order to bring these to the attention of all STOs. This could include preparing and disseminating to STOs an ACPAC briefing template, designed to ensure that all ACPACs are supported by broadly similar approaches. The objective would be to ensure that a more consistent approach to determining need was employed by all DoHA offices.

Identifying 'special needs'

3.36 The aged care legislation requires that in deciding the allocation of places, DoHA give particular attention to the needs of groups with special needs. These are specified by Section 11.3 of the Act, supplemented by the *Allocation Principles 1997*:

(a) people from Aboriginal and Torres Strait Islander communities;

(b) people from non-English speaking backgrounds;

(c) people who live in rural or remote areas;

(d) people who are financially or socially disadvantaged; and

(e) people who are veterans.

3.37 From a review of files and discussions held at each STO visited, the ANAO examined the extent to which STOs identified the levels of unmet need for people with special needs.

Aboriginal and Torres Strait Islander communities

3.38 STOs go to considerable lengths in endeavouring to identify relevant communities and ensure their fair access to the program. DoHA administers other Australian Government programs specifically targeting aged care needs of Indigenous Australians, including the National Aboriginal and Torres Strait Islander Aged Care Strategy.

3.39 DoHA advised that data it has on a national basis indicates that the percentage of Indigenous people receiving CACPs is generally on par with the proportion of this group in the ACAT target population.[35] While noting this advice, the ANAO found no STO among those it visited had assembled funding and service provision information across the various programs, to attempt to monitor the effectiveness of these efforts on a State basis. The ANAO noted that this meant that at the STO level, where needs are identified, analysis of whether the component of service provision to Aboriginal and Torres Strait Islanders represented by specific CACP allocations result in CACPs programs adequately meeting Indigenous needs, was not available.

3.40 DoHA's Office of Aboriginal and Torres Strait Islander Health (OATSIH) is represented in all STOs. The STOs could request submissions from OATSIH annually on the Level 2 ACAR and so tap into the expertise available in or through that group in DoHA. To facilitate their input to the ACAR, OATSIH would be able to consult with the Aboriginal health units in the State health systems and obtain advice sourced from Aboriginal health services.

Non-English speaking backgrounds

3.41 DoHA chiefly utilises the Partners in Culturally Appropriate Care (PICAC) program and the Community Partners Program (CPP) to obtain information about the needs of people of culturally and linguistically diverse backgrounds (CALD), which is ageing at a faster rate than the Australian population as a whole.

3.42 The PICAC program, developed in 1997, provides funding for eight organisations, one in each State and Territory. PICAC coordinators aim to improve the partnerships between aged care providers, culturally and linguistically diverse communities and DoHA, so that the special needs of older people from such diverse backgrounds are identified and addressed and

[35] DoHA response to Issues Papers, p 39-40.

service providers are informed on best practice in the delivery of culturally appropriate care.

3.43 The Community Partners Program was announced in the 2004–05 Budget and commenced on 1 January 2005. Following a competitive process, DoHA selected 35 organisations nationwide to facilitate increased and sustained access to aged care support services by culturally and linguistically diverse communities with significant aged care needs.

3.44 DoHA's STOs also use ad hoc contacts and networks of community organisations to obtain information about CALD needs. In some States, a member of the ACPAC may have been specifically identified to bring expertise about issues in service provision to people of non-English speaking background.

3.45 DoHA advised the ANAO that it has data that indicate that people from culturally and linguistically diverse backgrounds appear to access CACPs above what the ACAT target group proportion would indicate.[36] However, organisations representing CALD communities continue to make representations about inadequate service provision. The information assessment processes for the various STOs' ACPACs summarised in Table 3.2 indicated that STOs' capacities to identify service gaps in aged care for CALD communities are uneven. The ANAO's consultations with community representatives support this assessment.

3.46 STOs could benefit from a more systematic approach being implemented to obtain information on the needs of CALD communities. Specifically, the STOs could request submissions from State/Territory government multicultural affairs bureaus and/or ethnic affairs commissions. They could also request submissions from the ethnic communities' councils in each State/Territory. Currently, these organisations are not systematically consulted.

People in rural and remote areas

3.47 STOs make extensive efforts to seek to ensure the adequacy of services in rural and remote areas. Key issues are remoteness, the costs of travel, the thin population densities and the inaccessibility of some areas. STOs acknowledge that some areas in their States are ill-served, including Tasmania where areas in the northwest and parts of the east of the State have few suppliers. More populous States also have under-served areas. Community

[36] DoHA response to Issues Papers, p. 40.

Care Grants, discussed later in this chapter, could be used more strategically and systematically to target these gaps.

Financially and socially disadvantaged people

3.48 DoHA's places allocation system provides appropriate focus to financially and socially disadvantaged people as a special needs group. The ANAO noted that many of the allocations of places are made subject to a condition of allocation regarding provision of places to members of this group.

Veterans

3.49 The chief means by which STOs inform themselves about Veterans' needs is through maintaining close liaison with the State offices of the Department of Veterans' Affairs (DVA). Some STOs obtain systematic briefing from DVA on veterans' needs, for inclusion in their advice to the ACPAC. In some cases, membership of ACPACs has been designed to include someone with active veterans' services knowledge.

3.50 Consideration of veterans as special needs group members is complicated by the overlap between the CACPs and benefits available under veterans' programs, specifically VHC. This issue is examined in Chapter 2.

Allocation of places to approved providers – ACAR Level 3

3.51 In this third stage of the allocation process for CACP places, approved providers are invited to apply for places specified by the department for particular Aged Care Planning Regions as a result of the Level 2 stage. Again, as with Level 2, while assessment is undertaken in the STOs, the final decision is taken by DoHA in Central Office.

3.52 The model followed is akin to inviting tenders. An open and competitive approach is implemented with invitations to make applications advertised in major metropolitan and regional newspapers. Respondents to the invitations do not have to be approved providers. They can apply to become approved providers at the same time they apply for places. They must, however, be approved providers of the relevant aged care service type to be allocated places. The documentation provided to applicants contains detail on

the information that should be provided in an application and the assessment criteria which will be used.[37]

Assessment of applications

3.53 DoHA's STOs assess the applications submitted by respondents and make recommendations for selection of approved providers and service outlets and for the particular allocation of places to them. The assessment is undertaken on the basis of identifying how providers demonstrate that they can best meet the aged care needs within a particular Aged Care Planning Region, community or group.

3.54 The assessment is performed within a standard assessment framework across all STOs, the Community Care Assessment Instrument. This framework provides for the assessment and ranking of applications. The ANAO considers that, in its application to CACPs, the Instrument aligns with section 14-2 of the Act and the principles set out in part 5 of the *Allocation Principles 1997*.

3.55 As with the Level 2 stage, so as to assess how effectively the systems used by DoHA enabled achievement of the legislation's requirements, the ANAO reviewed a selection of assessments[38] as documented in STO files, and discussed the procedures employed with managers and staff. DoHA's conduct of this process was sound. These assessments were carried out within a framework designed to facilitate procedural integrity. Two assessors review each assessment in the light of the statutory requirements of the Act and Principles, under the supervision of a Quality Assurance Manager, to ensure consistency of approach.

3.56 The pre-set criteria against which applications are assessed include:

- the past conduct of a provider of aged care, including compliance with responsibilities and obligations;
- benefit to current and future care recipients;
- diversity of choice for care recipients;
- continuity of care considerations;

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[37] The newspaper advertising includes the number of new CACPs for allocation and any special needs groups or areas to be targeted. Information can also be accessed on DoHA's website, including the *Essential Guide* for that ACAR, the regional distribution of places for each State and Territory, and the results of the previous ACAR. The website provides a standard application form to be used by all providers:
<www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-acar2006-index.htm>.

[38] The ANAO reviewed four assessments of CACP provider applications in each STO visited.

- the ability of the applicant to provide the appropriate level of care;
- the measures to protect the rights of care recipients;
- the provision of appropriate care for people with special needs; and
- the expertise and experience of those who will manage the service.

Allocation of places to providers

3.57 ACAR Level 3 decisions are taken by the DoHA delegate on the basis of departmental submissions on the material generated out of each STO and sent to Central Office.

3.58 In its examination of relevant records, the ANAO observed that, prominent in STO advice to the delegate and in the analysis performed by DoHA in Central Office in preparing advice to the delegate, is the compliance history of providers in their performance as residential care providers. In this context, compliance generally related to matters where formal sanctions had had to be applied to providers, often at service outlets other than the ones for which the CACPs application was made. Generally, the recommendation made was to the effect that, notwithstanding such matters, the provider should be allocated places so as to ensure supply of places for particular regions or special needs groups.

3.59 As a corollary of this emphasis on compliance, the submissions to the delegate provided little or no emphasis on the question whether, if the delegate approved the proposed distribution of places to providers, the objectives of the CACPs program would be met in terms of meeting priority needs in the States and regions, including special needs groups. DoHA advised ANAO that the Level 3 delegates are responsible for ensuring that appropriate measures have been taken to identify and fill gaps.[39] Some issues may be highlighted (for example, the appropriate balance between various aged care types), however, from the records reviewed by the ANAO, the delegate is not advised systematically of any resultant gaps in service provision.

3.60 The ANAO considers that departmental assessments and decisions on this final ACAR stage should include explicit consideration of whether the proposed allocation of places to providers, in implementation of the objectives of the Act, meet priority needs in each State and region and meet the needs of special needs groups on a consistent basis.

[39] DoHA response to Issues Papers, p. 40.

3.61 DoHA should include as part of the advice contained in submissions to the delegate recommending the final allocation of places to providers, material on STOs' estimates of unmet needs, including ill-serviced areas and poorly-identified special needs groups' needs. This information would summarise for each State and Territory how effectively the CACPs program was achieving the objective of meeting priority needs; and provide a snapshot of the efforts STOs may be taking to address gaps. It would also form a source of data for more effective reporting to the Parliament on the performance of the program, as examined in Chapter 5 of this report.

3.62 Where the submissions note or identify the existence of gaps or shortfalls, lack of adequate balance in the distribution of places among and/or within Aged Care Planning Regions, discussion should be included in the submission of how the department plans to rectify these problems. The more consistent encouragement by DoHA of the use by providers of the legislation's facility of Community Care Grants, discussed later in this chapter, would form part of this discussion.

Recommendation No.3

3.63 The ANAO recommends that DoHA improve administrative effectiveness in the arrangements it makes for the allocation of new CACP places in the Aged Care Approvals Rounds (ACAR) at the State and Territory level by:

(a) issuing guidelines on 'better practice' procedures for State and Territory Offices to use in their collection and assessment of information to assist the Aged Care Planning Advisory Committees in their preparation of advice, so as to promote consistent quality levels of advice across all States and Territories to the departmental officer delegated to make the allocation decisions;

(b) requiring its State and Territory Offices to include in their annual submissions on proposed allocation of places in Level 3 of the ACAR, information on gaps in service provision, including for special needs groups, that would remain following approval of the proposed allocations; and

(c) requiring its State and Territory Offices to include in their annual submissions to DoHA's Central Office on the proposed allocation of places to providers, information on avenues or opportunities to address the gaps identified in (b) above.

DoHA's response

3.64 The Department agrees with this recommendation.

3.65 Aged Care Planning and Advisory Committees (ACPACs) are currently supplied with a range of data including population/demographic data and the number and ratio of operational and allocated places in each region at both Statistical Local Area and Local Government Area level. Committee members bring with them knowledge of aged care issues and have access to the submissions received from community groups, specialist organisations such as Members of Parliament and local governments, aged care providers, peak bodies and Partners in Culturally Appropriate Care. Consideration of the information provided, as well as the knowledge of ACPAC members, informs the Committees' recommendations to the delegate of the Secretary on the Regional Distribution of Aged Care Places.

(a) The Department of Health and Ageing notes the ANAO's finding that there are differences in the information formally provided to ACPACs from state to state and will consult on and develop national `better practice guidelines', before the 2008 Aged Care Approvals Round, to assist ACPACs in the preparation of advice.

(b & c) Currently, submissions from the Department's State and Territory Offices providing recommendations to Central Office on the allocation of places within states/territories include information about gaps in service provision. However, information on avenues or opportunities to address the gaps is generally not included. This will be included for future Aged Care Approvals Rounds.

Debriefing of providers after ACAR Level 3 decisions

3.66 After each ACAR round, DoHA's STOs offer to providers that made applications in the ACAR, an opportunity to receive feedback on their applications. This feedback may be oral and/or in writing. DoHA has issued national debrief guidelines to regulate this process.[40] In addition, written statements of reasons are provided on request in accordance with the *Administrative Decisions Judicial Review Act 1977*.

[40]. DoHA advised that around 290 verbal feedback sessions were provided after the 2005 ACAR (DoHA response to Issues Paper p.18). DoHA's national ACAR debrief guidelines, issued in February 2006 state 'if applicants seek written feedback, it must be provided. If written advice is provided, it should be kept to a summary of the outcomes of the debriefing and cleared through a senior officer in the Department.'

3.67 Many providers consulted by the ANAO expressed dissatisfaction with their experience of this feedback. The main reason cited was that STO staff conveyed minimal information to them in these sessions.[41] They stated that the information was confined generally to comment on technical aspects or specific content deficiencies of their applications.[42]

3.68 The ANAO considers that DoHA's practice in offering debriefing to providers is sound in principle. It follows well established procedures prescribed in other areas where departments engage with private-sector organisations, as in Australian Government competitive tendering and contracting arrangements.

3.69 However, there is a need for DoHA to comprehensively improve the ways it provides information to providers following the ACAR. Without compromising the need to ensure that providers receiving feedback are not given comparative information about other providers' submissions or coaching them in any way, greater transparency about the actual reasons for decisions on allocations should be achieved.

3.70 A specific area where greater transparency could be achieved is in the responses of DoHA to new providers entering the market place for CACP service provision. The ANAO noted that many places allocation decisions are made to enable new providers to participate at a reasonable level in service provision activity. This practice appears to be consistent with the need for the system to reflect the Government's policy objective of enhancing choice of provider for end-users. It would be appropriate for debriefing to include relevant general material about such factors where the allocation decisions took them into account.

3.71 To ensure that debriefing material is appropriately authoritative, the information that can be conveyed to providers should be assembled at the time the assessments are performed. This would mean that, whether debriefing is in writing or verbal, (and, if verbal, irrespective of the seniority of the officer actually providing the debriefing to the provider's representative), the provider will receive soundly-based, consistent and considered information about the decisions that were made. The information assembled would be in

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41 Providers advised the ANAO that they were told by STO staff in these sessions that the only information taken into account in the assessment was information contained within the boundaries of the written application. They therefore confined their feedback to that material.

42 These providers commented that, otherwise, they had very sound relationships with STO staff.

writing and cleared at an appropriately senior level. It would include reasons why applications were approved, not approved, or partially approved.

3.72 Where the reasons include lowering allocations to enable new entrants to the approved provider community for a particular area to receive an allocation of places, this reason should be included in such statements of reasons.

Quality assurance in provision of feedback to providers

3.73 The STOs reviewed by the ANAO had not taken steps to obtain information from providers as to their experience of their dealings with the department in the ACAR process, and especially in the quality of the feedback provided on their applications.

3.74 The ANAO considers that STOs should take steps to obtain formal feedback from providers about the ACAR and about their debriefing. If, for example, STOs issued a short survey form for providers to complete voluntarily following the feedback session, DoHA would obtain valuable information that would help STO officers to improve ACAR procedures, including how the debrief impacted on providers. This would, in turn, assist in improving the quality of applications in subsequent ACAR rounds.

Recommendation No.4

3.75 The ANAO recommends that DoHA increase the transparency of its decisions on the allocation of places to providers by requiring State and Territory Offices to:

(a) assemble in written form material that could be provided as debriefing to providers on the basis for allocation decisions made by DoHA on provider applications for places; and

(b) seek comment from providers on the quality of the supporting information provided in the running of the ACAR and on the quality of feedback on the allocation of places.

DoHA's response

3.76 The Department agrees with qualification to this recommendation.

(a) Applications in the Aged Care Approvals Round undergo a comprehensive assessment against the legislated criteria and comparative assessment against other applications for the same region. Currently, information on assessments is recorded and used to prepare

for verbal debriefs if requested, following the allocation of places. The Department of Health and Ageing provides written debrief material to applicants on request. However, as each Round is oversubscribed, large numbers of applicants are unsuccessful. The Department does not agree that written debrief material should be assembled for all applicants. Instead the Department will continue to provide written debrief information on request, as this is a more efficient use of staff resources. In order to improve the effectiveness of debrief meetings, the Department will review the current debrief guidelines and will provide training against the revised guidelines for relevant State and Territory Office staff.

(b) The Department agrees that seeking objective feedback from providers is an important tool and will be of value in considering the quality of information given to applicants by the Department and the debrief process. The Department will discuss with industry bodies the best way to obtain objective feedback on the process.

Community Care Grants

3.77 Part 5.2 of the *Aged Care Act 1997*, provides for the payment to providers of Community Care Grants. These grants also have their own Principles, the *Community Care Grant Principles 1997*.

3.78 The language used in the *Community Care Grant Principles 1997* indicates that one objective of the Grants is to foster the extension of CACP services to meet needs of people in isolated or remote communities, and of Aboriginal or Torres Strait Islander communities. As well, the grants could assist the extension of a service to areas of need where small numbers of places of care may be involved and so economies of scale are not available.[43] DoHA uses the terminology of 'establishment grants' to describe the functionality of this program component.[44]

3.79 While payment of subsidies to providers has been passed to Medicare Australia, payment of Community Care Grants has been retained by DoHA.[45]

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[43] *Community Care Grant Principles 1997*, Part 2 Allocations.

[44] For example, in *The Way Forward*, op. cit., p. 45.

[45] Refer to Chapter 5.

DoHA advised that expenditure on Community Care Grants is running at less than 0.005% of the CACPs allocation.[46]

3.80 As with the subsidy payments to providers for their provision of operational CACP places, where the allocation system depends on willing providers of places to come forward and apply for them, Community Care Grants are payable following a submission-based process from providers interested in extending and developing services. DoHA advised the ANAO that their purpose and outcomes are covered in pre and post ACAR documentation, including eligibility issues.

3.81 The grants typically assist providers to finance the infrastructure they need to effect service delivery in a new service area. They are 'one-off' for any one service extension 'project', with providers being able to apply for more than one. The limit of $50 000 applies to the Grant that may be paid for any one such project. The monetary limit has not been changed since the inception of the program. DoHA advised that the average amount of grant is less than the maximum and that applications are well in excess of the 'available budget'.[47]

3.82 Community grants may be payable, on application, to approved providers as part of the same application process that applies to allocation of new places – that is, within the ACAR.

3.83 The ANAO considers that DoHA has established adequate arrangements for the financial monitoring and acquittal of Community Care Grants, where they are made.

DoHA's employment of Community Care Grants in its administration of the legislation

3.84 The ANAO reviewed how Community Care Grants are actually used in the administration by DoHA of the *Aged Care Act 1997* across the various States and Territories.

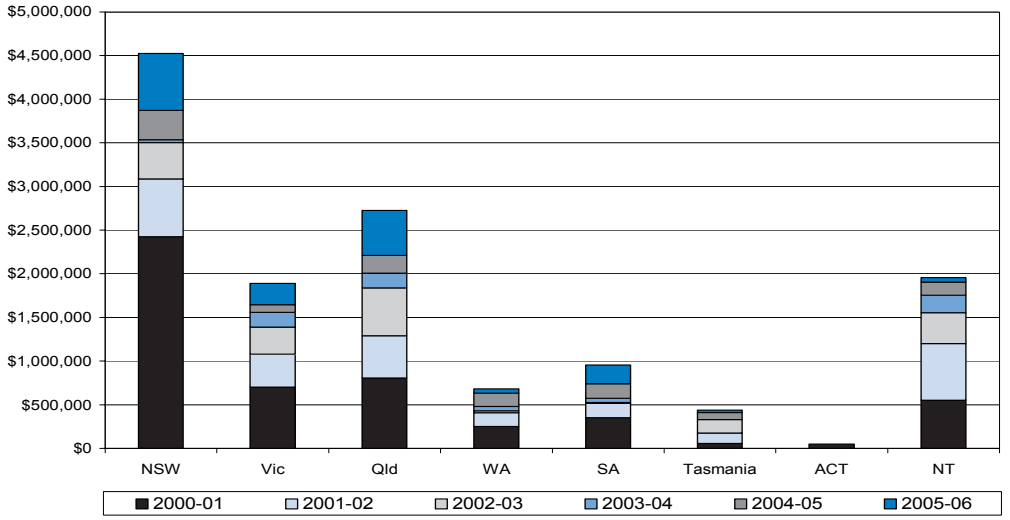
3.85 The ANAO found that the pattern of allocation of community care grants across Australia is uneven. The following tables indicate the pattern of distribution of Community Care Grants from 2000–01 to 2005–06.

[46] DoHA response to Issues Papers, p. 19.

[47] DoHA response to Issues Papers, p. 37.

Figure 3.2

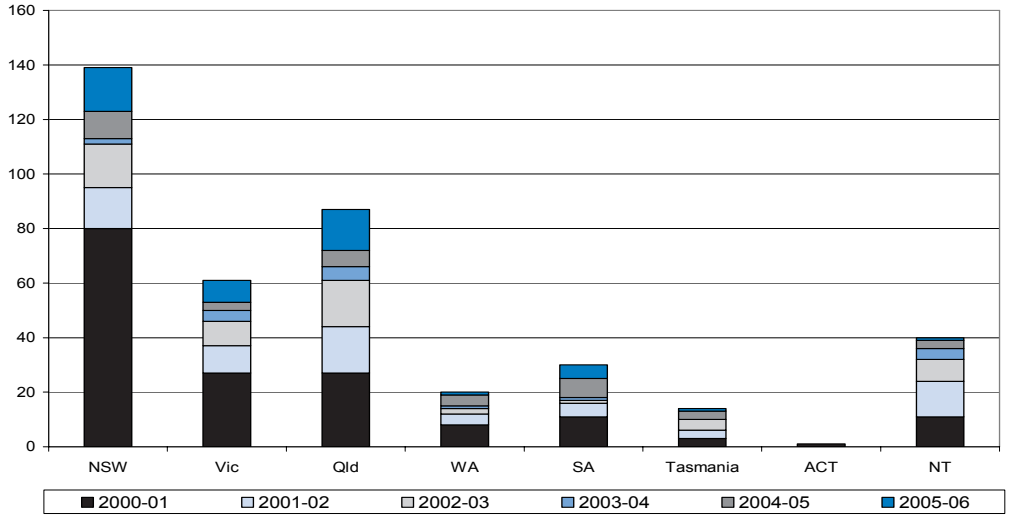
Total outlays on Community Care Grants by State and Territory



Source: Annual *Reports on the Operations of the Aged Care Act 1997*, DoHA.

Figure 3.3

Community Care Grant numbers by State and Territory



Source: Annual *Reports on the Operations of the Aged Care Act 1997*, DoHA.

3.86 Many providers consulted by the ANAO were unsure of the operation of Community Care Grants and some thought they could only access the scheme once, not understanding that the one-off character of the grant applied to projects. Little appreciation of their role in facilitating extensions of service

was evident, even among providers which had obtained one. Given that such funding can only be accessed by the initiative of approved providers, this might indicate one reason for the indiscriminate incidence of their distribution.

3.87 DoHA advised the ANAO that it considers that information about the purpose of grants is covered in detail in program management guidelines and ACAR documentation, and that this is done in a manner which essentially achieves the objectives in assisting providers extend services to meet unmet needs. It advised further that 'Health will continue to review the promotion of grants and the objectives of grants to maximise positive outcomes'.[48]

3.88 The ANAO considers that, notwithstanding these guidelines, actual administration of the Grants has little strategic focus. This means that practices among STOs lack consistency. Some STOs appear to encourage applications in situations of regional need. One STO reviewed by the ANAO informally utilised procedures that actively encouraged providers to apply for grants to extend CACP services to Aboriginal and Torres Strait Islander communities. On the other hand, other STOs do not take any particular steps to encourage use of grants. Instead, they relied on applicants to make applications at their initiative. They noted that no financial guidance is provided from Central Office.

3.89 The ANAO considers that the provisions for Community Care Grants in the aged care legislation comprise an important facility for DoHA to use in developing its administrative arrangements to promote the targeting of the CACPs program towards priority needs and to meet the needs of ill-served areas. Few other facilities, if any, are available.

3.90 A particular problem in the operation of the ACAR noted by the ANAO, for which Community Care Grants offer at least a part-solution, is the dependence of the ACAR program on a fully-populated market place of suppliers willing to service all areas where ageing people live. DoHA pointed out that demand for CACP places from providers significantly exceeds supply[49] at Aged Care Planning Region level. However, for some STOs, the possibility of lack of supply of willing providers for specific 'special needs', or

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[48] DoHA response to Issues Paper, p. 37.

[49] DoHA advised the ANAO that the demand for CACPs can be evidenced by recent ACARs applications for CACPs being heavily oversubscribed. For example in 2006, over 760 applications were received applying for nearly 23 000 places when only 1 926 were available for allocation. Given this high level of interest, the likelihood of not receiving an application of sufficient quality to allocate places to any region is very small. DoHA has noted a trend that applicants target those regions and special needs groups identified at the Level 2 stage in an effort to increase their chance of success.

to supply places in specific, usually isolated sub-regions, was observed by the ANAO to be one difficulty facing STOs in the ways they assessed allocation decisions at the intersect between the ACAR Level 2 and Level 3 stages. Smooth operation of the program design for the combined ACAR process depends on the market place in Level 3 responding in the ways hoped by the department in the Level 2 stage. While, at the aggregate level, it is clear that there is a significant excess of demand from providers over supply of new places, the ANAO noted that this provider response was not consistently forthcoming at the margin, where special needs may exist or where remote 'pockets' of need may be evident to aged care workers.

3.91 The ANAO noted that STOs react in different ways to the reality that willing suppliers may not materialise in the third stage. Unless the STO takes steps to generate an interest by a provider, potential users in affected areas do not access the CACP and go unserved by it.

3.92 The ANAO considers that DoHA should give appropriate emphasis in its CACPs program guidelines to the uses to which STOs could put the Community Care Grants mechanism as a means of encouraging service provision in poorly served areas or for unmet needs of special needs groups. These uses of Community Care Grants are clearly specified in the legislation. STOs could use them to assist in overcoming market imperfections.

3.93 The ANAO noted also that, at the Central Office level, DoHA has not developed program planning processes for Community Care Grants, for example budget planning for the STOs to use in administering Community Care Grants. Such budget planning would enable STOs to set planning targets for the optimum use of Community Care Grants in the funding mix appropriate to the assessed levels or areas of unmet need in the respective State/Territory.

3.94 After the ANAO's field work was completed, DoHA advised that, following the Government decisions on increased funding of CACPs in February 2007, decisions have been made to broaden the guidelines on the use of Community Care Grants.[50] DoHA advised that this includes increasing eligibility for grants to providers as they expand CACPs beyond particular thresholds (rather than just when they move into new regions) and extending

[50] DoHA's advice was that …'As a result of Government decisions taken as part of the *Securing the future of aged care for Australians*, the guidelines for [Community Care Grants] are to be broadened. This will provide a new opportunity for existing providers to utilise these grants to expand services to poorly served groups within a region'. DoHA response to Issues Papers, p 33.

the grants to the Extended Aged Care at Home (EACH) and EACH-Dementia programs.

3.95 The ANAO concluded that, while review of the issues involved is currently underway in DoHA as a result of Government policy decisions, DoHA could take the opportunity to develop procedures that enable it to ensure that consistent means are employed across its STOs to utilise Community Care Grants to encourage their use for the purposes set out in the Aged Care legislation.

3.96 The ANAO considers that DoHA could increase the effectiveness of its management of the CACPs program by developing administrative guidelines and procedures to:

- determine an appropriate basis, and plan for the use of Budget resources allocated to the CACPs program, for Community Care Grants provision to States and Territories, depending on their needs;
- identify opportunities for providers to develop services in areas or for community groups where the department has information pointing to service provision being below benchmark;
- foster and encourage service providers to extend services or meet unmet needs;
- distribute focussed information to the provider industry about the purposes and operations of Community Care Grants in serving the statutory objects of the CACPs scheme; and
- utilise applications for, and successful grants of, Community Care Grants in monitoring the operation of the program and in reporting on program outcomes.

Recommendation No.5

3.97 The ANAO recommends that DoHA implement administrative procedures to enable Community Care Grants to be deployed with greater consistency to improve the management and delivery of the CACPs program to all areas of need for CACP places. In particular, DoHA should:

(a) determine the basis of allocation of Community Care Grants provision to States and Territories, depending on their needs;

(b) issue guidelines for its State and Territory Offices to promote the use of Community Care Grants by providers to assist the provider industry to meet unmet or poorly served needs;

(c) collect information through State and Territory Offices, as part of their submission of recommendations for allocation of CACP places to providers in ACAR Level 3, on the need for, and use of, Community Care Grants to meet gaps in service provision; and

(d) use information on the performance of providers in their utilisation of any Community Care Grants successfully won by providers to enhance departmental reporting on gaps in service provision for CACPs.

DoHA's response

3.98 The Department agrees with this recommendation.

3.99 The Department of Health and Ageing agrees that allocation of Community Care Grants funding across states and territories would assist State and Territory Offices to promote the grants and make recommendations as to their allocation to service providers. As allocation of Community Care Grants is also dependent on the allocation of places, the Department will implement a `notional' distribution pending the outcome of the grant application process.

3.100 The Department agrees that better promotion of Community Care Grants will increase the industry's awareness and understanding of the grants. In response to b) and c) of this recommendation the Department will ensure that information provided for future ACAR rounds will give greater prominence to the importance grants can play in assisting providers to establish new services or extend existing services to new areas. This material will also reflect any changes which flow from the consideration of community care grants in the *Securing the future of aged care for Australians* initiative. The

Department will also work with State and Territory Office's to achieve greater consistency in the promotion of the grants.

3.101 The Department agrees that there is merit in reflecting on what is learnt through the allocation and use of Community Care Grants, however is unable to respond directly to part d) of this recommendation as information on the use of these grants would not enhance departmental reporting on potential gaps in service delivery. The Department will, however, work with State and Territory Offices to collect information on the use of these grants for consideration in future application processes and for examples of best practice for future applicants. At a national level, this will allow the Department to analyse best practice in the allocation and use of community care grants.

4. Providing Places to People

The distribution of places to providers is separate from decision-making on who accesses the places. The program design provides for aged care service providers to select, from among those approved for CACP care, the persons who will be admitted to vacant CACP places that are in their possession. This chapter examines the processes utilised in this vital final stage of delivering the benefit to people, including the pivotal role of the Aged Care Assessment Teams.

Access to aged care places

Decision mechanisms

4.1 The CACP shares with other Aged Care Act-funded aged care places identical mechanisms and processes for admitting people to places in the program.

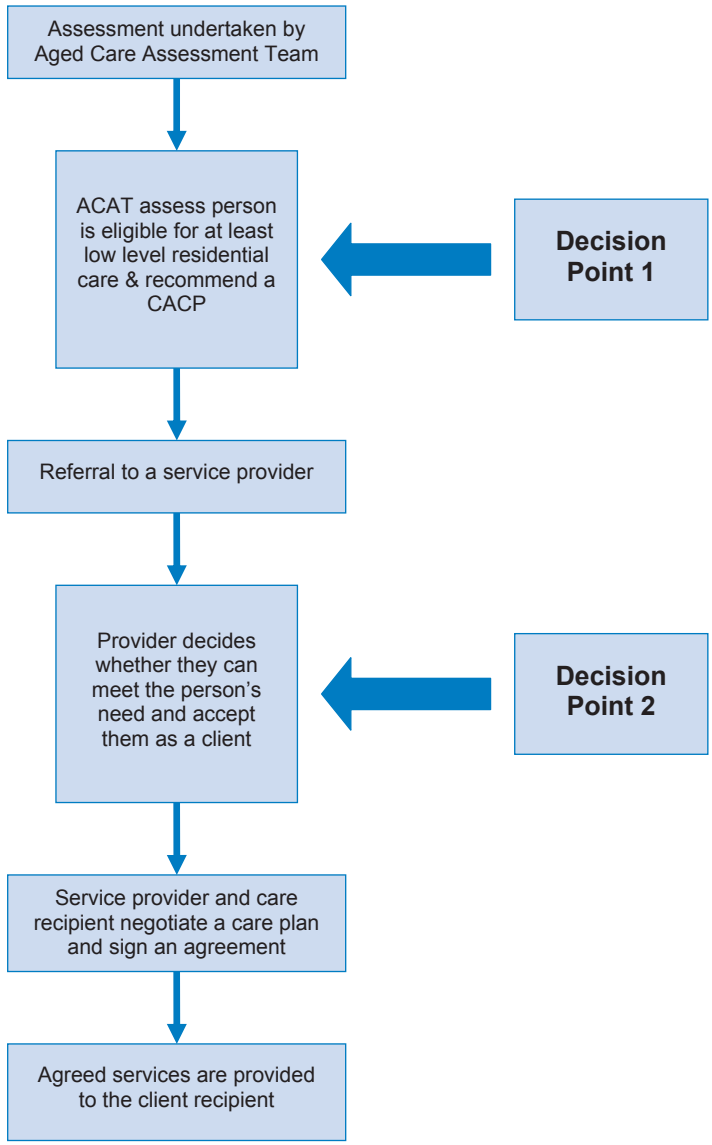
4.2 As with the residential program, the decisions that the Act requires be made about a person's access to a CACP place are at two key points. The first decision point is the professional assessment of the person's needs, performed by an Aged Care Assessment Team[51] (ACAT), which determines whether a person is eligible for a place by 'approving' the person as a care recipient for community care (or for residential or flexible care as the case may be).[52] The second decision point is the decision of a service provider to admit the eligible person to a care place in the provider's 'possession'.

[51] In Victoria the function is described as the Aged Care Assessment Services.

[52] The ACAT may make a number of assessments of the same person over time, as their needs change and different types of care become appropriate. An ACAT assessment recommending a CACP expires after 12 months so if a person approved for a place has not taken up the place in that time period, a fresh assessment has to be undertaken if the person requires access to a place.

Figure 4.1

Entry into CACPs



Source: ANAO.

4.3 At each decision-point the suitability of a potential recipient for a CACP place is assessed from separate, if overlapping, perspectives: the ACAT assesses what the appropriate care option is for a person in view of a holistic professional judgment about their heath condition and needs; it decides if the person is lawfully eligible to be a recipient of a CACP place. The provider assesses whether the person's needs and characteristics match the provider's

capability to provide the services needed.[53] If the provider has a vacancy, or a vacancy is in prospect, it decides to offer a person a CACP place and negotiates a care agreement with the person.

4.4 Neither of these decision points is under the control of DoHA. In combination, however, as two successive gateways into CACPs, they determine if and when users access this program.

4.5 These decisions, and the entities making them, have formal status within the aged care legislation.

4.6 The ACATs operate out of the State health or community services systems and are part of an Australian Government/State/Territory cooperative program, the Aged Care Assessment Program (ACAP). The eligibility decisions they make are made by specified members of the Teams who function as delegates of the Secretary of the Department of Health and Ageing. Appeal rights and processes applying to these ACAT decisions are spelt out in the *Aged Care Act 1997*. Decisions can also be questioned by the Ombudsman.

4.7 At the second decision point, the providers are generally private sector bodies which have been approved by DoHA for the purpose of CACP service delivery. The providers have received funding approval for the places. The places have been created by DoHA and have been allocated to the providers by DoHA. Their decisions are not decisions of an Australian Government delegate and attract no review rights,[54] nor are their decisions subject to DoHA's formal complaints processes, which are engaged only once people are accepted by a provider for care. For everyone wanting a care place, provider decisions are the final gateway into a CACP, so the providers have an important bearing on how effective is the CACPs program in meeting its objectives in providing packages to people in accordance with relative needs.

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[53] As described in Chapter 2, the service providers make these decisions taking their own professional assessments of the person into account. Service providers can only admit people to a place if there is a vacancy or prospective vacancy and they may, and do, also take business considerations into account in deciding whether a person is suitable for acceptance.

[54] About a quarter of providers are public sector bodies, usually State/Territory and/or local government entities. Where providers are state or local government organisations, decisions may be subject to forms of review provided by those organisations.

ACATs as the first 'gateway' to CACPs: the functions of the Aged Care Assessment Program and its ACATs

The Aged Care Assessment Program's function in CACP operations

4.8 The Aged Care Assessment Program (ACAP) is an intergovernmental agreement creating the framework which tasks, funds and controls the national system of Aged Care Assessment Teams, the ACATs. The ACATs perform a range of functions in State and Territory health systems as well as Commonwealth roles. They assess ageing people for their suitability for various forms of care including HACC programs.

4.9 While States and Territories manage the ACAP on a day-to-day basis, with joint funding by the Australian Government, the functions of the ACAP in regard to its role in approving persons as recipients of Australian Government subsidised *Aged Care Act 1997* places are specified in the *Approval of Care Recipients Principles 1997.*

4.10 ACATs deal with people in particular geographical areas. These areas are not aligned with the Australian Government's Aged Care Planning Regions discussed in Chapter 3. They are accountable to hospital managers and area health or community services managers. When decisions are made in regard to people's eligibility as recipients of Commonwealth *Aged Care Act 1997* care, ACAT personnel making the decisions function as delegates of the DoHA Secretary and they receive specific training from DoHA for this role.

4.11 Aged care assessment evaluation units, located generally in State health departments coordinate data collection from the ACAT networks in the respective States/Territories. Some of this data is systematically collected and maintained in a central holding, the National Data Repository.[55]

4.12 DoHA has developed manuals and guidelines to assist personnel involved in the ACAP to apply the requirements of the aged care legislation to their activities. Key among these documents is the *Aged Care Assessment and Approval Guidelines.* It is subject to ongoing revision.

4.13 The status of the ACAP as an Australian Government/State program means that DoHA has to work closely with the States and Territories in managing its interests and responsibilities in this program. The broad

[55] The data as maintained nationally is on a Minimum Data Set basis. Chapter 5 examines the relationship of ACAT data with DoHA's own data collection.

framework of the aged care assessment system is the subject of close attention inter-governmentally. Major review activity has been under way between DoHA and the States and Territories on the community care roles of ACAP, in the context of *The Way Forward* initiative. In addition to the ongoing work of the Community Care Review, the Council of Australian Governments (COAG), decided in February 2006 that there should be 'more timely, consistent and flexible assessments processes'[56] for community based (as well as residential) aged care services for frail older people by the ACATs. The Australian Government has committed specific additional funding for reform of the system.[57]

4.14 While acknowledging the major intergovernmental dimension of reform of the aged care assessment system, the ANAO noted that DoHA has crucial interests in how clearly the ACATs bring focus to the needs of the CACPs program, which is wholly Australian Government funded. It noted further that DoHA has directed considerable effort to seeking to ensure that the ACATs perform as effectively as possible to meet the needs of the *Aged Care Act 1997* programs.

Issues for people accessing CACPs in the operation of ACATs

4.15 It is timely for DoHA to be attending to reform of the ACAT system because the ANAO found that numerous aspects of their operations impede the achievement of consistency across Australia in the way this first 'gateway' into CACPs works.

4.16 In particular, the ANAO noted:

- inconsistency between ACAT practices on a State/Territory basis and among ACATs individually in their operating procedures in regard to assessments bearing on CACPs;
- uneven approaches to caseload management and use of statistical collections that throw light on areas of need;
- highly disparate approaches among ACATs to their roles of referral to possible aged care services of people approved for the CACP care type;
- claims by a number of providers that ACATs approved/referred unsuitable people; and

[56] Media Release by the Minister for Ageing, SS011/06 10 February 2006.

[57] Council of Australian Governments Meeting Communiqué 10 February 2006.

- claims by a number of providers that inadequate information about the health and/or environmental condition of assessed people was made available by some ACATs to service providers.

Inconsistency in ACAT assessment practices

4.17 The ANAO found a wide range of operating procedures and approaches among the ACATs and among assessment evaluation units in State government agencies with which it had discussions. ACATs frequently commented that, although DoHA's guidelines were reasonably clear and they had sound relationships with STO officers, the environment in which they worked was not conducive to their being able to follow the guidelines in a consistent way.

Caseload management and maintenance of statistical collections on performance

4.18 Some ACATs, and/or the evaluation units in the respective State/Territory operate sophisticated data collection about caseload management. They use it effectively to deal with their large client caseloads so as to ensure that assessment and referral of cases reflect priority need as far as practicable.

ACATs' perception of their referral roles

4.19 Different ACATs operate highly varying referral roles in regard to the people they assess as eligible for CACP care. Some are very proactive, actively seek placement with a provider and even adopt a case management role for care recipients after they are admitted to a CACP place. Others adopt a quite passive stance. Often, resource considerations underlie these variations, as the Guidelines issued by DoHA indicate what standards should be observed.[58]

4.20 Providers almost invariably had concerns about the ACATs' referrals practices, whether they are active or passive. In the case of the 'active' ACATs, providers typically were concerned about the fairness of the referral process, not having knowledge of whether approved care recipients other than those referred to them may be more suitable for their provider capabilities rather than the ones actually referred to them. For the less active ACATs, the main criticism was the lack of any order in the process, with a 'lucky-dip' outcome

[58] DoHA advised [response to Issues Papers, p 43] that the most recent version of the *Aged Care Assessment and Approval Guidelines* (September 2006) state that: 'ACATs should work with the CACP provider to help develop a care plan for the approved person, in line with their assessed care needs, or provide sufficient information to the CACP provider to inform the care plan development…'.

for them when they approached the ACAT to obtain details of a possible care recipient candidate.

Approval and referral of unsuitable people

4.21 Numerous providers expressed concerns that people are being approved for CACPs whose needs are not complex and could be better met by other non-packaged or lower level care types.

4.22 Providers noted that when such referrals occurred they appeared to relate to ACAT personnel judging that, among the several possible pathways for an assessed person after assessment, the CACP option was better than nothing and would provide the most cost-effective care for the person or the carer. They considered that some delegates may not give weight to all the relevant factors specified in the CACP *Approval of Care Recipients Principles 1997*.

4.23 On the other hand, some providers considered that ACATs frequently approved people as CACP care recipients when their needs were much greater than those suitable for a CACP, especially if the care recipient had an able-bodied carer and the ACAT knew that there were no other options capable of delivering the higher care services, such as EACH or EACH-Dementia places, or residential places, available in the area.

Inadequate information about the health or environmental condition of referred persons

4.24 A number of providers questioned the adequacy of ACAT referrals to address providers' needs for information about the health condition of people approved as aged care recipients. Concerns included providers: not being informed that particular approved persons may have health conditions making service delivery to them difficult, such as advanced dementia conditions or challenging behaviours; or not being informed of the possibly unsuitable housing environment of an individual for CACP services.

Key implications for CACPs program management

4.25 The ANAO understands that DoHA is working with State Government agencies and representatives of ACATs to address many of the policy and procedural issues underlying the concerns outlined above.

4.26 Two particular issues, however, stand out from others because they relate to DoHA's need to ensure that the legislated characteristics of CACPs are properly reflected in relevant management arrangements. These requirements are:

(a) that ACAT care recipient approvals for CACPs are made against clear assessment that all approved individuals have *complex* care needs and require *case management* from the provider; and

(b) the arrangements afford reasonable equity of access to CACPs by approved care recipients, regardless of the area in which they live.

Confining approval for CACPs to people with complex care needs

4.27 From discussions with providers, departmental STO staff, and review of STO and Medicare Australia payments claims records, it is clear that a significant number of the people in CACP places, while needing assistance:

- do not have complex care needs;
- receive at most two hours of service per week;
- draw on a single service type (for example, domestic assistance or assistance with shopping); and
- need little, if any, coordination and case management from the service provider.

For their part, and as noted earlier, providers have business as well as operational reasons to welcome such referrals as they contribute to the flexibility of their overall care management arrangements.[59]

4.28 Because of program drift (see Chapter 2), the proportion of care recipients in care places with less demanding service requirements is likely to increase. A number of providers indicated to the ANAO that, as the cohorts of those in their care in CACPs advance in age (and accordingly, needs), and without increases in funding amounts, providers would increasingly look to favour less intensive referrals in their selection of new clients.

4.29 Discussions with managers and team members of some of the ACATs consulted in the audit confirmed that ACAT members do not consistently address the need for case management when considering individuals' needs for care, and when recommending a CACP care option. They indicated that, notwithstanding the DoHA training efforts, individual team members were

[59] See Chapter 2 for discussion of provider business practices.

not always clear on the changing parameters of care service provision in operation, especially in the community care sector, and were not always aware of the elements that differentiate CACPs from other care types, especially with the emergence of larger numbers of packaged care options in other community care programs.

4.30 To identify how this misreading by ACAT delegates could occur, the ANAO examined, in conjunction with DoHA's Assessment Guidelines, the forms provided by DoHA to ACATs for the use of the DoHA delegate in completing the assessment of an individual and approving a care type for the person. This is the Aged Care Client Record. The form does not include a summary checklist of the attributes of the person (set out in the Guidelines) that would make them eligible for approval of any particular care type.[60]

4.31 ACAT managers indicated that it would significantly sharpen the effectiveness of the form for the approval process for CACPs if the form were extended in a simple way to include a summary of the key CACP criteria at the relevant recommendation section in the form. They considered that the form in its present language was not couched in terms that adequately assisted delegates to keep the program's focus in mind.

4.32 Overall, even though delegates have access to comprehensive documented guidance from DoHA which deals with the requirements of the legislation, there would be advantage if the assessment document itself summarised the key attributes of CACPs and required the delegate specifically to check these off when considering each individual.

Standardising ACAT referrals procedures

4.33 The ways the ACATs refer approved clients to providers determines to a significant degree how difficult it is going to be for would-be CACP users, their carers and family members, to proceed to the second decision point in the access process – referral to a provider. People in ACAT territories where ACATs perform a highly proactive role in referrals are significantly better served than those in areas where ACATs do not perform an active 'case management' role for the people they approve.

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[60] Part 7 of the form, 'Approval as a Care Recipient', to be completed by the Delegate only, provides check boxes for each of residential, community and flexible care, with a further box for the delegate to fill in with regard to community care to include 'date approval ceases'. The section of the form with the boxes is preceded by the certificate 'Having considered the care needs of the applicant, and in accordance with the relevant section(s) of the Aged Care Act, I approve this person to receive the following type(s) of care.'

4.34 Where ACATs operate in an open manner with all providers in their areas, end-users of the system, the persons approved for a CACP benefit from such transparency.

4.35 In principle, it should be practicable for all ACATs to implement a common format in the way they deliver (or make available) their assessment 'product', as regards their CACP approvals, to the approved providers in their territories. The ANAO considers that DoHA should develop such a common format, noting that it would need to do so in close consultation with the States and Territories which manage the ACATs. The format would include the following information:

- basic non-personally identified details of all individuals approved for CACP care;
- any special care needs information for each such approval, including any relevant health condition or home environment issue that may be relevant to initial provider assessment;
- any special needs group status of approved individuals, where disclosed to ACATs by the individuals;
- any other approvals for care for the person given by the ACAT – residential care and/or residential respite care;
- any preferences/exclusions specified by the individual for particular service provider(s); and
- provision for updating and review of the information – so that, as persons were placed in CACP places with a provider, their information would be removed from the listing.[61]

4.36 The ANAO concluded that DoHA should develop the Aged Care Assessment Guidelines so as to increase standardisation of the referral processes practised by the ACATs across Australia.

[61] This removal of approved persons from the 'published' list would not, of course, preclude ACATs from maintaining their own records of placed people so that they could maintain any desired level of 'case management' of individuals after placement.

Recommendation No.6

4.37 The ANAO recommends that DoHA consult with the States and Territories to:

(a) improve aged care assessment procedures for CACPs so that the approval of people as CACP care recipients effectively targets people with complex care needs requiring active case management by service providers; and

(b) increase consistency across Australia's regions in the procedures by which people are referred to CACP care, from the point of their aged care assessment to the point of their accessing the CACP services of a provider.

DoHA's response

4.38 The Department agrees with this recommendation. The Department of Health and Ageing agrees that improvements could be made to Aged Care Assessment Team (ACAT) assessment procedures to ensure that those approved for a CACP meet the eligibility criteria under the *Aged Care Act 1997*, including that a person has complex care needs.

(a) In consultation with the States and Territories, the Department will, as part of the 2006 Council Of Australian Governments (COAG) initiative to strengthen the Aged Care Assessment Program (ACAP), implement a national training strategy for ACAT members. This will include additional training in assessing for Australian Government subsidised aged care services. It will also incorporate assessment issues and service boundary clarification as they arise from *A New Strategy for Community Care: The Way Forward* and the *Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs*. The National ACAT Review will also highlight areas of good practice in consistency of ACAT assessments and recommendations, which will be disseminated to all ACATs.

(b) In addition, as part of the National ACAT Review, good practices in the procedures for referral of people to various services will be identified. While noting that some flexibility is required to allow for the different situations of ACATs and service providers, the Department will work with the States and Territories to improve national consistency of referral procedures. The work undertaken through *A New Strategy for*

Community Care: The Way Forward and through the *Review of Subsidies and Services in Australian Government Funded Community Aged Care Programs* will increase consistency of referral processes to CACPs and other service providers.

Providers as the second 'gateway' to CACPs: admission of people to places

4.39 When a provider commences consideration of whether someone approved by an ACAT for community care is to be offered a CACP place held by that provider, a further round of assessment and decision-making takes place, this time by the potential provider. At this stage, individual approved care recipients may be under consideration by several providers.

4.40 The *Aged Care Assessment and Approval Guidelines*, which apply to ACAT activities but, when describing any provider actions, are no more than suggested practice for providers, encourage the minimisation of duplication of assessment.

4.41 How provider consideration of a person takes place – the criteria used, for example – varies from provider to provider.

4.42 At one extreme the decision may already have been made by the provider, which may have already assessed the person and has referred them to an ACAT for the necessary formal approval. For other people, depending upon the scope of services of the provider's business, the approved person may already be resident in a retirement village or member of a community organisation run by (or linked by management agreements with) the approved provider and, because he or she is well known to the provider, may be placed against a CACP as soon as a vacancy arises.[62] Some provider businesses actively promote their service as including this facilitated pathway to a CACP or other types of community care.

4.43 At the other end of the spectrum are people who become known among providers as 'difficult cases' and who, because of their high care needs or challenging behaviours, stay unplaced for a long time, or who may never be placed.[63] Most cases appear to lie between these two extremes.

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[62] Such people may be encouraged to maintain their eligibility for a CACP by the provider by applying for ACAT reassessment every 12 months.

[63] Anecdotal comment provided by providers.

4.44 People with languages other than English, especially older-established former migrants who may be experiencing language loss as they age, as well as Indigenous people, may also stay unplaced for a long time. They may move on later to an ACAT reassessment for approval for higher types of care such as residential care.

4.45 One reason for non-placement of such special needs individuals drawn to the ANAO's attention by several providers was that provider practices in selection of placements that may be formally earmarked for special needs people, vary widely. Some providers allocate places to 'general' or 'mainstream' recipients quite quickly if they find they cannot identify suitable potential recipients from special needs groups at the time vacancies arise. Others leave the places vacant for longer periods. Each approach has different types of advantages in meeting different needs of the CACPs program.

Data limitations

4.46 DoHA can and does collect data about 'entry periods' for people entering provider places, that is, in regard to those people who want a CACP place and who succeed in getting one, the duration of the waiting times between their ACAT assessment and their admission to a provider place. This data does not capture the situations of people who do not succeed in getting a place, and it does not indicate waiting times prior to placement, until placement occurs. It is, therefore, of limited value.

4.47 The data available from the National Data Repository from the ACAT system is available to DoHA but it has systemic limitations. A number of people obtain ACAT assessments 'just in case'. That is, while the person obtains an ACAT approval, she or he may not immediately need external assistance and may not proceed to make an active application with any provider for some time or ever. Others may find different care solutions more convenient and maybe less costly to them, such as HACC services. This means that, while data about approvals of ACAT clients is captured electronically in the National Data Repository,[64] this data is not a reliable indicator of how the program delivers results and how many people may be left behind.

[64] See Chapter 5 for discussion of data systems relevant to the CACP.

DoHA's understanding of the patterns of provider decisions on access to CACPs

4.48 The decisions to admit people to care places are made by the providers and DoHA cannot be responsible for them. However, it could be expected that DoHA would need aggregated information on the overall performance of the providers in meeting the relative priorities for care of all assessed people in ACATs' territories, as this activity completes the 'front-end' of the program, that is, where people are actually admitted to it.

4.49 DoHA acknowledges the need for this information. It pointed out to the ANAO that the department has to operate in an environment where systematic data is unavailable on the aggregate performance of providers at admissions stage. It is working on various data needs assessment projects to improve the situation.

4.50 The ANAO considers that, could it be gathered, the ideal would be information on waiting times for placement by ACAT region, specifically information showing arrears in placement (the numbers of unplaced people approved as CACP care recipients, who are actively seeking placement, divided into categories showing (a) how long they have been waiting; and (b) what, if any, special needs group background they may have). Such information would assist DoHA to inform itself about the effectiveness of this final step in the care pathway. It would also be a major way of testing how well the allocation of places, undertaken through DoHA's Aged Care Approvals Round processes, was meeting relative needs in the real market place, and it would allow adjustments and reallocations to be made over time by DoHA.

Enhanced oversight of referrals and placements

4.51 The ACATs are at present best placed to monitor the step from assessment to placement. As indicated in the previous section, some ACATs see it as their responsibility to do this and some use automated data systems to help them. Many do not. DoHA advised the ANAO that work that is under way between Australian Government and State officials to implement reform of the ACAP under the Council of Australian Government (COAG) initiative, and in the Community Care Review, will address this issue.

4.52 The ANAO considers that improvement could be achieved more quickly by taking measures to standardise the way the ACATs deliver their

assessment product (as discussed in the previous section), in turn allowing a standardised approach across all regions for providers to access this product.

4.53 A further option would be to confer a formal overseeing role for referrals and placements into CACPs on existing Australian Government-funded care and referral organisations. Such organisations exist in, or have responsibilities in, all ACAT regions.

Role of Commonwealth Carelink Centres/Carer Respite Centres

4.54 DoHA funds Commonwealth Carelink Centres (CCCs) to provide information about community care, disability services and residential services within a defined region. It also funds Commonwealth Carer Respite Centres (CCRCs), which provide information on available respite care for defined regions, including residential, in-home, day care and emergency respite for people with disabilities. CCRCs also provide information about general services and support for carers and have brokerage money that enables them to purchase respite care on behalf of clients when necessary. Both these programs fund centres aligned with the Home and Community Care (HACC) Program planning regions.[65]

4.55 As part of *The Way Forward* initiative, the Australian Government is implementing a program of better aligning the functions and infrastructure supporting CCRCs and CCCs, including combining centres where appropriate.[66] Some of the centres are auspiced by bodies which themselves operate as not-for-profit CACP service providers.

4.56 These amalgamated centres are very well informed about CACP referral activity and placement decisions by providers. They get actively involved in referring people to ACATs and to providers known to have CACP places. They are keenly aware of gaps where they exist in the system. They are funded by the Australian Government, inter alia to assist potential care recipients and carers to find solutions.

4.57 In canvassing with the centres the need for ACATS to deliver their referral outputs in a more transparent and consistent form (see Recommendation No.6 above), the ANAO was informed that these Carelink/Carer Respite Centres were ideally placed to be able to play an

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[65] At the time of preparation of *The Way Forward* (2004), CCRCs had 61 centres and 32 outlets across Australia. CCCs had 54 centres with some 65 outlets. *A New Strategy for Community Care –The Way Forward*, p. 38.

[66] *A New Strategy for Community Care – The Way Forward*, Department of Health and Ageing, pp. 38-39.

overseeing role in regard to the transition of people from assessment to acceptance in a CACP place. They could do this by being authorised to access all the information on assessments generated by ACATs and thus being able to monitor the progress of people from assessment to placement.[67]

4.58 Such organisations could act in an overseeing role in relation to provider decisions on acceptance of referrals of approved persons. They could assist with more active referral activity on behalf of those more difficult to place in CACPs. Such a role would assist DoHA's STOs to identify systemic problems in the provision of CACP care places to people from special needs groups. This work would align with the existing roles of the case managers they employ.

4.59 These organisations could also play a reporting role to DoHA, building on their referral function by reporting regularly to DoHA's STOs on the course of overall placement activity in the ACAT territory. They could draw attention to any gaps in services emerging in the territory. The need for additional resources would be small and would mainly be to enable them to undertake the regular reporting function to DoHA's STOs. Using such information would position DoHA better to assure itself that its places allocation system was working well (see Chapter 5 for detailed discussion of program performance).

Recommendation No.7

4.60 To enable it to ensure more effectively that the CACPs program is operating equitably and that any gaps in service delivery are identified and minimised, the ANAO recommends that DoHA take steps to obtain systematic information about provider decisions on acceptance of people into CACP places, by utilising referral networks which it funds. Such information would enable DoHA through its State and Territory Offices to:

(a) assess whether people with special needs or who are difficult to place are being adequately served by the program;

(b) assure itself that people assessed as CACP recipients do not fall through market gaps in service provision and stay unplaced indefinitely or for excessive periods;

(c) better report on the patterns of supply and demand for CACP services; and

[67] Managers of the centres who were consulted by the ANAO suggested that their organisations would welcome such a role. They felt that it would buttress the main purpose for which they are funded.

(d) in conjunction with the measures proposed in other recommendations in this audit, through better matching of the numbers of places allocated to providers to actual demand for the places, alleviate access difficulties for people to CACP places and distribute limitations on access on an equitable basis.

DoHA's response

4.61 The Department agrees with this recommendation.

4.62 The *Securing the future of aged care for Australians* initiative provides funding to establish systems to gather better systematic data on services delivered by CACP providers and this will be used to inform reporting and program management. Within this context, the Department will explore options for obtaining information on provider decisions.

4.63 Developing this data collection system will take time. As an initial step, the Department will examine existing data, including from referral networks, to better understand its potential to identify any gaps in service provision.

4.64 *Securing the future of aged care for Australians* also includes an increase in the target ratio for community care from 20 to 25 places per 1 000 people aged 70 years and over. The increase in the number of new community care places will be targeted to special needs groups and to areas that may be under supplied at present.

5. Monitoring and Reporting Program Outcomes

This chapter examines how DoHA obtains and uses information to assess and improve CACPs program performance. It reviews how DoHA reports on CACPs program outcomes to Parliament; and identifies the main business systems used to capture program performance information.

Effective program management

5.1 The key objectives of the CACPs program are to provide:

(a) coordinated aged care packages tailored to meet the complex care needs of people, delivered where care recipients live; and

(b) an effective alternative to residential aged care for people who wish to stay at home.

5.2 The legislation requires that in deciding the allocation of places, DoHA give particular attention to the requirements of groups with special needs. As outlined already in Chapter 3, these are:

(a) people from Aboriginal and Torres Strait Islander communities;

(b) people from non-English speaking backgrounds;

(c) people who live in rural or remote areas;

(d) people who are financially or socially disadvantaged; and

(e) people who are veterans.

5.3 The breadth of these objectives means that improving the CACPs program could involve a wide range of performance characteristics. These would include, for example, providing greater numbers of places so that demand for places was increasingly met; and improving the quality of care provided on an individual package basis.

5.4 Furthermore, the aged care legislation specifies minimum content for the annual report that the responsible Minister must cause to be laid before

each House of the Parliament on the operation of the *Aged Care Act 1997*. Those matters that are directly relevant to CACPs[68] include:

- the extent of unmet demand for places; and
- the extent to which providers are complying with their responsibilities under the Act.

5.5 Management of the CACPs program requires administrative procedures and systems to enable DoHA to evaluate and report on the performance of the program, allowing the department to implement measures to continuously improve program capabilities and outcomes where possible. A range of indicators is therefore needed to inform DoHA of the performance of individual providers as well as of the program at an aggregate level.

Reporting outcomes to the Parliament

5.6 DoHA's external reporting on the operation of the CACPs program provides opportunities for the department to bring together key performance information on the program in addition to the annual report on the operation of the *Aged Care Act 1997* referred to above. Accordingly, the department has two occasions each year, which all agencies have, when it presents information relevant to the program's performance:

- the department's Annual Reports; and
- the Portfolio Budget Statements (PBS).

5.7 DoHA also presents two 'stocktake' reports to the Parliament annually. The stocktakes are provided in Senate Estimates Committee hearings on the department's annual budget estimates.

5.8 The ANAO examined how DoHA has reported on CACP performance outcomes to the Parliament since the commencement of the Act (1997–98). In doing so it applied the principle in the ANAO's *Better Practice Guide on Grants Administration* that accountability mechanisms for the program should be directed to outcomes as well as to inputs and outputs.

5.9 Review of the annual reports provided by DoHA over the period since the enactment of the *Aged Care Act 1997* indicates that DoHA emphasises:

- reporting allocations of new CACP places in the relevant year;

[68] *Aged Care Act 1997*, Section 63-2. A number of reporting requirements include reference to residential care or matters that only apply to residential care. A requirement to report on sanctions imposed for non-compliance under Part 4.4 of the Act is applicable to all care types.

- growth in allocations of places;
- gross expenditure outlays on community care, and estimates of expenditure;
- progress achieved in reaching planning ratio targets for numbers of places as a proportion of the population aged over 70;
- State/Territory and regional distribution of places and ratios achieved in each State and region; and
- changes in the ratios of operational places to allocated places.

5.10 The department provides narrative reporting on other selected aspects of CACPs program activities such as the operation of the Aged Care Complaints Resolution Scheme and various reform initiatives. The Aged Care Complaints Commissioner reports annually to the Parliament.

5.11 Material in each annual *Report on the Operation of the Aged Care Act 1997* on the specific requirements listed in the Act, noted in paragraph 5.4 above, is limited. In regard to the requirement to report on the extent of unmet demand for places, material provided was generally in narrative form, framed in the context of general discussion of arrangements to improve access. In regard to the requirement to report on the extent to which providers are complying with their responsibilities under the Act, reports included only summaries of the responsibilities, with recent reports placing this material in appendices to the main report.

Performance indicators

5.12 DoHA has applied from year to year different formats and descriptors for performance indicators to describe the Outputs/Outcomes framework relating to Aged Care. This was in line with changing whole-of-government requirements and internal changes in the Health and Ageing portfolio. The current aged care and population ageing outcome, Outcome 4, includes community care. Outcomes specific to the CACPs program are not identified.

5.13 The summary of performance information by individual outputs and output groups for Administered Programs lists two indicators relating to community care, as detailed in the following table:

Table 5.1

Key performance information for Outcome 4 for community care

Indicator	Measured by	Reference point or target
Provision of operational community care places to meet the target of 20 community care places per 1 000 persons aged 70 and over.	Extent to which target is met.	The provision of 20 community care places per 1 000 persons aged 70 and over.
Provider participation in the quality reporting process.	Percentage of providers of Community Aged Care Packages, Extended Aged Care at Home and National Respite for Carers Program services that participate.	Up to 30% of providers participate in the quality reporting process.

Source: Health and Ageing Portfolio Budget Statements, 2005–06.

5.14 The ANAO notes that these performance indicators focus on the creation of new places, especially meeting the Government's target ratio of service provision, and, in regard to quality of service, a measure of the extent of provider participation in the Quality Reporting (QR) initiative.[69] These indicators do not address the quality of CACPs program outcomes. They do not take into account the specified content of the annual reports required to be prepared annually on the operation of the *Aged Care Act 1997*, which address the assessment of unmet need and the extent to which providers are complying with their responsibilities under the Act. The ANAO considers that DoHA should improve the performance information it provides to the Parliament on the CACPs program, in line with the Act's minimum requirements.

5.15 The ANAO notes that the current information soundly captures the department's performance in regard to a major challenge to CACPs program administration, which is the maintenance of balanced growth in the whole

[69] The measure of the participation rate of providers in Quality Reporting (QR), important as it is, does not reach far beyond activity description. Even within current limitations on central data collection from the QR scheme, it would seem that a more appropriate measure would be the percentage of providers receiving an Outcome 1 assessment – the assessment that providers are meeting standards of performance successfully. DoHA's Quality Reporting is described later in this Chapter.

aged care program to achieve government-set targets. However, this information relates only to the 'front end' of the program.

5.16 The material described in DoHA's current performance measurement refers to limited CACP outputs and to processes, not outcomes. As earlier chapters in this report have shown, how well the CACPs program is delivering benefits to Australians requires DoHA to monitor and report on a greater range of indicators – at the aggregate, State and provider level.

5.17 It would seem desirable for the department, at a minimum, to use performance indicators that are aligned with the CACPs program objectives and reporting requirements specified in the aged care legislation.

5.18 Such objectives and reporting requirements include:

- the provision of coordinated care to people with complex needs;
- the provision of home care as an alternative to residential care;
- attention to people with special needs;
- the extent of unmet demand; and
- provider compliance with conditions of allocation and quality of care.

Performance measures aligned to legislated objectives and reporting requirements

5.19 The ANAO reviewed the monitoring and reporting systems employed by DoHA in relation to CACPs, to ascertain the extent to which information was currently available, monitored and utilised, at both an aggregate level and for individual providers, to address legislated objectives and performance reporting requirements. Table 5.2 summarises the ANAO's findings.

Table 5.2

DoHA's monitoring and reporting of CACPs against legislated requirements

Legislated objectives and reporting requirements	Provider level	Aggregate level	ANAO comment
Coordinated care to people with complex needs	X	X	DoHA has no data on providers' coordination and/or case management services to their care recipients and, therefore, cannot effectively monitor such performance, nor use this information to assess trends in CACPs use.
Alternative to Residential Care	X	X	DoHA has no systematic means of monitoring the pathways of CACP holders upon exiting a CACP – information necessary to quantify the extent to which, or for how long, the CACP provided an effective alternative for residential care.
Attention to people with special needs	X	P	DoHA's STOs do not typically maintain centralised records of places that have conditions of allocation attached to them. In particular, providers are not required to provide regular information to DoHA on their performance in regard to special needs groups either in their general clientele nor in regard to any specifically designated CACP places. Moreover, DoHA's acquittal system does not capture the performance of providers in regard to their fulfilment of all conditions of allocation of places to them.
***Aged Care Act 1997* operations annual report requirements**			
Extent of unmet demand	X	P	The information that DoHA can obtain that throws light on demand/supply imbalances of CACP places at the regional level is the elapsed period between ACAT approval of a person for a CACP and their placement into a service. The utilisation of this data is not consistent across STOs, as found in Chapter 4.
Provider compliance with conditions of allocation and quality of care	P	P	As above, DoHA's acquittal system does not capture the performance of providers in regard to their fulfilment of all the conditions of allocation of places to them. Although DoHA possesses hours of direct care service data from providers, some STOs use it in program delivery performance management, whilst others do not. Because it is not collected by any of the currently used business systems, DoHA has no systematic means of obtaining information about the profile of care services provided to individuals – that is, the extent, type and quality of services.

Source: ANAO.

Note: X = not met. P = partially met.

5.20 The ANAO considers that, while DoHA has introduced a QR system which may enable capture of some information on service provider performance every three years, DoHA can significantly improve the extent to which it collects, monitors and reports information on the CACPs program. The information and reporting so generated would assist in identifying areas for improvement and so facilitate its management of the CACPs program. In particular, DoHA should utilise its CACP annual acquittal system to obtain data on case management, and monitoring service provider compliance with conditions attached to place allocations.

Improving the monitoring and reporting of the CACPs program

Monitoring and performance management activities in program delivery

National program monitoring

5.21 In accordance with the devolved model of management for CACPs, the Central Office of DoHA monitors the overall operation of the CACPs program at a national level, with the STOs monitoring program delivery in the States and Territories.

State/Territory program monitoring

5.22 Monitoring of the supply/demand balance for CACP places is a key responsibility of the STOs in service delivery. It is directly relevant to their annual role of advising on the regional distribution of (new) CACP places, examined in Chapter 3. The STOs also have the key responsibility of monitoring program delivery for risk and to pursue enhancement opportunities. Most, if not all, of the STOs 'contract manage' most aspects of the relationship they have with providers in their States.

Monitoring CACP providers

5.23 As identified in Chapter 2, ongoing risks in service delivery arise from DoHA's reliance on provider performance. In addition, as indicated in Chapter 4, how providers act to enable access to the program of people approved for care, and how they maintain and improve their standards of service to those that they have taken into their places, is critical to whether the program works to achieve its legislated objectives. Very wide discretion is left to the provider. The STO role in monitoring provider activity for risk is critical to the program.

5.24 The need for service providers to submit annual acquittal statements to the STO affords the principal opportunity for the STO to monitor all providers' performance in a systematic way. Another opportunity for DoHA to monitor providers systematically arises from the payments function, where providers submit monthly claims for payment based on their detailed statements of the occupancy of the CACP places allocated to them (see 'CACP subsidy payment arrangements' below).

5.25 These are the two occasions when providers are obliged to report to DoHA on an annual, or more frequent, basis. They are required to report every three years under a QR initiative.

Annual acquittal of payments

5.26 Providers must submit to DoHA audited financial returns on the expenditure of their CACP subsidy payments over the financial year. They provide this information to the STOs which administer acquittals.

5.27 DoHA promulgates centrally the minimum data required from providers. This information includes subsidy income, other income, salaries and direct care costs, care-related travel, brokerage, other care-related costs and provision costs. STOs may, however, add other selected information requirements to this central data. How the STOs then assess the information in the returns varies between STOs.

5.28 Some STOs focus on financial compliance.[70] Others use the opportunity more broadly, as an occasion to obtain further information from providers about their programs of care. STOs develop their own approaches and templates for officers to use in assessing annual acquittal information provided by care providers.

Case management

5.29 A common gap in STO monitoring of service provision was measuring the time providers spent in providing case management and/or care coordination services, as opposed to individual services. The importance of case management for individual care recipients in the CACPs program is examined in Chapter 2. Providers consulted by the ANAO indicated that they would see no difficulty in furnishing to the department an estimate of the hours (or any other measure preferred by DoHA) they spent in coordination

[70] In one STO this financial focus is reflected in the tasking of the STO structure. In this STO, formal carriage of the function of assessing returns from providers belongs to the corporate management area of the STO, not the area responsible for monitoring providers (the Community Care section).

services for individual CACP placeholders, or for groups of them as specified by the department (for example, individuals with dementia).[71]

5.30 The annual acquittal return would present an ideal opportunity for DoHA to capture this case management data from service providers without additional cost to the department. Providers were interested in providing it and it would involve minimal additional work on their part because most already assembled the information as part of their own business management.

Monitoring provider compliance with conditions of allocation of places to special needs groups

5.31 The ANAO examined a sample[72] of deeds of agreement between STOs and providers. This sample indicated that most deeds of agreement have conditions of allocation attached to them. They often relate to the need for specific numbers of places, which may be in specific areas, to be allocated for particular special needs groups.

5.32 All deeds of agreement reviewed had a requirement for a minimum ratio of financially and socially disadvantaged (FSD) people in the care places occupied. However, in their acquittal statements, providers are not required to report specifically on their performance in meeting these conditions of allocation.[73]

5.33 DoHA's acquittal system does not purport to capture the performance of providers in regard to their fulfilment of all conditions of allocation of places to them. The ANAO found that none of the four STOs it examined gathered this information systematically.[74]

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[71] Providers generally went further than this and indicated that they thought that without such information the department was 'flying blind' in its capacity to monitor real CACP service delivery by providers. Certainly, they thought, the department was not obtaining from providers a full picture of the services provided to care recipients in only asking for direct care hours to be included in the monthly claims forms. Most providers indicated that they would welcome the opportunity to provide this information to the department on an annual basis.

[72] The ANAO reviewed twelve deeds of agreement in the STOs visited.

[73] Providers are required to certify in general terms that their activity in the reporting period reflects their obligations under the deed, but the specific list of matters which they are required to certify does not include the obligation to fulfil the conditions of allocation set out in the accompanying schedule to the deed of agreement.

[74] In the monthly payments claims forms which providers submit to Medicare Australia, providers are expected to indicate whether persons listed in the claims are of FSD status. An FSD ratio per service is calculated by the payments system from this data. However, the inclusion of this data is not regarded as reliable, as many providers do not fill in the FSD column on the claims form. The ratio is not considered in the further processing of claims. It does not appear to be utilised in any other way.

5.34 The ANAO considers that the emphasis in the aged care legislation on the need for targeting specific population groups should be adequately reflected in the way DoHA monitors provider performance. Other than information it obtains as part of the QR process (see Quality Reporting below) every three years, DoHA has no means of knowing whether special needs groups are being served by providers in the numbers assessed as appropriate at the time of allocation of places to providers. Where an STO is following more advanced risk management approaches, it is possible that such information may emerge during an inspection visit to a provider that falls into a higher risk category. Generally, however, follow-up will be on an infrequent basis.

5.35 Furthermore, other than at times when providers make applications for more places, DoHA has not introduced a review system to check whether particular conditions of place allocations in previous rounds continue to be relevant to the demographics of the areas serviced by providers. The deeds of agreement could be improved by inclusion of a review point relating to the conditions of allocation. A program of review could then be implemented.

5.36 The ANAO considers that such periodic review would enable DoHA to monitor the performance of the CACPs program in meeting the needs of the particular groups identified in the legislation, and to adjust conditions of allocation where appropriate. Such review would also require DoHA to introduce systematic monitoring of the providers' performance in fulfilling the existing conditions of allocation.

Quality Reporting

5.37 Schedule 4 of the *Quality of Care Principles 1997* identifies the seven standards relating to quality of community care. These are:

- information and consultation;
- identifying care needs;
- coordinated, planned and reliable service delivery;
- social independence;
- privacy, dignity, confidentiality and access to personal information;
- complaints and disputes; and
- advocacy.

5.38 In 2005, DoHA introduced the Quality Reporting (QR) scheme, which contained mandatory three-yearly quality self-reporting by providers of CACPs[75] (as well as for EACH packages and NRCP providers). It was in mid-cycle at the time of audit field work.

5.39 Quality Reporting followed an initiative by the Government in 2001-02 when the then Minister for Ageing requested the department to work to develop the accountability framework for the CACPs program. The primary objectives of the framework would be to ensure that CACP recipients continue to receive appropriate levels and quality of care and to improve measurement and reporting of the program operations.[76] DoHA was given additional recurrent funding in the 2004 Budget to provide resources for this initiative.

5.40 Quality Reporting is administered by the STOs under nationally promulgated forms and guidelines. Each service of every provider is to be separately covered by the QR process. By the end of each three-year cycle, all providers are expected to have undergone the full reporting process. DoHA has issued a comprehensive *Provider's Guide* kit to providers. The QR process commences with providers completing a Quality Reporting template.

5.41 In a section of the template itemising each of the Quality Standards relevant to CACPs, providers are required to describe their approaches to meeting the respective standards, and to separately detail their expectations and results for each standard. The QR procedure then involves detailed scrutiny by the department of these reports. STO staff use a Quality Review Tool document for their analysis of the provider's reports. This results in standardised assessment of each provider. The assessment stage includes visits by departmental officers to each of the provider's sites.

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[75] As implemented and projected to providers, the primary purpose of Quality Reporting is a means of encouraging continuous improvement on the part of providers, *assisting* them rather than *monitoring* them. Nevertheless, conceived as a means of increasing the accountability of the program, Quality Reporting provides an opportunity for the department to generate performance information about service delivery. This performance information could be quantitative as well as qualitative information, with the drawback of its only being able to be gathered once every three years.

[76] Department of Health and Ageing *Annual Report 2001–02*, p. 126.

5.42 The QR process concludes with an assessment by the STO team of the standards of service of each provider, based on the information that has been assembled. The team makes a recommendation to a senior manager in the STO as to which of three 'outcomes' should result from the review:

- Outcome 1, where the department notes the effectiveness of the processes and systems in place and agrees with the provider's Improvement Plan;
- Outcome 2 involves the department noting some remaining concerns and indicating further action to be taken by the provider; and
- Outcome 3, where the department identifies significant unmanaged risk and refers the provider to the compliance area of the department.[77]

5.43 The outcome is communicated in a letter to the provider. In the first year of the cycle, 40 per cent of providers completed the reporting cycle, and 92 per cent of the services reviewed received an 'Outcome 1' letter. None had received an Outcome 3 letter.[78] In discussions with the ANAO, DoHA emphasised that the general approach of the model chosen for QR is not to make a 'pass/fail' determination. They indicated that this distinguishes QR from the process used in the mandatory reporting applicable to HACC service providers.

5.44 In examining a selection of completed templates held on STO files, the ANAO noted that the reporting by providers contained various mixtures of narrative reporting, quantitative material from various internal surveys and illustrative case studies. In their assessment of this reporting, STOs can only take a similarly qualitative approach. Scoring methodologies are not used – rather check boxes for various indicators are ticked and provision is made for narrative comment. The procedures used were consistent with the broad approach adopted by DoHA, of regarding the QR process as facilitating the introduction of better practice into providers' management of their roles in CACP delivery, and supporting self-improvement.

5.45 A suggested improvement would be the introduction of quantitative assessment mechanisms. Because qualitative description does not facilitate consistent, comparable review across all STOs, and makes an aggregate view difficult to compile, the ANAO noted that DoHA was limited in capturing

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[77] *Quality Reporting Provider's Guide*, Department of Health and Ageing, 2005, p. 05.

[78] The ANAO was advised that, while the QR process had not led to any referral of a CACP provider for compliance action, lesser forms of referral had been instigated for a small number of providers.

nationally anything more than general data about provider performance of their CACP service delivery roles.

5.46 DoHA is assembling national data on the 'action' outcomes from QR – that is, data on the action category assigned each service following the departmental assessment. This will provide useful information of a general nature, indicating in very broad terms how far the provider community is meeting CACP standards in service delivery. It will not yield information about the content of service delivery. DoHA advised the ANAO that it is not the department's intention to do so, at least in the first cycle of reporting. As a result, the department will not be able to learn much from QR about how the CACPs program is performing to deliver its objectives.

5.47 The ANAO considers that, while a good start has been made with the QR scheme in its present form, DoHA should take action to revise the scheme so as to enable the effective generation, and central collection and reporting, of data on providers' performance of their legislative responsibilities. This action would be consistent with the original intention expressed by the Government in establishing the QR scheme. It would not involve moving away from the self-improvement emphasis of the current system of assessment. Such development of the scheme would need to be done in close consultation with the aged care provider industry. As a minimum, the ANAO suggests that DoHA report on the percentage of providers receiving an Outcome 1 assessment, as illustrated above.

DoHA's CACPs program business information systems

5.48 DoHA's ability to manage the performance of the program against better practice standards is a function of the nature and capabilities of its IT systems and databases developed for CACPs program management, and their capacity to exchange data items. The audit identified the information systems developed through and around the CACPs program to capture information about it and its performance, for either management or public reporting purposes. Because the CACPs program has developed as a result of cumulative Government initiatives taken over time, disparate processes capture and record information relevant to the CACPs program. Moreover, CACPs program administration is closely linked with the Residential Care program, and systems used to obtain information for the CACPs program have frequently been designed as an *adjunct* to the Residential program, so that they are shared systems often driven by Residential program needs. Figure 5.1

illustrates the main business information systems used in CACPs program management and their inter-relationships.

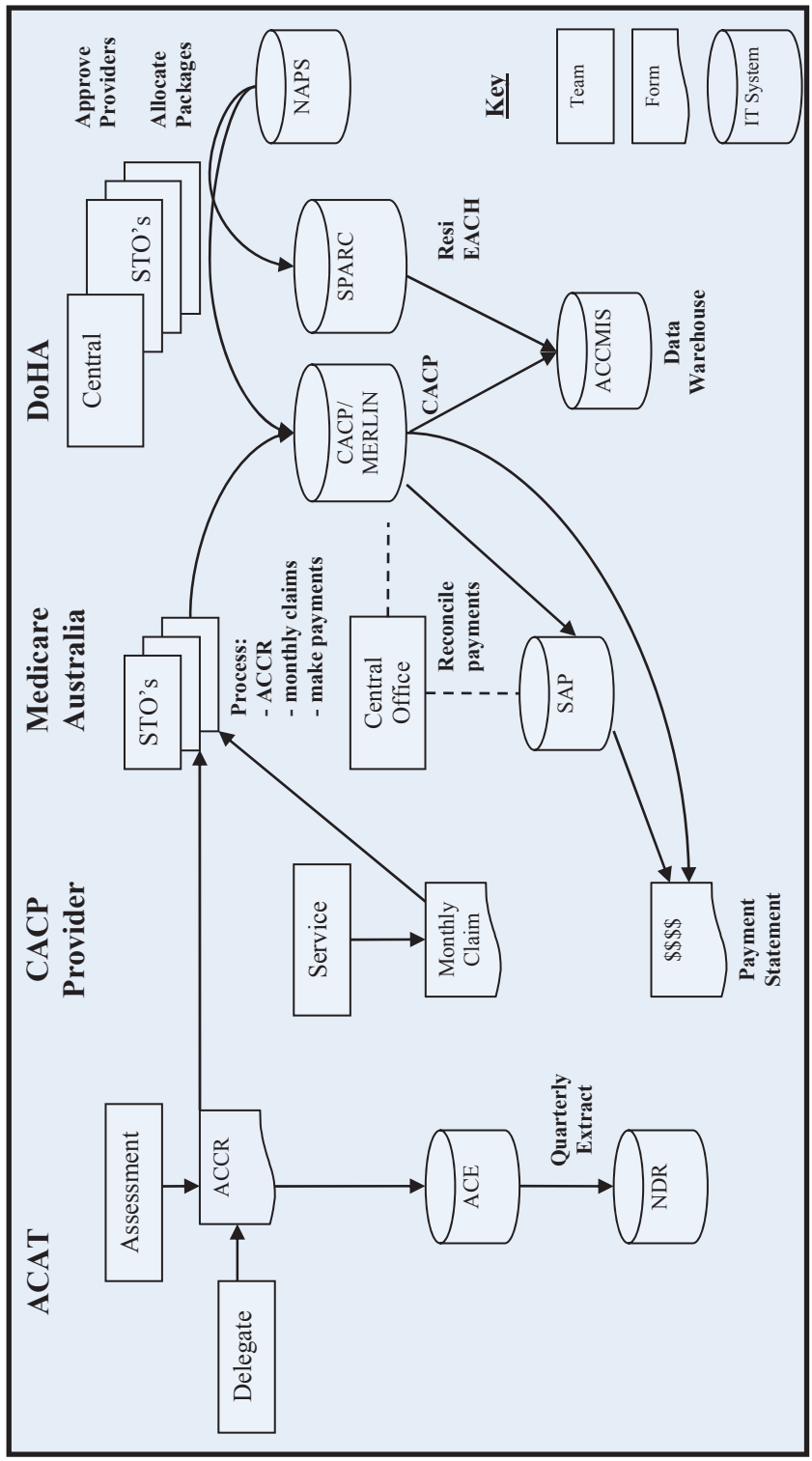
5.49 To facilitate monitoring and reporting functions, IT systems should interface, have common personal identifiers, common fields and allow interrogation. However, data held on the NDR uses different concepts, field descriptors and item identifiers to those in the DoHA systems, so that data generated by the full content of Aged Care Client Records cannot consistently or readily be analysed with data from other community care systems, even after the necessary ethics approvals have been obtained to access it.

5.50 DoHA is aware of the problems inherent in the systems' incompatibility for CACPs and community care generally[79]. Efforts to create compatible data sets in Community Care programs (not only in the CACPs program) are included the Community Care Review initiative.

[79] Of the business and reporting systems in use for community care, only the HACC, ACCR and components of the NRCP have Minimum Data Set (MDS) definitions.

Figure 5.1

CACPs business information systems



Source: ANAO, after the Residential Program Management Branch, Department of Health and Ageing

5.51 Acknowledging the limitations of its datasets, DoHA utilises alternative means of obtaining information on the operation and performance of the program. Such means include commissioning research from the AIHW and utilising narrative reporting provided by ACATs. In terms of obtaining information on the standards of practice followed by providers in their role as CACP providers, DoHA will have access to quite extensive information from providers every three years, following full implementation of the first cycle of Quality Reporting (that is, from 2007).

CACP subsidy payment arrangements

5.52 Until 2005 DoHA performed all payment functions for the CACPs program. Its STOs delivered the payments. The payment function was transferred to Medicare Australia[80] in October 2005.[81] The CACP subsidies are managed under a Memorandum of Understanding and a Business Practice Agreement (BPA) between DoHA and Medicare Australia. Medicare Australia, through its units located in most States and Territories, now make the payments on behalf of DoHA. It is a purchaser/provider relationship where DoHA is the purchaser.

Respective roles of Medicare Australia and DoHA

5.53 For the control of payments, such as decisions on determining who are payees, determining what payee entitlements are, and determining what monthly payments should be made to them, Medicare Australia uses IT applications and computer systems that are owned by DoHA. Data in these systems are captured by DoHA as part of CACP administration (payee details and the number of authorised operational CACP places held by each payee) and by Medicare Australia (data about approved care recipients and currency of approval, and the input of all data in the monthly claims forms from provider services).[82] In accounting for payments Medicare Australia uses its own financial accounting systems.

5.54 Though there have been exceptions, providers generally consider that the transfer of functions to Medicare Australia proceeded smoothly. While some have experienced problems in having matters resolved, most often

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[80] In the Department of Human Services, in the Finance and Administration portfolio.

[81] The change of arrangements for Aged Care payments was directed by the Prime Minister in correspondence to the Minister for Health and Ageing on 22 May 2005. The changes include Residential Care and Flexible Care payments as well as the CACP. They do not cover payments of Community Care Grants.

[82] See Figure 5.1 at the beginning of this Chapter 5.

providers have found the new arrangements to be user-friendly and officers accessible to assist in resolving problems.

5.55 The combined system architecture is ageing, complex and requires extensive manual data input. Before the decision to transfer, DoHA had received additional funding in the 2004–05 Budget to upgrade the systems it used and permit the introduction of e-commerce. Medicare Australia is now planning to re-engineer the systems in line with broader corporate directions for its service delivery networks and its goals for introducing e-commerce across its programs.

5.56 The Parliamentary appropriations for CACPs are at present to the Department of Health and Ageing. The Government plans to transfer the departmental appropriation for aged care payments functions to Medicare Australia in 2008–09. DoHA will still be responsible for the administered funds appropriated to be paid as subsidies to approved providers. By the time of the transfer, Medicare Australia expects to have completed the building of new control systems to replace the legacy applications and data repositories inherited from DoHA.

5.57 In the meantime, the BPA and various agreements made under it between groups in Medicare Australia and DoHA, regulate the control and accountability arrangements for the payments function. Regular meetings of consultative groups of officers take place. Reviews of the transfer of functions have been undertaken, including an outside review by a major management consulting organisation[83]. The external review *inter alia* applied the tests in the ANAO's *Better Practice Guide on Public Sector Governance* (July 2003) to the governance structure for ongoing operations and endorsed the arrangements made. It concluded that effective risk management decisions were applied in the hardware and software solutions applicable to the transfer[84].

5.58 The ANAO considers that Medicare Australia's implementation of e-commerce will generate new issues in DoHA's program management of CACPs. DoHA and Medicare Australia are aware of this.

5.59 Feedback from CACP service providers indicates that many of them are unprepared for dealing with the payments system through e-commerce. Increasing automation of systems in Medicare Australia may mean that DoHA

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[83] *Post-Implementation Review of the Transfer of the Aged Care Payments Function from the Department of Health and Ageing to Medicare Australia*, PricewaterhouseCoopers, for the Department of Human Services, the Department of Health and Ageing, Medicare Australia, May 2006.

[84] ibid., pp. 1, 12.

will need to refine and develop the consultative arrangements it has with Medicare Australia so as to ensure seamlessness in service delivery to providers.

Residual risks in payments arrangements

5.60 The ANAO held discussions with managers of relevant Medicare Australia units in three States and viewed the detailed operation of the systems in each unit. The same business and checking processes continue largely to be implemented as were employed when DoHA directly managed payments. A significant number of DoHA staff 'followed the function' into Medicare Australia so that corporate experience was retained.

5.61 The ANAO considers that there is effective cooperation between DoHA and Medicare Australia in program administration. The ANAO did not conduct an audit of the information technology employed. The arrangements do not materially differ from State to State. ANAO noted that there is separation between data inputting and authorisation functions. Change warning routines are built into the system and controls ensure that only one claim per service per month can be made.

5.62 Nevertheless, the ANAO noted that the quality of the payments system depends wholly on the accuracy of returns submitted by providers each month. The possibility of inaccurate data entry, either by fraud or error, exists. Amounts of payments depend on accurate entry of start and termination dates of care recipients, and the appropriate calculation of any leave periods taken by the care recipient. Provider staff could mis-enter or miscalculate data, e.g. calculate for the wrong type of leave. Some Medicare Australia managers felt that this led to scope for inaccurate payments.

5.63 Medicare Australia has advised the ANAO that measures are in place that mitigate such risks and assist the approved providers' staff to complete their monthly claim forms. These include the provision by Medicare Australia of pre-populated claim forms to the provider using information stored in the payments system as at the previous claim. This allows the provider to simply record the changes within the claim period. Nevertheless, there are risks associated with pre-populated claim forms and such measures do not necessarily address the main issue involved: provider accuracy of data input.

5.64 To further assist providers' staff, Medicare Australia also provides payment and processing information to DoHA's monthly *Payment E$$ential$* newsletter, distributed to all community aged care service providers. Furthermore, providers have telephone access to Medicare Australia's

payment teams should they need assistance with finalising their CACP claims. In addition to this, where identified by Medicare Australia staff or requested by the provider, Medicare Australia provides claim processing training to a provider's staff.

5.65 The ANAO concluded that while the risk of fraud is slight, the system of monthly data collection, conducted as part of the payments claim process by providers, contains scope for inaccuracy, and that such inaccuracy can be carried forward into payments. The ANAO suggests that DoHA investigate possible ways of minimising the incidence of the risk, whether through fraudulent conduct or through error.

5.66 Section 9–3 of the Act (Obligation to give information relevant to payments under this Act) enables DoHA and/or Medicare Australia (as delegated) to request payment related information from providers. ANAO suggests that DoHA implement a program of random as well as risk-based spot audits, to check a changing sample of individual provider returns sent to Medicare Australia, against service records of relevant providers, to minimise the risk of inappropriate payments of subsidy.

Recommendation No.8

5.67 ANAO recommends that DoHA utilise the legislated objectives of the CACPs program, and specifically the minimum content requirements for annual reporting on the operation of the *Aged Care Act 1997* set out in the Act, to improve the performance information it provides to the Parliament about community care. To do this, DoHA should improve the effectiveness of its program management and reporting by:

(a) introducing administrative arrangements enabling it to generate, assemble and collate information about areas of unmet need for CACPs in a systematic way, which would also permit it to implement mitigating strategies;

(b) enhancing its ability to monitor the performance of providers in regard to:

- providers' fulfilment of all the conditions of allocation of their CACP places, especially in regard to special needs groups; and
- providers' performance of their case management responsibilities;

(c) introducing arrangements for the periodic review of the appropriateness of conditions of allocation of places, to ensure that the conditions continue to be relevant to demographic needs; and

(d) so as to facilitate DoHA's assessment and reporting to the Parliament of program performance improvement over time, implementing procedures in the Quality Reporting system to capture, at a national level, aggregated quantitative information about providers' performance of their legislated responsibilities.

DoHA's response

5.68 The Department agrees with this recommendation.

5.69 The Department of Health and Ageing agrees there is scope to improve the collection and provision of performance information for inclusion in annual reporting on the operation of the *Aged Care Act 1997* as required under Section 63-2 of the Act. The Department will undertake to provide additional information on areas where there is inequitable supply of CACPs in this report.

5.70 The Department is currently developing a new computer based system to centrally record and track aged care places, including the conditions of allocation attached to individual places. This new system is scheduled to be operational by the end of 2007–08.

5.71 Once readily accessible this information, which will include, for example, allocations for a particular special needs group in a planning region, will be provided to Aged Care Planning Advisory Committees to assist in making recommendations on the needs in each planning region.

5.72 The improved accessibility of this information will enhance the Department's capacity to review the ongoing suitability of existing conditions of allocation and will inform discussions with providers about them.

Ian McPhee
Auditor-General

Canberra ACT
23 May 2007

Appendices

Appendix 1: Extract from the *Aged Care Act 1997*

Division 2—Objects

2-1 The objects of this Act

(1) The objects of this Act are as follows:

(a) to provide for funding of aged care that takes account of:

(i) the quality of the care; and

(ii) the type of care and level of care provided; and

(iii) the need to ensure access to care that is affordable by, and appropriate to the needs of, people who require it; and

(iv) appropriate outcomes for recipients of the care; and

(v) accountability of the providers of the care for the funding and for the outcomes for recipients;

(b) to promote a high quality of care and accommodation for the recipients of aged care services that meets the needs of individuals;

(c) to protect the health and well-being of the recipients of aged care services;

(d) to ensure that aged care services are targeted towards the people with the greatest needs for those services;

(e) to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location;

(f) to provide respite for families, and others, who care for older people;

(g) to encourage diverse, flexible and responsive aged care services that:

(i) are appropriate to meet the needs of the recipients of those services and the carers of those recipients; and

(ii) facilitate the independence of, and choice available to, those recipients and carers;

(h) to help those recipients to enjoy the same rights as all other people in Australia;

(i) to plan effectively for the delivery of aged care services that:

(i) promote the targeting of services to areas of the greatest need and people with the greatest need; and

(ii) avoid duplication of those services; and

(iii) improve the integration of the planning and delivery of aged care services with the planning and delivery of related health and community services;

(j) to promote ageing in place through the linking of care and support services to the places where older people prefer to live.

(2) In construing the objects, due regard must be had to:

(a) the limited resources available to support services and programs under this Act; and

(b) the need to consider equity and merit in accessing those resources.

Appendix 2: Aged Care Planning Advisory Committees (ACPACs)

Section 12-7 of the *Aged Care Act 1997* provides that the Secretary may establish Aged Care Planning Advisory Committees to provide advice about the distribution of places among Aged Care Planning Regions (ACPRs) within each State and Territory, based on comparative aged care needs across ACPRs, including consideration of people from the prescribed special needs groups.

ACPAC members in each State and Territory are appointed by the Secretary and comprise people from government and the community with experience and/or interest in aged care. Members are not appointed to represent a particular body or group. They are chosen because of their ability to contribute to the planning of aged care and to give effective advice to the Secretary.[85]

The *Allocation Principles 1997* set out detail about the roles of ACPACs. The committees are required to operate by taking into account Government policy and planning objectives (4.16(3)). Division 4 'Giving advice to the Secretary', provides that in giving advice to the Secretary, ACPACs must 'assess, and report to the Secretary on, the extent and priority of need among the regions [in the State/Territory]' (4.15(1)). In advising the Secretary, committees must take into account:

(a) the planning objectives

(b) the findings of any relevant working party;

(c) demographic and other statistical data on the balance of care in each region;

(d) relevant information obtained by the committees from local and regional sources (4.15(2)).

If the Secretary requests advice from a committee about the making of determinations under s12-5 of the Act (with regard to stated groups of people such as those in the special needs groups and people needing particular levels of care), the committees must

(a) identify community needs, including the needs of particular groups nominated by the committee;

(b) rank the identified needs in priority order;

[85] More information on the function, membership and operational parameters of ACPACs can be found in Part 4 of the Allocation Principles, within the *Aged Care Principles*.

(c) consider the types of care that should be provided in particular regions;

(d) consider the most appropriate proportion of places for the different groups of people mentioned in subsection 12-5(1) of the Act (4.16(2)).

DoHA's CACPs Program Guidelines state that, when providing advice in relation to distributing CACPs in a State or Territory, ACPACs utilise demographic data on relative community needs and seek advice from relevant service provider and consumer advisory networks.

Additional factors meant to be taken into account when distributing CACPs include:

(a) areas where aged care homes are considered to be inappropriate for meeting local needs (for example, some Aboriginal and Torres Strait Islander communities);

(b) areas where aged care homes would be difficult to establish or sustain (for example, inner city areas where land costs are prohibitive, or rural and remote communities with small populations); and

(c) areas that do not have an adequate level of existing community aged care alternatives.

Appendix 3: DoHA's response

The Department welcomes the audit findings and will develop a program of work to meet the objectives identified in the response to the audit recommendations, noting that some aspects will involve a stepped process over several years. Funding provided though the Securing the Future of Aged Care for Australians measure will provide resources to improve monitoring of service provider performance as part of a broader quality initiative. The Department will develop better practice guidelines and improve consistency in the practices of its State and Territory Offices and has already commenced action to address particular issues, including clearer Aged Care Approvals Round documentation and guidelines for the process of assessing applications. The Department is working with state and territory governments, through the 2006 Council of Australian Governments initiative to improve the Aged Care Assessment Program including the implementation of a national training strategy for Aged Care Assessment Teams. The Department will undertake to provide additional information in annual reporting on the operation of the *Aged Care Act 1997*, as required under Section 63-2 of the Act.

Appendix 4: DVA's response

The Veterans' Home Care (VHC) program is a Department of Veterans' Affairs (DVA) program to help eligible veterans and war widows/widowers with low-level needs remain living independently in their homes for longer.

The VHC program is not designed to meet the needs of veterans or war widows/widowers with complex or high-level needs. If such cases are identified by the VHC assessment agency they are referred to more appropriate programs of care, such as the Community Aged Care Packages (CACP) program. VHC is not designed to replicate or replace CACPs or to provide any duplication of services.

Whilst the Department of Health and Ageing (DoHA) does not have guidelines to address the boundary between the CACP and VHC programs, the VHC program Guidelines (Section 5.9) do specifically address this boundary. As a CACP provides higher levels of service, a veteran receiving a CACP is unlikely to require extra services from VHC.

The VHC Guidelines state that 'the veteran's CACP case manager should be consulted prior to allocating any service to ensure a coordinated and holistic management of the veteran's care is maintained and that no duplication of services occur.' The VHC Guidelines do not permit VHC providing the same services as another program (so that a client should not get, for example, house cleaning through both VHC and a CACP).

DVA expects that where a person is receiving a CACP, the package will be the primary source of all the person's care needs and that all services covered by that package are supplied by the CACP service provider. DVA may assist, where appropriate, with community nursing, the provision of Rehabilitation Appliance Program items or respite service.

The VHC Guidelines require that 'protocols are established with local Home and Community Care (HACC) assessors so that complex cases can be managed in a way that provides the best outcome for the veteran involved and allows for the allocation of CACPs to be distributed in a fair and equitable way across the whole community.'

The VHC program is well regarded and has been enormously successful since it was established in 2001, with over 149,000 veterans having been assessed for services. However, VHC clients are ageing and becoming frailer and increasingly requiring higher levels of service and additional services not

currently available. The program is not designed to cater to these higher level needs in the longer term. There are also an increasing number of war widows entering the program who have different needs who are requesting services outside those currently provided.

To address these issues, DVA is conducting an independent review of the VHC program which commenced in March 2007. The review is primarily focusing on examining the VHC model and policies in order to identify any necessary adjustments to enable the program to respond to the changing needs into the future. The findings will assist DVA in ensuring that the VHC program reflects the changing needs of veterans, war widows/widowers and carers.

DVA welcomes the recommendation by the ANAO for DoHA to promulgate guidelines for its CACP Program to ensure a consistent approach to veterans as a special needs group in their access to CACPs. The introduction of clear guidelines in this area will significantly assist in the understanding by CACPs managers and providers of how the VHC program should interact with the CACP program to the benefit of veterans.

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