The Auditor-General
ANAO Report No.53 2016–17
Performance Audit

# Indigenous Aged Care

## Department of Health

## Australian Aged Care Quality Agency

Australian National Audit Office

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Australian National Audit Office

Canberra ACT

31 May 2017

Dear Mr President
Dear Mr Speaker

The Australian National Audit Office has undertaken an independent performance audit in the Department of Health and the Australian Aged Care Quality Agency titled *Indigenous Aged Care.* The audit was conducted in accordance with the authority contained in the *Auditor-General Act 1997*. I present the report of this audit to the Parliament.

Following its presentation and receipt, the report will be placed on the Australian National Audit Office's website—http://www.anao.gov.au.

Yours sincerely

Rona Mellor PSM
Acting 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 (ANAO). The ANAO assists the Auditor-General to carry out his duties under the *Auditor-General Act 1997* to undertake performance audits, financial statement audits and assurance reviews of Commonwealth public sector bodies and to provide independent reports and advice for the Parliament, the Australian Government and the community. The aim is to improve Commonwealth public sector administration and accountability.

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# Summary and recommendations

## Background

1. The Australian Government provided $15.2 billion in funding to the aged care sector in 2014–15 and $16.2 billion in 2015–16. Aged Care services were delivered to 35 083 Aboriginal and Torres Strait Islander people in 2014–15 at an estimated cost of $216 million[1] (approximately 1.4 per cent of the total aged care budget).[2]

2. Health conditions associated with ageing often affect Aboriginal and Torres Strait Islander people earlier than other Australians.[3] This is reflected in the Australian Government policy to provide Aboriginal and Torres Strait Islander people access to aged care services from 50 years old, in comparison to 65 years old for the broader population. Aboriginal and Torres Strait Islander people are also designated as a special needs group under the *Aged Care Act 1997* and all aged care service providers must have regard to the particular physical, physiological, social, spiritual, environmental and other health related care needs of individual recipients.[4]

3. The Australian Government funds aged care services to assist frail older people, and the carers of frail older people, to remain living at home as well as residential aged care services. The programs funded include:

- the Commonwealth Home Support Program, which provides entry-level home support for older people who need assistance to keep living independently;
- the Home Care Packages Program, which provides services tailored to meet individuals' specific care needs including care services, support services, clinical services and other services to support older people to remain living at home and connected to their communities; and
- residential aged care, which provides supported accommodation services for older people who are unable to continue living independently in their own homes.

4. Aboriginal and Torres Strait Islander people also have access to aged care services funded through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (Flexible Program). In 2015–16 funding for the Flexible Program was approximately $37 million, based on agreed funded places rather than occupancy. The Flexible Program aims to provide aged care services that meet the specific needs of Aboriginal and Torres Strait Islander people in a culturally appropriate setting, close to home and community. The majority of Flexible Program services are delivered in regional, remote and very remote locations.[5]

1 Consists of claim payments to aged care recipients that have self-identified as Aboriginal and Torres Strait Islander.

2 At the time of the audit, data was not available for the Commonwealth Home Support Program.

3 Australian Institute of Health and Welfare 2011. *The health and welfare of Australia's Aboriginal and Torres Strait Islander people, an overview 2011*. Cat. no. IHW 42. Canberra: AIHW.

4 For programs not covered under the *Aged Care Act 1997*, including the Commonwealth Home Support Program, program manuals are aligned with these requirements.

5 In most cases during this audit, the Australian Bureau of Statistic's Australian Statistical Geography Standard has been used to define major city, inner regional, outer regional, remote and very remote service providers.

5. The Department of Health is responsible for leading the development of evidence based policy, determining the allocation of funding, and regulation of the Commonwealth aged care system to improve the wellbeing of older Australians as well as the implementation of the aged care reforms. The Australian Aged Care Quality Agency is responsible for assessing the quality of care of Australian Government funded aged care service providers. This is done through:

- the accreditation of residential aged care service providers;
- quality reviews of aged care provided to people living in their own homes or in the community; and
- education and training on quality aged care to the aged care sector.

### Audit objective and criteria

6. The objective of the audit was to assess the effectiveness of Australian Government-funded aged care services delivered to Aboriginal and Torres Strait Islander people. To form a conclusion against the audit objective, the ANAO adopted the following high level criteria:

- Is there an effective framework in place to support access by Aboriginal and Torres Strait Islander people to quality aged care services?
- Do the Department of Health and the Australian Aged Care Quality Agency have effective frameworks to oversee the delivery of aged care services to Aboriginal and Torres Strait Islander people?
- Does the Department of Health have appropriate arrangements in place for monitoring and reporting on the achievement of program objectives and supporting the cost effectiveness and service continuity of aged care delivery to Aboriginal and Torres Strait Islander people?

## Conclusion

7. Australian Government-funded aged care services are largely delivered effectively to Aboriginal and Torres Strait Islander people.

8. The ageing of Australia's population and growing diversity among older people, in terms of their care needs, preferences and socioeconomic status, are placing pressure on the depth and agility of Australia's aged care system. There are additional challenges in ensuring access to culturally appropriate care and service continuity for Aboriginal and Torres Strait Islander people, particularly for those living in remote and very remote communities. Some Aboriginal and Torres Strait Islander people may also have language or cultural preferences that influence their specific requirements.

9. The National Aboriginal and Torres Strait Islander Flexible Aged Care Program has been effective in increasing the access to culturally appropriate aged care services for elderly Indigenous Australians. The direct selection and recurrent funding approach of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program provides few opportunities for new service providers to enter the market. There would be benefit in the Department of Health extending the application process to new service providers and better aligning the funded places with service capacity.

10. The Department of Health has developed sufficient guidance materials and provides supplementary funding to support Indigenous-focused services that operate under the Commonwealth Home Support, Home Care Packages and residential programs. However, not all Indigenous-focused services are aware of the Department of Health's sector support programs.[6]

11. The Department of Health and the Australian Aged Care Quality Agency have been largely effective in their administration of Australian Government-funded aged care services delivered to Aboriginal and Torres Strait Islander people. Each entity has developed sound administrative arrangements to manage the delivery of aged care services and to review the quality of care delivered through aged care programs. The Department of Health can strengthen its administration by implementing a coordinated approach that ensures the timely sharing of relevant information to facilitate risk assessments across the Ageing and Aged Care Group.

12. Consistent with its policy intent, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program is a more cost effective and viable model for specialised aged care delivery to Indigenous Australians when services are located in remote and very remote communities. A 25.8 per cent share of National Aboriginal and Torres Strait Islander Flexible Aged Care Program funding is allocated to services located in major cities and inner regional areas. To optimise recurrent funding decisions, it is important the Department of Health ensures that the existing service providers, their location and number of places, remain the most appropriate.

13. Given that the majority of Aboriginal and Torres Strait Islander people access aged care through Commonwealth Home Support Program, Home Care Packages Program and residential aged care programs, further work is required by the Department of Health to maintain the service continuity of Indigenous-focused service providers in areas where there are no culturally secure alternatives. The Department of Health has an opportunity to leverage its datasets to improve the targeting of sector support initiatives to Indigenous-focused services and to monitor the ongoing impacts of aged care policies and programs on Aboriginal and Torres Strait Islander people.

## Supporting findings

### Access and use of aged care services by Aboriginal and Torres Strait Islander people

14. Aboriginal and Torres Strait Islander people were most likely to access aged care services through the Commonwealth Home Support Program or the Home Care Packages Program, at rates consistent with their share of the aged care population. Fewer than one per cent of residential aged care places were taken up by Aboriginal and Torres Strait Islander people.

15. The Department of Health has created clear and consistent pathways for individuals to access and progress through the aged care system. The My Aged Care Contact Centre and website are the main entry points to the aged care system. Aboriginal and Torres Strait Islander people are encouraged to connect with the My Aged Care Contact Centre, and can call directly or use a trusted representative to speak on their behalf. Following an initial screening

6 The Department of Health's sector support programs include the Service Development Assistance Panel, Rural Regional and Other Needs Building Fund, and viability and workforce supplements.

undertaken by Contact Centre staff, the Regional Assessment Service assesses older people's needs for lower intensity services available under the Commonwealth Home Support Program. Aged Care Assessment Teams assess the more complex needs of people requiring access to higher intensity care available under Home Care Packages, Transition Care, and within residential aged care.

16. A key challenge in targeting aged care services is assessing the eligibility of individuals seeking to access them as well as the scope of services. This can be particularly challenging in the context of facilitating access for individuals in remote or very remote areas, including Aboriginal and Torres Strait Islander people.

17. The Department of Health advised the ANAO that it is working with the aged care sector to identify opportunities to improve client pathways for diverse groups, including Aboriginal and Torres Strait Islander people, to address the specific difficulties they may experience.

18. The Department of Health manages the planning and allocation of aged care residential places and Home Care packages for service providers based on the national planning benchmark, population projections and the current level of service provision. The Commonwealth Home Support Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program are funded through a grants process.

19. Between 2012–13 and 2015–16 the number of Home Care Level 1–2 packages allocated to Indigenous-focused service providers has not grown at the same rate as those allocated to mainstream service providers. However, the growth in Home Care Level 3–4 package and residential place allocations to Indigenous-focused service providers have both been higher than for mainstream counterparts.

20. The distribution of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program funding has remained largely unchanged since its inception. This is largely due to the continuation of grant agreements to existing services that have been in place over the life of the program. These arrangements limit the potential for new providers to access the program.

21. The Department of Health has developed operational manuals and/or guidelines to support providers in the delivery and management of aged care services for the programs reviewed as part of the audit. The Department of Health also funds two peak bodies to develop additional resources to assist with managing the change introduced by aged care reforms (including resources targeted towards remote and very remote Indigenous-focused service providers).

22. The Department of Health funds a Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel (SDAP) to support aged care providers. ANAO consultations with Indigenous-focussed service providers indicated that awareness of SDAP funding varied across states and territories. There would be benefit in the Department of Health raising the awareness of this assistance in a consistent manner across jurisdictions, and measuring the financial management and governance capacity that has been built and maintained among service providers as a result of having received the funding.

## Administration and regulation of aged care services

23. The Department of Health has internal governance committees, templates and guidance to coordinate program administration. Health's state and territory offices have also adopted various local strategies for engaging with Indigenous-focused service providers. The department has commenced work to strengthen relationships between its National Office and its state and territory offices, to improve links between policy development and program implementation, while still allowing for specific approaches within each jurisdiction.

24. The Department of Health has developed an Enterprise Risk Management Plan that is updated annually as part of the department's business planning processes. Each of the programs reviewed as part of the audit included risk management (identification, analysis and evaluation) in its business processes. Risk is considered against the type of activity being funded and may result in different risk ratings being given to the same organisation across each activity or program being funded. For service providers that are funded under multiple programs, there is an opportunity for Health to implement a more coordinated approach that facilitates the timely sharing of relevant information across program areas.

25. The Australian Aged Care Quality Agency has developed policies, procedures and guidance materials to support the accreditation of residential aged care service providers, and specific policies for the quality review of Home Care Packages, Commonwealth Home Support Program and National Aboriginal and Torres Strait Islander Flexible Aged Care Program service providers. Documents reviewed by the ANAO demonstrate that the relevant accreditation and quality review procedures were followed internally.

26. The Australian Aged Care Quality Agency has collected information on assessments of all residential service providers against the accreditation standards. This information shows that between 2000-01 and 2015-16, 95 per cent of residential Indigenous-focused service providers had at least one episode of non-compliance, in comparison with 53 per cent of non-Indigenous-focused Residential service providers. Reported instances of non-compliance mostly related to governance, including regulatory compliance, risk management and human resources as opposed to issues relating to quality of care.

27. In 2014–15 the Australian Aged Care Quality Agency delivered 716 courses, seminars and compliance assistance training events to 10 638 participants from residential and Home Care service providers. Flexible service providers receive compliance assistance training as determined through a case management process. There would be benefit in the Australian Aged Care Quality Agency expanding the proposed cost recovery model to include the indirect and direct costs recovered from courses and workshops to be consistent with the Australian Government's stated policy intention, as well as the Australian Government Cost Recovery Guidelines.

## Performance monitoring and reporting

28. The Department of Health does not monitor the access and use of Indigenous-focussed aged care services outside of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This reduces the Department of Health's capacity to accurately monitor and report on the degree to which its programs and internal activities are meeting the expenditure objectives for Aboriginal and Torres Strait Islander ageing and aged care.

29. The Department of Health administers a viability supplement aimed at ensuring the continuity of small, specialised and rural aged care services. The provision of the viability supplement to eligible Indigenous-focused approved providers under the Home Care and residential programs has been well targeted and effective in supporting service continuity. The targeting of viability supplements to residential and mixed services under the Flexible program could be improved by refocusing funding away from major city and inner regional services.

30. The Department of Health does not conduct regular analysis of whether the Flexible Program is meeting its objectives. There would be value in the department aggregating reporting data more effectively to inform the ongoing policy direction of the Flexible Program.

31. ANAO analysis indicates that consistent with its intent and design, the Flexible Program has improved access to culturally secure aged care for Aboriginal Torres Strait Islander people (as noted in Chapter 2). For residential aged care, the Flexible Program is also a more cost effective and viable model for service delivery in remote and very remote locations. However, the majority of Flexible Program recurrent funding for residential aged care is allocated to services located in major cities and inner regional areas.

## Recommendations

**Recommendation No.1**
**Paragraph 2.43**

The Department of Health:

(a) provide an opportunity for eligible existing Indigenous-focused aged care service providers, which are not currently funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, to access the available funding under this scheme; and

(b) apply a consistent assessment process to ensure that places allocated through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program align with service provider capacity and are targeted to those service providers who will generate the greatest community benefit.

**Department of Health response**: *Agreed with qualification.*

**Recommendation No.2**
**Paragraph 3.12**

The Department of Health implement a coordinated approach to risk management for providers who receive multiple sources of program funding, which combines the assessments and ratings from different program areas and is centrally located.

**Department of Health response**: *Agreed.*

**Recommendation No.3**
**Paragraph 4.13**

The Department of Health monitor the number of:

(a) Aboriginal and Torres Strait Islander people accessing Commonwealth funded aged care services; and

(b) Service providers that deliver aged care services to a significant number of Aboriginal and Torres Strait Islander people.

**Department of Health response**: *Agreed.*

**Recommendation No. 4**
**Paragraph 4.50**

To ensure that the funding provided through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program is appropriately targeted to services that will benefit most from the program's design and intent, the Department of Health:

(a) regularly review the ongoing needs of the communities serviced by culturally secure service providers;

(b) develop performance indicators capable of measuring the achievement of cost effectiveness and viability objectives; and

(c) identify and communicate available sector support and pathways for service providers to enter and exit the program.

**Department of Health response**: *Agreed.*

## Summary of entity responses

32. The Department of Health's summary response to the report is provided below. Full responses by the Department of Health and the Australian Aged Care Quality Agency are provided at Appendix 1.

> I am pleased that the ANAO found the Australian Government-funded aged care services are largely delivered effectively to Aboriginal and Torres Strait Islander people, and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (Flexible Program) has been effective in increasing access to culturally appropriate aged care services for elderly Indigenous Australians. The report has identified areas for potential improvement, particularly with regard to re-establishing appropriate allocation and targeting of Flexible Program funding, risk management approaches and monitoring access to aged care services for Aboriginal and Torres Strait Islander people.

# Audit Findings

# 1. Background

## Introduction

1.1 The Australian Government provided $15.2 billion in funding to the aged care sector in 2014–15 and $16.2 billion in 2015–16. This figure includes all aged care expenditure by the Australian Government on all aged care programs under and outside the *Aged Care Act 1997* (the Act). An estimated $216 million (approximately 1.4 per cent) can be attributed to the delivery of services to Aboriginal and Torres Strait Islander people. Demand for aged care services is expected to increase over the coming decades, with the Australian Bureau of Statistics projecting the number of Australians aged over 65 to double from 2012 to 2040.

1.2 Health conditions associated with ageing often affect Aboriginal and Torres Strait Islander people earlier than other Australians. This is reflected in the Australian Government policy to provide Aboriginal and Torres Strait Islander people access to aged care services from 50 years old, in comparison to 65 years old for the broader population. Aboriginal and Torres Strait Islander people are also designated as a special needs group under the Act and all aged care service providers must have regard to the particular physical, physiological, social, spiritual, environmental and other health related care needs of individual recipients.

## Administrative responsibilities for Australian Government-funded aged care programs

1.3 The Australian Government funds aged care services to assist older people and their carers. The programs funded include:

- the Commonwealth Home Support Program, which provides entry-level home support for older people who need assistance to keep living independently;
- the Home Care Packages Program, which provides services tailored to meet individuals' specific care needs including care services, support services, clinical services and other services to support older people to remain living at home and connected to their communities[7]; and
- residential aged care, which provides supported accommodation services for older people who are unable to continue living independently in their own homes.

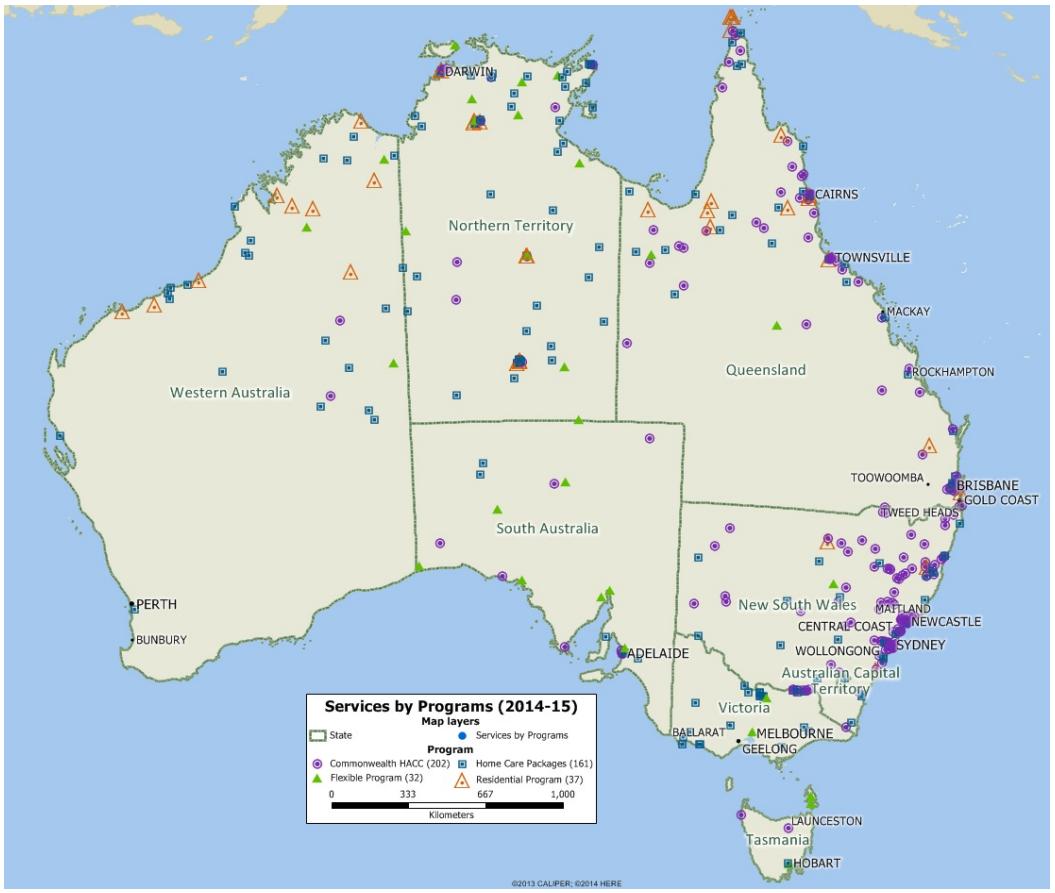
1.4 Aboriginal and Torres Strait Islander people may also access the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (Flexible Program[8]) service providers. Annual funding for the Flexible Program in 2015–16 was approximately $37 million, based on agreed funded places rather than occupancy. The Flexible Program aims to provide aged care services that meet the specific needs of Aboriginal and Torres Strait Islander people aged 50 years and older in a culturally appropriate setting, close to home and community. The majority of Flexible Program service providers (28 out of 32) are located in regional, remote and very remote

7 The Home Care Packages Program provides four levels of services. Level 1-2 (support for people with basic and low level care needs) and Level 3-4 (support for people with intermediate and high level care needs).

8 This term is used throughout the report to refer to only the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

locations. Figure 1.1 shows the location of service providers with 30 per cent or more care recipients who have identified as Aboriginal and Torres Strait Islander.

**Figure 1.1: Location of Indigenous-focused aged care programs**




Note: The map does not include Home and Community Care services provided in Victoria or Western Australia. The Home and Community Care Program services outside of these states were transitioned to the Commonwealth Home Support Program from 1 July 2015.

Source: ANAO from Department of Health data.

## Department of Health

1.5 The Commonwealth Department of Health's (Health's) Ageing and Aged Care Group and Health State Network lead the development of policy, allocation of funding, and the co-regulation of the Commonwealth aged care system to improve wellbeing for older Australians. Health is also tasked with implementing aged care reforms, including in relation to Indigenous aged care.

1.6 The Ageing and Aged Care Group comprises three divisions including the Ageing and Aged Care Services Division, the Aged Care Policy and Regulation Division and the Aged Care Access and Quality Division. The Ageing and Aged Care Services Division's purpose is to deliver effective programs that provide services to older Australians either at home or in a residential setting. This

includes the delivery of the Commonwealth Home Support Program, residential aged care and Flexible Programs. The other two divisions have responsibility for the implementation of reforms, access pathways to aged care services, management and reform of the Home Care Packages Program and for the quality and regulation of aged care services under the Act.

### Australian Aged Care Quality Agency

1.7 The Australian Aged Care Quality Agency (the Quality Agency) undertakes accreditation and assessment of Australian Government-funded aged care service providers. The Quality Agency also provides education and training to the aged care sector.

1.8 In 2014–15 the Quality Agency received Australian Government funding of $24.7 million, and generated revenue of $21.7 million. During that year, the Quality Agency audited 1 425 residential aged care facilities, commenced its quality review program of aged care in the community, and provided education and training to 10 636 participants. At 30 June 2015, the Quality Agency had 266 total full time equivalent staff to complete its functions, 121 of which were assessors who undertake accreditation activities, and 28 quality reviewer staff.

1.9 The Quality Agency assesses the quality of care of service providers against three different standards:

- residential aged care service providers undergo a re-accreditation audit, usually every three years[9], and are assessed each year on their compliance with the standards;
- Home Care and Commonwealth Home Support Program service providers undergo quality reviews every three years to assess their compliance with the Home Care Standards; and
- Flexible Program service providers undergo quality reviews every two years and assessment contacts in alternate years to assess their compliance with the National Aboriginal and Torres Strait Islander Flexible Program Quality Standards (Flexible Standards).

1.10 Each standard has different processes and requirements. While all standards cover governance systems and health care quality, residential aged care service providers comply with additional requirements related to resident lifestyle and physical environment. Residential service providers must comply with four requirements comprising 44 expected outcomes.[10] Home Care and Commonwealth Home Support Program service providers must comply with three requirements comprising 18 expected outcomes. Flexible Program service providers must comply with two requirements comprised of nine expected outcomes.

## Aged care reforms

1.11 The Productivity Commission's 2011 Inquiry Report, *Caring for Older Australians*, recommended fundamental changes to the aged care system. In 2012, an aged care reform

9 The period of accreditation is determined by the Quality Agency's CEO based on a performance assessment against the standards during a re- accreditation site audit. The period of accreditation is generally three years but may be varied or revoked depending on performance.

10 The term 'expected outcomes' is prescribed in the *Quality Agency Principles 2014.* The Quality Agency describes an expected outcome as a statement of expected performance that does not prescribe a standardised process for demonstrating quality.

package was announced, and Health was allocated $3.7 billion over five years to reform the system.

1.12 Since 2012, a number of changes to the aged care system have been introduced. This includes:

- establishing and expanding the My Aged Care website and Contact Centre as the national gateway for clients to: receive information about and be assessed for aged care; and find Australian Government-funded aged care services in their local area;
- consolidating existing entry level support for people to remain at home through the Commonwealth Home Support Program[11];
- transferring the complaints power of the Secretary of the Department of Health to the newly established Aged Care Complaints Commissioner;
- transitioning Home Care Packages to the Consumer Directed Care model;
- changes to user contribution arrangements; and
- increasing the target ratio for the number of aged care places per 1 000 people over 70 years of age while also shifting the emphasis towards providing more flexible places and Home Care packages.

1.13 The current phase of implementation includes an independent review of the reforms during 2016–17. The review will examine the operation of legislative amendments implemented during the reforms, and will include public consultation. Over the next few years Health is planning further changes, including:

- changing the funding model for the delivery of Home Care packages so that funding follows the client;
- reforming some funding programs; and
- establishing a single quality framework for all aged care services.

## Audit approach

1.14 The objective of the audit was to assess the effectiveness of Australian Government-funded aged care services delivered to Aboriginal and Torres Strait Islander people.

1.15 To form a conclusion against the audit objective, the ANAO adopted the following high level criteria:

- Is there an effective framework in place to support access by Aboriginal and Torres Strait Islander people to quality aged care services?

11 Since the reforms were announced four existing entry-level programs were consolidated into the Commonwealth Home Support Program in all states except Western Australia (WA), where the WA Home and Community Care program continues to be joint funded by the Commonwealth and Western Australian governments. On 1 February 2017, the Minister for Aged Care, the Hon Ken Wyatt AM, MP, announced that the Commonwealth would assume full funding, policy and operational responsibility for WA HACC services from 1 July 2018.

- Do the Department of Health and the Australian Aged Care Quality Agency have effective frameworks to oversee the delivery of aged care services to Aboriginal and Torres Strait Islander people?
- Does the Department of Health have appropriate arrangements in place for monitoring and reporting on the achievement of program objectives and supporting the cost effectiveness and service continuity of aged care delivery to Aboriginal and Torres Strait Islander people?

1.16 The audit examined service providers which the ANAO assessed as having 30 per cent or more of care recipients who identified as Aboriginal and Torres Strait Islander. The ANAO adopted this definition as a proxy measure for service providers that can be considered as 'culturally secure' or 'Indigenous-focused' in their aged care delivery to Aboriginal and Torres Strait Islander people. In 2014–15 this included 432 service providers out of a total of 7 968 in the sector. The ANAO reviewed the documentation for 117 of these service providers against the audit criteria, and interviewed 42 service providers from the sample. The audit methodology also included an analysis of the activities of Health and the Quality Agency, interviews with Department of Health staff in national and regional offices, and stakeholder consultation through interviews and written submissions.

1.17 The audit did not examine: the Aged Care Financing Authority, complaints handling processes through the Aged Care Complaints Commissioner, Aged Care Funding Instrument; payments made through the Department of Human Services to aged care providers; aged care programs related to carers (with the exception of a component of the Commonwealth Home Support Program which delivers planned respite services to carers); and aged care services delivered in collaboration with the state and territory governments.

1.18 The audit was conducted in accordance with the ANAO's Auditing Standards at a cost to the ANAO of approximately $653 596.

1.19 The team members for this audit were Corinne Horton, Emily Arthur, Helen Frost, Jarrad Hamilton, Nazia Nur and Fiona Knight.

# 2. Access and use of aged care services by Aboriginal and Torres Strait Islander people

**Areas examined**

This chapter examines whether the Department of Health has effective processes in place to support access by Aboriginal and Torres Strait Islander people to aged care services.

**Conclusion**

The ageing of Australia's population and growing diversity among older people, in terms of their care needs, preferences and socioeconomic status, are placing pressure on the depth and agility of Australia's aged care system. There are additional challenges in ensuring access to culturally appropriate care and service continuity for Aboriginal and Torres Strait Islander people, particularly for those living in remote and very remote communities. Some Aboriginal and Torres Strait Islander people may also have language or cultural preferences that influence their specific requirements.

The National Aboriginal and Torres Strait Islander Flexible Aged Care Program has been effective in increasing the access to culturally appropriate aged care services for elderly Indigenous Australians. The direct selection and recurrent funding approach of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program provides few opportunities for new service providers to enter the market. There would be benefit in the Department of Health extending the application process to new service providers and better aligning the funded places with service capacity.

The Department of Health has developed sufficient guidance materials and provides supplementary funding to support Indigenous-focused services that operate under the Commonwealth Home Support, Home Care Packages and residential programs. However, not all Indigenous-focused services are aware of the Department of Health's sector support programs.[a]

**Areas for improvement**

The ANAO made one recommendation aimed at improving the Department of Health's processes for the allocation and funding of places under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

The ANAO also suggested there would also be benefit in the Department of Health raising awareness of the workforce capacity building assistance available to services.

Note a: The Department of Health's sector support programs include the Service Development Assistance Panel, Rural Regional and Other Needs Building Fund, and viability and workforce supplements.

## What aged care services are used by Aboriginal and Torres Strait Islander people?

Aboriginal and Torres Strait Islander people were most likely to access aged care services through the Commonwealth Home Support Program or the Home Care Packages Program, at rates consistent with their share of the aged care population. Fewer than one per cent of residential aged care places were taken up by Aboriginal and Torres Strait Islander people.

2.1 In the financial year 2014–15, 34 283 people that identified as Aboriginal and Torres Strait Islander accessed aged care through the residential programs (2 279), Home Care (2 214) and Home and Community Care (29 552) programs. The Flexible Program delivered services to 800 Aboriginal and Torres Strait people.[12] Health analysis indicates that Aboriginal and Torres Strait Islander people comprise around 3.4 per cent of the total aged care target population. Over the period from 2012–13 to 2014–15, the share of Aboriginal and Torres Strait Islander people accessing aged care has progressively increased from 2.4 per cent to 2.7 per cent. Table 2.1 outlines the number of distinct self–identified Aboriginal and Torres Strait Islander aged care recipients by program.

**Table 2.1: Aboriginal and Torres Strait Islander aged care usage by program**

| Program | 2014–15 | | 2015–16 | |
|---|---|---|---|---|
| | Aboriginal and Torres Strait Islander recipients | % of total recipients | Aboriginal and Torres Strait Islander recipients | % of total recipients |
| Residential | 2 279 | 0.9 | 2 423 | 0.9 |
| Home Care | 2 214 | 3.6 | 2 100 | 3.7 |
| Home and Community Care[a] | 29 552 | 3.1 | n/a[b] | n/a |
| Flexible Program | 800 | 100 | 820 | 100 |

Note b: Does not include state-based Home and Community Care services provided in Victoria or Western Australia.

Note c: Data collection for the Commonwealth Home Support Program (formerly Home and Community Care) commenced on 1 November 2015 to 30 June 2016. This data is currently not available. In 2016–17 a full set of CHSP client data will be available.

Source: ANAO analysis of Health data.

2.2 In 2015–16, the majority (55 per cent) of residential places and Home Care packages in remote and very remote locations were accessed by Aboriginal and Torres Strait Islander people. Aboriginal and Torres Strait Islander people were more likely to access residential aged care facilities in a major city and Home Care services in inner regional and very remote areas of Australia. Table 2.2 shows the location of services used by Aboriginal and Torres Strait Islander people.

12 In 2015–16, Health allocated to fund 820 places to service providers through the Flexible Program. Places can be occupied by more than one person during the year. Places can also be unoccupied throughout the year.

**Table 2.2: Location of services used by Aboriginal and Torres Strait Islander aged care recipients in 2015–16**

| Location | Number of places - Home Care | Number of places - Residential |
|---|---|---|
| Major Cities of Australia | 490 | 731 |
| Inner Regional Australia | 505 | 512 |
| Outer Regional Australia | 430 | 646 |
| Remote Australia | 240 | 380 |
| Very Remote Australia | 434 | 154 |
| **Total**[a] | **2 100** | **2 423** |

Note a: Totals do not sum due to rounding. Not all individuals accessing services have declared whether they identify as Aboriginal or Torres Strait Islander. The number of places being accessed by Aboriginal and Torres Strait Islander people are estimated based on proportions of individuals who have declared their status applied to the total number of places.

Source: ANAO analysis of Health data.

2.3 The majority (61 per cent) of Aboriginal and Torres Strait Islander people who access Home Care services do so from Indigenous-focused providers. By contrast, the majority (78 per cent) of Aboriginal and Torres Strait Islanders who access residential services do so from a mainstream provider. This is because there are no Indigenous-focused residential aged care services in any of the major cities across Australia (outside of the Flexible Program).

## Service providers

2.4 The ANAO identified that of the of 7 968 aged care service providers in 2015–16, 2 866 had delivered either Home and Community Care, Home Care or residential services to Aboriginal and Torres Strait Islander people. Of the 2 866, there were 400 service providers for which 30 per cent or more of their clients identified as Aboriginal and Torres Strait Islander. As shown in Table 2.3, the majority of Home Care and residential organisations (89 per cent) that specialised in delivering services to Aboriginal and Torres Strait Islander people were from the not-for-profit or government sector.

**Table 2.3: Types of Indigenous-focused services providers**

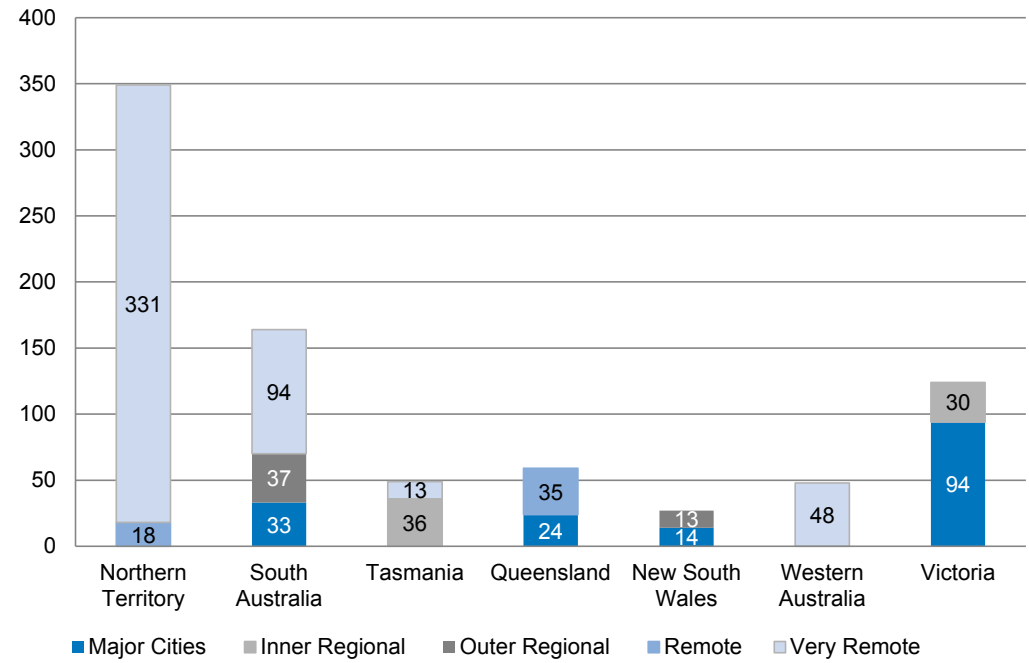
| Organisation type | Home Care | Residential |
|---|---|---|
| Community Based | 58 | 16 |
| Local Government | 39 | 1 |
| Private Incorporated Body | 12 | 9 |
| State Government | 13 | 3 |
| Charitable | 11 | 0 |
| Religious | 17 | 8 |
| **Total** | **150** | **37** |

Source: ANAO analysis of Health data.

## Flexible Program providers

2.5 In 2015–16, the Australian Government funded 32 Flexible Program service providers to deliver 820 aged care places to Aboriginal and Torres Strait Islander people. A further 30 places are proposed to be allocated to a new Flexible Program aged care service in Nhulunbuy in the Northern Territory in early 2018. The majority of Flexible Program service providers are located in remote and very remote locations (65 per cent). The Northern Territory has the highest share (43 per cent) of places of any state or territory. Figure 2.1 displays the allocation of Flexible Program places by state/territory and remoteness location.

**Figure 2.1: Allocation of Flexible Program places by state/territory and location**




Source: ANAO analysis of Health data.

## Are Aboriginal and Torres Strait Islander people assisted to access culturally appropriate aged care services?

The Department of Health has created clear and consistent pathways for individuals to access and progress through the aged care system. The My Aged Care Contact Centre and website are the main entry points to the aged care system. Aboriginal and Torres Strait Islander people are encouraged to connect with the My Aged Care Contact Centre, and can call directly or use a trusted representative to speak on their behalf. Following an initial screening undertaken by Contact Centre staff, the Regional Assessment Service assesses older people's needs for lower intensity services available under the Commonwealth Home Support Program. Aged Care Assessment Teams assess the more complex needs of people requiring access to higher intensity care available under Home Care Packages, Transition Care, and within residential aged care.

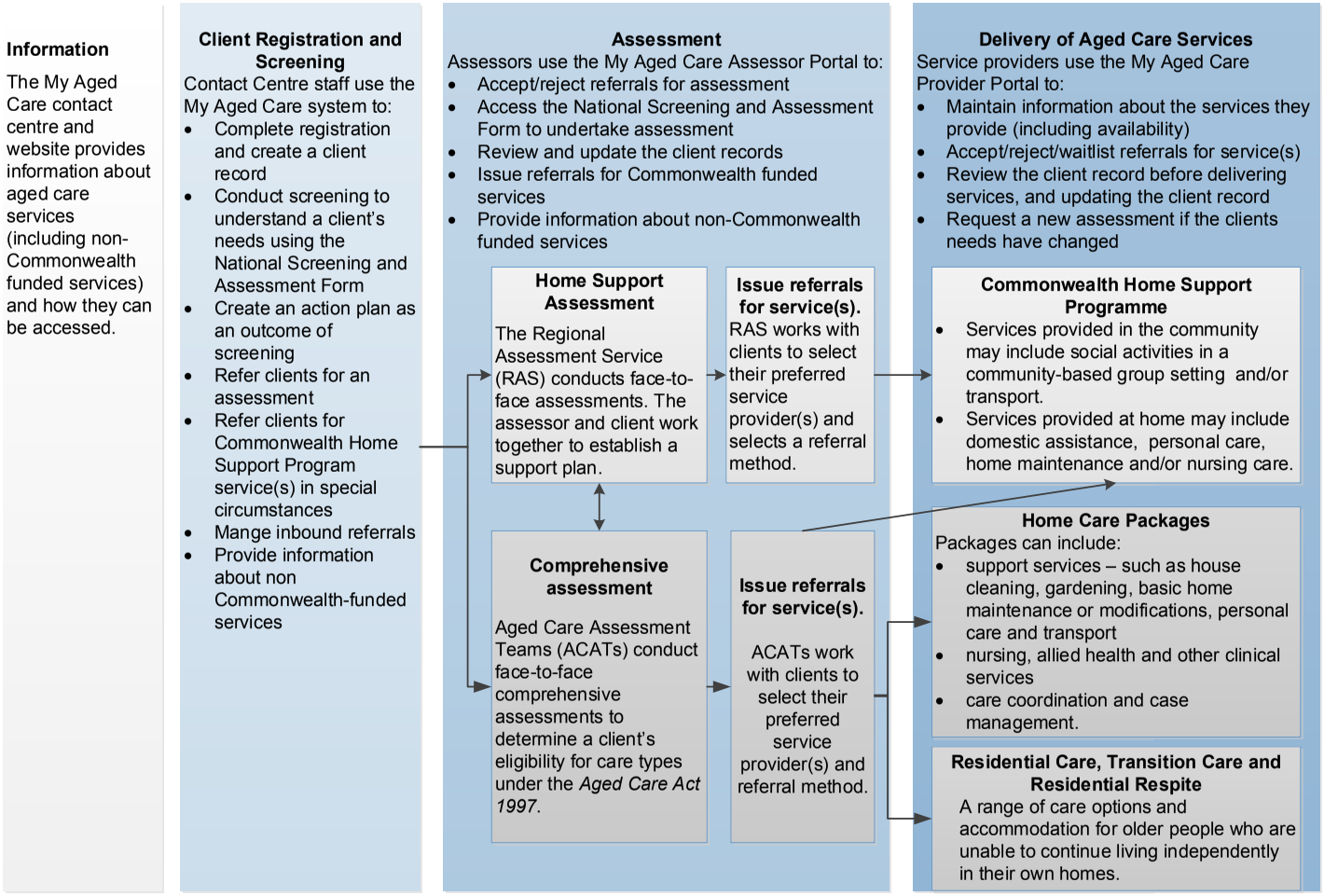
A key challenge in targeting aged care services is assessing the eligibility of individuals seeking to access them as well as the scope of services. This can be particularly challenging in the context of facilitating access for individuals in remote or very remote areas, including Aboriginal and Torres Strait Islander people.

The Department of Health advised the ANAO that it is working with the aged care sector to identify opportunities to improve client pathways for diverse groups, including Aboriginal and Torres Strait Islander people, to address the specific difficulties they may experience.

2.6 One of the objectives of the *Aged Care Act 1997* (the Act) is to facilitate access to aged care services by those who need them, regardless of race, culture, language, gender, economic circumstance or geographic location. To ensure services are appropriate to the needs of all clients, the Act designates certain people as 'people with special needs'. Aboriginal and Torres Strait Islander people are one of the designated special needs groups. For programs not covered under the Act, including the Commonwealth Home Support Program, program manuals are aligned with these requirements.

2.7 Figure 2.2 provides an overview of the pathways for accessing aged care services.

**Figure 2.2: Pathways for accessing aged care services**




Source: ANAO adaptation of the Department of Health – My Aged Care Guidance for Providers.

## My Aged Care Gateway

2.8 As noted earlier, the My Aged Care website and Contact Centre are the national gateways for clients to: receive information about aged care; be assessed for aged care; and find Australian Government-funded aged care services in their local area. Aboriginal and Torres Strait Islander people accessing aged care services through the service providers funded by the Flexible Program are not required to register with the My Aged Care Contact Centre or go through the national screening and assessment process. The implementation of the My Aged Care Gateway facilitates clear and consistent pathways into, and through, the Commonwealth Home Support, Home Care Packages and Residential Programs for people that are confident with, or supported in, communicating their needs through the telephone or via the website.

2.9 Aboriginal and Torres Strait Islander people seeking aged care are encouraged to use the My Aged Care Contact Centre to discuss their aged care needs and how to access services in the region. Using the National Screening and Assessment Form, Contact Centre staff ask callers a broad and high-level set of questions. The answers provided are used as inputs to a referral tool that creates an action plan for either: a follow-up assessment to access the Commonwealth Home Support Program; or where an individual's aged care needs are more complex, a comprehensive assessment for access to the Home Care and Residential Programs. The relevant assessment services are responsible for carrying out the action plan and contacting individuals to set up appointments for the next assessment.

2.10 My Aged Care presents challenges for some Aboriginal and Torres Strait Islander people, particularly those living in remote and very remote areas. My Aged Care relies on people having access to communication technologies which are not always available or easily accessible to Aboriginal and Torres Strait Islander people. Unaffordable or unreliable internet service, unstable phone lines, poor mobile phone reception in rural and remote areas and insufficient call credit can limit access to the My Aged Care Contact Centre and website.

2.11 In planning for the implementation of the model, Health identified other barriers older Indigenous people may face in accessing aged care services through My Aged Care, including:

- not wanting to leave their community and their land to obtain information on aged care, receive an aged care assessment or make use of aged care services;
- preference for accessing Indigenous-focused services rather than non-Indigenous services;
- generally preferring intimate personal contact to be delivered by people of the same skin group and gender, reducing the number of suitable candidates that can undertake aged care assessments and deliver services; and
- difficulty understanding the language and terminology used to ask questions about their health status and cognitive functions.

2.12 Service providers advised the ANAO that My Aged Care processes did not allow sufficient time to create the trust and build rapport with Aboriginal individuals and communities necessary for the sensitive communication required to register, screen and assess their needs for aged care services. Service providers also noted that Aboriginal and Torres Strait Islander clients often provided incomplete or inaccurate answers as a result. Such responses reduce the effectiveness of

My Aged Care in directing individuals to receive services for the aged care program/s that best meet their needs.

2.13 Health developed a strategy which outlines the approach for removing or reducing barriers to support people with diverse needs (including Aboriginal and Torres Strait Islander people) accessing My Aged Care. The model includes provisions for people to connect with My Aged Care through:

- a trusted service (for example a service provider, outreach service, other government agency or health service); or
- a trusted person (for example a family member, friend, doctor or local community representative).

2.14 Health advised the ANAO that the department was working with the aged care sector through co-design workshops to identify opportunities to amend policies, processes and systems to improve the client pathway and engagement with assessors and providers. Specific issues being considered include referral practices; feedback loops/tracking clients; and the application of rules around representatives and privacy/consent.

2.15 Health advised the ANAO that trusted parties such as families, friends, service providers and other government agencies are options to operate as regional coordinators and facilitate aged care access in some remote communities. However, Health could not provide coordinators and their locations and none of the services providers consulted as part of the audit identified themselves as coordinators. Those service providers who assisted their Indigenous clients in using the My Aged Care and accessing assessments advised the ANAO that it was done through their own initiative and that they did not have the capacity or resources to navigate the My Aged Care system.

2.16 The proportion of clients registered in My Aged Care who identified as an Aboriginal and Torres Strait Islander has steadily increased from 1.3 per cent in July 2015 to 1.9 per cent in the first quarter of 2016–17.

## Aged Care Assessment Teams and the Regional Assessment Service

2.17 The Aged Care Assessment Program is administered by Health and is an arrangement between the Australian and state and territory governments to operate Aged Care Assessment Teams (ACATs) across Australia. ACATs conduct face-to-face comprehensive assessments to determine a client's eligibility for care types under the Act. Feedback provided to the ANAO through the audit was that the ACATs had been assessing the need for comprehensive aged care services for many years and have well established relationships with local communities and providers, especially those that service remote communities.

2.18 The Regional Assessment Service (RAS) commenced on 1 July 2015 as a national assessment workforce operating at a regional level in all states and territories (excluding Victoria and Western Australia).[13] In contrast to the ACATs, the RAS is a new service and is therefore is in

13 From 1 July 2015, the HACC program was consolidated into the Commonwealth Home and Community Care Program in all states and territories except Victoria and Western Australia, where HACC services continue to be delivered as a jointly funded Commonwealth-State program. The Australian Government and the Victorian and Western Australian Governments maintain bilateral agreements for that purpose.

the early stages of establishing strong relationships with relevant communities. Approximately $70 million previously allocated for assessment, case management and client care coordination under the Home and Community Care Program (HACC) was redirected to support the establishment of the RAS. At the time of the audit, there were 13 individually contracted RAS providers across 52 aged care planning regions. Current arrangements with RAS providers will expire on 30 June 2018.

2.19 Between 1 July 2015 and 30 December 2015 (the first 6 months of the RAS' operation), completed assessments were 50 per cent down on estimates, 22 per cent of referrals issued by the My Aged Care Contact Centre to a RAS contractor were rejected and 60 per cent of referrals from a RAS contractor were rejected by service providers. Health analysed RAS performance reports for the period July to December 2015 and identified that the performance of the RAS contractors was dependent on the actions of the My Aged Care Contact Centre, Aged Care Assessment Teams and Commonwealth Home Support Program providers. Almost half (44 per cent) of the rejected referrals were due to:

- clients being unaware they have been referred for an assessment (and rejecting an assessment when contacted by the RAS);
- incorrect client details recorded (preventing the RAS from contacting the client and completing the assessment and referral);
- clients not being eligible for Commonwealth Home Support Program services; and
- clients already receiving services (and rejecting an assessment when contacted by the RAS).

2.20 Health reviewed the referral process from the My Aged Care Contact Centre to the RAS and implemented an amended process, supported by refresher training for My Aged Care Contact Centre staff. In July 2016 Health revised and reduced the assessment volume estimates for the 2016–17 financial year based on the number of assessments completed in 2015–16. In the first three months of 2016–17 assessment volumes were significantly higher than the revised forecast due to the Victorian HACC Program transitioning to the Commonwealth Home Support Program.

2.21 The RAS providers consulted by the ANAO advised that they had received very low referrals to conduct assessments in remote communities, making face-to-face assessments financially unviable. Health advised that My Aged Care assessment and service referral processes may be further amended to accommodate the difficulties in traveling to remote destinations and are currently under discussion with key stakeholders. Health also commenced a program evaluation to improve the operation of the RAS in October 2016, which is expected to be completed in June 2017.

### Training and guidance for Contact Centre Staff and Regional Assessment Services

2.22 My Aged Care Contact Centre staff receive training on the history, the role of relationships, elders and kinship within Aboriginal and Torres Strait Islander culture and conversation techniques. The session also covers eligibility for services and barriers faced by Aboriginal and Torres Strait Islander people in accessing aged care services.

2.23 In addition to a compulsory Statement of Attainment, RAS assessors receive training which builds capability in recognising and providing appropriate services to people with cultural or other special needs. Health did not monitor how many RAS assessors completed the elective. The online training module expired in August 2016 and is currently being redeveloped. A revised elective is expected to be available for the My Aged Care National Assessment Workforce in early 2017. Health advised that it would monitor completion of the elective training from early 2017.

## Accessing Aged Care services

2.24 The decision to offer an eligible person a Home Care package, and the level at which the package is offered (within the scope of approval) is made by the service provider in partnership with the client. Service providers can also be allocated new packages and places to specifically meet aged care demand from Aboriginal and Torres Strait Islander people in the community. The Increasing Choice in Home Care reform, which commenced on 27 February 2017, is intended to make the aged care system more client driven, market based and streamlined.[14] Prior to this, the decision to offer an eligible person a home care package was based on the client being approved by an Aged Care Assessment Team and the provider having a place available to provide care at the approved level. Health did not monitor if a client took up approved care. It is therefore unclear whether packages allocated to Aboriginal and Torres Strait Islander people were taken up by the intended population group.

2.25 Health is in the process of implementing improvements to its allocation and monitoring of Home Care packages. For instance, Health's consultation paper for Increasing Choice, issued in September 2015, outlined the need for a national waiting list to allocate Home Care packages to clients, with the goal of allowing a more equitable and flexible distribution of Home Care packages based on the individual needs and circumstances of clients, regardless of where they live. To that end, the *Prioritised Home Care Recipients Principles 2016* were made on 23 September 2016.

2.26 As part of the reforms introduced from 27 February 2017, a national prioritisation queue will be introduced for the Home Care Packages Program, which will assign packages to clients who have been approved for Home Care and have advised of their interest in seeking this type of care. The queue will be managed through My Aged Care and will determine access to Home Care based on the client's assessed need, and the time that has elapsed since their care was approved.

2.27 Health advised the ANAO that it will introduce a performance monitoring strategy to closely examine the performance of the queue, including separate analyses of outcomes for groups including Aboriginal and Torres Strait Islander people.

14 For further information see Department of Health, 'Increasing Choice in Home Care' [Internet] 5 April 2017 <https://agedcare.health.gov.au/increasing-choice-in-home-care> [accessed 26 April 2017]

## Are processes in place for the planning and allocation of funding?

The Department of Health manages the planning and allocation of aged care residential places and Home Care packages for service providers based on the national planning benchmark, population projections and the current level of service provision. The Commonwealth Home Support Program and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program are funded through a grants process.

Between 2012–13 and 2015–16 the number of Home Care Level 1–2 packages allocated to Indigenous-focused service providers has not grown at the same rate as those allocated to mainstream service providers.[a] However, the growth in Home Care Level 3–4 package and residential place allocations to Indigenous-focused service providers have both been higher than for mainstream counterparts.

The distribution of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program funding has remained largely unchanged since its inception. This is largely due to the continuation of grant agreements to existing services that have been in place over the life of the program. These arrangements limit the potential for new providers to access the program.

Note a: The term mainstream is used to represent service providers that the ANAO assessed as having less than 30 per cent care recipients who identified as Aboriginal and Torres Strait Islander. As discussed at paragraph 1.16, service providers with 30 per cent or more care recipients identifying as Aboriginal and Torres Strait Islander has been used as a proxy measure for service providers that can be considered as 'culturally secure' or 'Indigenous-focused' in their aged care delivery to Aboriginal and Torres Strait Islander people.

### Home Care Packages Program and residential aged care

2.28 The process by which new (non-Flexible Program) residential places are allocated is through the Aged Care Approvals Round (ACAR). The broad objectives of the ACAR are to provide an open and clear planning process, and to identify and allocate places in a way that best meets the aged care needs of the community. Each year, new aged care places are made available for allocation in each state and territory, having regard to the national planning benchmark, population projections provided by the Australian Bureau of Statistics, and the current level of service provision.

2.29 Between 2012–13 and 2015–16, Health estimates that the self-identified Aboriginal and Torres Strait Islander aged care population cumulatively increased by 14.9 per cent, while the rest of the aged care population grew by 10.9 per cent. Over the same time period, the number of Home Care Level 1–2 packages allocated to Indigenous-focused service providers cumulatively increased by 3.2 per cent, whereas the number of allocated Home Care Level 1–2 packages to mainstream service providers increased by 7.2 per cent.

2.30 The majority of Indigenous-focused service providers consulted by the ANAO noted that the lack of growth in entry level Home Care packages allocated to them meant that clients were serviced through Commonwealth Home Care Program grant funding despite being assessed as having more complex health needs that are beyond the intended scope of the Program.

2.31 Allocations for higher level aged care packages have grown more for Indigenous-focused service providers relative to mainstream providers. In particular, the growth in allocated Home Care Level 3–4 packages across Indigenous-focused providers (51.4 per cent) has been higher than for mainstream providers (46.1 per cent). Likewise, the number of places allocated to Indigenous-

focused residential service providers increased by 6.2 per cent over 2012–13 to 2015–16 compared to 2.4 per cent for the rest of the population.[15]

2.32 Health advised that packages and places are allocated on the basis of which providers demonstrate the greatest capacity to meet the needs of the local community. Capital grants are also provided through each ACAR. Grants are only available where the majority of residents are from a range of special needs groups, one of which is Aboriginal and Torres Strait Islander people. These grants are highly competitive, with the outcomes published on Health's website after each ACAR. Feedback is also offered to all applicants to assist them to improve future applications.

2.33 Most Indigenous-focused service providers consulted by the ANAO expressed the view that places and packages for Aboriginal and Torres Strait Islander people are often allocated to mainstream providers in the region on the basis of application professionalism rather than a demonstrated cultural competence in delivering services to Aboriginal and Torres Strait Islander people. As recognised by Health in designing My Aged Care, Aboriginal and Torres Strait Islander people have a preference for accessing Indigenous-focused services rather than non-Indigenous services. Many service providers expressed concern that the inability to secure a Home Care package or residential place with an Indigenous-focused service provider could lead to Aboriginal and Torres Strait Islander people disengaging from the aged care system entirely or until their circumstances deteriorate.

### Flexible Program

2.34 The Flexible Program is a non-competitive grant program with a finite number of places that has been in operation since 1994. Funding is based on agreed funded places, and not the occupancy of these places. The funding amount is based on an agreed number of high care residential, low care residential and Home Care packages. The program's objectives are very broad and can range from a single aged care service (such as the delivery of chopped wood), to the regular delivery of services (such as meals and other supplies up to three times a day), to the provision of full time residential aged care services. Health advised the ANAO that the care provided under the Flexible Program must be based on assessed need of the care recipient and may include the provision of services that support people to be more independent at home and in the community, thereby enhancing their quality of life and/or preventing their inappropriate admission to long term residential aged care.

2.35 During each funding round (conducted yearly until 2013–14 and every two years since 2014–15), existing providers are invited to submit an application for recurrent funding. These applications are then subject to a desktop assessment by Health which is summarised into an Assessment Report. The June 2015 Assessment Report noted no concerns with the 28 service providers currently funded under the Flexible Program. It recommended that funding be provided over two years, comprising: $60.9 million over 2015–16 and 2016–17 for 26 organisations approved for two year grant agreements; and $1.2 million in 2015–16 for two organisations approved for four month and one year grant agreements respectively.

15 For Indigenous-focused service providers, the growth in allocated residential places between 2012–13 and 2015–16 is occurring off a very small base.

2.36 As part of the aged care reforms, $43.1 million was provided to expand the Flexible Program over five years from 2012–13. Health allocated 93 places, based on a 2008 in-principle agreement by the Health Minister to establish two new Flexible aged care services in the Northern Territory. Another 95 places were allocated to convert existing residential aged care services funded under the Act and 15 places to flexible service providers to ensure service continuity in a location that was at risk of aged care services being withdrawn. Health intends to run a further limited expansion funding round in 2017.

2.37 To determine the amount of funding to be allocated to each of the Flexible Program service providers, Health identified a base daily rate for each high and low care residential place and each Home Care package. As well as the base daily rate for the type of places allocated, additional supplements were also allocated where relevant. High care residential places receive more funding per place than low care residential places and Home Care packages. Table 2.4 shows the number of service providers, amount of recurrent funding and places allocated by state/territory.

**Table 2.4: Funded places and funding by state/territory in 2015–16**

| State | Service providers | 2015–16 Funding | Type of places | | | Total Places |
|---|---|---|---|---|---|---|
| | | | High care | Low Care | Home Care | |
| New South Wales | 2 | $760 090.50 | 1 | 12 | 14 | 27 |
| Western Australia | 2 | $2 876 496.48 | 36 | 4 | 8 | 48 |
| Tasmania | 3 | $735 616.08 | 0 | 0 | 49 | 49 |
| Queensland | 3 | $3 361 223.22 | 39 | 12 | 8 | 59 |
| Victoria | 2 | $4 033 162.62 | 40 | 15 | 69 | 124 |
| South Australia | 6 | $7 839 698.04 | 87 | 32 | 45 | 164 |
| Northern Territory | 14 | $13 344 589.08 | 93 | 89 | 167 | 349 |
| **Total** | **32** | **$ 32 950 876.02** | **296** | **164** | **360** | **820** |

Source: ANAO analysis of Health data.

### *Funded places*

2.38 The direct selection approach for recurrent funding rounds removes the opportunity for new providers to enter the Flexible Program, except in the event that a provider withdraws from the market or Health conducts an expansion round. During the most recent recurrent funding round assessment (July 2015) there was limited assessment made to determine if the funded places remained appropriate to meet the program objectives.

2.39 The ANAO identified instances where:

- providers had been allocated more high care and low care places than were available at their facilities; and
- a provider received funding under the Home Care Packages Program as well as Flexible Program funding to deliver services in one location (although the provider reported that they had not delivered Home Care funded through the Flexible Program).

2.40 Health advised the ANAO that the department monitors the levels and types of services being delivered by Flexible services through the six-monthly service activity reports (SARs).

2.41 If a service provider is funded for more places than it has the capacity to deliver or has not delivered over a number of years, the opportunity to allocate additional places to existing or new service providers is reduced. During the life of the Flexible Program, Health has, on a case by case basis, assessed and changed the number of allocated places or the type of program funding of services providers funded through the Flexible Program. In one example, Health funded an aged care needs assessment to determine the aged care needs in the region being serviced by a Flexible program funded service provider. As a result of the assessment, alternative services were established to meet the aged care needs of the region.

2.42 Four of the 32 Flexible Program services are located in major city areas and account for 21 per cent of the allocated places and 19 per cent of the funding. Health advised the ANAO that the service providers in major city areas were offered the opportunity to transition to the Flexible Program during the early stages of the program (mid 1990s). The current Program Guidelines outline that when selecting any new service, priority would be given to:

- those communities where demand for aged care services exceeds availability of services;
- locations that are assessed as being able to support and operate an aged care service to Aboriginal and Torres Strait Islander people; and
- remote and very remote locations.

## Recommendation No.1

2.43 The Department of Health:

(a) provide an opportunity for eligible existing Indigenous-focused aged care service providers, which are not currently funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, to access the available funding under this scheme; and

(b) apply a consistent assessment process to ensure that places allocated through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program align with service provider capacity and are targeted to those service providers who will generate the greatest community benefit.

**Entity response:** *Agreed with qualification.*

2.44 *The Department will brief the Government on the relevant opportunities for funding under the program.*

### Commonwealth Home Support Program

2.45 The Commonwealth Home Support Program commenced on 1 July 2015 and combined the Commonwealth Home and Community Care (HACC) Program; National Respite for Carers Program; Day Therapy Centres Program; and the Assistance with Care and Housing for the Aged Program. In July 2015, a desktop assessment was conducted by Health to identify the amount of funding that would be offered through a direct selection process to existing providers. Service providers were initially offered transition funding between 1 July 2015 and 31 October 2015. Organisations are

required to deliver activity outputs across four sub programs from 1 November 2015 until 30 June 2018. In 2015–16, there were 1 163 Commonwealth Home Support Program services providers (or grant recipients). The majority of the funding (84 per cent) was provided to organisations to deliver activities under the Community and Home Support Sub Program.

## Are guidance materials and other funded programs available to support service providers?

The Department of Health has developed operational manuals and/or guidelines to support providers in the delivery and management of aged care services for the programs reviewed as part of the audit. The Department of Health also funds two peak bodies to develop additional resources to assist with managing the change introduced by aged care reforms (including resources targeted towards remote and very remote Indigenous-focused service providers).

The Department of Health funds a Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel (SDAP) to support aged care providers. ANAO consultations with Indigenous-focussed service providers indicated that awareness of SDAP funding varied across states and territories. There would be benefit in the Department of Health raising the awareness of this assistance in a consistent manner across jurisdictions, and measuring the financial management and governance capacity that has been built and maintained among service providers as a result of having received the funding.

2.46 To support providers through the implementation of the aged care reforms, Health has developed a comprehensive suite of communication products supported by communication strategies. Each of the programs reviewed as part of the audit had program operation manuals that were published on Health's website. Client and provider information for each of the programs was also available on the My Aged Care website. Updates to the changes being rolled through the aged care reforms are also communicated through webinars, newsletters, emails, and fact sheets (available for both clients and providers). Guidelines for the Flexible Program outline the composition of recurrent funding; priority for the allocation and expansion of aged care places and services; provider eligibility; and care services covered by the program.

2.47 The guidance materials identify Aboriginal and Torres Strait Islander people as a special needs group and included general acknowledgement that processes will need to be culturally appropriate. There is limited information on how to address the challenges that Aboriginal and Torres Strait Islander people face in accessing and using aged care services. The Australian Government also provides contestable grant funding to peak bodies[16] and universities to develop and deliver additional resources (including resources targeted towards rural, remote and Indigenous-focused service providers) to support service providers in the delivery of aged care services and to assist in implementing the aged care reforms. The peak bodies have also run forums and developed financing tools to assist Home Care service providers to transition to the Consumer Directed Care operating model.

16 The funding provided to the peak bodies was as a result of their successful Aged Care Service Improvement and Healthy Grants applications. The grants covered the period April 2015 to 30 June 2017. Total funding provided between 2014–15 and 2016–17 is $3.7 million.

### Remote and Aboriginal and Torres Strait Islander Aged Care Service Development Assistance Panel (SDAP)

2.48 SDAP consists of suitably qualified organisations that are engaged by Health (on the recommendation of its regional offices) to provide professional advice on quality care, governance, financial and business management. Projects providing aged care to Aboriginal and Torres Strait Islander people anywhere in Australia, and/or aged care providers located in remote and very remote areas, can access support from the Panel. Table 2.5 outlines the funding available under the SDAP since 2012–13.

**Table 2.5: Service Development Assistance Panel funding**

| | 2012–13 | 2013–14 | 2014–15 | 2015–16 | Total |
|---|---|---|---|---|---|
| Expenditure | $2.1 m | $2.1 m | $2 m | $2.5 m | $8.7 m |

Source: Department of Health documents and analysis.

2.49 Between 2012–13 and 2015–16, 31 Indigenous-focused aged care providers received a total of 46 professional advice projects through the SDAP funding and more than half received services over two financial years. Four service providers received projects from SDAP funding each year between 2012–13 and 2015–16 and accounted for 33 per cent of the funds spent (two providers accounted for 22 per cent of total funds spent). The majority (54 per cent) of the aged care providers who had received SDAP assistance were located in the Northern Territory. Throughout the life of each project, Health has monitored the objective and expected outcomes for each project that received funding.

2.50 In consultations with Indigenous-focused service providers the ANAO observed there was a general lack of awareness of SDAP funding. In addition, there would be benefit in Health better ensuring funding was targeted towards building financial management and governance capacity within organisations, rather than supplementing financial losses that are likely to persist unless changes in organisational culture and skills are made. Raising awareness of the availability of SDAP funding, and ensuring that funding was conditional on entities building financial management and governance capacity, could result in a more equitable and targeted allocation of SDAP funding.

# 3. Administration and regulation of aged care services

**Areas examined**
This chapter examines the effectiveness of the Department of Health and the Australian Aged Care Quality Agency administrative arrangements to support the delivery of aged care services to Aboriginal and Torres Strait Islander people.

**Conclusion**
The Department of Health and the Australian Aged Care Quality Agency have been largely effective in their administration of Australian Government-funded aged care services delivered to Aboriginal and Torres Strait Islander people. Each entity has developed sound administrative arrangements to manage the delivery of aged care services and to review the quality of care delivered through aged care programs. The Department of Health can strengthen its administration by implementing a coordinated approach that ensures the timely sharing of relevant information to facilitate risk assessments across the Ageing and Aged Care Group.

**Area for improvement**
The ANAO made one recommendation aimed at improving the Department of Health's risk assessment recording processes and the sharing of risk assessment information.

## Were appropriate administrative arrangements in place to coordinate activities across the different aged care programs?

The Department of Health has internal governance committees, templates and guidance to coordinate program administration. Health's state and territory offices have also adopted various local strategies for engaging with Indigenous-focused service providers. The department has commenced work to strengthen relationships between its National Office and its state and territory offices, to improve links between policy development and program implementation, while still allowing for specific approaches within each jurisdiction.

3.1 Service providers can receive multiple sources of funding under different aged care programs which are spread across the three divisions and 10 branches in the Department of Health's Ageing and Aged Care Group. The Ageing and Aged Care Group Departmental Budget for 2014–15 was $63.3million, in 2015–16 was $59.9 million and in 2016–17 is $48.6million.[17]

3.2 The high level administrative arrangements and responsibilities are outlined in a group business plan which included information on the Group's purpose, operating environment and challenges, capabilities, stakeholders, strategic priorities, deliverables and key performance indicators. Each of the divisions within the Group has developed and promulgated business plans. Health has also developed internal templates and guidance to assist with program administration.

17 Aged Care departmental funding has been impacted by machinery of government changes and internal restructures including the establishment of the Aged Care Complaints Commissioner in 2016.

3.3 The Ageing and Aged Care Group has established a number of governance committees with management, coordination and decision making responsibilities for various aspects of aged care activities. These committees included members from across the different branches and divisions and were chaired by senior executives.

3.4 Broadly, Health's National Office in Canberra develops policy and manages the separate aged care programs, whereas the department's regional offices are more focused on local program implementation. The ANAO observed that state and territory offices had adopted different duties in relation to the management of aged care services and programs. In June 2016, Health commenced implementation of a revised operating model for the state and territory network to improve the linkages and interactions between National Office teams and staff located in the state and territory local offices.

3.5 The department's state and territory offices play an important role in gathering intelligence for the policy and program areas and as a communication channel for service providers. Feedback from service providers on the effectiveness of communication and consultation with Health was mixed. Service providers that reported they had regular direct interactions with their local Health offices were very positive about their working relationship with Health. Service providers who reported having limited contact with their local office were less positive and considered that communication and consultation was not adequate. Health has noted that some providers were overwhelmed by the amount of information being provided through emails, newsletters and other printed materials being produced and disseminated and had a preference for information to be more targeted or directly communicated to them from the department.

## Are risks associated with the delivery of aged care services to Aboriginal and Torres Strait Islander people being assessed and managed?

The Department of Health has developed an Enterprise Risk Management Plan that is updated annually as part of the department's business planning processes. Each of the programs reviewed as part of the audit included risk management (identification, analysis and evaluation) in its business processes. Risk is considered against the type of activity being funded and may result in different risk ratings being given to the same organisation across each activity or program being funded. For service providers that are funded under multiple programs, there is an opportunity for Health to implement a more coordinated approach that facilitates the timely sharing of relevant information across program areas.

3.6 Health's 2016–17 Corporate Plan states that the department's risk management framework aligns with broader requirements and meets the requirements of section 16 of the *Public Governance, Performance and Accountability Act 2013*.

3.7 Health has developed an Enterprise Risk Management Plan which is informed by risks identified in divisional business plans and is updated annually. Health has identified 11 key enterprise level risks across six categories (people, fraud, policy, delivery, governance and regulatory). Each of the divisions within the Ageing and Aged Care Group has assessed each of the

11 risks as part of their annual business planning/risk management processes for the 2015–16 financial year.[18]

### Service provider risk ratings

3.8 Health's monitoring of the different types of aged care funding accessed by Indigenous-focused and Flexible service providers could be improved through better internal coordination and information sharing among Health's various aged care program areas. Indigenous-focused and Flexible Program service providers can have multiple contracts of varying lengths in force with Health depending on the type and number of services delivered across Commonwealth Home Support, Home Care, residential and Flexible Programs.

3.9 Branches within the Ageing and Aged Care Group can undertake multiple risk assessments within close time intervals for the one provider. Health does not have a consistent approach for accessing information that is common to the risk assessment process. There is an opportunity for Health to reduce the duplication of effort and utilise the risk assessments conducted by different program areas to inform the risk rating of service providers when making funding decisions.

3.10 A lack of coordination between the program areas in the Ageing and Aged Care Group has also led to delayed risk escalation for some large providers that deliver care to Aboriginal and Torres Strait Islander people across different programs. There have been instances where intervention from Health occurred at a later stage than might have otherwise occurred had the risk assessments been shared between program areas.

3.11 Health conducts fortnightly service providers of concern (SPoC) meetings which are attended by representatives from the Ageing and Aged Care Group and each Health State Network Office. The purpose of the SPoC meeting is to advise on and discuss strategies for: providers who are non-compliant with the quality of care; user rights and accountability standards under the Act; and providers who have been rated as requiring case management.

## Recommendation No.2

3.12 The Department of Health implement a coordinated approach to risk management for providers who receive multiple sources of program funding, which combines the assessments and ratings from different program areas and is centrally located.

**Entity response:** *Agreed.*

18 The ANAO is reviewing the department's risk management in a forthcoming cross-entity performance audit report on The Management of Risk by Public Sector Entities.

## Were processes in place for the accreditation and quality review of aged care service providers?

The Australian Aged Care Quality Agency has developed policies, procedures and guidance materials to support the accreditation of residential aged care service providers, and specific policies for the quality review of Home Care Packages, Commonwealth Home Support Program and National Aboriginal and Torres Strait Islander Flexible Aged Care Program service providers. Documents reviewed by the ANAO demonstrate that the relevant accreditation and quality review procedures were followed internally.

3.13 The Quality Agency was given responsibility for accrediting residential service providers on 1 January 2014.[19] The Quality Agency has developed comprehensive policies for the accreditation of residential aged care services that cover identifying better practice, the use of accreditation certificates, reconsideration of accreditation decisions, decision-making and a timetable for improvements. These accreditation policies are supported by six underlying procedures covering administration, application fees, reconsideration of decisions, and a general procedure titled Re-accreditation Audits.

3.14 Responsibility for the quality review of Home Care Packages, Flexible Program and Commonwealth Home Support Program service providers transferred from Health to the Quality Agency on 1 July 2014. The Quality Agency has developed specific policies for the quality review of each of the programs.

### Conducting accreditation audits and quality reviews

3.15 The Quality Agency plans its assessment activities through an internal audit tool, which creates a historical record of interactions with the aged care service provider. All documents that have been provided to the service provider, or received from the service provider, can be accessed through this system.

19 Established by the *Aged Care Act 1997*, the Aged Care Standards and Accreditation Agency Ltd was responsible for the accreditation of residential aged care service providers until it became the Quality Agency on 1 January 2014.

**Table 3.1: Accreditation and quality reviews conducted from 2014–15 to 2016–17**

| Audit type | 2014–15 | | 2015–16 | | 2016–17 |
|---|---|---|---|---|---|
| | Planned | Actual | Planned | Actual | Planned |
| Accreditation audits | 1 425 | 1 425 | 829 | 858 | 443 |
| Quality reviews[a] | N/A[b] | 565 | N/A[b] | 908 | 870 |

Note a: The Quality Agency advised that figures for quality review do not include Victorian Home and Community Care services which transitioned to the Commonwealth Home Support Program on 1 July 2016. This exclusion was not reflected in the 2015–16 Portfolio Budget Statements.

Note b: In 2014–15 and 2015–16 the Quality Agency did not report on the planned number of quality reviews. This was a new performance measure introduced in 2016–17.

Source: ANAO from Annual Reports and Health Portfolio Budget Statements and Department of Social Services Portfolio Budget Statements.

3.16 The Quality Agency has developed a records management policy which complies with legislative requirements and supports ongoing policy review and monitoring of internal compliance. While a number of out of date policies were identified, the Quality Agency advised the ANAO that the document management system alerts the document owner when policies and procedures are due for review, and that documents remain in force as new draft policies and procedures are developed. Documents reviewed by the ANAO demonstrate that the relevant accreditation and quality review procedures were followed.

3.17 Indigenous-focused service providers interviewed by the ANAO had largely positive feedback on the conduct of the quality assessors who visited their services, including that quality assessors shared best practice to improve their service delivery, and were culturally appropriate. This feedback was also received from service providers that had been continuously assessed as not meeting the standards.

## Communication between Departments

3.18 The Quality Agency, Health and the Australian Aged Care Complaints Commissioner each have responsibilities related to the provision of high quality of care by Australian Government-funded aged care services. These organisations are in a position to identify when the quality of an Australian Government-funded aged care service provider is at risk. The *Australian Aged Care Quality Agency Act 2013* provides for the Quality Agency to share relevant information with the Australian Aged Care Complaints Commissioner and Health so they can undertake their responsibilities more effectively.

3.19 To support the legislative provision, the Quality Agency and the Australian Aged Care Complaints Commissioner established a Memorandum of Understanding in January 2016. The Memorandum of Understanding outlines the key points at which information should be shared about at-risk aged care service providers. This includes three types of referrals that can be made, depending on the severity and impacts of the issues identified. The Quality Agency and the Australian Aged Care Complaints Commissioner have agreed on the actions that must be taken in response to a significant issue/concern (Type 2) referral or major issue/concern (Type 3) referral. However, relevant issue/concern (Type 1) referrals have no agreed actions.

3.20 The Quality Agency and Health finalised their Memorandum of Understanding in April 2017.

## What are the results of Indigenous-focused service providers' assessment against the relevant Standards?

The Australian Aged Care Quality Agency has collected information on assessments of all residential service providers against the accreditation standards. This information shows that between 2000-01 and 2015-16, 95 per cent of residential Indigenous-focused service providers had at least one episode of non-compliance, in comparison with 53 per cent of non-Indigenous-focused Residential service providers. Reported instances of non-compliance mostly related to governance, including regulatory compliance, risk management and human resources as opposed to issues relating to quality of care.

3.21 Residential, Home Care and Flexible service providers must comply with a range of different standards. All standards cover governance systems and health care quality, with residential aged care service providers also required to comply with additional standards related to lifestyle and accommodation facilities.

3.22 Residential service providers must comply with the Accreditation Standards, which were established in 1999 and include four standards and 44 expected outcomes. Nine expected outcomes relate to governance systems, 17 on health and personal care, ten relate to care recipient lifestyle and eight relate to the physical environment. Residential service providers must undergo an unannounced assessment contact every year and re-accreditation audits at least every three years. If non-compliance is identified, providers may also be subject to additional assessment contacts or a review audit against all 44 expected outcomes.

3.23 The Home Care standards were established under the *Quality of Care Principles 2014,* and the Flexible standards were established by Health in 2011 as part of the grant agreements for Flexible service providers. These include fewer expected outcomes than the Accreditation Standards. Home Care and Commonwealth Home Support Program service providers must be assessed against the Home Care standards once every three years, and Flexible service providers at least once every two years. Flexible service providers can also be assessed as partially meeting an expected outcome. Health is responsible for developing the standards that the Quality Agency assesses service providers against. Health advised the ANAO that it intends to develop a Single Quality Framework for all service types.

3.24 Indigenous-focused residential, Home Care and Commonwealth Home Support Program service providers are more likely to be assessed as having not met standards, in comparison to other service providers. As outlined in Table 3.2, between 2000–01 and 2015–16, only 5 per cent of Indigenous-focused service providers had not received a 'not-met' finding. Therefore, 95 per cent of residential Indigenous-focused service providers had at least one episode of non-compliance, in comparison with 53 per cent of non-Indigenous-focused residential service providers.

**Table 3.2: Service providers' compliance with the relevant standards**

| Number of episodes of non-compliance | Indigenous-focused service providers | | Non-Indigenous service providers | |
|---|---|---|---|---|
| | Residential[a] | Home Care[b] | Residential | Home Care |
| Never had a 'not-met' episode | 5% | 63% | 46% | 89% |
| One 'not-met' episode | 22% | 33% | 29% | 11% |
| Two to four 'not-met' episodes | 43% | 4% | 23% | 0% |
| Five or more 'not-met' episodes | 30% | 0% | 1% | 0% |

Note a: Residential aged care data is from 2000–01 to 2 June 2016, and includes all reviews of residential aged care services receiving Australian Government funding during that period.

Note b: Home Care data is from 1 July 2014 to 2 June 2016, and includes 1 360 of the 2 124 active Home Care services that had undergone a quality review as at 2 June 2016.

Source: Australian Aged Care Quality Agency.

3.25 Quality Agency records indicate that the main standards with which service providers (including Indigenous-focused) were non-compliant related to governance, including regulatory compliance, risk management and human resources, as opposed to issues relating to quality of care.

3.26 The Quality Agency has advised that assessment and quality reviews of Indigenous-focused service providers are conducted based on policies and procedures for residential, Home Care and Flexible Program service providers. The Quality Agency works closely with Health in the Northern Territory to assist Indigenous-focused service providers with poor compliance records and advised that it has developed a site for employees to share information and strategies for conducting assessments in various areas with each other.

3.27 The Quality Agency conducts National Better Practice Awards and holds Better Practice conferences to promote quality innovation and continuous improvement. In the 2016 National Better Practice Awards the Quality Agency recognised three service providers that had implemented Aboriginal cultural care programs, and had conducted research into improving aged care accessibility through cultural safety.

## Are aged care services provided with information, education and training on the Standards?

In 2014–15 the Australian Aged Care Quality Agency delivered 716 courses, seminars and compliance assistance training events to 10 638 participants from residential and Home Care service providers. Flexible service providers receive compliance assistance training as determined through a case management process. There would be benefit in the Australian Aged Care Quality Agency expanding the proposed cost recovery model to include the indirect and direct costs recovered from courses and workshops to be consistent with the Australian Government's stated policy intention, as well as the Australian Government Cost Recovery Guidelines.

3.28 Residential service providers can access comprehensive courses, workshops and compliance assistance training. The Quality Agency has developed policies, guidance materials and processes to support the delivery of the education services. The Quality Agency advised that

policies and procedures related to recovering costs for courses and workshops are under review. The Quality Agency was trialling different approaches to providing education and training to Home Care and Commonwealth Home Support Program service providers, such as sending compliance assistance training to service providers via external hard drives.

## Education and training on the Standards

3.29 Residential, Home Care and Commonwealth Home Support Program service providers can access compliance assistance training targeted to their education needs for no cost, and can also access a variety of courses and workshops for a fee.

3.30 The Quality Agency has not developed a specific education program for the Flexible Program service providers. Quality reviewers provide compliance assistance training targeted to meet the needs of individual Flexible service providers while on site. Flexible service providers also advised the ANAO they had received assistance from Quality Agency assessors while they were conducting the quality reviews.

### *Compliance assistance*

3.31 Compliance assistance includes targeted education sessions to services identified as in need of support. Compliance assistance is provided at no cost to the service provider, and can be accessed through a request for assistance form or through the Quality Agency identifying the service provider's need during the state and national Case Management processes.

3.32 The Quality Agency completed a new compliance assistance implementation guide in October 2016. A key priority for the program is providing targeted support for Indigenous-focused Home Care service providers who experience higher rates of non-compliance than non-Indigenous-focused service providers. The implementation guide establishes criteria to target compliance assistance activity, including services with Indigenous care recipients and remote services.

### *Courses and workshops*

3.33 Courses and workshops are provided to service providers or nominated attendees for a fee. The Quality Agency charges between $266 to $770 per person, depending on the course or seminar, or around $2 955 for the education activity to be delivered directly to the service provider. There are two courses available to help Home Care service providers and residential service providers to understand the quality review and accreditation process, and six targeted courses that can be accessed by Home Care and residential service providers.

3.34 The Quality Agency has authority to charge fees for courses and workshops in accordance with Part 2 of the *Quality Agency Principles 2013*. This specifies that fees for delivering education and training on the standards must not exceed the cost of providing those services. In the 2015–16 Budget Papers the Australian Government announced that a new fee schedule would be introduced from 1 July 2016 to recover the full operating costs of accreditation, education and training activities performed by the Quality Agency. The Quality Agency has developed and consulted on a draft cost recovery implementation statement, which is available on its website. This document outlines the proposed cost recovery model for accreditation activities, and the Quality Agency advised it is not intended to cover education courses, seminars and conferences.

3.35 The Quality Agency provided the ANAO with information showing that in 2015–16 the total cost of providing courses and workshops was $2.78 million.[20] The total revenue collected from fees charged for these activities was $1.37 million. Expanding the proposed cost recovery model to include the total cost of providing courses and workshops will enable the Quality Agency to meet the Australian Government's stated policy intention, as well as the *Australian Government Cost Recovery Guidelines*.

### *Evaluation of education activities*

3.36 Course and seminar participants are provided with participant feedback forms, and are able to raise concerns with the facilitators or by lodging a formal complaint via the Quality Agency website. The Education Code of Practice outlines that the Quality Agency is committed to the continuous improvement of its education activities through reviewing and updating training material, collecting and analysing feedback from participants and facilitators, implementing a facilitator observation program and conducting internal and external self-assessments. In 2015–16, 98 per cent of course participants strongly agreed or agreed that the course improved or reinforced their knowledge/skills. The Quality Agency advised that evaluation of its compliance assistance programs had not been implemented as at November 2016.

20 The total cost of providing courses and workshops was comprised of both direct and indirect expenses. Direct expenses (including travel, venue hire, printing and insurance) were $1.236 million. Indirect expenses (administrative costs, staff leave and other on-costs) were $1.546 million.

# 4. Performance monitoring and reporting

**Areas examined**

This chapter examines the Department of Health's arrangements for monitoring and reporting on the achievement of program objectives, and the cost effectiveness and service continuity of aged care delivery to Aboriginal and Torres Strait Islander people.

**Conclusion**

Consistent with its policy intent, the National Aboriginal and Torres Strait Islander Flexible Aged Care Program is a more cost effective and viable model for specialised aged care delivery to Indigenous Australians when services are located in remote and very remote communities. A 25.8 per cent share of National Aboriginal and Torres Strait Islander Flexible Aged Care Program funding is allocated to services located in major cities and inner regional areas. To optimise recurrent funding decisions, it is important the Department of Health ensures that the existing service providers, their location and number of places, remain the most appropriate.

Given that the majority of Aboriginal and Torres Strait Islander people access aged care through Commonwealth Home Support Program, Home Care Packages Program and residential aged care programs, further work is required by the Department of Health to maintain the service continuity of Indigenous-focused service providers in areas where there are no culturally secure alternatives. The Department of Health has an opportunity to leverage its datasets to improve the targeting of sector support initiatives to Indigenous-focused services and to monitor the ongoing impacts of aged care policies and programs on Aboriginal and Torres Strait Islander people.

**Areas for improvement**

The ANAO made two recommendations aimed at improving the Department of Health's monitoring processes.

## Is the delivery of aged care to Aboriginal and Torres Strait Islander people monitored and reported?

The Department of Health does not monitor the access and use of Indigenous-focussed aged care services outside of the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. This reduces the Department of Health's capacity to accurately monitor and report on the degree to which its programs and internal activities are meeting the expenditure objectives for Aboriginal and Torres Strait Islander ageing and aged care.

### Internal performance monitoring

4.1 Performance monitoring and reporting activities for the ageing and aged care include few measures that are specific to Aboriginal and Torres Strait Islander people and Indigenous-focused service providers. Health annually monitors and reports the number of operational places under the Flexible Program. Of the 35 083 Aboriginal and Torres Strait Islander people that accessed aged care services in 2014–15, 2.3 per cent did so through the Flexible Program (refer to table 2.1).

4.2 Health does not measure, monitor or report on the number of residential places and Home Care packages used by Aboriginal and Torres Strait Islander people or occupancy rates of

Indigenous-focused service providers. Approximately 13.5 per cent of Aboriginal and Torres Strait Islander people accessed aged care through the residential and Home Care Program, accounting for 65.1 per cent of the direct funding claimed by this population group.

4.3 Residential and Home Care services receive funding through an activity-based funding model. Under this model, service provider funding is contingent on the occupancy of places and packages, rather than just the number of places available. There are a number of factors, specific to aged care delivery to Aboriginal and Torres Strait Islander people, which can impact the level and stability of occupancy rates for Indigenous-focused service providers. These include:

- a preference to access aged care services episodically when health deteriorates and a preference to receive care at home;
- greater population transiency, particularly in remote areas; and
- extended absences from aged care due to cultural reasons (for example sorry business) and seasonal conditions.

4.4 Historically, these factors have tended to contribute to volatility in demand for places and packages for Indigenous-focussed service providers. However, since 2012–13 the difference between the occupancy rates of Indigenous-focused and mainstream service providers has been narrowing. In 2015–16, the average occupancy for Indigenous-focused and Home Care and residential service providers was largely comparable to mainstream service providers (see Table 4.1).

4.5 In contrast, Flexible services receive a set amount of funding based on the number of allocated places rather than the occupancy of those places. This block funding arrangement is intended to offer those service providers at greatest risk of experiencing low or volatile occupancy rates, the funding security required to maintain their quality of operations. On average, the occupancy rates of Flexible residential services were higher than equivalent Indigenous-focused service providers under the residential program in 2014–15.

**Table 4.1: Occupancy of service providers in 2014–15**

| | Home Care | | Residential | | |
|---|---|---|---|---|---|
| | Indigenous-focused | Mainstream | Indigenous-focused | Mainstream | Flexible[a] |
| All service providers | 82% | 86% | 89% | 92% | 93% |
| Small service providers | 81% | 81% | 83% | 93% | 85% |
| Large service providers | 89% | 86% | 92% | 92% | n/a |
| Major city service providers | 78% | 86% | n/a | 93% | 110% |
| Remote and very remote service providers | 76% | 84% | 86% | 86% | 85% |

Note a: This column only reports data for those Flexible service providers that offer residential aged care.

Source: ANAO analysis based on Health data.

4.6 The Commonwealth Home Support Program also does not include monitoring and measurement of service usage by Aboriginal and Torres Strait Islander people. The My Aged Care

Contact Centre monitors the number of people that access the phone and website who identify as Aboriginal and Torres Strait Islander on a monthly basis.

## Public performance measurement and reporting

4.7 In the 2016–17 Corporate Plan, Health's strategic priorities for Aboriginal and Torres Strait Islander people are to enable access to aged care programs, assure the cultural appropriateness of services, and ultimately promote better ageing outcomes. There is one performance measure on improved equity of access to aged care for special needs populations in Health's Corporate Plan.

4.8 Health's obligations for managing ageing and aged care were also reflected in Outcome 6 in its 2016-17 Portfolio Budget Statements. The objective of the Outcome is to improve the wellbeing of older Australians through targeted support, access to quality care and related information services. The Outcome is supported by four Programs. Of the 43 performance criteria[21] ascribed to the Outcome, three relate to the provision of aged care for Aboriginal and Torres Strait Islander people (shown in Table 4.2). Results against each measure are reported in Health's Annual Report.

**Table 4.2: Performance criteria relating to aged care service provision to Aboriginal and Torres Strait Islander people in 2016–17 Portfolio Budget Statement**

| Performance criteria and objective | 2016–17 target |
|---|---|
| *Program 6.3–A: Providing a range of residential and Flexible care options and accommodation for older people who are unable to continue living independently in their own homes* | |
| Expand the National Aboriginal and Torres Strait Islander Flexible Aged Care Program and the Multi-Purpose Service Program. | Conduct a funding round to expand existing services funded under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program, with places allocated in 2016; and conduct a Multi-Purpose Service approvals round with places allocated in 2016. |
| Number of Flexible places available for Aboriginal and Torres Strait Islander people through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. | 850 |
| *Program 6.4–C: Supporting the needs of people with dementia through the Dementia and Aged Care Services fund* | |
| Projects to support older Aboriginal and Torres Strait Islander people and services that provide care to this group are delivered, including grants of capital assistance. | The 2016 grant funding round is advertised in 2016 and will include a focus on Aboriginal and Torres Strait Islander people and services. |

Source: Department of Health Portfolio Budget Statement 2016–17, Section 2, pages 139–140 and 146.

4.9 The Act requires Health to produce a yearly *Report on the Operation of the Aged Care Act* (ROACA). Similar to Health's other public reports, ROACA focuses on the Flexible Program to demonstrate the availability of culturally appropriate care for Aboriginal and Torres Strait Islander people. This is a partial indicator of service usage and availability that does not reflect that the

21 Health was required to develop and outline performance criteria and targets in place of deliverables and key performance indicators for the 2016–17 Portfolio Budget Statements as part of the enhanced Australian Government performance framework.

vast majority of Aboriginal and Torres Strait Islander people access and receive aged care outside of the Flexible Program.

4.10 Additional performance information is available through the following sources:

- National Aboriginal and Torres Strait Islander Health Plan 2013–2023 Priorities by Health[22];
- Report against the Health Performance Framework by the Department of Prime Minister and Cabinet[23]; and
- Report on government services by the Productivity Commission.[24]

4.11 The performance information across Health and other Australian Government reporting is disparate and does not give a clear and comprehensive indication of how government expenditure is effectively facilitating access to culturally appropriate care for Aboriginal and Torres Strait Islander people.

4.12 Health collects wide-ranging client and service provider data for each of its aged care programs through the mandatory reporting requirements placed on clients and service providers that claim Australian Government funding. Given the concerns raised by stakeholders around the risk of disengagement by Aboriginal and Torres Strait Islander people since the introduction of My Aged Care and the RAS, it will be worthwhile for Health to leverage its existing datasets to benchmark the impact of the reforms for this group over time.

## Recommendation No.3

4.13 The Department of Health monitor the number of:

(a) Aboriginal and Torres Strait Islander people accessing Commonwealth funded aged care services; and

(b) Service providers that deliver aged care services to a significant number of Aboriginal and Torres Strait Islander people.

**Entity response:** *Agreed.*

### Ongoing evaluation arrangements

4.14 Health has undertaken evaluations for aspects of aged care reforms including the consolidation of the Commonwealth Home Support Program and Home Care Packages Program, the introduction of My Aged Care and Regional Assessment Services. To date Health's analysis of

22 Department of Health, 'National Aboriginal and Torres Strait Islander Health Plan 2013-2023' [Internet] 27 June 2013, available from: <http://www.health.gov.au/internet/publications/publishing.nsf/Content/oatsih-healthplan-toc> [accessed 27 June 2016].

23 Department of Prime Minister and Cabinet, 'Aboriginal and Torres Strait Islander Health Performance Framework 2014 Report' [Internet] 9 June 2015, available from: < https://www.dpmc.gov.au/resource-centre/indigenous-affairs/aboriginal-and-torres-strait-islander-health-performance-framework-2014-report> [accessed 22 March 2016].

24 Productivity Commission, 'Report on Government Services 2016' [Internet] 4 February 2016, available from: < http://www.pc.gov.au/research/ongoing/report-on-government-services/2016/community-services/aged-care-services> [accessed 22 March 2016].

the impact of the reforms on Indigenous-focused service providers and Aboriginal and Torres Strait Islander people has been limited.

4.15 The effectiveness of arrangements for protecting the equity of access to aged care services for different population groups, which includes Aboriginal and Torres Strait Islander people, will be considered as part of the Aged Care Legislated Review. A call for submissions opened on 14 October 2016 to seek feedback on the changes to aged care announced in 2012. A final report on the Review must be completed by 1 August 2017.

## Has Health supported the service continuity of providers?

The Department of Health administers a viability supplement aimed at ensuring the continuity of small, specialised and rural aged care services. The provision of the viability supplement to eligible Indigenous-focused approved providers under the Home Care and residential programs has been well targeted and effective in supporting service continuity. The targeting of viability supplements to residential and mixed services under the Flexible program could be improved by refocusing funding away from major city and inner regional services.

4.16 To maintain current capacity and continuously deliver high quality aged care to clients, approved providers must be financially viable. Approved providers[25] must either hold adequate funds to preserve and replace the working capital supporting facilities or be able to attract financial capital from lenders. The retention of a skilled workforce, including administrative, management and clinical staff, increases corporate knowledge and also contributes to the quality of operations. Without these features, aged care approved providers are at a higher risk of closure.

4.17 ANAO analysis indicates that Indigenous-focused approved providers are more likely to record large net losses in consecutive years than comparable mainstream approved providers. Operating under a single-service model[26] is strongly linked with poorer financial performance, followed by geographic remoteness and smaller scale. Approximately 80 per cent of Indigenous-focused approved providers display at least one of these operational characteristics, with 12 per cent exhibiting all three. By comparison, the equivalent figures for the rest of the sector are 60 per cent and less than one per cent.

4.18 A single-service operating model limits the capacity for approved providers to cross-subsidise their services, or to save on fixed costs by centralising administrative functions. The majority of consulted Indigenous-focused providers advised that the responsibility for business support and regulatory compliance tasks were shared across care staff. In contrast, multi-service approved providers tended to receive head-office support for these functions. Similarly, smaller approved providers are constrained in their ability to realise economies of scale and cover the fixed costs of operations.

25 A parent organisation that has been approved to provide Residential care or Home Care under the *Aged Care Act 1997*. An approved provider may have one or multiple service providers delivering care on the ground.

26 A single-service operating model has been defined in ANAO analysis as those providers that operate one facility that provides one care type.

4.19 While operating in remote and very remote areas raises the costs of aged care delivery, Indigenous-focused approved providers based in remote and very remote areas were significantly less financially viable than similarly located mainstream approved providers. This result can largely be attributed to the higher proportion of remote and very remote Indigenous-focused approved providers that are also small single-service operators.

4.20 Indigenous-focused approved providers had a lower propensity to charge fees and collected less from clients when fees are charged, impacting their ability to generate sufficient revenues to cover operating costs. Indigenous-focused approved providers noted a reluctance to charge fees due to the socioeconomic circumstances of an Aboriginal and Torres Strait Islander client base.

### Viability supplement

4.21 Health administers a viability supplement with the aim of supporting service continuity in environments where structural factors such as a smaller operational size and geographic remoteness adversely impact financial performance. Once Health establishes the eligibility of service providers, the viability supplement is administered each month.[27]

4.22 Additional viability funding may also be available for residential service providers that can demonstrate specialisation in delivering aged care to Aboriginal and Torres Strait Islander people or people who are homeless or at risk of becoming homeless, with complex behavioural needs. The viability supplement funding is calculated on a points-based system, and service providers already in receipt of a high number of points may not benefit from this expansion component as the total points accruable are capped.

4.23 In 2015–16, approximately $10.1 million in viability supplements were paid to Indigenous-focused Home Care and residential service providers, representing around 24 per cent of total viability supplement funding. As Table 4.3 shows, the viability supplement is targeted to outer regional, remote and very remote service providers under the residential and Home Care Packages programs. Reflecting the complex needs client base and typically smaller size of operations, in addition to being located in rural areas, Indigenous-focused service providers receive significantly more in viability supplements per place than the rest of the sector on average.

4.24 There have been recent changes made to further improve the targeting of the viability supplement under the Residential and Home Care Packages Programs. Over four years from 2016–17, the Australian Government will provide an additional $102.3 million of funding under the viability supplement and replace the current remoteness classification system with the updated Modified Monash Model.[28] The changes are expected to increase the average annual viability supplement for Residential and Home Care service providers currently receiving it, and support a number of service providers with viability supplement payments for the first time.

27 Since the introduction of Consumer Directed Care under the Home Care Program on 1 July 2015, the viability supplement has been attached to the care recipient and is incorporated in individualised budgets.

28 The Modified Monash Model is a remoteness classification system that considers both geographic remoteness and population size. The Modified Monash Model establishes seven remoteness categories to target viability funding.

**Table 4.3: Average viability supplements per place/package by remoteness in 2014–15**

| | Home Care | | Residential | | |
|---|---|---|---|---|---|
| | Indigenous-focused | Mainstream | Indigenous-focused | Mainstream | Flexible[a] |
| Major Cities of Australia | $0 | $0 | n/a | $46 | $11,950 |
| Inner Regional Australia | $125 | $44 | $154 | $79 | $10,224 |
| Outer Regional Australia | $674 | $383 | $12 664 | $894 | n/a |
| Remote Australia | $2 754 | $1 834 | $8 408 | $5,112 | $18,005 |
| Very Remote Australia | $3 705 | $2 869 | $14 272 | $9,217 | $18,005 |

Note a: This column only reports data for those Flexible service providers that offer residential aged care.
Source: ANAO analysis based on Health data.

4.25 The targeting of viability supplements to Flexible Residential service providers could be improved by refocusing towards remote and very remote locations In 2014–15, three Flexible Residential services located in major cities and inner regional Australia received a combined total of $987 832 in viability supplements. Where viability supplements are paid over several years and comprise a significant source of a service's total funding, Health should review whether the recurrent funding rates for Residential Flexible services remain appropriate.

4.26 The Aged Care Financing Authority (ACFA) monitors the ongoing effectiveness of viability supplements as reforms are implemented at a sector-wide level. In its report on the *Issues Affecting the Financial Performance of Rural and Remote Providers*, ACFA concluded the viability supplement was generally well targeted and strengthened the sustainability of the aged care sector as a whole.

4.27 Neither Health nor ACFA monitor the effectiveness of viability supplements administered to Indigenous-focused service providers. Examining the financial impact of viability supplements for this segment would assist Health target its other sector support initiatives and safeguard service continuity for Aboriginal and Torres Strait Islander people as close as possible to community.

### Impact of viability supplements on financial performance

4.28 Of the 16 eligible Indigenous-focused Home Care approved providers, 15 received the viability supplement in 2014–15. The ANAO estimated that in the absence of a viability supplement, five Indigenous-focused Home Care approved providers would have recorded a net loss greater than five per cent of total revenue. In 35 per cent of cases, the viability supplement was the difference between Indigenous-focused Home Care approved providers recording a net loss or breaking even.

4.29 All nine of the eligible Indigenous-focused Residential approved providers received the viability supplement in 2014–15. Of these approved providers, one has been recording significant net losses over a number of years. Without the viability supplement, it is estimated that six Indigenous-focused residential approved providers would have recorded a consecutive net loss greater than five per cent of total revenue. In a third of instances, the viability supplement was the deciding factor between an Indigenous-focused Residential approved provider breaking even instead of reporting a net loss.

4.30 In 2014–15 Health administered approximately $6.7 million in viability supplements to services under the Flexible Program. All eligible Flexible services received viability supplements over the sample period. In the absence of the viability supplement, all five Flexible Residential services would have recorded a consecutive net loss greater than five per cent of total revenue. When the viability supplement is factored in, only one Flexible Residential service recorded such a financial result.

4.31 Of the 20 Flexible services delivering mixed Residential and Home Care, 10 would have recorded successive net losses of more than five per cent without viability supplements. In 2014–15, $660 836 in viability supplements were paid to four mixed care Flexible service providers that reported net profits of over 15 per cent of total revenue, representing approximately 10 per cent of the total viability supplements allocated to the Flexible Program at the time. In instances where viability supplements are paid to Flexible services that go on to record large profits in a financial year, Health should monitor whether the surplus funds are being invested in service continuity.

4.32 In total, there are nine Indigenous-focused approved providers (six in Home Care Packages Program, one in Residential and two providers in the Flexible Program) that have recorded sizable net losses despite receiving viability supplements over 2013–14 to 2014–15. In itself, recording large net losses does not imply that viability supplement funding is ineffective in assisting services meet the additional costs imposed by geographic remoteness and small scale.

4.33 Health's examination of reporting for Indigenous-focused approved providers in financial distress suggest that weak governance and risk management practices are the primary contributors to poor financial results. This is consistent with the Quality Agency's assessment records which show the incidences of non-compliance for Indigenous-focused service providers are more likely to be against standards related to effective management and accountability, such as regulatory compliance, information managements systems and human resource management. These, more provider specific, issues sit outside both the scope of viability supplements and funding arrangements.

4.34 Where Indigenous-focused approved providers consistently exhibit poor financial performance after receiving the viability supplement, Health should monitor whether its other sector support initiatives, aimed at assisting services adjust to change and instilling risk management and governance workforce skills , are being fully utilised.

## Did Health assess whether the National Aboriginal and Torres Strait Islander Flexible Aged Care Program is meeting its objectives?

The Department of Health does not conduct regular analysis of whether the Flexible Program is meeting its objectives. There would be value in the department aggregating reporting data more effectively to inform the ongoing policy direction of the Flexible Program.

ANAO analysis indicates that consistent with its intent and design, the Flexible Program has improved access to culturally secure aged care for Aboriginal Torres Strait Islander people (as noted in Chapter 2). For residential aged care, the Flexible Program is also a more cost effective and viable model for service delivery in remote and very remote locations. However, the majority of Flexible Program recurrent funding for residential aged care is allocated to services located in major cities and inner regional areas.

4.35 The Flexible Program aims to provide aged care services that meet the needs of Aboriginal and Torres Strait Islander people aged 50 years and older in a culturally appropriate setting, close to home and community. The program objectives are to:

- deliver a range of services to meet the changing aged care needs of the community;
- provide aged care services to older Aboriginal and Torres Strait Islander people close to home and community;
- improve access to aged care services for Aboriginal and Torres Strait Islander people;
- improve the quality of culturally appropriate aged care services for Aboriginal and Torres Strait Islander people; and
- develop financially viable cost effective and co-ordinated services outside of the existing mainstream programs.

4.36 In September 2009, the Office of Evaluation and Audit[29] conducted a performance audit of residential aged care services for Indigenous Australians. The report concluded, amongst other aspects:

> … there appears to have been limited assessment made of the program since its commencement, despite undertaking by DoHA to implement regular evaluations. Given the increase in numbers of older Indigenous Australians, it would be timely for DoHA to formally review the level and location of need and how this aligns with the current distribution of services. This would allow the Department to take a more strategic approach to the management of the Flexible Program.

4.37 The report also made four recommendations, agreed to by Health, two of which were directed to performance monitoring and reporting. The report recommended that Health:

- undertake an evaluation of the Flexible Program, including a formal needs analysis and identify a formal process for monitoring changing levels of need; and
- develop a performance framework that included key performance indicators, within the service activity reports, that can assess the performance of the Flexible Program in meetings its intended objectives.

4.38 Since the 2009 report, Health has not undertaken an evaluation of the Flexible Program or a formal process for monitoring changing levels of need. Under the Grant Agreement for the Flexible Program, providers are required to meet eight Activity Performance Indicators reported through a Service Activity Report (SAR) submitted to Health every six months. Health does not use the information from Activity Performance Indicators to assess if the Flexible Program is meeting its intended objectives. Analysis of the information contained in the SARs focusses on the performance of the individual service providers.

4.39 The SAR includes: a summary of staff, hours worked and qualifications; staff vacancies; number of visiting health professionals; overview of care recipients; complaints received; and waiting list status. Service providers can also identify challenges that may be experienced during the reporting period. Health's analysis of the SAR includes a summary of: care type delivered versus funding provided; staffing; health care professional visits; complaints received; and a

29 In December 2009, the Office of Evaluation and Audit (Indigenous Programs) was transferred from the Department of Finance and Deregulation to the ANAO.

summary statement concluding whether there are any concerns with the provider's delivery of aged care services and that the program's objectives are being met.

4.40 Based on information provided in the SARs and Financial Activity Reports, Health also conducts additional ad-hoc analysis when resourcing allows. For example, Health has analysed the occupancy rates of some service providers, as well as conducting detailed analysis of the proportion of provider budgets spent on various components (operational, staffing etc.). Health advised the ANAO that 'this analysis has not been collated in a way that enables identification of trends'.

### Cost effectiveness of Flexible service providers

4.41 The cost per place of delivering specialised residential aged care to Aboriginal and Torres Strait Islander people under the residential program and Flexible Program is displayed in Table 4.4. The average cost per place across Flexible Program service providers offering residential services as opposed to home care or mixed services (Flexible Residential) was $83 861, 13 per cent lower than Indigenous-focused approved providers under the residential program.

**Table 4.4: Cost per residential place of service providers in 2014–15**

| | Indigenous-focused | Residential Flexible |
|---|---|---|
| All service providers | $96 374 | $83 861 |
| Small service providers | $74 214 | $86 002 |
| Large service providers | $99 196 | $83 098 |
| Major city service providers | $96 550 | $79,741 |
| Remote and very remote service providers | $123 601 | $86 002 |

Source: ANAO analysis based on Health data.

4.42 The cost per place for Flexible Residential service providers in remote and very remote Australia was approximately 30 per cent less than equivalent Indigenous-focused approved providers under the residential program. Indigenous-focused service providers commented the higher reporting and quality compliance requirements of the residential program significantly raised the cost of operations, particularly for smaller single-service organisations. These service providers expressed a strong desire to transfer to the Flexible Program to reduce compliance costs.

4.43 Over the period 2012–13 to 2014–15, Flexible service providers were required to submit a financial activity report to Health, demonstrating financial acquittals bi-annually. In comparison, approved providers under the residential program were required to submit a General Purpose Financial Statement to Health which had been externally audited, an Annual Prudential Compliance Statement and participate in the annual Survey of Aged Care Homes.

4.44 The Quality Agency also assesses Flexible services against a separate Flexible Standard with nine expected outcomes, tailored to consider their specific operating environments and client base. Flexible service can be rated as 'met', 'partially met' and 'unmet' against an outcome. In contrast, Indigenous-focused approved providers under the residential program are assessed against 44 expected outcomes in the Accreditation Standard. Service providers are rated as either 'met' or 'unmet' against expected outcomes. Residential program service providers also undergo

more site visits, with a minimum of one announced visit a year, and more visits triggered if 'unmet' ratings are given.

4.45 Several Indigenous-focused residential approved providers noted the staff time directed at maintaining accreditation across a large number of expected outcomes and preparing for frequent site visits placed pressure on workforce resourcing and perpetuated 'unmet' ratings.

### Developing financially viable, cost effective and flexible aged care services

4.46 One of the objectives for the Flexible Program is to develop financially viable, cost effective and coordinated services outside of the existing mainstream programs. Although the aged care sector and program funding models have undergone significant reform since the Flexible Program was instituted, many Flexible services have been funded recurrently by Health since the program commenced in the 1990s or through expansion programs in 2006–07 through to 2009–10.

4.47 The ANAO assessed which program – Flexible or mainstream residential – is more likely to enhance the cost effectiveness and viability of culturally secure residential aged care services. Cost per place was used to measure cost effectiveness and a composite of average occupancy rates, supplements and funding growth per place were used as indicators for viability. Results from the analysis for services with different attributes are outlined in Table 4.5.

**Table 4.5: Effectiveness of program models to Indigenous-focused Residential services**

| | Improved cost effectiveness | Improved viability |
|---|---|---|
| Small service providers | Activity-based | Activity-based |
| Large service providers | Flexible | Activity-based |
| Major city service providers | Flexible | Activity-based |
| Remote and very remote service providers | Flexible | Flexible |

Source: ANAO analysis based on Health data.

4.48 In remote and very remote locations, where occupancy rates are typically lower and the stability of block funding assists with service continuity, the Flexible Program is a more cost effective and viable model for residential aged care delivery to Aboriginal and Torres Strait Islanders. This result is consistent with the original design and intent of the Flexible Program. However, in 2015–16 approximately 69 per cent of Flexible Program funding for residential only aged care was allocated to services operating from major city and inner regional locations.

4.49 There are nine comparable Indigenous-focused service providers, which are also in very remote locations with low occupancy rates, that would benefit from block funding more than their current arrangements under the mainstream Residential Program. Most consulted Indigenous-focused Residential services expressed a desire to transition to the Flexible Program, however were unaware of entry pathways into the program.

## Recommendation No.4

4.50 To ensure that the funding provided through the National Aboriginal and Torres Strait Islander Flexible Aged Care Program is appropriately targeted to services that will benefit most from the program's design and intent, the Department of Health:

(a) regularly review the ongoing needs of the communities serviced by culturally secure service providers;

(b) develop performance indicators capable of measuring the achievement of cost effectiveness and viability objectives; and

(c) identify and communicate available sector support and pathways for service providers to enter and exit the program.

**Entity response:** *Agreed.*

4.51 Smaller service providers are more likely to benefit most from the Residential Program's funding arrangements and, as demonstrated in Table 4.4, achieve lower costs per place than equivalent Flexible services. Between 2012–13 and 2014–15, the annual funding per place for smaller service providers under the Residential Program grew by 13 per cent annually. Over the same period, the funding per place for Flexible Residential services grew by three per cent annually due to the program's prevailing indexation pause.

4.52 For larger or major city services, it is less clear which program is likely to yield an optimal balance between cost effectiveness and viability objectives. Given the aged care system is in the midst of reforms, there would be value in Health undertaking analysis on a case-by-case basis to determine which program, Flexible or mainstream Residential, would enhance service sustainability under the new settings.

4.53 In the direct selection recurrent funding approach of the Flexible Program, there are few allowances for the entry of new services that are transitioned in from mainstream programs (discussed previously in 2.42). In order to optimise recurrent funding decisions, it is important that Health ensure that the existing set of Flexible services remain the most appropriate to meet the aged care needs of local Indigenous communities.

Rona Mellor PSM
Acting Auditor-General

Canberra ACT
31 May 2017

# Appendices

# Appendix 1 Entity response

## Department of Health

Australian Government
Department of Health

SECRETARY

27 February 2017

Ms Michelle Kelly
Group Executive Director
Performance Audit
Australian National Audit Office
GPO Box 707
Canberra ACT 2601

Dear Ms Kelly

**Department of Health response to the Proposed Report – Performance Audit of Indigenous Aged Care**

Thank you for providing the Australian National Audit Office's (ANAO) report under s.19 of the *Auditor-General Act 1997* on *The Performance Audit of Indigenous Aged Care.*

The following wording has been provided for the Summary Response:

I am pleased that the ANAO found the Australian Government-funded aged care services are largely delivered effectively to Aboriginal and Torres Strait Islander people, and the National Aboriginal and Torres Strait Islander Flexible Aged Care Program (Flexible Program) has been effective in increasing access to culturally appropriate aged care services for elderly Indigenous Australians. The report has identified areas for potential improvement, particularly with regard to re-establishing appropriate allocation and targeting of Flexible Program funding, risk management approaches and monitoring access to aged care services for Aboriginal and Torres Strait Islander people.

I would like to advise the department has commenced work on some of the items identified in the report including:

- developing a Single Aged Care Quality Framework in consultation with the aged care sector to develop a single set of quality standards and streamline accreditation processes. The single set of standards will replace the current four sets of aged care standards, including the standards under the National Aboriginal and Torres Strait Islander Flexible Aged Care Program Quality Framework, and apply to all aged care services.

GPO Box 9848 Canberra ACT 2601

- using the department's Service Provider Capacity Risk Assessment Tool in the assessment process to offer new funding agreements under the Flexible Program. This assessment will include a review of the usage and ongoing need of the aged care services in each community. Enhancement of these processes will strengthen the department's risk management approach of providers who receive multiple sources of program funding.

- clarifying messaging around priority being given to services in remote locations when expanding or establishing new services under the Flexible Program. The Flexible Program guidelines have also been updated to prioritise aged care services in remote and very remote locations.

Attachment A provides the Department of Health's response to each recommendation.

I would like to thank the ANAO for its professional and comprehensive audit of Indigenous Aged Care and the collaborative way in which it was conducted.

If you have any questions regarding the Department's response, please contact Ms Celia Street on (02) 6289 7735.

Yours sincerely

Martin Bowles PSM

## Australian Aged Care Quality Agency

Australian Government
Australian Aged Care Quality Agency
From the Office of the Chief Executive Officer

3 March 2017

Ms Michelle Kelly
Group Executive Director
Performance Audit
Australian National Audit Office
19 National Circuit
BARTON ACT 2600

Dear Ms Kelly

**ANAO Proposed audit report on *Indigenous aged care***

Thank you for the report received via email on 3 February 2017 inviting comments on the proposed audit report on *Indigenous aged care*.

I note there are no recommendations directed to the Australian Aged Care Quality Agency (Quality Agency).

We acknowledge the results of the audit and the matters identified.

I would like to thank the ANAO audit team for the cooperative and professional approach in undertaking the audit and working with the Quality Agency.

Yours sincerely

Nick Ryan
Chief Executive Officer

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