Home Care Package Environmental Scan

Technical Paper
June 2019

Victorian Healthcare Association
Vision • Value • Voice

CONTENTS

ABBREVIATIONS

ACAT	Aged Care Assessment Team
ACFA	Aged Care Financing Authority
ACPR	Aged Care Planning Region
AIHW	Australian Institute of Health and Welfare
CCW	Community Care Workers
CHSP	Commonwealth Home Support Program
DHS	Department of Human Services
EBITDA	Earnings Before Interest Tax Depreciation and Amortisation
LGA	Local Government Area
MAC	My Aged Care
NPBT	Net Profit Before Tax
NPQ	National Prioritisation Queue
PCPD	Per Consumer Per Day
VHA	Victorian Healthcare Association

INTRODUCTION

As a consequence of various reforms in the home care package (HCP) sector over the last five years, the Victorian Healthcare Association (VHA) has undertaken an environmental scan of the sector to inform members of factors that may affect their participation in the industry. This technical paper supplements the primary environmental scan document and provides additional information on the seven topic areas of:

/ consumer and provider responsibilities
/ the HCP sector
/ financial characteristics of the HCP sector
/ trends in the uptake of HCPs
/ fee arrangements and means testing
/ scope of delivery in the public sector, and
/ the HCP workforce.

Readers should note that the information presented in these appendices should be considered with care as any future reforms may affect the accuracy of the information presented.

APPENDIX A / CONSUMER AND PROVIDER RESPONSIBILITIES

The following section provides a detailed description of the roles consumers and providers play in the management of HCPs.

Consumer responsibilities

Apply for a HCP through My Aged Care (MAC)

Prospective consumers need to contact the MAC contact centre and:

- Arrange a face-to-face assessment to determine their needs
- Be referred to appropriate aged care services
- Receive information and details on services that may be of assistance, and
- Provide details for a personalised client record account.

Organise an Assessment with an Aged Care Assessment Team (ACAT)

Following a discussion with My Aged Care, prospective consumers are asked to arrange a time with an ACAT to undergo a comprehensive assessment. These assessments are free and determine eligibility for a number of government subsidised aged care programs, including HCPs. They take into account a person's physical, medical, psychological, cultural, social and restorative care needs before determining what level of support an individual requires.

Choose a provider

Under the *Increasing Choice in Home Care* reforms (2017) packages are now allocated directly to clients, who must engage a service provider. Consumers can use the MAC website to find a provider that:

- Best meets their service needs
- Has acceptable fees, and
- Provides a high-quality service.

Clients are able to change their HCP provider at any time but may be subject to an exit fee.

Arrange an income assessment with the Department of Human Services (DHS)

Consumers are required to undergo an income assessment by DHS to determine if they are required to pay income tested care fees. This requires consumers to fill out the *Aged Care Fees Income Assessment* form. The DHS will calculate an income tested care fee based on the consumer's financial information. Following the assessment, DHS will advise the provider and the consumer of the maximum fees payable.

Sign a HCP agreement

The Home Care Agreement is a document developed by providers and includes information specified under the *Aged Care Act* including:

- The home care service that will provide care to the client
- The level of care and services that the provider has capacity to provide
- The policies and practices for setting care fees
- The circumstances under which services may be suspended or terminated by either party, and the amounts that the client will need to pay during the suspended period
- The complaints process, and
- Client responsibilities.

Clients must sign this agreement before providers may begin service provision.

Collaborate with providers to develop a care plan

A client's care plan provides direction for services organised by the provider and includes:

- The client's goals, needs and preferences
- The services that will support the client's care needs and support progression to identified goals
- Who will provide the care and services
- When care and services will be provided, including the frequency and details of when regular services are expected to be provided (e.g. days/ times)
- Case management arrangements, including how ongoing monitoring and reviews will be managed
- The level of involvement the client will have in managing their package, and
- The frequency of formal reassessments.

Make choices about service requirements

The Consumer Directed Care reforms introduced in 2015 aimed to give control to consumers by enabling them to make decisions regarding the types of care and services most suitable for their needs. Consumers collaborate with providers to determine what services they receive and the timing and suppliers of those services.

Continuously evaluate changes in need

Consumers should notify providers of changes to their needs and goals. This should occur through regular conversations with providers to discuss if their care needs are being met [1].

Provider requirements

Review of client's Aged Care Client Record

Providers should always review a prospective consumer's ACAT Aged Care Client Record prior to commencing service delivery. This provides information about their characteristics, needs and circumstances and should be used in conjunction with consumer reported information to determine if packaged care is appropriate and which services are relevant.

Develop a HCP agreement

The *Home Care Agreement* contains important information about key elements of package delivery (as specified under the consumer requirements section). It is the provider's responsibility to offer a HCP agreement to consumers prior to the package commencing. Providers are required to explain the agreement to consumers and ensure it is written in simple, easy to understand language. Failure to provide a HCP agreement prior to service provision will result in the provider forfeiting subsidy payments.

Develop a care plan

Providers should work in partnership with consumers to develop their care plan. Details about what should be included in the care plan are provided under the consumer requirements section of this document.

Work with clients to identify appropriate services

By discussing care needs with clients, providers can assist consumers to determine which services will enable them to achieve their care goals. It is important that providers offer unbiased information that empowers consumers to make choices regarding their care.

Provide an individualised budget

The provider should develop an individualised budget in partnership with consumers, based on the consumer's care plan. An individualised budget should take into consideration:

- the consumer's goals, assessed needs and preferences
- the value of the HCP
- the services required by the consumer.

The budget should clearly identify the total funds available to the consumer and be amended whenever the care plan or costs change.

Deliver services

Providers have an obligation to deliver the number and types of services outlined in the consumer's care plan. A list of approved services can be found under the Quality of Care Principles [2].

Prepare monthly financial statements

Providers must present consumers with a monthly financial statement that clearly shows their available funds, how those funds have been spent in the previous month and the balance of any unspent funds from the HCP budget allocation. This statement must specify:

- The amount of HCP subsidy paid or payable to the provider (including eligible supplements)
- The total amount of HCP fees paid or payable by the consumer
- The total amount paid or payable by the provider in respect of the HCP service provided
- An itemised list of the care and services provided to the consumer and the total amount for each kind of care or service
- The total of any unspent funds received from any previous month, and
- That any amount of HCP fees paid by the consumer to the provider that has not been spent, and that is not refundable, will not be refunded to the consumer if the provider ceases to provide HCP services to the consumer.

Continually assess client needs

Providers have responsibility for constantly reviewing client needs and ensuring the services being provided are meeting these needs. This requires ongoing review and updating of the client's care plan and communicating with consumers to ensure they are satisfied [3].

APPENDIX B / THE HCP SECTOR

Demand for HCP services

Prospective consumers apply for a HCP assessment through the online My Aged Care platform. These individuals are assessed by the Aged Care Assessment Service using the *National Screening and Assessment Form*. Once approved, clients are placed onto the National Prioritisation Queue (NPQ), until a package at an appropriate care level (1, 2, 3 or 4) becomes available. Clients are ordered in the queue according to their determined urgency for HCP services and the date they were approved for a package level [4].

NPQ by Aged Care Planning Regions

Aged care services in Australia are funded and delivered in regions called Aged Care Planning Regions (ACPR). There are nine ACPR in Victoria, four of which are in the Melbourne metropolitan area. The number of people in the NPQ by ACPR as at 30 June 2018 is summarised in Table 1.

Table 1: Number of individuals in the NPQ as at 30 June 2018[1].

ACPR	Level 1	Level 2	Level 3	Level 4	Total	% total NPQ	People in the NPQ per 1,000 people aged 70+
Barwon South Western	≤10	348	446	216	1,012	6.3%	19.6
Eastern Metropolitan	17	1,184	871	644	2,716	16.9%	18.9
Gippsland	≤10	239	309	216	1,012	6.3%	23.9
Grampians	≤10	377	177	77	638	4.0%	20.6
Hume	≤10	290	334	152	778	4.8%	18.9
Loddon Mallee	≤10	259	227	235	723	4.5%	14.1
Northern Metropolitan	≤10	662	833	678	2,180	13.5%	23.9
Southern Metropolitan	21	1,271	878	1,135	3,305	20.5%	20.4
Western Metropolitan	≤10	642	554	436	1,634	10.2%	19.6
Total	**76**	**6,072**	**5,412**	**4,533**	**16,093**	**87.0%**	

(Australian Institute of Health and Welfare, 2018, Home Care Packages Program data report September, p. 25)

Table 1 demonstrates that regions with the highest proportion of 70+ population awaiting a package are the Northern Metropolitan and Gippsland regions. The regions with the lowest proportion of 70+ population awaiting a package reside in the Loddon Mallee and Eastern Metropolitan regions.

The Commonwealth's planning for HCPs is determined by a set planning ratio of 45 HCPs per 1,000 people aged 70 years and over [5]. The total number of individuals currently receiving services through a HCP at 30 June 2018 by ACPR is described by Table 2.

1. The figures displayed in Table 1 are sourced directly from AIHW data. Differences observed between the totals displayed and column figures are not explained by the source document.

Table 2: Number of HCP recipients by ACPR and per 1,000 people of the 70+population (June 2018).

ACPR	Level 1	Level 2	Level 3	Level 4	Total	Packages per 1,000 people aged 70+
Barwon South Western	114	1,223	196	418	1,951	37.9
Eastern Metropolitan	264	3,009	409	879	4,561	31.7
Gippsland	179	968	206	341	1,694	40.1
Grampians	62	737	87	192	1,078	34.8
Hume	99	913	160	270	1,442	35.1
Loddon Mallee	59	923	82	297	1,361	26.4
Northern Metropolitan	205	1,989	327	739	3,260	35.7
Southern Metropolitan	194	3,411	451	1,031	5,087	31.4
Western Metropolitan	62	1,743	266	700	2,771	36.0
Total	**1,238**	**14,916**	**2,184**	**4,867**	**23,205**	**33.6**

(Australian Institute of Health and Welfare, 2018, Home Care Packages Program data report November, p. 18).

Table 2 shows that the number of packages currently in operation is lower in comparison with the planning ratio allocations. However, the size of this gap varies – the greatest divergence is in Loddon Mallee (26.4 packages operational per 1,000 people aged 70+), and the lowest gap is in Gippsland (40.1 packages operational).

Supply of HCP services

As part of the *Increasing Choice in Home Care reforms* (2017) the Commonwealth made several legislative changes to provider requirements, reducing red tape as a means of increasing service availability to consumers. These changes streamlined the approval process for providers, reduced restrictions on registration status, allocated HCPs directly to clients, and allowed providers to easily alter the services they offer through HCPs [6]. These changes have contributed to an increase in the number of providers in the sector as shown in Table 3.

Table 3: The number of registered HCP providers in 2017 and 2018.

ACPR	31 December 2017	31 December 2018
Barwon South Western	25	27
Eastern Metropolitan	45	53
Gippsland	18	20
Grampians	16	19
Hume	25	28
Loddon Mallee	11	13
Northern Metropolitan	32	37
Southern Metropolitan	56	60
Western Metropolitan	42	52
Total	**270**	**309**

(Australian Institute of Health and Welfare, 2018, Home Care Packages Program data report June, p. 25).

Over the course of 2018 the number of providers increased by 14.4 per cent in Victoria[2]. The largest number of providers are operating in the Eastern and Southern Metropolitan areas, aligning with the number of packages available in these areas. The largest growth in providers was observed in Western Metropolitan area.

2. Due to the limitations of public data availability, comparisons of the change in the number of providers in Victoria over a longer time period are not possible.

Reporting on operational HCPs according to Aged Care Planning Regions has occurred since 2016. Table 4 compares the number of operational HCPs and ratios (HCPs per 1,000 people aged 70+) at 30 June 2018 to the planned number of HCPs, according to the Commonwealth Government's aged care planning ratio (45 places per 1,000 people aged 70+) [5].

Table 4: HCP distribution by ACPR compared to the number of operational providers.

ACPR	Total operational HCPs (30 June 2018)	Operational ratio (HCPs per 1,000 people aged 70+) (2018)	Provider to package ratio	Planned HCPs	% difference between planned and operational HCPs
Barwon South Western	1946	37.8	0.014	2,318	19.1
Eastern Metropolitan	4559	31.6	0.012	6,482	42.2
Gippsland	1680	39.7	0.012	1,903	13.3
Grampians	1071	34.5	0.017	1,395	30.3
Hume	1431	34.8	0.019	1,851	29.4
Loddon Mallee	1348	26.2	0.009	2,315	71.7
Northern Metropolitan	3260	35.7	0.011	4,113	26.2
Southern Metropolitan	5092	31.5	0.011	7,279	42.9
Western Metropolitan	2703	35.2	0.016	3,460	28.0
Total	**23,090**	**33.4**	**0.013**	**31,116**	**34.8**

The provider to package ratio was calculated by comparing the number of active providers at 30 June 2018 to the number of HCPs in the region. The planned HCPs were calculated by applying the Government ratio of 45 HCPs per 1,000 of the population aged 70+ to each region (Source: Australian Institute of Health and Welfare).

Table 4 shows all regions fall short of meeting the package allocations according to the planning ratio. The largest variation between planned and operational packages is in the Eastern Metropolitan and Southern Metropolitan regions, while the regions where the operational packages are closest to meeting the planning ratio are Gippsland and Barwon South Western.

APPENDIX C / FINANCIAL CHARACTERISTICS OF THE HCP SECTOR

Overview

Anecdotal evidence suggests that the financial viability of the sector has reduced since those reforms took effect, because it is no longer possible to cross-subsidise direct care delivery costs across care recipients.

The comments on financial viability provided in this document must be considered in the context described above.

The ACFA reported that the total revenue for HCP providers across Australia was $1.85 billion in 2016–17, with a collective profit margin of $201 million. The Commonwealth contributed $1.68 billion in funding, while consumers paid $150 million towards the cost of their care via fees [7]. Other key findings from the ACFA report included:

- 75 per cent of HCP providers generated a profit in 2016–17, and
- The average Earnings Before Interest Tax Depreciation and Amortisation (EBITDA) per consumer per annum was $2,989 in 2016–17.

A full summary of the financial performance of HCPs delivered by all provider types[3] is given in Table 5.

Table 5: Financial performance of Australian public HCP service providers, 2016–17.

Financial indicator	Government HCP service providers	Private HCP providers	Not-for-profit HCP providers
Total revenue ($m)	$96.8	$239.5	$1,397.2
Total expenses ($m)	$88.5	$195.7	$1,264.3
Profit ($m)	$8.3	$43.8	$132.9
EBITDA ($m)	$8.7	$44.8	$141.7
Average EBITDA per consumer ($)	$1,883	$6,767	$2,621
Average net profit before tax (NPBT) per consumer ($)	$1,803	$6,617	$2,460
EBITDA margin	9.0%	18.7%	10.1%
NPBT margin	8.6%	18.3%	9.5%

Source: Aged Care Financing Authority Annual Report, p. 69

Table 5 reveals the significantly higher profit margins achieved by private HCP providers in comparison with Government and not-for-profit providers.

Revenue

A more recent analysis of the sector's profitability by StewartBrown, a large, mid-tier accounting firm specialising in Australia's aged care sector, revealed an aggregate decrease in revenue of 6.1 per cent in 2017–18 for all providers across the country. This was attributed to increased pricing pressure as a result of increased competition and a higher amount of unspent funds by clients [8].

Expenditure

StewartBrown's Aged Care Report revealed the average expenses for all HCP providers decreased by 4.2 per cent between 2016–17 and 2017–18. The reason for this decrease was explained by a reduction in case management, advisory, and administrative costs as providers seek to improve efficiencies.

3. The ACFA report defines three types of provider ownership – For profit, Not for profit, and Government.

Cost drivers

Provider expense per consumer varied by geographic region. The expense per consumer per day (PCPD) among metropolitan providers nationally was $66.05, while regional providers incurred an expense of $60.65 PCPD and providers operating in both metropolitan and regional areas had an average expense of $65.01 PCPD [7].

Profitability

The total profit for all HCP providers in 2016–17 was estimated by ACFA at $201 million, an increase of 10 per cent from 2015–16. The growth was attributed to the significant increase in the number of HCP consumers, as opposed to higher profit margins per consumer.

Government providers recorded an EBITDA per consumer of $1,883, a decrease of 28.2 per cent from the previous financial year and the lowest of all provider types. According to ACFA, this decline was associated with the willingness of Government providers to operate in unfavourable sector segments. Although Government providers had an increase in revenue of 1.3 per cent in 2016–17, this was offset by a 4.6 per cent increase in costs [7].

StewartBrown's Aged Care Report, which provides more recent data, found that, despite a drop-in cost for 2017–18, there was a decrease in sector-wide profitability. The average surplus per client day in 2017–18 was $3.77 compared with $5.37 in 2016–17.

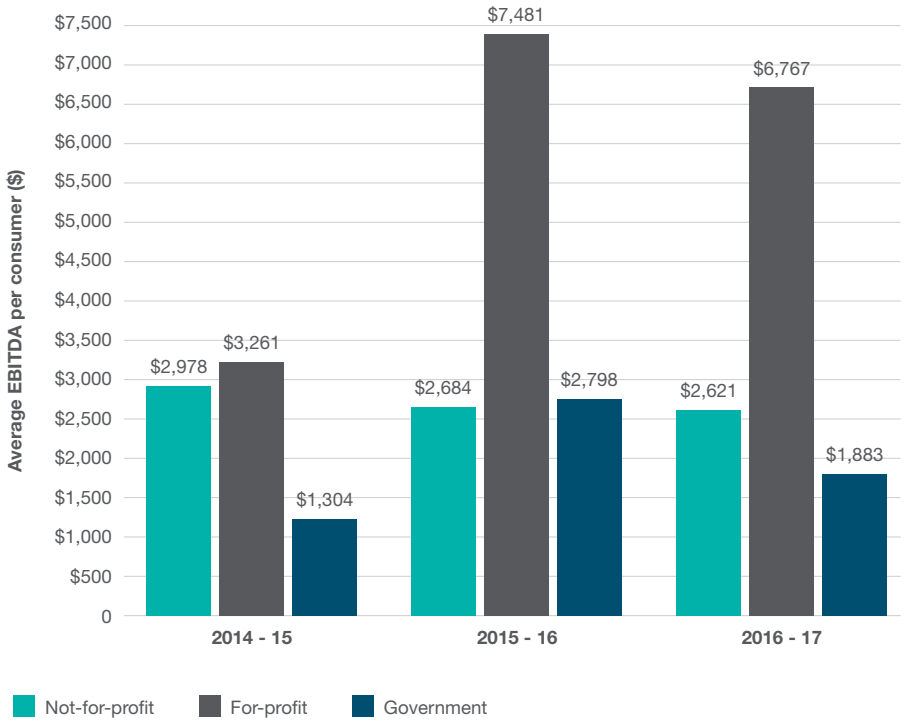
A comparison of profitability by provider type between 2014 and 2017 can be observed in Figure 1: Comparison of profitability by provider type.

Profit drivers

Geography: when considering profitability by location, providers that operated in metropolitan areas achieved the highest level of average EBITDA per claim in 2016–17, averaging $3,431 compared with $2,960 for regional providers and $2,026 for providers operating in both regional and metropolitan areas. This contrasted with 2015–16 where regional providers slightly outperformed metropolitan providers [7].

Number of services offered: providers that operated two to six services achieved the highest average level of EBITDA ($3,420 per consumer) compared to single service providers, which generated an average return of $2,803 per consumer [7].

Figure 1: Comparison of profitability by provider type across Australia.



(Source: Aged Care Financing Authority, Annual Report, p.74)

APPENDIX D / TRENDS IN THE UPTAKE OF HCPS

To assist with estimating future planning requirements for HCP services, Table 6 provides the projected number of HCPs expected by 2021 and 2031 and the percentage increase in comparison with HCPs available at June 2018. These projections were calculated by applying the planning ratio to the 70+ population projections across ACPRs.

Table 6: Projected increase in HCPs by 2021 and 2031 across ACPR.

ACPR	Number of operational HCPs at June 2018	Number of HCPs required according to application of the planning ratio, 2021	% increase in packages 2021	Number of HCPs required according to application of the planning ratio, 2031	% increase in modelled operational packages 2031
Barwon South Western	1946	2648	36.1	3623	86.2
Eastern Metropolitan	4559	6700	47.0	8675	90.3
Gippsland	1680	2086	24.1	2834	68.7
Grampians	1071	1546	44.4	2130	98.9
Hume	1431	1961	37.0	2714	89.7
Loddon Mallee	1348	2288	69.7	3133	132.4
Northern Metropolitan	3260	4821	47.9	7102	117.9
Southern Metropolitan	5092	8129	59.6	11407	124.0
Western Metropolitan	2703	4294	58.8	6700	147.9
Total	**23,090**	**34,472**	**49.3**	**48,319**	**109.3**

(Source: Australian Institute of Health and Welfare)

This data shows the **expected growth in HCP demand by 2021** will be particularly strong in the Loddon Mallee (+69.7%, compared to June 2018 operational HCPs) and Southern Metropolitan (69.7%) regions, while the Gippsland (+24.1%) and Barwon South Western (+36.1%) regions will experience the smallest growth in the requirement for additional HCPs.

By 2031 the largest increase in **operational packages required by 2031** when compared to 2018 are expected in the Western Metropolitan region (+147.9%) and Loddon Mallee regions (+132.4%) while the lowest increase in HCPs are expected to occur in the Gippsland (+68.7%) and the Barwon South Western regions (+86.2%).

Table 7 provides the number of projected additional HCPs required by 2021 and 2031 by local government areas (LGAs).

This data can serve as a reference for providers seeking more detailed information on future demand for HCPs in their local catchment regions.

Table 7: Comparison of the number of operational and theoretical HCPs between 2018, 2021 and 2031[4].

LGA	Region	Number of operational HCPs 2018	Number of HCPs required according to application of the planning ratio, 2018	Modelled HCPs 2021	Number of HCPs required according to application of the planning ratio, 2021	Modelled HCPs 2031	Number of HCPs required according to application of the planning ratio, 2031
Boroondara	Eastern Metropolitan	550	938	770	1027	986	1315
Knox	Eastern Metropolitan	629	774	705	941	1086	1448
Manningham	Eastern Metropolitan	612	887	739	985	906	1209
Maroondah	Eastern Metropolitan	576	601	506	674	667	890
Monash	Eastern Metropolitan	826	1136	887	1183	971	1296
Whitehorse	Eastern Metropolitan	770	1004	790	1053	924	1232
Yarra Ranges	Eastern Metropolitan	596	741	627	837	964	1286
Banyule	Northern Metropolitan	479	725	605	797	782	1032
Darebin	Northern Metropolitan	652	768	569	750	689	909
Hume	Northern Metropolitan	433	661	585	772	1059	1396
Moreland	Northern Metropolitan	752	820	632	833	718	946
Nillumbik	Northern Metropolitan	114	244	240	316	432	569
Whittlesea	Northern Metropolitan	433	769	728	960	1273	1679
Yarra	Northern Metropolitan	397	312	298	394	434	572
Bayside	Southern Metropolitan	289	660	501	729	674	979
Cardinia	Southern Metropolitan	179	369	315	459	579	841
Casey	Southern Metropolitan	594	1005	903	1312	1572	2286
Frankston	Southern Metropolitan	584	692	515	749	721	1048
Glen Eira	Southern Metropolitan	727	740	513	746	638	927
Greater Dandenong	Southern Metropolitan	603	753	548	797	668	971
Kingston	Southern Metropolitan	520	906	660	960	855	1243
Mornington Peninsula	Southern Metropolitan	837	1319	930	1353	1204	1750
Port Phillip	Southern Metropolitan	385	399	272	396	410	596
Stonnington	Southern Metropolitan	374	559	432	628	526	764
Brimbank	Western Metropolitan	765	855	809	1029	1129	1437

4. Theoretical HCPs have been determined by applying the Government planning ratio of 45 HCPs per 1,000 people of the population aged 70+ to ABS population projections.

LGA	Region	Number of operational HCPs 2018	Number of HCPs required according to application of the planning ratio, 2018	Modelled HCPs 2021	Number of HCPs required according to application of the planning ratio, 2021	Modelled HCPs 2031	Number of HCPs required according to application of the planning ratio, 2031
Hobsons Bay	Western Metropolitan	298	458	388	494	533	678
Maribyrnong	Western Metropolitan	332	274	222	282	366	466
Melbourne	Western Metropolitan	237	312	408	519	661	841
Melton	Western Metropolitan	305	352	479	610	799	1017
Moonee Valley	Western Metropolitan	496	667	548	697	695	884
Wyndham	Western Metropolitan	270	521	521	663	1082	1377
Colac-Otway	Barwon South Western	98	147	121	155	156	199
Corangamite	Barwon South Western	80	118	92	118	110	140
Glenelg	Barwon South Western	105	139	112	143	155	198
Greater Geelong	Barwon South Western	1093	1452	1237	1582	1703	2177
Moyne	Barwon South Western	99	94	85	109	119	153
Queenscliff	Barwon South Western	16	40	30	39	36	47
Southern Grampians	Barwon South Western	119	122	98	125	121	155
Surf Coast	Barwon South Western	89	163	127	162	207	265
Warrnambool	Barwon South Western	247	213	168	215	227	290
Bass Coast	Gippsland	331	297	258	298	336	388
Baw Baw	Gippsland	184	316	303	350	449	518
East Gippsland	Gippsland	405	409	378	437	486	562
Latrobe	Gippsland	422	439	409	473	570	658
South Gippsland	Gippsland	124	213	196	226	254	293
Wellington	Gippsland	214	267	261	302	359	415
Ararat	Grampians	74	86	67	90	79	106
Ballarat	Grampians	503	574	460	614	628	839
Golden Plains	Grampians	36	81	74	99	118	157
Hepburn	Grampians	61	117	93	124	137	183
Hindmarsh	Grampians	34	52	32	43	36	48
Horsham	Grampians	135	131	99	132	121	162
Moorabool	Grampians	84	153	145	194	244	325
Northern Grampians	Grampians	51	90	73	98	95	127
Pyrenees	Grampians	28	54	46	62	61	82
West Wimmera	Grampians	25	32	22	29	23	31
Yarriambiack	Grampians	40	61	46	61	54	72

LGA	Region	Number of operational HCPs 2018	Number of HCPs required according to application of the planning ratio, 2018	Modelled HCPs 2021	Number of HCPs required according to application of the planning ratio, 2021	Modelled HCPs 2031	Number of HCPs required according to application of the planning ratio, 2031
Alpine	Hume	65	96	81	102	107	135
Benalla	Hume	99	115	92	116	120	151
Greater Shepparton	Hume	352	367	296	373	400	504
Indigo	Hume	79	99	90	113	127	160
Mansfield	Hume	16	64	49	62	68	86
Mitchell	Hume	89	182	188	236	306	385
Moira	Hume	165	237	205	258	269	339
Murrindindi	Hume	46	99	96	121	132	166
Strathbogie	Hume	40	93	81	103	102	128
Towong	Hume	20	49	40	50	49	61
Wangaratta	Hume	247	211	169	212	218	275
Wodonga	Hume	213	188	171	216	258	324
Buloke	Loddon Mallee	28	57	34	53	38	59
Campaspe	Loddon Mallee	280	283	194	302	253	394
Central Goldfields	Loddon Mallee	38	120	83	130	103	161
Gannawarra	Loddon Mallee	60	95	66	102	76	118
Greater Bendigo	Loddon Mallee	337	639	447	695	636	988
Loddon	Loddon Mallee	38	64	47	73	60	93
Macedon Ranges	Loddon Mallee	89	241	190	295	295	458
Mildura	Loddon Mallee	291	324	231	359	314	489
Mount Alexander	Loddon Mallee	63	146	99	154	140	217
Swan Hill	Loddon Mallee	124	126	81	126	101	157
Total		**23,090**	**30,976**	**25,707**	**34,476**	**36,059**	**48,322**

APPENDIX E / IMPACT OF FEE ARRANGEMENTS AND MEANS TESTING

History

The Commonwealth Government covers the majority of costs for HCP delivery via the provision of subsidies. In 2014, as part of the *Living Longer Living Better* reforms, the then Gillard government announced significant changes to the fee structure for HCPs. These changes are described in detail in the next section.

Consumers entering HCPs from 1 July 2014

For consumers entering the HCP scheme from 1 July 2014, providers are able to charge consumers the basic daily fee of 17.5 per cent of the single basic age pension and the income tested care fee only if their income is over the maximum income for a full pension[5]. A consumer's income is defined as income after tax and the Medicare levy. The rate of the basic daily fee is readjusted on 20 March and 20 September each year in line with changes to the age pension rate [9].

Fee arrangements

The Department of Human Services (DHS) calculates the income-tested care fee based on an assessment of the consumer's financial information. The assessment does not include consideration of the value of a consumer's home or any other assets. Consumers can only be asked to pay an income-tested care fee if their yearly income is above the set thresholds, which are summarised in figure 2 [7].

Figure 2: Thresholds for income tested care fees, as at March 2017.

(Source: D Tune, Legislated Review of Aged Care, 2017, p. 71)

If a consumer is a member of a couple, half of their combined income is considered when determining the income-tested care fee, irrespective of which partner earns the income.

Following the assessment, DHS will advise both the provider and consumer of the maximum fees payable. A provider may determine to charge consumers a lower amount than that required by the income test but the full range of services must still be provided. Under this arrangement the **subsidy paid by Government reduces by the maximum amount of income-tested care fee the consumer may be charged, with a taper rate of 50 per cent**. This model places increased financial responsibility on the consumer and encourages providers to charge some or all of the income-tested care fees.

Consumer contributions are capped by DHS (Figure 2). Under the regulations applying to HCPs, once the cap is reached, consumers cannot be required to contribute any additional income-tested fees to the cost of their care, i.e. the Commonwealth Government increases the amount of subsidy provided.

5. Different fee arrangements apply to consumers who had commenced the receipt of HCPs prior to 1 July 2014. See the Department of Health website for details.

Consumers cannot be charged fees when a package is suspended because they are on leave. Leave types may include: hospital leave, transition leave, respite care and social leave.

A quarterly review of income-tested care fees is carried out automatically by DHS (or sooner if requested by a consumer) [9].

Provider requirements

Providers are required to include information about fees payable in the Home Care Agreement. The calculated fee amount will also be recorded in the consumer's individualised budget [9].

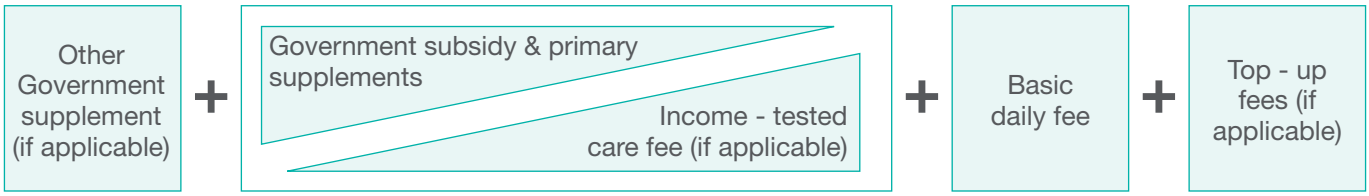
By 1 July 2019, HCP providers will be required to publish their pricing information in a standardised template on the My Aged Care website, to allow for an easier fee comparison by consumers.

Charging fees

- Providers are not able to charge consumers fees prior to the commencement of services.
- Any fees paid by Government contribute to the provision of services received by the consumer.
- Once a Home Care Agreement has been signed, providers can ask the consumer to pay fees up to one month in advance. Any fees paid in advance must be refunded if the consumer leaves the HCP or changes providers.
- It is the responsibility of consumers to pay agreed fee amounts to providers.
- If consumers are unable to pay the required fees, they can ask to be considered for financial hardship assistance.

Consumers can receive assistance with the basic daily fee or the income-tested care fee. If granted approval, the Government will make additional contributions by way of a Hardship Supplement, which may include some or all of the consumer's fees. The overall fee structure is described in Figure 3 [9].

Figure 3: HCP fee structure.



(Source: Australian Government Department of Health, Home Care Packages Programme Operational Manual, p. 25)

Implications of fee arrangements

The changes to fee arrangements were implemented with the aim of:

- ensuring equity in consumer contributions so that people with similar financial resources make similar contributions
- protecting people with low levels of wealth so that they receive the care they need without having to make contributions that they cannot afford
- contributing to the long-term sustainability of the aged care system by ensuring that those who can afford to contribute to the cost of their aged care do so [9].

In respect to achieving these objectives the Tune Report (2017) [5] found:

- The amount of income-tested care fees collected following the changes to fee arrangements is relatively small compared to the contributions by Government. This is partly attributable to the fact that a large number of HCP consumers are full pensioners (82 per cent at 30 June 2016) and are therefore not required to contribute to the cost of their care, beyond the basic daily fee. Of the remaining 18 per cent, a majority are part pensioners (15 per cent) with only three per cent of HCP consumers being self-funded retirees who are required to pay an income-tested care fee up to the second cap (as at 30 June 2016).
- The relatively high proportion of the basic daily fee compared to the package value in level 1 packages is contributing to decreased demand for these packages.
- The current fee structure for HCPs has issues associated with equity when compared to the charging arrangements for CHSP programs; it does not provide an incentive for consumers to move through the system from the lowest level of support (CHSP) to higher levels of support (HCP levels 1 to 4).

APPENDIX F / SCOPE OF DELIVERY IN THE PUBLIC HCP SECTOR

Table 8 below shows the proportion of public HCP service providers that operate in each ACPR in 2019.

Table 8: Percentage of HCPs by ACAT region January 2019.

ACPR	Total approved providers	Total public providers	% of public providers
Barwon South Western	27	6	22.2
Eastern Metropolitan	53	3	5.7
Gippsland	20	6	30
Grampians	19	7	36.8
Hume	28	4	7
Loddon Mallee	13	3	23.1
Northern Metropolitan	37	3	8.1
Southern Metropolitan	60	5	8.3
Western Metropolitan	52	4	7.7
Total	**309**	**41**	**13.3**

(Source: AIHW, Home Care Packages Data Report September, p. 22)

This data demonstrates the relatively small number of public HCP service providers making up the HCP sector. In particular, the metropolitan areas are made up of non-government providers.

APPENDIX G / THE AGED CARE WORKFORCE

According to 2016 Census data the total number of paid workers in home care and home support amounted to 235,764, of which 153,854 (65%) were direct care workers.

Workforce considerations

- In home care and home support: 49 per cent of services reported skill shortage, with shortages more common in remote areas.
- Fifty-one per cent of HCP and CHSP outlets reported using volunteers
- A regular daytime shift is the most common work schedule for all direct care workers
- 14 per cent of CCWs reported an irregular work schedule.
- Eighty-one per cent of home care support workers expected to still be with their current employer after 12 months [10].

Aged Care Workforce Strategy

In 2018 an independent Aged Care Workforce Strategy Taskforce was appointed to develop a strategy for growing and sustaining an aged care workforce to meet the needs of older Australians across a variety of settings throughout Australia. This taskforce delivered a report in June 2018 that included **fourteen key strategic actions** aimed at preparing the workforce for the future and improving the quality of aged care for all [11].

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Since 1938, the Victorian Healthcare Association has been supporting Victoria's publicly funded healthcare providers to respond to system reform, shape policy and advocate on key issues. The VHA proudly represents 96 per cent of the state's public hospitals and community health services.

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