

Yuwaya Ngarra-li Briefing Paper

Caring for Elders, Community and Culture:

A study of the potential impact of changes to the funding of home care on the aged care services provided by Dharriwaa Elders Group (DEG)

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This Briefing Paper has been prepared at the request of the Dharriwaa Elders Group (DEG) and its Yuwaya Ngarra-li partners at UNSW to assist DEG to understand and respond to possible changes in the basis of funding for the aged care services it provides. The paper should also be of interest to other organisations in determining their responses to the proposed changes.

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Abbreviations

ACAT	Aged Care Assessment Team
ACBF	Aboriginal Community Benefit Fund
ACSA	Aged & Community Services Australia
AMS	Aboriginal Medical Service
ATSI	Aboriginal and Torres Strait Islander
CDC	Consumer Directed Care
CHSP	Commonwealth Home Support Programme
DADHC	(former NSW) Department of Ageing Disability and Home Care
DEG	Dharriwaa Elders Group
DEX	(DoH) Data Exchange system
DoH	(Australian) Department of Health
EACH	Extended Aged Care at Home
GEAT	Goods, equipment and assistive technologies
HACC	(former) Home and Community Care program
HCPP	Home Care Packages Program
IEI	Indigenous Employment Initiative
IT	Information Technology
kms	kilometres
LGBTI	Lesbian, Gay, Bisexual, Trans and Gender Diverse, and Intersex
MMM	Modified Monash Model
NAGATSIAC	National Advisory Group on Aboriginal and Torres Strait Islander Aged Care
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NDIS:	National Disability Insurance Scheme
para(s)	Paragraph(s)
RCAC	Royal Commission into Aged Care Quality and Safety
RAC	Residential Aged Care
SAHP	Support At Home Program
TAFE	(State departments of) Technical and Further Education
UoW	University of Wollongong
UNSW	University of NSW
WAMS	Walgett Aboriginal Medical Service
YN	Yuwaya Ngarra-li (DEG-UNSW partnership)

KEY MESSAGES - Caring for Elders, Community and Culture

The purpose of this paper is to identify how the aged care services currently provided by Dharriwaa Elders Group (DEG) in Walgett may be affected by proposed changes to the system for funding and regulating home and community care services for older Australians. The paper may also assist other Indigenous and locally-based service providers to understand and respond to the proposed changes.

1. DEG provides a number of services for local Aboriginal Elders (transport, individual social support, group social support) that are funded through the Commonwealth Home Support Programme (CHSP). These services are important to the Elders as individuals, as members of the community, and as local custodians of Aboriginal culture. The success of the services is underpinned by the current arrangements for funding and regulating CHSP services, especially block grant funding.
2. The future design of the home and community care system is currently very fluid and uncertain.
3. Following the Aged Care Royal Commission, the Department of Health (DoH) has been developing proposals for a single Support At Home Program (SAHP). The proposals they have put forward so far represent a major change from CHSP in terms of philosophy, structures, and program mechanisms.
4. The DoH Proposals are problematic in a number of ways. Some do not flow from the findings of the Royal Commission and contradict those findings in some respects. The proposals make no attempt to address the substantial evidence of problems in human services that are created by the measures being suggested. The proposals have been a matter of significant concern across the home care sector, especially among the users and providers of locally-based services. There is a need to pause the development of SAHP and recast its key parameters.
5. In particular, there are concerns about introducing (a) a fee-for-service funding model for all providers replacing block grants for the current CHSP services (b) NDIS-like individualised entitlements for all service users (c) less regulation of providers for some services (d) the end of a program focused on the specific circumstances of older people with low care needs, and (e) the payment of providers in arrears.
6. The DoH Proposals also include a number of other suggested changes to the administration of home and community care that are less disruptive and which in principle can be an improvement if designed properly, but much more work needs to be done on them.

7. From DEG's perspective, the changes proposed by DoH, especially the end of block grants for current CHSP providers, would create a more volatile and uncertain operating environment and one that is inconsistent with the DEG philosophy and goals concerning group and community approaches. In turn, DEG's current capacity to support the well-being of each individual Elder and to enable Elders to contribute to the community and to the strengthening of Aboriginal culture could be threatened.
8. However, the DoH Proposals also include a number of measures that are only or substantially for Indigenous users, providers, and services, including Indigenous-specific assessment and care-finder services, and top-up grants for some providers in so-called 'thin markets'. These may temper the negative effects of the broader changes on Indigenous providers and even give them some opportunity to enhance their current services.
9. In the above context, DEG may be able to largely continue its current operations and services in the short term, although some organisational adjustments will be necessary. However, the risks and threats for all service providers inherent in the overall DoH Proposals will necessitate further and more significant changes for DEG in the intermediate and longer term.

A. Introduction

Purpose of the Paper

1. The purpose of this paper is to identify how the aged care services currently provided by Dharriwaa Elders Group (**DEG**) in Walgett may be affected by proposed changes to the systems for funding and regulating home and community care services¹ for older Australians. DEG currently receives funding from the Commonwealth Home Support Programme (CHSP).
2. These changes are being proposed by the Australian Department of Health (**DoH**) as part of a new Support at Home Program (**SAHP**) it is developing following the Final Report of the Royal Commission into Aged Care (**RCAC**) in February 2021 (RCAC 2021) and the Australian Government Response to that report in May 2021 (DoH, 2021).
3. The Dharriwaa Elders Group has a number of roles in considering the impact of SAHP - as users of the aged care services, as the governance body for a provider, as community leaders, and as local custodians of Aboriginal culture.
4. This paper aims to give DEG and its members an overview of the potential situations and options facing them as a basis for discussion and decisions about future action they may need to take in response to changes to the home and community care system.
5. The paper is written from the perspective of how to best ensure the well-being of Aboriginal² Elders³ in Walgett. This involves ensuring quality care and support for each individual Elder, but their well-being as individuals is also deeply grounded in their desire to maintain and enrich their

¹ The term 'home care' has been formally used for these services since 2015. Prior to that, the term 'home and community care' was used, which is more accurate given that a number of much used services are outside the home and in the community. For example, in 2020-21, 23.2% of total expenditure for CHSP services was for transport and social support services, with a further 1.8% for centre and cottage respite (Deloitte 2020). In this paper, the terms are used interchangeably, although 'home care' is mainly used where the discussion relates to government programs.

² The terms, Aboriginal, Indigenous, and First Nations are often used interchangeably. In this paper, 'Aboriginal' is used in references to Walgett and DEG as it is the term preferred by the Dharriwaa Elders Group, while 'Indigenous' is used in references to broader situations (e.g. national policy and programs). Many Elders also identify themselves by their nation or language group, which in Walgett includes Gamilaraay, Yuwaalaraay and Ngayiimbaa people.

³ There are different conceptualisations of 'Elders' used in different contexts in Australia. Indigenous people 50 years old and over (50yo+) are eligible for Australian Government aged care programs (compared to 65 yo+ for the general population). Dharriwaa Elders Group define Elders as Aboriginal people aged 60 years and over (60yo+).

community and culture. In turn, it is vital that the organisation they have created can survive and thrive in order to enable these outcomes to be achieved.

6. The paper may also assist other Indigenous and community-based service providers in understanding and responding to the proposed changes.
7. In describing and analysing the proposed changes, the paper draws on relevant theoretical and empirical evidence about the provision of human services, and especially home and community care for older people, to support its findings, conclusions, and suggestions.
8. At a broader level, the paper represents a study of the relationship between national policy proposals and their likely effect 'on the ground' in terms of the impact on the people and organisations at the local level in a small remote community. The paper points up that these impacts are not always as intended or foreseen by central policy makers.

Structure of the Paper

9. The next section outlines the current situation in relation to DEG, DEG's aged care services, and the current funding arrangements for those services (Section B). The paper then sets out the imperatives for change (Section C), a description and analysis of the DoH Proposals for SAHP (Section D), the potential impact of the DoH Proposals on DEG (Section E), what could happen with SAHP (Section F), action required by DEG (Section G), and the future development of SAHP (Section H).

B. The Current Situation – DEG and Aged Care Services

DEG - The Organisation and its Activities

10. The Dharrivaa Elders Group (DEG) is an association of Aboriginal Elders that provides leadership on a range of community development and cultural engagement activities in Walgett. It was established in 1999 as part of the Walgett Aboriginal Medical Service (WAMS) and incorporated as a separate non-profit body in 2005.
11. The Gamilaraay word 'Dharrivaa' means 'common meeting place' in English. Facilitating meetings of Aboriginal Elders with each other, with others in the Aboriginal community, and with the broader Walgett community, has been a major goal and function of DEG throughout its existence.
12. DEG has been actively engaged in advocacy and research over the past two decades in a wide range of matters of significance for the Aboriginal community, Aboriginal culture, and the broader community. Its activities are aimed at (a) improving the economic, social, and environmental well-being of Aboriginal people in Walgett (b) maintaining the independence and the social and cultural connections of local Aboriginal Elders, and (c) enabling the Aboriginal community and broader community, especially young Aboriginal people, to benefit from the knowledge and experience of the Elders.
13. DEG's current and previous projects have encompassed aged care services, cultural heritage and knowledge, water, justice, youth, the environment, community well-being, community leadership, and relationships with police, councils and other bodies. A recent project of particular relevance to this paper is the Ageing Well study (see paragraphs 48-57 below).
14. The broader philosophical, psychological, and sociological rationale for the work of DEG is set out in McCausland et al (2021a) and McCausland et al (forthcoming). DEG's work embodies a strong commitment to Aboriginal cultural traditions and values, and to community and group-based approaches in the range of services and activities it provides for Aboriginal Elders and for others in both the Aboriginal and general community. Importantly, its approach is holistic and collective, recognising the structural drivers and interconnectedness of the challenges and issues affecting Aboriginal people, as well as ensuring that its priorities and activities are determined by the group and organised to benefit the community.
15. An important aspect of DEG is the Yuwaya Ngarra-li (YN) partnership with UNSW, a holistic, community-led model based on collaboration on evidence-based initiatives, research and

building local community capabilities and control underpinned by the long-held vision for community well-being of Aboriginal Elders in Walgett (McCausland et al 2021). The structures, processes and projects of DEG and Yuwaya Ngarra-li represent a valuable model that other Indigenous communities may wish to consider and adapt to their own situation and needs. ⁴

16. DEG has brought together a number of elements in a way that makes it a highly innovative, if not unique, development in the Indigenous and community space in Australia. Here we have a small community-based organisation that operates at a number of levels. It is a body that provides a number of multi-faceted holistic services for local Elders; that has established an impressive range of projects of social, economic, and environmental benefit for the wider community; that has a research partnership with a major university; and that can draw on a variety of high-level professional support. Importantly, all of this has been generated by and remains under the direction of local Aboriginal Elders.

Walgett

17. DEG operates in Walgett, a small town in the north-west of NSW that is relatively remote from major population centres.
18. Walgett is approximately 650 kilometres (kms) from Sydney, 275 kms from the nearest large town (Dubbo, population 38,943 in 2016 Census), and 130 kms south of the Queensland border. The closest settlement is Lightning Ridge, 73 kms to the north on the way to the Queensland border (population 2,284 in 2016). Under the Modified Monash Model (MMM) for classifying remoteness in relation to health services,⁵ Walgett is in the second most remote category (MMM6); the next town to the west (Brewarrina, 133 km away) is in MMM7 (the most remote classification).⁶
19. Walgett has consistently been measured over the decades as one of the most disadvantaged locations in Australia (Vinson & Rawsthorne, 2015). At the same time, the Aboriginal community in Walgett has significant strengths, drawing on a long history of its people engaged in political activism, advocacy, and research. These strengths have underpinned the growth and success of strong local community organisations such as WAMS and DEG.

⁴ Dew & McEntyre (2017) reports on one of the early projects that led to the establishment of the YN partnership.

⁵ See <https://www.health.gov.au/health-topics/rural-health-workforce/classifications/mmm>

⁶ Walgett is also classified as Remote (the second most remote category) in the Accessibility/Remoteness Index of Australia (ARIA). (<https://www.qgso.qld.gov.au/about-statistics/statistical-standards-classifications/accessibility-remoteness-index-australia>)

The population of Walgett^{7 8}

20. There are two major features of the profile of the population of Walgett that are particularly relevant to this paper - the small total population and the relatively high proportion of Aboriginal people in that population.
21. In the 2016 Census, the town and surrounds of Walgett had a total population of 2,145, of whom 935 (43.4%) were Indigenous, comprising 498 females (53.3%) and 435 males (46.5%).⁹ This is a very high proportion of Indigenous people compared to the rest of NSW (2.9% in the 2016 Census) and Australia (3.3%).
22. There is also a high proportion of Aboriginal people in the broader Walgett Shire, although this is less pronounced than in the town. In the 2016 Census, the Walgett Shire (a large area of 22,376 square kms) had a total population of 6,107, of whom 1,798 (29.4%) were Indigenous, comprising 925 females (51.4%) and 874 males (49.6%).
23. The age structure of the local Aboriginal population in Walgett is obviously important in the context of this paper.¹⁰
 - Of the 935 Aboriginal people in Walgett in 2016, some 218 (23.1%) were aged 50 or more (50+ yo). This included 61 (6.5%) who were 65+ yo.
 - As in most places in Australia, the Aboriginal population in Walgett (median age of 27, with 23.1% who were 50+ yo), was younger than the non-Aboriginal population (median age of 33, with 41.3% who were 50+ yo).
 - At the same time, the Aboriginal population in Walgett (median age 27) was relatively older compared to the Aboriginal population for NSW as a whole (median age 22).
 - The Aboriginal population in the area has been getting older. For example, the number in the Walgett Shire in the 2016 Census who were 65+ yo had grown by 6% since the 2011 Census

⁷ The data about population that follows is primarily from ABS 2016 Census documents (ABS 2017a, Table G07; ABS 2017b; ABS 2017c, Table G07; and ABS 2017d). Other documents drawing on ABS 2016 Census data were also consulted (e.g. NSW Government, 2017).

⁸ Note that there are some minor discrepancies in the additions of some of the numbers shown in the following paragraphs and Table 1. The numbers of people cited are exactly as they appear in the above ABS publications. ABS (2017a) explains that “there are small random adjustments made to all cell values to protect the confidentiality of data. These adjustments may cause the sum of rows or columns to differ by small amounts from table totals.”

⁹ In the 2016 Census, over 99% of the Indigenous people in both the town and the shire were Aboriginal.

¹⁰ Subject to other eligibility criteria, government-funded aged care services are available to people who are 65 years or older (65+yo), and to Indigenous people who are 50 years or older (50+yo).

and 25% since 2006. This is also the case in NSW as a whole for Indigenous and non-Indigenous people.

24. Table 1 summarises the above data for the town of Walgett.

TABLE 1: THE POPULATION OF WALGETT (2016 Census)

		Total		Indigenous	
Total	Number	2145		935	
	% of total population	100		43.4	
		Number	%	Number	%
x Gender	Male	1087	50.6 %	435	46.6%
	Female	1061	49.4 %	498	53.4%
x Age	<50 yo	1476	69.1 %	727	76.9%
	50-59	302	14.1 %	119	12.6%
	60-64	121	5.7 %	38	4.0%
	65+	238	11.1 %	61	6.5%
	Total 50+	661	41.3%	218	23.1%
Median	Median Age (Walgett)	33		27	
Ages	Median Age (NSW)	38		22	

Sources: ABS (2017a), ABS (2017b)

Note: See footnote 8 regarding the minor discrepancies in additions in the table.

25. From the above data we can see that in 2016, some 218 Aboriginal people in Walgett were potentially eligible for Australian government-funded aged care services, including 61 who were aged 65 or more (65+) and a further 157 aged between 50 and 64 yo. In addition, the Census indicated that there were another 216 Aboriginal people who were 50+ living in other parts of the Walgett Shire, including 59 who were 65+ yo and 157 between 50 and 64.

Key Structural Dimensions of DEG as a Service Provider

26. The discussion thus far has identified four key structural dimensions of DEG that are important in determining what aged care services it provides and how it provides them. It is a *small, community-controlled* organisation that serves *Aboriginal* people in a *remote* region.
27. First, it is a *small* organisation. The scale of an organisation can be measured in a number of ways (e.g. number of employees, number of clients, financial turnover). By any of these measures, DEG is small in the context of aged care providers in Australia. It is also small in terms of the scope of services that it provides, compared to the many other organisations that provide services across the three major forms of aged care (Residential, Packages, CHSP) as well as a wider range of home and community care service types.
28. Second, it is *community-controlled*. This is central to its operation and success. It has grown from the Walgett community, has developed and manages its service in response to local needs and circumstances, and is controlled by local people who remain directly accountable to the people that DEG supports. As such, it can identify and respond more rapidly and appropriately to changing and emerging needs. Such an approach has been critical to the success of Aboriginal organisations in many fields. It has also been at the core of the success of the Home and Community Care (HACC) Program¹¹ and CHSP more generally over four decades, with many providers controlled by - and organised around the needs of - local people who live in and understand those communities.
29. Third, it is an *Aboriginal* organisation that serves Aboriginal people. While DEG is linked into the wider local community and supports activities that benefit Walgett in general, its prime focus is on Aboriginal people, the Aboriginal community, Aboriginal culture, and the relationship of Aboriginal people with the broader community and society. Long experience from many sectors has proven the value and essentiality of Indigenous people directing and delivering services for Indigenous people if the services are to be most effective. Indeed, this principle has been accepted by DoH in its proposals for two Indigenous-specific services (user assessment and care-finders) within the DoH Proposals for SAHP (see paras 185-187).
30. Fourth, as outlined earlier, Walgett is located in a relatively *remote* region. DoH pricing policy recognises that overall this leads to increased costs. As well there are substantial intrinsic limits on human service providers in remote areas in obtaining most key inputs for their services. These issues of high cost and limited availability of inputs are especially true in relation to staff. Commonly in remote areas, there are no or few local people available with the necessary skills

¹¹ See next section for an explanation of HACC

for key jobs, but the costs of incentives to attract people to the area are prohibitive. Conversely, funding levels may only allow for part-time jobs such that local people with skills look elsewhere.

31. Another aspect of remote areas is that there are relatively few people who require services and few, if any, providers. Even strong proponents of marketisation concede that in these 'thin markets', many of the assumptions underpinning simplistic market-based approaches cannot work. As we see later, the DoH Proposals acknowledge this fact. (It is also important to note at this point - and this is central to the later critique of the DoH Proposals - that the limitations of market-based approaches are not confined to thin markets, but exist virtually everywhere in the provision of home and community care more generally, and indeed with most human services).
32. In general, Aboriginal providers and providers in remote areas are relatively small in terms of scale, scope and geographical spread (Deloitte, 2020; SCRGSP 2022). This means some loss of economies of scale and scope, but it also enables providers to continue to develop and manage services in ways that enable them to stay in touch with the actual and current needs and situations of the people who require their services.
33. Later (paras 226-235) we look at how these four dimensions are relevant to the DoH Proposals for changes to the funding and regulation of CHSP services, both in relation to (a) the immediate impact on DEG's services, and (b) the extent to which the changes may affect whether DEG in fact retains those four dimensions over the intermediate and longer terms.

Aged Care Services and Funding in Australia

34. There are three main forms of aged care in Australia:
 - Residential aged care
 - Home and community care for people living at home who have a need for more extensive and complex external care and support, with these services currently funded via the Home Care Packages Program (HCPP), and
 - Home and community care for people living at home who have relatively limited external care and support needs, with these services currently funded via the Commonwealth Home Support Programme CHSP).^{12 13}

¹² CHSP is the descendant of the Home and Community Care (HACC) program, which was first established in 1985 and re-named CHSP in 2015 (with some changes, plus integration of three smaller programs). From 1985-2012, HACC was jointly Commonwealth-State funded, and administered by the states. In 2012, full responsibility for the funding and administration of HACC for older people was transferred to the Commonwealth in most states and territories, although the transfer was not completed for WA and Victoria until 2018.

¹³ There is no clear one-to-one correspondence between the level of care/support needs of an older person and the program and services he/she uses. Someone with high needs may have a lot of family support and thus only draw on CHSP in a limited way. Conversely, someone with relatively low

There are also a number of smaller home care programs, including Assessment and Information, Department of Veterans Affairs (DVA) Community Nursing, DVA Veterans Home Care, Multi-purpose services, Short-term Restorative Care (STRC), and the National ATSI Flexible Aged Care Program (NATSIFACP).

All the above services are administered by the Australian Department of Health (DoH), in conjunction with various regulatory bodies (e.g. Aged Care Quality and Safety Commission, Aged Care Pricing Commissioner). There are also some smaller State and Territory Transition Care programs for older people returning home from hospital.

35. In 2020-21:

- Residential care was used by 243,117 people at a cost to government of \$14.30B;
- Home Care Packages were used by 212,293 people at a cost to government of \$4.19B;
- CHSP was used by 825,383 people at a cost to government of \$2.71B.

36. Table 2 presents a snapshot of some key statistics concerning funding and the number of users of each of the three major forms of aged care in Australia in 2020-21.

**TABLE 2: AGED CARE FUNDING in AUSTRALIA, 2020-21
THE THREE MAJOR PROGRAMS**

Category	Total Funding (\$B)	% of Funds	Number of users	% of Aged Care Users	% of Home Care Users	Mean cost per user (\$)
Residential Aged Care (RAC)	13.37	65.46	243,117	18.98	n/a	54,994
Home Care Packages Program (HCPP)	4.19	20.53	212,293	16.58	20.46	19,752
Commonwealth Home Support Programme (CHSP)	2.86	14.01	825,383	64.44	79.54	3,466
Total	20.42	100.00	1,280,793	100.00	100.00	15,946

Source: AIHW (2021)

Note: The user numbers represent the total numbers during the financial year 2020-21. There is some double counting, as some people used more than one program during the year.

support needs may have no family and require assistance at the level of a Package. The true distinction in determining what program is used in each case is the need for *external paid* care and support. This point is particularly relevant in the Indigenous context.

37. The total Commonwealth government expenditure on aged care in 2020-21 was \$23.63B (AIHW, 2021). For example, the Department of Veterans Affairs (DVA) residential and home support programs, which cost a total of \$0.92B, are not included in Table 2.
38. CHSP and its predecessor, HACC, have been the bedrock of the Australian aged care system for the past forty years from a number of perspectives.¹⁴
- It is the form of assistance for the large majority of not only users of home care (79.5%), but also aged care in general (64.4%).
 - The work it does helps keep people active, independent, and socially connected, thereby reducing the pressure on the other two more expensive forms of care.
 - It also provides important social capital in the community from which older people can take advantage, separate from the formal care they can receive through CHSP.
 - It makes this contribution at a much lower cost per person than the other two major forms. While there are nearly four times as many people receiving CHSP services as Packages, the total cost of CHSP is only just over two-thirds (68%) of the total cost of Packages.

In summary, CHSP has long been - and still is - an easy-to-access, low cost, very effective form of aged care for people with relatively low support needs that has great benefits for local communities and the public purse.

¹⁴ The main services that CHSP funds for older people living at home include personal care, nursing care, domestic assistance, transport, individual social support, group social support, respite care, centre-based day care, allied health services, home maintenance, home modifications, goods and equipment, and meals.

DEG's Aged Care Services - An Overview

39. An important focus of DEG is to provide a number of essential aged care services for Aboriginal Elders in Walgett who have relatively low external support needs, but who nevertheless need ongoing assistance to maintain their social connections and independence.

CHSP-funded services

40. Currently, DEG receives funds from the Commonwealth Home Support Programme (CHSP) for three types of home and community care services - Transport, Group Social Support, and Individual Social Support. A brief description of each of the three services follows.
41. *Transport:* Walgett has no public transport, taxis, or community transport. DEG has its own bus and provides transport for Elders that, for example, enables them to shop (both locally and regionally in larger centres), attend medical appointments, attend funerals, attend local and regional community events, catch up with family living elsewhere, and meet Elders from other places that are linked culturally. A vital function of this service is to ensure Elders can participate in DEG activities and attend the DEG Cultural Centre. In these ways, the transport service supports Elders to remain independent, active and involved in the community as individuals, while also contributing to bringing them together as a group to progress the DEG projects aimed at enhancing their community and culture.
42. *Group Social Support:* This service supports a wide range of group activities for Aboriginal Elders, including a weekly Elders Health Program with lunch and meetings, On-Country outings, information and learning sessions, and occasional movies. More significantly, this service provides a platform for discussions between Elders that contribute to the learning, policy development and advocacy activities in the projects noted earlier.
43. *Individual Social Support:* This service plays a number of roles. At a basic level, it extends the transport service in cases where the Elder needs extra assistance (e.g. with shopping or other commitments). DEG also plays a 'troubleshooting' role for Elders in many ways, such as helping them to access essential services that would be otherwise be inaccessible (e.g. where experience with internet/digital devices or higher levels of literacy is needed, or services that have a poor client interface). For DEG staff, it often appears that some services are almost *designed* to be inaccessible for Aboriginal Elders, and they see it as their obligation to try to redress this human rights deficit by ensuring the access of Elders to services to which they are entitled like every other Australian. Staff also help Elders understand and complete documents, read and write their letters, put them in touch with an advocacy service where necessary, and sort out myriad minor problems (e.g. starting up a new phone).

44. Any individual can receive all three service types subject to being assessed as eligible, and DEG having sufficient funding for the total trips and hours that are being requested by Elders. However, as discussed below (paras 80-83), the level of funding means that DEG is not able to provide services to a large proportion of eligible Aboriginal Elders in Walgett.

Other DEG services

45. DEG also provides a range of other services for Elders not directly funded by CHSP, although some dovetail with the transport and social support services funded by CHSP. For example, DEG (a) has premises that house the office that administers all its programs, but which also serves as a cultural centre and Elders meeting place (b) provides advocacy and support services for Elders (e.g. assisting them to access legal advice on many matters including Stolen Generations Reparations funds, ensuring Elders are registered as creditors for funeral funds currently under administration, etc) (c) provides some emergency services for Elders (e.g. providing food and water to Elders during COVID) (d) is able to identify people who need support, but do not have the information or capacity to seek assistance, and (e) plays an important role in confirming the Aboriginal identity of people in Walgett for housing and other benefits.
46. There are other organisations within Walgett that provide aged care services for older people with more complex and extensive needs through Home Care Packages and residential care. For example Australian Unity (which has an office but no permanent staff presence in the town) provides Home Care Packages; Whiddon has a small (8 beds) residential care facility (although it has recently been announced that this will soon close because it is not financially viable); and the Walgett Hospital provides some residential care as part of its multi-purpose care program. However, while some Aboriginal people in Walgett do have Home Care Packages, relatively few have accessed these services, and Aboriginal Elders with higher needs are commonly cared for largely by family.

Potential for expansion of DEG's services

47. There is a need for further aged care services for Aboriginal Elders in Walgett. Table 3 shows a range of possible enhancements and extensions to its services that DEG has identified as necessary to meet recurring needs in the local area. These would require, most fundamentally, additional funding, but it would also require some additions and amendments to DEG's organisational structure, and identifying and acquiring a number of essential 'inputs' (e.g. palliative care counselling and other specialist staff; buildings; communications equipment). This is briefly discussed in Section G (paras 247-248).

TABLE 3: POSSIBLE ENHANCEMENTS OF DEG AGED CARE SERVICES

1. *Grief and Loss program*
 - Including Sorry Business caseworkers and various support for families with funerals
2. *Aboriginal Palliative Care Service*
 - Including palliative care specialists and nurses, access to physical equipment
3. *Elder Counsellors experienced in Grief and Loss and Stolen Generations-related situations*
4. *Isolation Communications Equipment*
 - Including smart TVs, webcams, falls alert systems
5. *Additional Transport services and drivers*
6. *Training of Aged Care staff*
 - Including trainee positions, school-based traineeships, a Training Mentor, subsidies for TAFE to provide Certificate III courses
7. *An Elders Health program in conjunction with WAMS*
 - Including a dedicated Elders Health Worker position, Elder health programs, equipment
8. *Housing and Accommodation options*
 - Including independent living, hostels, high need (dementia) residential care, wet supported accommodation, and bespoke residential accommodation
9. *Respite services*
 - Including On Country respite accommodation, and meetings with Elders in other areas
10. *Evening individual and group social support services*
11. *Food services*
 - Including more nutritious and attractive meals than current Meals on Wheels services
12. *Elders Advocacy Service*
 - Including assistance with complex accommodation and legal matters
13. *Well-being Promotion*
14. *A Creative Active Elders program*

The Value of DEG's Aged Care Services

'Ageing well' for Aboriginal Elders in Walgett

48. In 2019, researchers from UNSW worked with the Dharriwaa Elders Group (DEG) as part of the Yuwaya Ngarra-li partnership to better understand what ageing well means to Aboriginal people in Walgett and what supports and services they need to receive for their well-being as they get older.
49. The interviews and focus groups conducted with Elders are recorded in an internal report to DEG (Jamieson, Andersen and McCausland, 2020). McCausland et al (forthcoming) discuss the outcomes and implications of the study. A brief summary of the major findings of the DEG Ageing Well study follows.
50. Older Aboriginal people may have different health care and support needs from other older Australians due to historical, cultural, economic, social, and community factors. As part of this, older Aboriginal people hold important roles in caring, connecting, and strengthening community, culture and Country. The Royal Commission into Aged Care also identified that there are key issues relating to access and inclusion for Aboriginal people in remote areas.
51. The Walgett Elders seek an approach to ageing well that is holistic, intergenerational, and life-long. They reflected on past and current experiences and described how their personal journey and health and well-being through their whole life connects to their health and well-being now. Importantly, they saw their own health and well-being as also closely related to the well-being of the whole community.
52. The Elders identified ten key dimensions of ageing:
 - 1) Social well-being (connection to family, friends, community and other Elders)
 - 2) Physical well-being (diet, exercise, good management of health and chronic conditions)
 - 3) Emotional well-being (a positive mindset, good memories, hopefulness, wisdom and perspective)
 - 4) Community well-being (providing leadership, building capacity and a legacy for the next generation)
 - 5) Cultural and spiritual well-being (being on Country, being in touch with culture)
 - 6) Staying mentally active (through community advocacy, volunteering, good conversation, playing cards)

- 7) Continuing important roles (passing down knowledge and stories, care-giving, leadership, safeguarding family, and caring for Country, for community and the well-being of younger generations)
 - 8) Ageing at home (which sometimes means they need support)
 - 9) Maintaining independence and choice (being able to do things that make you happy)
 - 10) Survival and resilience (Elders have survived a tough life, and deserved to feel connected, safe and respected in their older years).
53. The Elders then identified a number of barriers to ageing well, namely loneliness, a lack of access to culturally safe aged care, limited transport, limited access to affordable healthy food, destruction of the physical environment, loss of language, concerns about the well-being of the younger generations, disruption to traditional care systems, and limited access to appropriate housing and health care.
54. Finally, the Elders made a range of recommendations for how to ensure older Aboriginal people are supported to age well in Walgett, including:
- An increase in social and recreational activities for older people
 - Increased access to mental health services and loss and grief services
 - Developing a model of culturally safe aged care, including residential aged care that allows family to stay and be involved, residential respite care, and low level care
 - Developing a culturally safe model of palliative care
 - The growth of community-controlled services
 - The growth of a local Aboriginal workforce capacity
 - A one-stop-shop model of services specifically for older people, including support with technology access and online services
 - Increased community transport.
55. McCausland et al (forthcoming) notes that 'Aboriginal Elders in Australia are recognised as having an important role as community leaders and cultural knowledge holders' in the context of 'the [ongoing] effects of colonisation and systemic racism', but 'there has been a systemic lack of attention to the worldviews and priorities of Aboriginal people as they age.'
56. Moreover, there are specific challenges to ageing well from a service delivery perspective arising from Walgett being a small remote community. The study found that current government contracting arrangements and service delivery models are not well-designed for small remote

communities such as Walgett, particularly if they are to obtain services that are culturally safe for Aboriginal people.

57. At the same time, the Elders saw significant benefits for them associated with living in Walgett, from ageing on and caring for Country, being connected to extended family, and being able to fulfil their roles as knowledge holders. Central to the Elders' message that what is needed to age well is 'not just care, but love'.

What the DEG services do for Elders

58. DEG's aged care services are important to the Aboriginal Elders in Walgett at three main levels - *as individuals, as members of the community, and as the local custodians of Aboriginal culture*. As well as providing assistance to individual Elders, the services are critical in enabling them to undertake group activities that both enhance their own lives and contribute more broadly to the community and the maintenance of Aboriginal culture.
59. First, the well-being of *each individual person* is important. The brief description above of the role of DEG's transport and social support services makes clear the benefits of these services in enabling individual Elders to carry on their day-to-day lives and to maintain their independence and social connections. However, the benefits of the services go well beyond these purely individual outcomes.
60. Second, the services are also very important to the Elders at a *community* level. By simply bringing people together, the transport and social support services create and extend the linkages and networks that represent the social capital of any community and society. In addition, however, the services provide the means by which groups of Elders can come together to actively work to improve their community. People are brought together to find and pursue common passions and make their lives more meaningful.
61. The importance of strengthening community-based action was brought home in the recent national election when a number of candidates from outside the major parties were successful by running very strongly on the basis of their community support. In the coming years it will be both good policy and good politics for governments to support strengthening communities.
62. Thirdly, DEG also uses the CHSP-funded services to bring Elders together to maintain and re-energise *Aboriginal culture*. Again this is important to them as individuals, especially since many of the Elders are either members of the Stolen Generation or are children of those who were stolen. Beyond that, each of DEG's activities aimed at enhancing the Walgett community is strongly grounded in Aboriginal culture and plays a central role in ensuring that Aboriginal people in Walgett can maintain their culture and retain community sovereignty over it. Allied with

this is the importance that DEG places on ensuring that all of its services are culturally safe for Aboriginal Elders.

63. While funding for the various DEG projects has often subsequently been found from other sources, a number of those projects originated from - and continued to be sustained by - the relatively simple transport services and group sessions supported by CHSP. Hence, the aged care services underpin a form of multiplier effect that generates and leverages even further funds and activities for the Aboriginal community and the town more broadly.
64. Moreover, DEG's various projects and activities generate important social capital at the local level, by both cementing and deepening linkages between the Aboriginal Elders themselves (bonding social capital), between the Aboriginal and broader communities (bridging social capital), and between Aboriginal Elders and Aboriginal youth (which represents both bonding and bridging social capital) (Putnam 2000).
65. In these ways, DEG is facilitating a process that (a) increases the well-being of individual Elders and extends the period for which they can remain independent and socially connected (b) increases social capital in Walgett that ultimately assists both the individual Elders and the wider community, and (c) creates greater unity in the community (a major issue facing the Aboriginal and broader community in Walgett).
66. Hence, even at the level of each individual, the aged care services as they are designed and produced by DEG, mean so much more than simply assistance with a task or activity.
67. It is important to note that the individual and community benefits outlined above can - and do - result from CHSP services for the general population. As outlined later, it is a major flaw of the DoH Proposals for SAHP that they fail to recognise these benefits of CHSP, but worse, that they propose mechanisms that will undermine the processes that generate the benefits.
68. DEG's innovative approaches, however, have taken the value of the CHSP services to another level, both with the breadth and depth of its community development activities and the platform it provides for supporting Aboriginal culture.

How the DEG services are organised

69. Of critical importance to these multiple benefits at the level of the individual, community, and culture is not just *what* the services do, but *how* they are organised. While the services commonly involve a series of defined tasks and activities, they go well beyond simple atomised transactions for each person and the narrow conception of home care embodied in the DoH Proposals.
70. Many of the services and specific trips and sessions are *planned by and delivered for the group and the community*. These apparently simple functional services are the key to enabling DEG to facilitate a very meaningful set of structured and unstructured experiences for Elders where they can jointly explore issues of central emotional and psychological importance to them in ways that serve to improve their own individual well-being, especially in relation to exploring their culture and traditions.
71. In these ways, DEG's aged care services are more than simply assistance with a task or activity. Moreover, DEG's community and cultural work with Elders enhances social capital in Walgett and helps produce a local living environment that improves the well-being of others, old and young, Aboriginal and non-Aboriginal.
72. It is extremely important to note that DEG plan and deliver the CHSP-funded services in a *holistic and collective way*. What they do cannot be reduced to individualised atomised services and transactional approaches. The full range of benefits only happens because the CHSP-funded services are planned and delivered holistically and collectively where people are able to participate in a range of different activities at the times and in the ways that best suits their own circumstances and needs. Such a centre-based approach does not easily fit into a funding model based on contracted outputs for discrete 'services'.
73. Thus, in both what they do and how they are organised, DEG's CHSP-funded aged care services contribute directly and significantly to the current and future well-being of Elders, and to achieving the broader overall goals of DEG.

Current Funding of DEG's Aged Care Services

74. DEG's aged care services are primarily funded through the Commonwealth Home Support Programme (CHSP), which is administered by the Australian Department of Health (DoH).

Levels of funding and outputs

75. The funding for DEG aged care services began in 2005-06, auspiced by the (Dubbo-based) Thubbo AMS with a very small grant from the HACC program via the then NSW Department of Ageing, Disability and Home Care (DADHC). By 2009-10, the total funding was still only \$11,172 for Centre-Based Day Care. Over the last decade, extra funding has been obtained for additional services.
76. The total CHSP funding to DEG for its aged care services in 2021-22 was \$123.653. The funding and required outputs for each of the three services in 2021-22 was as follows:
- Transport - \$32,297 p.a. for which it had to provide a minimum of 1,816 trips during the year (an average of about 35 trips per week at an average cost per trip of \$17.78)
 - Group Social Support - \$61,731, for which it had to provide a minimum of 7,500 hours during the year (an average of about 150 hours per week at an average cost per hour of \$8.23)
 - Individual Social Support - \$29,625, for which it had to provide a minimum of 1,026 hours during the year (an average of about 20 hours per week at an average cost per hour of \$28.87)
77. Table 4 shows the situation for DEG for (a) Financial Year 2021-22, in relation to dollars and contracted outputs for its CHSP funding, and (b) for 2022-23 based on formal advice from DoH.

TABLE 4: DEG - CURRENT AGED CARE SERVICES, FUNDING AND CONTRACTED OUTPUTS

(a) 2021-22

		<i>Transport</i>	<i>Group Social Support</i>	<i>Individual Social Support</i>	<i>Total</i>
<i>A</i>	<i>Total dollars</i>	\$32,297.08	\$61,730.89	\$29,625.24	\$123,653.21
<i>B</i>	<i>Contracted Outputs</i>	1816 (trips)	7500 (hours)	1026 (hours)	n/a
<i>C</i>	<i>Average Outputs per week.</i>	35	144	20	n/a
<i>D</i>	<i>Unit Cost/Price</i>	\$17.78	\$8.23	\$28.87	n/a

Source: DoH email to DEG, 9 November, 2021

(b) 2022-23

		<i>Transport</i>	<i>Group Social Support</i>	<i>Individual Social Support</i>	<i>Total</i>
<i>E</i>	<i>Possible Prices</i>	\$18 - \$36	\$17 - \$27	\$39 - \$60	n/a
<i>F</i>	<i>DEG Prices</i>	\$18.05	\$17.00	\$39.00	n/a
<i>G</i>	<i>Contracted Outputs</i>	1816 (trips)	7500 (hours)	1026 (hours)	n/a
<i>H</i>	<i>Average Outputs per week.</i>	35	144	20	n/a
<i>I</i>	<i>Total dollars</i>	\$32,781.54	\$127,500	\$40,014	\$200,295.54

Sources: Row E is from DoH CHSP update, 29 October 2021
Rows F-I are from a DoH email to DEG, 9 November, 2021.

[Note that the numbers in the two tables have been derived in a different sequence, arising from changes in the basis of CHSP funding between the two years.

- For 2021-22, the unit cost has been derived from the (historically determined) dollars and contracted outputs.
- For 2022-23, the total dollars have been derived from the set prices and contracted outputs].

78. For DEG, the CHSP funding covers the cost of staff to deliver the services (58% of expenditure from CHSP funds in 2020-21), rent and operating costs of the office (18%), vehicles (7%), insurance and financial charges (9%), and other costs associated with group activities (8%).
79. DEG employs three people part-time to deliver and report on the aged care services - one for 20 hours per week to work directly with clients; one for 10 hrs per week to manage the transport service, including vehicle maintenance and operation; and one for 10 hrs per week for administrative tasks (including data entry into DEX, the DoH data system). There are also other DEG staff who contribute to the home care services, but are not charged against CHSP expenditure, notably the DEG Manager who oversees the services.
80. While these current services are of immense value to local Elders, the current level of funding falls short of what is necessary to meet the range of necessary and reasonable home and community care needs of all older Aboriginal people in Walgett.¹⁵
81. Aboriginal people are eligible for government-subsidised aged care services if they are aged 50 or more (50+ yo).

¹⁵ As Table 4 shows, DoH has informed DEG of the unit prices it will pay for trips and hours in 2022-23. These are higher than DEG's unit costs in 2021-22, but the increased prices are still not sufficient to address all of the needs of local Elders that have been identified by DEG.

- As noted earlier (para 25), in 2016 there were 218 potentially eligible people in the Walgett town and surrounds (of whom 61 were 65+yo), with another 212 (59 who were 65+) in the larger Walgett Shire area.
 - However, as Table 4 shows, CHSP funding only allows for 35 people to be given transport and for 20 to get individual social support once each week.
82. There is much variation among Walgett Elders in their use of DEG CHSP services, ranging from those who make frequent use of the services, others who are regular but relatively limited users, others who are occasional users, and finally a much larger number who are registered but have made little if any recent use. Moreover, COVID has had a big impact on reducing the number of different people who have used DEG services in the last two years. In general, however, in a 'normal' year (i.e. prior to 2020) around 40 people have used the services each year, most of these on a regular basis. Further, most of DEG's clients are 65 + yo (with no more than 5 who were 50-64 in any of the last three years).
83. Thus, given the available funding, a high proportion of Aboriginal Elders in Walgett are unable to receive any CHSP services from DEG (or from any other alternative provider). The above numbers also suggest (given that most DEG clients are 65+yo) that the government policy of accepting the need for Indigenous people to receive aged care services at a younger age (i.e. at 50 rather than 65) can only (at best) be partially implemented in Walgett given the current limited funding for DEG.

The current funding arrangements

84. As with all CHSP services and providers, the current funding arrangements for DEG have the following characteristics:
- Funding is paid directly to DEG via block grants;
 - Payments are made quarterly in advance (to change to payments in arrears on 1/7/22);
 - DEG continues to receive its funds each year as long as it provides an agreed minimum level of service outputs (as defined by the number of transport trips and the number of hours of social support); and
 - The Elders who use DEG services are required to meet eligibility requirements for each CHSP service they use, but they have no set financial entitlement that limits their individual use of services (the assumption being that people requiring substantial services will graduate to a more comprehensive Home Care Package).

85. CHSP-funded providers are able to charge their service users a small fee (co-payment) if they wish, but DEG's policy is firmly against any form of co-payment. It does not charge any users for the cost of any of its services, and would strongly oppose the introduction of a mandatory co-payment for all home care services.
86. Under the current funding model, DEG cannot obtain additional funding for exceeding its contracted outputs regardless of the support needs of its users.
87. DEG is required to provide DoH with data on its outputs every quarter in order to show its targets are being met and thus ensure continuation of funds at the agreed level. DEG currently employs someone for five hours a week primarily for the task of inputting data into DEX. (From 1/7/22, it will have to provide the data monthly).

Positive benefits of the current funding arrangements

88. It is critical to understand that central to the value and benefits of DEG's aged care services is the way that the services are currently funded.
89. The current funding arrangements under CHSP have five major benefits for DEG.
90. First, they provide *security and stability* for the services because block grants give certainty about revenue. DEG's revenue for the coming year (and realistically for some time beyond that) is known and guaranteed (subject to meeting agreed outputs). Moreover, they do not face periodic financial crises arising from disruptions to the supply of services or short-term changes in demand, such as have been experienced since the outbreak of COVID.
91. On this basis DEG is able to plan ahead, including, most importantly, being able to give its staff reasonable certainty in terms of their income security (i.e. their weekly hours and hence income) and job security (the duration of their period of employment). It is well-documented that the continuity of staff is one of the major factors necessary for quality home and community care and one of the factors most sought by users of the service.
92. Second, block funding best *supports the group and community-based approaches* that (as outlined above) are central to DEG's objectives and achievements for Aboriginal Elders. A fee-for-service model will generate not only additional administrative and logistic burdens, but pressures to move towards an 'organisational culture' more narrowly focused on each service transaction. Both these changes would be impediments to DEG's successful holistic and collective group-based approach.
93. Third, the funding arrangements enable the DEG Council, management, and staff to *focus on improving services* rather than (as is necessary under a fee-for-service model) having to divert time, money, and effort to 'chase customers' to ensure its revenue.

94. The counter-argument, of course, is that competition improves service by requiring providers to increase the quality of their services and their responsiveness to users if they are to remain in business. While that is not irrelevant, there are also multiple examples of how competition in human services has had negative effects on quality by encouraging a focus on maximising 'sales', reducing costs, and maximising profit (Davidson, forthcoming).
95. Fourth, there are some *efficiency benefits* from block grants. While fee-for-service models supposedly increase both allocative and productive efficiency, there is much research to indicate that these benefits often do not eventuate in practice. For a start, many providers, including small ones such as DEG, are already very concerned with improving their productive efficiency, given that they have an overarching motivation to help as many people as much as possible and that means making better use of available funds. As well, clearly there are some lower costs associated with block funding. For example, it avoids a number of significant administrative costs created by monitoring and managing individual entitlements for each user (e.g. IT investment, staff time), while providers do not have to maintain as large a financial 'war chest' to cover exigencies (using money that could be devoted to services).
96. Fifth, the *lack of a requirement to impose a co-payment* on people using its services means lower administrative costs and Elders are not financially deterred from using DEG's services.

Concerns with the current funding arrangements

97. DEG is also limited in some ways by the current funding arrangements.
98. First, there are *insufficient funds* to enable the most effective response to meet the range of needs of Elders, as the Royal Commission found was true for home care in general. CHSP (and its predecessor, HACC) has always been under-funded relative to identified need and this was worsened in 2018 when the then Government reduced the annual indexation of CHSP grants (RCAC, Vol 3B, pp.643-644).
99. From DEG's perspective there has never been enough money to assist all the Elders with support at the level they require. The current level of funding only enables one part-time person for 20 hrs per week to assist clients. As shown above (paras 80-83), the funding does not allow for all of the Elders in Walgett who are eligible to receive services. Currently, DEG has no financial surplus from its aged care services.
100. The new funding systems being proposed by DoH will increase the financial pressures on DEG, even if there is no change in demand for and usage of its services. Some financial surplus will be needed to maintain reserve funds, given the fee-for-service funding model (which requires a

greater 'war chest' to cover unforeseen contingencies) and the payment in arrears model that DoH is due to introduce on 1 July, 2022 (see paras 199-201).

101. Second, there are problems stemming from the fixed amounts paid under block grants. DEG (as with all CHSP-funded providers) get *no financial credit for any additional activity or outputs above the contracted levels*, and thus incurs extra costs without recompense when they do this. Linked to this, it cannot significantly respond to extra demand for its services without departmental approval for additional funds.
102. Third, there are a number of *administrative and financial costs* to meet the compliance requirements of DoH and regulatory bodies. However, these costs are likely to be currently less than would be the case under fee-for-service and individual funding systems.

Operational issues for DEG

103. This paper is concerned with the potential impact on DEG's aged care services of possible changes in the funding and regulation arrangements for home care. As such it is not directly examining a range of operational issues that affect how well and how efficiently DEG can and does provide the services, except in so far as those issues may be affected by DOH's proposed changes.
104. Thus, for example, one problem for DEG arising largely from the remoteness of Walgett has been in obtaining and then retaining sufficiently skilled staff. There are a range of factors causing that problem that are outside the scope of this paper. However, it is relevant to this paper in so far as the proposed change to a fee-for-service model is likely to worsen that problem in that with less certainty about future revenue, many providers will not be able to offer the same guarantees about income and job security as they currently can (see para 151).

C. Imperatives for Change

Previous change in home and community care programs for older people

105. A major watershed in the development of home and community care services for older people in Australia was the establishment of the Home and Community Care (HACC) program in 1985, which involved the consolidation, standardisation, and expansion of a disparate range of national and state programs that had developed since the 1940s. Home Care Packages were then introduced in 1992, with higher levels of Packages introduced in 2001 (EACH) and 2005 (Each Dementia).
106. Since DEG began providing home and community care services in 2005-06 (under HACC), there have been a number of changes in the policy, funding and regulatory environment for home and community care services for older people.
107. Two major milestones in that time have been the Productivity Commission Report, *Caring for Older Australians* in June 2011 (PC, 2011), and the *Living Longer, Living Better Aged Care Reform Package* introduced in April 2012 by the then Labor Government (Australian Government, 2012). Subsequently, in part building on those two documents, significant changes to the home care service system have been progressively made over the last decade, especially since the election of a Coalition government in 2013.
108. The major changes to home care programs over the last decade have involved:
- the Commonwealth government taking full responsibility for the funding, administration, and regulation of the aged care elements of HACC (for most states in 2012, Victoria in 2016, and finally WA in 2018);
 - the integration of three separate home care package programs into HCPP in 2013;
 - the integration of HACC and three other programs¹⁶ to form CHSP in 2015;
 - the introduction of Consumer Directed Care (CDC) into HCPP in 2015; and
 - reduced barriers to entry for providers in HCPP from 2015 on.
109. The sector has also been influenced by more general developments, such as the government acceptance of the Harper Competition Review (unsubstantiated) assertion that *the* key goal of policy for human services should be to put 'consumer choice ... at the heart of services' (Harper

¹⁶ The three programs were the National Respite for Carers Program, the Day Therapy Centres Program, and the Assistance with Care and Housing for the Aged Program.

et al 2014), and the issuing of the Aged Care Roadmap (Aged Care Sector Committee, 2016) with its (similarly unsubstantiated) support for increased marketisation across aged care.

110. Davidson (forthcoming) notes that a number of the changes since 2013 have been in the wrong direction and represent 'own goals' by those who designed the system and ultimately by the government for accepting that advice. Some of the current DoH Proposals for SAHP effectively seek to rectify some of the changes from the past decade, while other Proposals exacerbate errors made in that period.

The Royal Commission and the Government Response

111. By 2018, multiple problems had emerged in the aged care system (some long-standing, some introduced since 2013), leading to the establishment of the Royal Commission into Aged Care Quality and Safety (RCAC) on 8 October 2018.
112. The Final Report of the Royal Commission in February 2021 (RCAC, 2021) identified substantial problems with the aged care system in Australia. The major focus of the RCAC Report was on residential aged care, but it also identified a number of problems in home care, notably (a) a shortage of funds for Home Care Packages for people with more complex needs (b) low quality providers gaining entry in recent years, and (c) some inconsistencies within and between the two major programs.
113. The RCAC's greatest concern about home care related to the lack of adequate funding for Packages at a level that could meet the needs of the numbers of people that had been approved. Similarly, CHSP does not have adequate total funds to meet the identified need for services from the program.
114. The RCAC did support a proposal for 'risk-based requirements for provider approval and market entry ...[whereby] ...the regulator should be able to adjust the rigour of the approval process' (RCAC, Vol 3B, p.494), but how this should be implemented (if indeed it is correct) must be seen in the context of numerous times where the RCAC pointed to the increasing entry of low quality providers in recent years after the introduction of CDC. For example:

There is a concerning lack of oversight of new home care providers (Vol 3B, p.492)

[An] area of risk arises from the rapid expansion in home care providers, with limited scrutiny applied to assess their suitability (RCAC (2021), Vol 2, p.202)

[A]bout 1 in 5 quality reviews of home care providers in 2018–19 concluded that the provider failed to meet at least one home care outcome. (RCAC (2021), Vol 1 , p. 29

115. RCAC Recommendation 25 is of direct relevance to the DoH Proposals for SAHP. It states

Recommendation 25: A new aged care program

By 1 July 2024, the System Governor should implement a new aged care program that combines the existing Commonwealth Home Support Programme, Home Care Packages Program, and Residential Aged Care Program, including Respite Care and Short-Term Restorative Care.

The new program should **retain the benefits of each of the component programs** (*emphasis added*), while delivering comprehensive care for older people with the following core features:

- a. a common set of eligibility criteria identifying a need (whether of a social, psychological or physical character) to prevent or delay deterioration in a person's capacity to function independently, or to ameliorate the effects of such deterioration, and to enhance the person's capability to live independently as well as possible, for as long as possible
- b. an entitlement to all forms of support and care which the individual is assessed as needing
- c. a single assessment process based upon a common assessment framework and arrangements followed by all assessors
- d. certainty of funding and availability based upon assessed need
- e. genuine choice and flexibility accorded to each individual about how their aged care needs are to be met (including choice of provider and level of engagement in managing care, and appropriate and adapted supports to enable people from diverse backgrounds and experiences to exercise choice)
- f. access to one or multiple categories of the aged care program simultaneously, based on need
- g. portability of entitlement between providers throughout Australia.

116. While Recommendation 25 calls for a new single aged care program, it saw this as also encompassing residential care. But it certainly does *not* suggest that home care and residential care should have identical funding arrangements, nor that CHSP be collapsed into Package-type arrangements.
117. In its volume entitled "The New System", the Royal Commission report contained a chapter specifically on aged care for Aboriginal and Torres Strait Islander People (RCAC, Vol 3A, Chapter 7), together with a set of recommendations (Recs 47-53). It noted that there 'should be active partnership with Aboriginal and Torres Strait Islander people through consultation, co-design, building cultural expertise and regional relationships', and that 'there are significant opportunities for integrated, flexible and innovative aged care services that prioritise the well-being of older Aboriginal and Torres Strait Islander people (RCAC 2021: Vol 3A, 266).
118. The Australian Government Response to the RCAC Report in May 2021 (DoH, 2021) accepted virtually all of the RCAC recommendations and presented Five Pillars of Aged Care Reform over a five year period. The first pillar was Home Care, with a commitment to action concerning more Packages, service centres to provide information, increased respite care and support for

informal carers, local community care-finders, a new support at home program (with no detail given), and a single assessment workforce.

119. The RCAC did *not* propose major changes to the CHSP funding model or significantly less regulation of the entry of providers, nor were these matters mentioned in the Government Response. Later (para 216) we note the relationship between the features contained within the DoH Proposals and what the RCAC Report actually said on certain aspects.
120. One new measure since the 2021 Government Response to the RCAC Report that is relevant to DEG was the announcement in April 2022 by the then government of a series of grants to assist home care providers to 'grow and upskill their workforce'. The National Aboriginal Community Controlled Health Organisation (NACCHO) was a recipient of one of these grants, with a key focus being to address the greater challenges of recruiting workers in remote communities.

NAGATSIAC Proposals

121. One further source of imperatives for change of particular relevance to DEG has come from the National Advisory Group on Aboriginal and Torres Strait Islander Aged Care (NAGATSIAC), which has produced two major documents relevant to home care. The first one (NAGATSIAC, 2020) was released in April 2020 prior to the RCAC Final Report.
122. The second NAGATSIAC document was a Five Year Plan for ATSI Aged Care which was released in June 2021 following the Government Response to the RCAC Final Report. A key thrust of the NAGATSIAC Plan was to give Indigenous people greater control over the systems through which aged care is provided to Indigenous people through establishment of parallel Indigenous-specific services for access, assessment, delivery, and the workforce.
123. Table 5 sets out the main proposals contained in NAGATSIAC's Five Year Plan (NAGATSIAC 2021a, 2021b). As noted later (paras 186-187), one positive aspect of the DoH Proposals is the adoption of the proposals for a separate Indigenous Trusted Navigator (carefinder) service and a separate Indigenous Assessment service (i.e. Actions 2 and 3 in Table 5 below).

TABLE 5: NAGATSIAC PROPOSALS FOR AGED CARE

<i>Reform Areas</i>		<i>Priority Actions</i>	
1	Indigenous Access Pathways	1	Annual Access Targets
		2	Indigenous Trusted Navigators
2	Indigenous Assessment Pathways	3	Indigenous Assessment Services
3	Indigenous Service Delivery Pathways	4	Aged care capacity building program - major expansion of Indigenous providers
4	Indigenous Urban/Regional Strategy	5	Investment to respond to urbanisation
		6	Preserve and extend NATSIFACP
5	Integrated Service Delivery	7	Integrated aged care and primary health care
6	Indigenous Direct Care Workforce	8	(a) Expand the direct care workforce (b) Mandated minimum qualifications (c) Expand Indigenous Employment Initiative (IEI) program

Source: NAGATSIAC (2021b), Table 1, pp.5-6

Labor policy and the Albanese Government

124. The pre-election policy statements of the Labor Party contained little directly affecting home and community care, other than funding for more packages, together with the general commitment to implement the recommendations of the RCAC and fund whatever wage rise is determined by the Fair Work Commission in the current case before the Commission.
125. The next section looks in some depth at the DOH Proposals for SAHP. These proposals were developed and released prior to the election on May 21, which led to the election of the new Albanese Labor government. The full new ministry was sworn in on 31 May 2022. As at the end of June 2022, neither the Labor Party prior to the election nor the new Government had made any public reference to the DoH Proposals for SAHP.

D: Department of Health (DoH) Proposals for a new Support At Home Program (SAHP)

Development of DoH Proposals thus far

126. Following the RCAC Final Report and the Government Response, DoH began developing a new Support At Home Program (SAHP) that is aimed at providing a single integrated program for all Commonwealth-funded home and community care services for older people. DoH has stated that SAHP is due to commence in July 2023.
127. When this briefing paper was initially commissioned, there were no specific proposals for SAHP. The intention at that point was to present an analysis of the impact on DEG of likely and possible changes to the future funding and regulation of CHSP services based on theory and empirical evidence of human service funding systems and markets. Since then, however, DoH has started to publicly set out some of its current intentions about how it proposes to design SAHP.
128. Beginning in January 2022, DoH gradually revealed its thinking about the future SAHP (the 'DoH Proposals') via a number of documents, notably a SAHP Overview Paper released on 6 January 2022 (DoH, 2022a), and a Regulation Concept Paper for all of aged care released on 8 February 2022 (DoH, 2022b). Senior DoH officials have further explained some of their proposals in tightly managed public forums (e.g. a Webinar on 8 March 2022 (DoH, 2022c)), meetings with some of the key stakeholder bodies, and forums with selected groups on specific implementation issues.
129. Table 6 summarises the current DoH Proposals for SAHP. The Proposals involve some major changes to home and community care systems and services (especially for people with relatively low needs) that have the potential to have a substantial impact on the future organisation, operation, and outcomes of DEG's aged care services.
130. Davidson (forthcoming) contains a detailed critique of the DoH Proposals together with some alternative proposals.¹⁷ What follows in this section is essentially a summary of that paper together with an indication of the implications for DEG.

¹⁷ That document draws on the now vast theoretical and empirical literature concerning the funding, regulation, and marketisation of human services, aged care and home care internationally. The literature ranges from macro cross-sector/cross-national studies such as Gingrich (2011) to multiple studies of national systems, service sectors, service providers, and service users. Davidson (2018),

131. Note that the categorisation in Table 6 is not from DoH, but is our interpretation. Indeed (as discussed below) much of the space in the SAHP Overview Paper is devoted to the proposed new system for classifying user assessments and service types (Rows 5 and 6 in Table 6), while the major changes are only mentioned in passing in that paper.
132. The DoH Proposals for SAHP represent a major change in terms of philosophy, structures, and funding and other program mechanisms from the CHSP that currently funds DEG. However, up to the end of May 2022, there had been no public opportunities to engage with DoH about the philosophy, overall strategy, and viability of their Proposals. In public forums, DoH staff have only been interested in receiving comments on the detail and implementation of their proposals.
133. This section considers the Proposals from a number of perspectives in terms of (a) each of the specific features (b) the gaps in what is proposed, and (c) some broad drivers and impacts of the Proposals.

A Fluid and Uncertain Situation

134. The current situation with the future of SAHP is very fluid and uncertain. No final decisions appear to have yet been made by government about SAHP. The DoH Proposals are *not* proposals made by the former government, let alone decisions. For the most part, they seem to be simply proposals by the bureaucracy that are yet to be formally considered by government.
135. There are a number of factors contributing to the current complexity and uncertainty about the future of SAHP.
 - First, the design of any system that provides a wide range of services to over one million diverse older people across a country as large and diverse as Australia is an intrinsically and unavoidably complex task that is subject to much difference of opinion about the best way forward.
 - Second, much of what is being proposed by DoH not only does not flow from the RCAC Report, but is diametrically opposed on some key aspects (see para 216).
 - Third, a number of the key current DoH Proposals are problematic in principle, with substantial theoretical and empirical evidence that raises questions about the wisdom of their use (paras 143-175).

which was released in the same week that the RCAC was announced, presents the author's view of the overall state of aged care in Australia at that time.

- Fourth, even within their own terms, there are still many details of the Proposals to finalise (paras 178-184, 204-205).
- Fifth, nothing has been thus far presented on a number of central issues for funding (e.g. co-payments) (paras 202-206).
- Sixth, there are a number of broader concerns about the wider and dynamic effects over time of the Proposals (paras 208-215).
- Seventh, the DoH Proposals have generated criticisms and concerns across the sector (paras 252-254).
- Eighth, from an Indigenous perspective, the National Advisory Group on ATSI Aged Care (NAGATSIAC), which has thus far had some of its proposals accepted by DoH, has other measures it would like to see adopted (paras 121-123, Table 5).
- Ninth, the impending national election in May 2021 and the likelihood of a new Minister for Aged Care (which ever party won government) added to the uncertainty and delay in consideration of, and decisions about, SAHP, while the position of the new government is not yet clear and likely is not yet determined.

136. Thus the design of the new program is far from finalised and there are many scenarios and outcomes for what the final form of SAHP may be. Many aspects have yet to be presented, while much may change - possibly very substantially - from the DoH Proposals that are currently on the table.

137. Given this very fluid and uncertain context, *the analysis here begins with three core assumptions:*

- a) The current DoH Proposals will ultimately apply.
- b) The DoH Proposals for mainstream services will fully apply to Indigenous services.
- c) DEG will seek to continue its current services with as little change as possible.

138. We later consider some likely alternative scenarios as each of these assumptions is relaxed and more complex circumstances apply. For example:

- a) The current DoH Proposals will ultimately apply.
 - As detailed below, the DoH Proposals are unclear or incomplete at a number of points, and hence some further assumptions have had to be made about what DoH intends, while the new government will obviously be made aware of the concerns that exist about the Proposals. Hence it is likely that the final program will, at the very least, not fully reflect the current proposals.

b) The DoH Proposals that refer to mainstream services will also apply to Indigenous services.

- At this stage there are already some potential alternatives to this assumption including
 - (i) the impact of the DoH Proposals for two separate Indigenous-specific services and
 - (ii) the possibility of additional grants for some providers in so-called ‘thin markets’.
- As well, government may accept more of the additional NAGATSIAC proposals

c) DEG will seek to continue its current services with as little change as possible.

- We will later briefly consider the Overview Paper and alternatives in terms of how they affect current plans that DEG has to extend, expand, or amend its current services (paras 223-225).

139. In assessing the nature and impact of the DoH Proposals, it is critical to understand the likely and potential *dynamic effects over time* of each of the proposed features. Such changes, for example, are at the core of the argument for using market mechanisms, the assumption being that turning service users into ‘consumers’ and removing barriers to entry for new providers will, over time, change how providers and users function in ways that improve the operation and outcomes of the services. A long history of empirical research shows that such measures do indeed have on-going and long-term effects - but all too often those changes also generate substantial *negative* effects. This was surely one of the major lessons of the RCAC. A key feature of the following analysis is to note the actual likely long-term dynamic effects of the DoH Proposals.

140. Hence this paper will look at both the DoH Proposals and some alternative approaches when each of the above three assumptions is modified. However, the key focus of this paper is on the DoH Proposals as they stand at the time of writing (i.e. June 2022) and their potential impact on locally-based Indigenous providers of aged care services and the users of those services.

Specific Features of the Proposals

141. We first set out the specific features of the DoH Proposals. These are listed in Table 6 which are organised in terms of the nature and significance of each feature.

- The features are not presented in this format in the DoH documents, but represent our analysis of the major proposals contained in those documents described in terms of specific features of the proposed system.

TABLE 6: The Future SAHP – DoH’s Proposed New Features

<i>Nature and significance of the Feature</i>		<i>Feature</i>
I. Four major proposed changes	1	Replacement of block grants to current CHSP providers by fee-for-service payments from each user for each transaction
	2	Introduction of individualised financial and service entitlements for all users of government-subsidised services
	3	Changes to regulation, with a ‘risk-proportionate’ system, whereby regulation will be reduced for some service types and specific providers
	4	End of a specific program focus on older people with relatively low support needs (who are the large majority of the users of home care services)
II. Other proposed changes affecting all services	5	Single common classification system for the assessment of all home care users
	6	Single common service list and classification system for all service types
	7	Grants for providers in ‘thin markets’
	8	Introduction of point-of-delivery payments
III. Proposed extra services.	9	Digital services added to the list of services
	10	Expansion of re-enablement and restorative services
	11	Increased support for unpaid carers
	12	Separate assessment and entitlements for goods, equipment and assistive technologies (GEAT) and home modifications
IV. Proposed Indigenous-specific measures	13	New Indigenous single assessment service
	14	New national Trusted Navigator support service for senior Indigenous people
V. Payment measures previously announced and to be implemented on 1/7/22	15	Unit prices - standard prices and processes for negotiation of prices by providers in MMM6 and MMM7 regions
	16	Payment in arrears to service providers

142. In summary, the items in Table 6 comprise 16 features:

- Four features represent major changes to the structure and functioning of the home and community system and that will fundamentally change how CHSP providers will be funded and how the services will need to be delivered (Rows 1-4 in Table 6);
- Four other features affecting all services that will be less disruptive, and if designed properly can be positive, although much more work needs to be done on each of them (Rows 5-8);
- Four new or expanded services (Rows 9-12)

- Two features that are totally or substantially directed to Indigenous services that should be of benefit to DEG (Rows 13-14); and
- Two previously announced features implemented on 1 July 2022, that will have a significant impact on some providers, especially small ones such as DEG, one positively, the other negatively [Rows 15-16]

A brief outline of each of the 16 features and their significance follows. Davidson (forthcoming) considers the nature and implications of each of these features in more detail.

Four major changes

143. There are four features of the DoH Proposals that represent major changes to the structure and functioning of home care that will fundamentally alter how current CHSP providers will be funded and how their services will need to be delivered. These features are:
- a fee-for-service funding model will operate for all providers, replacing the block grants that currently fund CHSP services;
 - a NDIS-like individualised entitlement for all service users;
 - a 'risk-proportionate' regulation system; and
 - the end of a specific program focus on people with low care needs.
144. Each of these four features represents a major change in terms of the philosophy, program structures, and program mechanisms from the CHSP that currently funds DEG.
145. Each of the four is problematic and (as currently proposed) all are likely to be steps in the wrong direction if the goal is to improve services for older people.
146. In the documents that contain the DoH Proposals, there is either no justification for these changes or the justification is limited to terms that ignore the large body of evidence that would, at the very least, question the wisdom of using these features. They are simply assumed to be *fait accomplis*. Hence, to some extent it has been necessary below to assume the rationale for introducing each of the four features.

Fee-for-service model [Row 1 in Table 6]

147. A fee-for-service model would apply to all home care services and would thus replace block grants for current CHSP providers. Under this funding model, revenue would not be guaranteed for a provider at the start of each year, with its revenue coming from the sum of payments on behalf of, and by, approved people who choose to use its services.

148. Thus

- Instead of obtaining its revenue from Commonwealth Government subsidies for aged care via three block grants paid quarterly (for which it must meet output targets), DEG will need to obtain its revenue from the sum of payments for each individual client for each service transaction (e.g. each bus trip or social support session).
- Each approved user will have an approved set of services and financial entitlements from which they can pay fees for the services they obtain.

149. Such a model has long been used for home care packages from their beginnings in 1992, although it was less explicit and obvious before the introduction of CDC in 2015 (Davidson 2015a). This model will now apply for all home and community care services (subject to the provision for additional grants for some providers in ‘thin markets’ outlined below (paras 180-181).

150. There is no attempt anywhere in the DoH documents to justify or argue for this feature to apply to current CHSP services. The DoH Overview Paper just asserts it will be introduced. However, the rationale for the feature (based on similar features commonly introduced in other human services over recent decades) appears to be:

- A belief that it will put pressure on providers to be more responsive to service users and hence increase ‘consumer control’;
- A belief that it will put pressure on providers to find efficiencies in their operation (in order to be able to offer the most competitive prices to users) thereby giving better value-for-money, and reducing the total cost of home care and/or allowing more people to be assisted; and
- Uniformity for all home care funding.

151. However, while some of these processes will likely happen, much theory and empirical evidence tells us that, over time, it will in fact also mean:

- a) Less stability and less certainty for providers, especially small and medium size non-profit bodies, as a result of the end of block grants for CHSP;
- b) Greater difficulty for providers to plan (including being less able to give guarantees of income and job security to staff)¹⁸;
- c) Services will become more commodified and commercialised and less relational in terms of both (i) how users are treated as individuals, with services becoming more transactional than person-centred, and (ii) the relationships *between* users, with services becoming more

¹⁸ For example, Cortis et al (2013) examines the impact of fee-for-service models on the workforce.

- atomised, aimed at separate individuals at the expense of community and group-based approaches that have underpinned the success of CHSP and HACCC for many years;
- d) A loss of social capital at community level as a result of the more atomised services and the relative decline of locally-based non-profit providers;
 - e) A major increase in leakages of the public and private service dollar (e.g via marketing, IT, consultants, legal costs, etc);
 - f) A reduced capacity for the sector to attract workers (arising from the greater uncertainty of revenue for providers); and
 - g) Greater potential for fraud (as has occurred, for example, in child care and the NDIS).
152. Notwithstanding the above, some level of fee-for-service is desirable providing that it is combined with:
- rigorous regulation of the entry/exit of providers;
 - rigorous regulation of the commercial practices of providers (e.g. prices, marketing, profits);
 - the availability of basic block grants to ensure the capability, stability, and viability of a network of locally-based non-profit providers at community level.
153. The proposed movement from block-funding to a fee-for service model is the most disruptive and potentially damaging feature for DEG from the DoH Proposals.

Individualised entitlements for users [Row 2]

154. Individualised entitlements for users (based on the NDIS model) will be introduced. Under this approach, an assessor will determine an individualised set of set of services and entitlements which will be unique for that user. This is essentially what currently occurs in the NDIS.
155. Currently, a system of entitlements for individual users exists for HCPP, but this proposal is different.
- Under the current Packages arrangement, a user is assessed within one of four levels of need, with each level having a maximum financial entitlement.
 - Each person is thus given a maximum financial entitlement and then works out the detail of their services with their family and provider(s).
 - Under the NDIS and the proposed SAHP, each user has an Individual Support Plan determined by a government assessor that has an individualised financial amount and a precisely defined set of services. The user must return for re-assessment if her/his needs change.

156. The Proposal is very different from the current arrangements for user entitlements within the CHSP, where formally there are no limits on the financial entitlements of any user. An older person is simply approved for certain services. The assumption is that if they need extensive services they will go onto a package, but for various reasons (especially the poor design of current co-payment arrangements in CHSP and HCPP) a small number of people have a high use of CHSP services when logically they should go onto a Package.¹⁹
157. Again, there is no attempt anywhere in the DoH documents to justify or argue for this feature. The DoH Overview Paper just asserts it will be introduced. However, the rationale for the measure (as with similar measures introduced in other sectors in the past) appears to be:
- Assistance can be tailored to meet the unique needs of each individual;
 - Services will thus be more appropriate and more efficient (by giving each user just what they need, but no more); and
 - To create a mechanism for greater government control over total expenditure by arbitrarily reducing an individual's entitlement, as has been increasingly happening in the NDIS. (This, of course, is an administratively cumbersome lever and ultimately no more precise than just changing the maximum amount for each level in one decision).
158. However, again, much experience with such schemes tells us that it will in fact mean:
- a) A system of determining entitlements that is excessively bureaucratic and paternalistic, with central assessors specifying in detail what is in a person's plan;
 - b) Less choice and control for users;
 - c) Constant reassessments for many users, leading to disruptions in the continuity of care and high administrative costs;
 - d) Increased transaction and administrative costs (both dollars and time) for all parties in both the initial assessment and any reassessments; and
 - e) Increased inequities (and certainly increased complaints about inequity) arising from the spurious precision claimed by the system.
159. While clearly it is necessary for government to ration dollars and thus place limits on what each individual can get, government should not prescribe every detail of service as occurs with the NDIS. Such a system is particularly unsuitable for older people with relatively low support needs who use CHSP.

¹⁹ This is a general proposition and does *not* apply to DEG.

160. The current arrangements for the HCPP, whereby users have a set of approved service types and a maximum financial entitlement amount, with the detailed services then worked out between the user, their family, and providers, is preferable.

- The NDIS has demonstrated that totally individualised entitlements, while ostensibly aimed at being responsive to the unique needs of each individual, can in practice reduce a person's choice and control and leave them open to arbitrary cuts in their services.
- Moreover, as we have seen with the NDIS, many individual users who have had their entitlements arbitrarily cut have become political footballs as they seek to appeal decisions,.

Risk-proportionate regulation [Row 3]

161. The approved provider model is to be replaced by a 'risk-proportionate' system of regulation. Under such a system, regulation requirements will vary according to the perceived 'risk' of the service type and specific provider in each case. The overall effect will be to reduce the regulation of the entry and exit of providers and the regulation of provider behaviour.

162. This is presumably aimed at (a) reducing the administrative burden on providers and users (b) encouraging the entry of new innovative and responsive providers to better meet the needs of older people (c) enabling all providers to be more innovative in their service offerings, and (d) giving users more choice and control over who can provide their services.

163. A major implication of this change is that it would be much easier for new providers to enter, and there would be less control over the capability of providers and the quality of their services for much of the sector. For example, DoH proposes to actively encourage the entry of sole providers (DoH 2022c) many of whom will have had no experience in the sector and for whom there will be minimal regulation.

164. Again, experience tells us that substantially reducing the regulation of the entry of providers will in fact mean:

- a) More low capability and low quality providers (albeit accepting the possibility that there may also be some new good providers);
- b) More lower quality services through (a) a certain lowering of the floor of quality, and (b) the possible lowering of average quality across the sector;
- c) Users exposed to a much greater risk of (a) receiving poor services, and (b) physical, emotional, and financial abuse;
- d) Greater search costs and uncertainty for users (i.e. an even greater confusopoly²⁰ of providers);

²⁰ Adams (1997) has used this term for the unmanageable plethora of options that buyers face in many markets.

- e) A major change in the profile of providers that will have an overall negative effect; and
 - f) Greater potential for fraud.
165. Perversely, the proposed system appears overall to be both more complex and less rigorous than current regulation.
166. The DoH Regulation Concept Paper (DoH 2022b) does at least set out some rationale for the new system, in relation to increased flexibility for providers and users and the alleged benefits of that, but at no stage does it enter into debate about the very powerful reasons for tighter regulation, and the problems identified by the RCAC in regard to the increasing entry of low quality providers in recent years (para 114).
167. Much experience from other human service sectors tells us that under the proposed changes to the regulation for entry, it is likely that virtually *anyone* will be able to start up a new provider for some service types. Relaxing entry requirements has also been one of, if not the, major cause of debacles in human services over recent decades²¹. In addition, Indigenous communities have much experience of carpetbaggers in poorly regulated service sectors.²²
168. An important question here is “Who bears the risk?” in a risk-proportionate system of regulation - and the answer is obvious. It is of course, vulnerable older people.

End of a specific program focus on older people with relatively low support needs [Row 4]

169. It would appear that there will no longer be a distinct program focus on older people with relatively low external support needs who form the large majority (79%) of the users of home and community care services (see Table 2). This also suggests there may no longer be a dedicated policy focus on this group.
170. The CHSP and HACC have been the bedrock of aged care in Australia for nearly 40 years, providing easy-to-access, low cost, essential services for people with relatively low support needs (para 38).
171. This proposal by DoH is presumably aimed at ensuring uniformity of benefits and arrangements for all services and all people receiving home care so as to (a) remove confusion for users as their needs change, and (b) reduce administrative costs for providers by having to comply with only one program.

²¹ See especially the case of vocational education and training in Australia (Toner 2014, 2018). There are also major current problems in this regard with the NDIS.

²² The long-running saga of the (non-Aboriginal) company, the Aboriginal Community Benefit Fund (ACBF, later known as Youpla) is a lesson in the damaging effects on Indigenous people of poor regulation of service providers (Butler & Allam, 2022).

172. However, it will in fact mean:

- a) The program that services the large majority of home care users and that is fundamentally working well (CHSP) will be dismantled;
- b) Less focus on the distinctive circumstances and needs of older people who are still active in terms of (i) supporting their current activities, and (ii) assisting them to remain relatively independent and socially connected for longer, with the health and fiscal benefits that brings;
- c) Potentially higher total aged care costs if older people have to obtain more complex home care and residential care earlier than otherwise; and
- d) As with the effects of a fee-for-service model, (i) reduced presence of locally-based small and medium providers (ii) reduced use of community and group approaches in planning and providing services, and (iii) reduced social capital at community level.

173. DoH's proposed change seems to be simply in the name of integration. In this context, the end of the distinctive focus on people with lower needs may almost be 'collateral damage' rather than a conscious and deliberate intention, since it seems hard to imagine such an approach being deliberately adopted. It may be that they have something else in mind to achieve this focus, but that has not yet been announced.

174. It is a distorted notion of 'integration' that results in the dismantling of a program that is fundamentally working well and that embodies decades of substantial investment by local communities. Integration should not mean rigid uniformity for all older people or the destruction of long-established and successful structures and processes that have been, and continue to be, used and appreciated by so many older Australians.

175. A similar problem affects the NDIS with a lack of adequate (or sometimes any) services for people with relatively low levels of disability.

- Prior to the NDIS, government support for people with a disability came primarily from state and territory government programs. The NDIS was predicated on the basis that it would serve people with more substantial (i.e. significant and permanent) disabilities, and that the state and territory governments would modify their mainstream programs to ensure access and quality services for other people with disabilities.

- While the situation varies between jurisdictions, a number of state governments have abrogated their responsibilities such that many people who had previously received some support no longer get anything.

Other features affecting all services

176. The DoH Proposals include a number of features that would result in changes to the administration of home care, but which would be less disruptive to the basic structure and functioning of the home care system than the four major changes, and which could all be basically positive (even if only slightly so with some of the features).

177. There are four such features:

- A single common classification system for assessing the support needs of SAHP users
- A single common service list and classification system for all service types
- Grants to providers in so-called ‘thin markets...who deliver services to small cohorts of senior Australians who have unique aged care support needs that can’t be met elsewhere.’
- A point-of-delivery payment service.

178. However, publicly much remains to be done in clarifying and finalising the detail of how each of these features will operate, with some having the potential to generate problems for users and providers unless they are designed well.

179. The two proposed measures for single common classification systems for user assessment and service types [Rows 5-6] are moves in the right direction by ensuring greater consistency in these aspects.

- However, while they take up much of the space in the DoH Overview Paper, much more work is necessary on them. For example (a) the proposed system for assessing the support needs of older people has been criticised as excessively complex and (b) the proposed system for service types appears to be overly rigid in the context of multi-service sessions that workers commonly provide (e.g. personal care and domestic assistance in one visit) or that is characteristic of much of DEG’s most valuable work with Elders (e.g. see para 72).

180. The proposal for grants to some providers in so-called ‘thin markets’ [Row 7] is likely to be relatively positive for DEG, and may in part offset the effect of the fee-for-service as the prime means of funding.

- However, a combination of fee-for-service and block grants will increase the administrative complexity for both providers and DoH, and still leave providers subject to some greater volatility.
- Moreover, it seems to be putting the cart before the horse to have the grant as an add-on to the fee-for-service payments, when what should logically happen is to ensure the basic capacity and stability of providers (via block grants) and then allow for them to meet any additional demand (via a fee-for-service arrangement) (along the lines of what is proposed in the UoW/ACSA model (ACSA, 2022)).

181. It will be important for providers such as DEG to monitor the development of the criteria and procedures for obtaining these grants to ensure that they reflect the reality of the providers at which they are aimed.

182. The point-of-delivery payment for services [Row 8] is one proposed change that is intended to support the fee-for-service and individualised entitlement models, but it could possibly still be implemented in their absence in a way that benefits DEG and other small providers.

- If we envisage a system where payments to providers are made via a block grant system, but individual usage is monitored so as ensure that high users of CHSP services can be moved onto Packages, then something along the lines of a ‘tap-on’ system or Medicare bulk-billing each time someone uses a service could reduce the administrative burden in reporting outputs for small providers such as DEG.
- Unfortunately, the prototype that has been presented is reported to do the opposite and require the installation of overly complex IT systems and require additional staff time.
- There is also strong opposition to this feature in some quarters as it is seen to provide the basis to introduce a very individualised (‘uber-like’) platform for directly linking users and workers, a model rejected by the RCAC which considered it could not be adequately covered by regulation.
- Notwithstanding these very real concerns, there would seem to be scope to further develop this sort of system in ways that lead to positive outcomes for users and small providers.

New and expanded services

183. There are four changes to the range of services that can be obtained, all of which would appear to be unambiguously positive, although at this stage it is unclear the extent of the proposed improvement.

184. These are:

- Addition of digital services as a new type of service [Row 9];
- Expansion of re-enablement and restorative services [Row 10];
- Increased support for unpaid carers [Row 11]; and
- The separate assessment and entitlements for goods, equipment and assistive technologies (GEAT) and home modifications [Row 12]m which will ‘quarantine’ funds for these one-off purposes to ensure they do not reduce the amounts available for regular ongoing services.

Indigenous services

185. A relatively positive aspect of the DoH Proposals is the inclusion of some features that are only or substantially for Indigenous users, providers, and services.
186. There are proposals for two parallel Indigenous systems designed to assist Indigenous people to get more and better services than is currently the case:
- A separate Indigenous assessment service [Row 13]
 - A Trusted Navigator (care-finder) service [Row 14]
187. Both measures are based on recommendations by NAGATSIAC (2021a) and thus reflect an Indigenous perspective on what is needed for Indigenous people. Both will be managed and staffed by Indigenous people.
188. In addition, Indigenous people and providers should benefit from (a) the extra block funding for some providers in ‘thin markets’ that are ‘working with groups for whom there are no other options’,²³ and (b) the capacity for providers in remote areas to negotiate higher unit prices (see para 196).
189. Again, much detail still remains to be filled out for each of these proposals. But together, they should temper some of the concerns about the general DoH Proposals, and could in fact give Indigenous providers some opportunity to extend their current services.
190. As well, there are further Indigenous-specific measures proposed by NAGATSIAC that are being considered by DoH (see Table 5).
191. Many of the things being accepted for Indigenous people are also necessary for the general population. Indeed, it may be that in future, Indigenous home and community care works well while the mainstream system has major problems arising from the DoH Proposals. However,

²³ Note that this could also benefit providers working with other groups such as CALD and LGBTI service users.

that has intrinsic problems if some in the wider community see that Indigenous people have options not available to non-Indigenous people.

Previously announced features

192. Finally, there are two features that have been previously announced that are due to be implemented on 1 July 2022 - a system of unit prices and payment in arrears.

Unit Prices

193. From 1 July, 2022 a consistent, standard system of unit prices will be introduced into CHSP for all providers, with the capacity for providers in remote regions (MMM6 and MMM7) to apply for higher unit prices) [Row 15 in Table 6]. This should be of direct benefit to DEG in two main ways.
194. First, the standard unit prices in 2022-23 for all three DEG services are higher than the level of unit costs for which DEG has been funded for many years.²⁴ This is especially so with the two Social Support services, with a 106.6% increase in the price for group social support and 35.1% for individual social support. The effect of these price changes is to increase the total funds for the three services by 62%. Table 7 summarises the changes.
195. This is an indication of how severely under-funded DEG has been for its CHSP services for some time now. Indeed, the services have only been possible to this point because some staff time (notably that of the DEG manager) and other costs are not charged to CHSP. The discrepancy is further emphasised by the fact that DEG has still only been allocated the lower limit of possible prices for all three of its three services.
196. A second benefit for DEG from the new system of unit prices is that Walgett is an MMM6 region and hence will be able to negotiate for additional increases, presumably subject to providing DoH with data to show the essentiality of further funds. Again, given the fact that DEG has been allocated the lower limit of possible prices for all three of its services indicates there would appear to be some scope for DEG to obtain additional funds.

²⁴ Note that the figures for unit cost for the three service types in 2021-22 are not set directly, but simply derived from the historical levels for total funding and contracted outputs.

**TABLE 7: CHANGES IN DEG UNIT PRICES
From 2021-22 to 2022-23**

		<i>Transport</i>	<i>Group Social Support</i>	<i>Individual Social Support</i>	<i>Total</i>
A	<i>Derived unit cost in 2021-22</i>	\$17.78	\$8.23	\$28.87	n/a
B	<i>Unit price in 2022-23</i>	\$18.05	\$17.00	\$39.00	n/a
C	<i>Dollar increase in unit price.</i>	\$0.27	\$8.77	\$10.13	n/a
D	<i>Percent increase in unit price</i>	1.5%	106.5%	35.1%	n/a
E	<i>Total Funds in 2021-22</i>	\$32,297.08	\$61,730.89	\$29,625.24	\$123,653.21
F	<i>Total Funds in 2022-23</i>	\$32,781.54	\$127,500.00	\$40,014.00	\$200,295.54
G	<i>\$ increase in funds</i>	\$484.46	\$65,769.11	\$10,388.76	\$76,642.33
H	<i>% increase in funds</i>	1.5%	106.5%	35.1%	62.0%

Source: Derived from Table 4

197. Presumably, whatever prices are finally determined for 2022-23 will be the basis of the prices to be paid in future years should the full fee-for-service model be adopted.
198. It will be important for DEG to monitor the development of the processes and criteria for remote providers to negotiate higher prices.

Funding in arrears

199. The other previously announced change to CHSP to be introduced from 1 July 2022 is the change from quarterly payments of funds in advance to monthly payment in arrears [Row 16 in Table 6]. This will create cash flow pressures for smaller providers and require them to hold more reserve funds.
200. The poor design of the CDC which led to large amount of unspent funds from Packages - (something that, intrinsically, was not a problem under the old ACAR system (Davidson, 2015b)) - eventually led to DoH changing funding for Package providers from payment in advance to payment in arrears. CHSP is now also to be changed, simply, it would seem, for consistency and to get CHSP providers used to the fee-for-for-service system, despite the difficulties it may cause quite a few providers.
201. This appears to be an unnecessary change for current CHSP services, especially if the block grants are continued. Currently, if a CHSP provider has unspent funds arising from failing to meet contracted outputs, that amount can simply be subtracted from the next year's grant.

Gaps in the Proposals

202. A further major concern with the DoH Proposals is that (as presented thus far) they do not adequately explain why some of the major changes should be made nor do they address a number of issues that are central to the design of any effective government-funded human service system. Even allowing for some aspects that are yet to be announced, there are many factors that have not been - and appear unlikely to be -covered.
203. Table 8 lists these issues. In summary there is:
- 1) No discussion of some key unavoidable issues (e.g. co-payments, rationing mechanisms for total expenditure);
 - 2) No recognition of the relevance of the two major constraints on the growth of aged care (total funding, workforce);
 - 3) No or inadequate justification for the four major changes;
 - 4) No recognition of the major strengths of the current programs (especially CHSP and local providers);
 - 5) No mention of some key problems relating to providers (lack of transparency, the growing maze of providers) that will be exacerbated by the DoH Proposals; and
 - 6) No recognition of the lessons from previous use of market-based systems.

Co-payments

204. DoH is still to announce any aspect of its proposed policy on co-payments in SAHP. This is a major gap given that the adequacy of government subsidies and the feasibility of other aspects of the proposed SAHP are intimately interconnected with the level of payments by users. It is impossible for the various stakeholders representing users and providers to agree on any aspect of a funding policy until the co-payments policy is set out.
205. As noted earlier, DEG would strongly oppose any mandatory co-payment or any mechanism that cut payments to providers not charging co-payments. Aside from the possible effect of a co-payment deterring Elders from using services that are essential to their well-being, there is a strong argument for all or most Indigenous users, providers, and services to be exempt from co-payments for primary care services, given the historically-driven greater likelihood of poverty amongst older Indigenous people, and the various moral and practical considerations that arise from those factors. For example, would the funds received under any reasonable means test justify the administrative costs involved? In addition, it will be the case for some years to come

that a significant proportion of older Aboriginal people will be Stolen Generation survivors (as is the case in Walgett).

TABLE 8: Gaps in the DoH Proposals for SAHP

1. No discussion thus far of some key unavoidable issues	
a	No explanation of what rationing mechanism(s) will control total expenditure either currently or in the future with a rapidly ageing population.
b	No mention of co-payments
2. No recognition of the relevance of major constraints on the growth of aged care	
c	No reference to the impact arising from the limitations on total government funding that is available
d	No reference to the implications of and for workforce issues
3. No or inadequate justification for the four major changes	
e	No justification for a fee-for-service model to be applied to all services
f	No justification for the individualised entitlements
g	No adequate justification for the risk-proportionate regulation model being proposed
h	No adequate justification for ending the policy and program focus on low need users
4. No recognition of the long-established major strengths of the current programs	
i	No recognition of the positives of the design of CHSP
j	No recognition that a high proportion of services are provided <i>outside</i> the home (i.e. it is home and <i>community</i> care)
k	No recognition of the community support and social capital development role played by CHSP
l	No recognition of the contributions of locally-based non-profit providers of CHSP to communities
m	No recognition of the role of CHSP in helping to ensure services for socially marginalised people
5. No mention of key problems relating to providers	
n	No recognition of the problems for users from the growing maze and 'confusopoly' of providers
o	No recognition of the need for providers to be more transparent about their capability and offerings
6. No recognition of the lessons from previous use of market-based systems	
p	No recognition of the findings and complaints by the RCAC about the use of markets
q	No recognition of the own goals and errors built into the system in recent years
r	No recognition of the extensive empirical evidence about human service markets and the problems of excessive marketisation
s	No recognition of the problems in the NDIS arising from using the same features as proposed
t	No recognition of the major transition costs to the proposed new program as it is envisaged

206. Davidson (forthcoming) elaborates on some of the key problems that arise from these gaps. They include, for example:

- The lack of a rationing mechanism for total expenditures and the failure to effectively future-proof the system in the face of a rapidly ageing population over the next 30 years means a fiscal time-bomb for government, as has now occurred with the NDIS.
- There is no recognition of the implications of a fee-of-for-service model for the workforce, by reducing income and job security for workers, thus making working in the sector even less attractive.
- Of particular concern is the lack of any recognition of the important social capital and community development role played by CHSP and by locally-based providers such as DEG, and the way in which block grant funding is an essential support for that role.
- There is nothing about enhancing the capacity of the home and community care system to identify and provide services for older people who are socially marginalised despite evidence of growing numbers of such people (let alone any measures to improve services for this group).
- The DoH Proposals do not recognise RCAC Recommendation 33 that

From 1 July 2022, the Australian Government should implement a social supports category within the aged care program that (a) provides supports that reduce and prevent social isolation and loneliness among older people (b) can be coordinated to the greatest practicable extent in each location with services and activities provided by local government, community organisations and business designed to enhance the wellbeing of older people (c) includes centre-based day care and the social support, delivered meals and transport service types from the Commonwealth Home Support Programme (d) is grant funded.

Indeed the Proposals seems to either ignore or work against each of the four elements in that recommendation (which was accepted in the Government Response to RCAC).

- My Aged Care simply does not work as a source for information for most people looking for aged care services. It is also far from clear that the proposed care-finders will help overcome the problems and they will certainly bring their own problems.
- The RCAC Report expressed strong concern about the ways that markets have been used in aged care (e.g. RCAC (2021), Vol 2, Section 4.6). The DoH Proposals ignore this and the mountain of similar evidence in other human services, and simply assume that an increase in the extent of marketisation is acceptable.

- There is no recognition of the major leakages of the public and private service dollar that have grown from increased marketisation in the last decade (e.g. via user fees, marketing, consultants, IT, legal costs, profits, etc).

207. Not all of these issues directly affect DEG, but most do to some extent.

Some broad drivers and impacts of the DoH Proposals

208. The stated and implicit goals of the DoH Proposals are the conventional (and largely universally agreed) goals of human services reform, such as higher quality and more diverse services, better access to services, greater horizontal and vertical equity between users in relation to access and quality, more efficient use of resources at both a system and provider level, and greater choice and control for service users and their families.

209. However, there is a large body of theory and empirical evidence that indicates that key structures and mechanisms being proposed by DoH are unlikely to achieve - and may in fact impede – these goals, as well as losing many of the long-established positive features of the current programs (CHSP and HCPP).

210. Flowing from the specific proposed changes and gaps outlined above are a range of broader problems underpinning or flowing from the DoH Proposals.

211. In terms of what underpins the four major changes in the Proposals, they:

- do not flow from the RCAC report and actually contradict it in key respects;
- are based on some perceptions and ‘diagnoses’ of the home care sector that do not reflect important aspects of the reality for the majority of older people using home care, many longer-term providers, and the way the system operates;
- are designed around some ideal ‘consumer’ rather than the real needs, circumstances, and wishes of most older people;
- embody an excessive faith in market mechanisms, ignoring evidence and lessons from other marketised human service systems;
- are based on a distorted concept of ‘person-centred’, a term generally used to mean that services are designed around the unique needs of each person, but which is used in the Regulation Paper (DoH 2022b) to emphasise an individual’s responsibility for his/her care;
- are based on a distorted notion of ‘integration’ of existing programs (para 174); and
- replicate many of the problematic elements of the NDIS.

212. In terms of their impact, the Proposals will no doubt lead to better services and outcome for some people as per the goals of the changes as set out earlier (e.g. paras 150, 157, 162, 171, 208).
213. However, there is much evidence to indicate that, in practice, the Proposals will also:
- a) make home care more commercialised and commodified, with services more transactional and less relational for each user, while promoting more atomised services focused on separate individuals at the expense of the community and group-based approaches that have underpinned the success of CHSP and HACC for many years and which are central to successful services for Indigenous people;
 - b) remove a specific and distinct policy and program focus on older people with relatively low support needs;
 - c) have negative effects for many service users in terms of less genuine choice and control, greater search costs but less certainty and confidence about providers, reduced quality and safety of services from a number of providers, and a reduced capacity to ensure services for socially marginalised people;
 - d) lead to the loss of significant community investment and social capital built up over decades, and the removal of well-established places in the community from which people can get information about services and providers;
 - e) generate major disruption and transition costs (for changes that are not necessary or desirable);
 - f) lead to reduced stability and certainty for providers;
 - g) more poor and opportunist providers;
 - h) more complex but less rigorous regulation of providers;
 - i) reduced income and job security for many workers and hence greater difficulty for providers (and the overall sector) in attracting staff;
 - j) add to the current maze and 'confusopoly' of providers;
 - k) lead to a major change in the profile of providers with an overall negative effect; and
 - l) do nothing to address the lack of transparency of providers
214. Taken together, the Proposals represent some perverse and paradoxical aspects, notably:
- 1) An odd combination of overly marketised and overly bureaucratic measures. with an excessive faith in market mechanisms where strong control is essential (e.g. reduced regulation of the entry of providers), combined with greater central control where a more

- decentralised approach is desirable (e.g. government assessors determine the precise services each person can receive);
- 2) A regulation system that will be both more complex and less rigorous;
 - 3) An implicit assumption that the operation and outcomes of services will be improved by increasing the number and market share of more commercially focused providers that may have little or no experience in human services, at the expense of long established, experienced and successful social-maximising non-profit bodies;
 - 4) In spite of the excessive faith in market mechanisms, the proposals will significantly work against key market goals such as efficiency and choice in a number of ways;²⁵ and
 - 5) The system that is basically working well for the large majority of home care users, despite increasing under-funding in recent years (CHSP), is to be dismantled.
215. Davidson (forthcoming) outlines in more detail the processes by which the DoH Proposals will lead to the above effects.
216. The DoH Proposals allegedly flow from the RCAC Report and the Government Response, but some of them go well beyond anything suggested by either of those documents. Indeed, not only do a number of the key DoH Proposals not flow from the issues and problems raised in the RCAC Report, but they directly contradict it in a number of core aspects.
- For example, the RCAC noted the problems of markets in aged care (see para 206 above) and the entry of low quality providers in recent years (para 114), but the DoH Proposals would increase marketisation and further weaken the regulation of entry.
 - In practice, the proposals do nothing and even work against the aims of RCAC Recommendation 33 regarding social isolation, linkages with existing local provisions, supporting centre-based care and retaining grant-funding for social support services.
 - The proposals also include an NDIS-like system of individualised entitlements, something not recommended by the RCAC and which has been very problematic for the NDIS.
- In short, DoH appears to have gone well beyond its public brief in developing its proposals for a new Support at Home Program (SAHP).

²⁵ A concern with improving efficiency in the sector appears to have been a major driver of the DoH Proposals, but there seems to have been little account taken of the complexities of improving efficiency in home care and the ways in which the measures embodied in the DoH Proposals can significantly *reduce* allocative, productive, and dynamic efficiency (See, for example, Davidson (2015b) and Davidson (2016), and the references contained in those documents.. Davidson (forthcoming) discusses the potential impact on efficiency of the DoH Proposals).

E. The Potential Impact of the DoH Proposals on DEG

217. In considering the impact of the DoH Proposals, it is important to note that these current proposals will almost certainly be amended, perhaps very significantly, before SAHP actually begins, and hence the opportunities and risks noted below are likely to change.
218. From DEG's perspective, there are both potential positives and opportunities and potential risks and threats arising from the *current* DoH Proposals for SAHP.
219. Many of the impacts of the changes on DEG and its users and services will be as for providers, users, and services in general. Other changes arise as a result of (a) Indigenous issues (b) remoteness (c) the size (scale and scope) of DEG.

Potential Positives and Opportunities

220. From a positive perspective, there may be little real change in how DEG operates or in the services that it can provide to Elders, while it may also have some extra scope to enhance and extend its current services.
221. Specifically:
 - a) First, the changes may have little or no practical effect for DEG in the short term. If the same people who now come to DEG are assessed as needing the same services and they keep coming, there would be little change in DEG's total revenue from the current CHSP block grants.
 - b) Second, DEG is in one of the remote areas (MMM 6 and 7) where providers are able to negotiate for higher prices (and the current prices allocated to DEG for 2022-23 are at the bottom of the possible range of prices for each of its three services). Hence there would appear to be scope to obtain additional funds to enhance the current services.
 - c) Third, the new prices are higher than DEG' current unit costs.
 - d) Fourth, the grants for providers in thin markets open the way for some extra block funding above its fee-for-service revenue. (It will be important to monitor the development of the criteria and procedures for these grants, but they certainly appear to be designed to assist Indigenous providers).

- e) Fifth, the Indigenous-specific assessment and Trusted Navigator services could lead to additional entitlements for DEG clients, in turn leading to an expansion of DEG's services. After all, the goal of creating these parallel services using Indigenous people and organisations to undertake assessment and support functions is to address the current relative lack of access of Indigenous people to aged care services.²⁶
- f) Sixth, DEG could expand both the volume of its services and the types of services it provides without needing to make submission for funds. Under a fee-for-service model, it could simply take on additional approved users for its transport and social support services. Further, subject to it being approved to offer other service types (e.g. domestic assistance, personal services), it just has to obtain new clients and/or have existing clients expand the volume and range of services they want. This would also enable DEG to be paid for the additional outputs it currently provides above its contracted minimum (subject to its users having been approved for that level of services).
- g) Seventh, the fee-for-service model will presumably allow Indigenous providers to take on non-Indigenous clients, (although it may be that access by providers to additional Indigenous provisions will preclude taking on non-Indigenous clients).

Potential Risks and Threats

222. On the other hand, there are a number of risks and threats for DEG arising from the current DoH Proposals. Specifically:

- a) First, there will be more volatility and uncertainty in regard to DEG's revenue (both the week-to-week cash flow and the annual total) since it will depend on the fluctuating number of people who use its services and the frequency they use those services rather than a fixed grant.

In this scenario, there are a number of reasons why DEG's revenue could decline over time under a fee-for-service model that are unrelated to the quality of its services. For example:

- the total assessed individualised entitlements for DEG's current clients may be less than what is currently spent on them, and/or
- the total number of clients may decline if the number of new clients (from the ageing of the population or more current local Elders wanting support) is less than the number of clients

²⁶ NAGATSIAC (2020, 2021a, 2021b) contain data to show this relative access of access.

lost (from death, growing infirmity such that they move onto more complex home care or residential care, or Elders moving to new providers),²⁷ and/or

- the average use of services per client may decline (for the same reasons as above as to why the total number of clients may decline), and/or
- there is a major interruption to either demand for its services, or its capacity to supply services, such as has occurred for many organisations during COVID.

These constitute new risk factors for DEG for the smooth operation of its services, and could ultimately threaten the viability of the services, (although the capacity for providers in thin markets to obtain grants may help to offset this threat to some extent).

- b) Second, the volatility and uncertainty about revenue reduces a provider's capacity to confidently plan for the future, while making it less possible to give staff any guarantee of job and income security. This will make it more difficult to obtain and retain staff, especially more experienced and higher quality staff.
- c) Third, another implication of the greater volatility of revenue and the introduction of funding in arrears is that DEG will need to maintain a larger financial reserve as a 'war chest' to cover exigencies and to ensure adequate cash flow.
- d) Fourth, the reduced regulation of entry for new providers that is proposed will increase the problem identified by the RCAC of low quality providers entering home care in recent years. Indigenous communities have suffered from a range of carpetbaggers and poor providers in other sectors and it is almost certain that this will occur in some communities under the so-called 'risk-proportionate' regulation. DEG may then be called on to sort out the mess.
- e) Fifth, the lower regulation of entry would also enable the easier entry of other providers, from larger chains based outside Walgett through to local sole traders with no previous background in home and community care. Certainly, some of these will offer cosmetic incentives to Elders to switch providers. Over time this is likely to lower the quality and local responsiveness of services at an individual level for some Elders, and cut away at the important community and cultural work being achieved by DEG. This may not be such an issue with the current group of clients, but the problem could develop over time.
- f) Sixth, the proposed system will be much less supportive of - and a potential threat to - the community and group-based approaches that are central to what DEG seeks to achieve. This will arise inevitably from the logistics of operating fee-for-service funding arrangements and from the individualised user entitlements, and will be exacerbated by differences in

²⁷ That is, the 'replacement rate' of clients is less than one over the longer term.

approved services and financial entitlements for each Elder resulting from the new system of individualised entitlements.

- g) Seventh, a fee-for-service model inevitably leads to management needing to give a greater relative priority to obtaining new clients (and hence revenue) with less time devoted to improving services.
- h) Eighth, the two parallel Indigenous services (assessment and navigators) will mean that other Indigenous organisations will be responsible for assessing, advising, and supporting DEG's clients. This may impinge on DEG's independence and its relationship with its clients, leading to the potential for tension or conflict with the new services. This could also have an effect on the use of DEG services by local Aboriginal Elders, exacerbating the problems of greater volatility and insecurity of DEG's revenue.

Impact on DEG plans for expansion

- 223. We have noted above (see Table 3) that DEG has identified a range of possibilities for how it might expand the range of the aged care services that it provides.
- 224. It may be that with the extra funding from higher prices for existing services and the possibility of additional funds from the proposed additional block funding for providers in thin markets, more can be done. Alternatively the options for expansion would presumably be reduced if DEG's revenue was adversely affected by the new program (as per some of the scenarios in para 222).
- 225. In addition, there are a number of proposals by NAGATSIAC, which if adopted by government could open the way to enable some of the DEG plans to eventuate.

Four Structural Dimensions of DEG

- 226. We earlier noted (para 33) that there are four structural dimensions of DEG that could potentially affect and be affected by changes in the funding and regulation of CHSP - scale, community control, Aboriginal, and remote.

Scale

- 227. DEG's current small size is important in determining its response to the DoH Proposals for changes to the home and community care system.

- It is likely the changes would require some increase in DEG's back-office services (especially in relation to its financial management and IT capabilities).
- In addition, if DEG wishes to expand its services (see para 47 and Table 3), there will be substantial implications for the structure, resources, and capacity of the organisation.

228. Three questions that DEG will need to consider in the context of the forthcoming changes to the funding and regulation of home care are (a) how big will it *have to* become (b) how big does it *want to* become, and (c) how big *can* it become?

- Ultimately the answers to the last two of these questions will be limited by the level of demand in the Walgett area, even if it decided to take on non-Aboriginal clients. Would it then want to provide services to a wider area within western NSW - or even further afield.²⁸

Community control

229. There would not appear to be anything in the DoH Proposals that would directly lead a loss of community control of DEG.

230. However, as noted earlier (paras 151, 213), there will be stronger pressures on all providers to become more commercialised at the expense of community and group based approaches. The DEG Council will need to be aware of the possible implications in this regard of any decisions they make to adapt the content and operation of DEG's aged care services.

An Aboriginal organisation

231. The DEG home and community care services are governed by and serve Aboriginal people.

232. The DoH Proposals (and possible further changes that might flow from NAGATSIAC proposals) should strengthen the capacity of DEG to be an organisation that is managed by and focused on Aboriginal people. If anything those changes are likely to increase the level and range of home and community care services that Aboriginal people in Walgett can obtain.

233. At the same time, the movement to a fee-for-service model of payments (either in total, or as an add-on to block grants) opens the way for DEG to take on non-Aboriginal clients. In turn that could lead to pressures for non-Aboriginal people to be on the DEG Council that oversees home and community care services.

²⁸ A striking example of how a non-profit home and community care provider can grow from a single small town is Feros. In 2000, it had only 25 packages and was restricted to the Byron Bay area. It now operates nationally with a turnover of nearly \$100M p.a.

Remoteness

234. Regardless of what changes are made to home and community care in the new SAHP, DEG will continue to be impacted by two factors arising from remoteness, namely (a) the cost and availability of key inputs to its services, especially staff, and (b) the 'thin market' on the demand side which unavoidably limits the extent to which DEG can gain any economies of scale.
235. From this perspective, the current DoH Proposals, which intrinsically favour the growth of larger provider organisations, potentially pose some threats to the operation - and ultimately viability - of the DEG services.

Overall Impact on DEG

236. From DEG's perspective, the main concern is that the changes proposed by DoH (especially in relation to block grants) would create a more volatile and uncertain operating environment and one that is inconsistent with the DEG philosophy and goals concerning group and community approaches. In turn, DEG's current capacity to support the well-being of each individual Elder and empower Elders to contribute to the community and to strengthening Aboriginal culture would be threatened.
237. Notwithstanding that, given all of the above factors, DEG may be able to largely continue its current operations and services, at least in the short term, although some organisational adjustments will be necessary. However, the risks and threats for all service providers inherent in the DoH Proposals are likely to necessitate more significant further changes for DEG in the intermediate and longer term.
238. The above assessments of the impact of the changes on DEG arising from the DoH Proposals are necessarily very tentative and subject to two major caveats, namely that (a) future developments in the design of SAHP may take the program a long way from the current DoH Proposals, and (b) there needs to be further in-depth analysis of DEG's organisation to identify the specific changes that would be required in response to the final design of SAHP.
239. As the new SAHP is developed and more details are clarified, the nature and impact of some of the above considerations may change. But at this stage there appear to be some grounds for optimism for DEG and other Indigenous providers that do not exist more generally for all CHSP providers.

F. What Could Happen with SAHP?

240. This paper has argued that while there are number of positive aspects to the current DOH proposals for SAHP, some of the key changes that are proposed are very problematic and will work against the best interests of the Aboriginal Elders who use DEG's aged care services.
241. The following suggestions are made in light of DEG 's goals and philosophy and the likely impact of the currently proposed changes on its future. More detail can be found in Davidson (forthcoming) about each of these suggestions and how they would function.
242. In order to ensure that DEG and other Indigenous and community-based service providers can continue to best serve older people and their community and cultures, the design of the future system for home and community care needs to include the following elements:
- a) *Retain a distinct policy and program focus on people with relatively low external support needs.*
- This does not preclude more integration and consistency with services for people with more complex needs, including the development of a common basis for assessment systems and service types across all home care users and services.
 - But 'integration' does mean total uniformity for all users and all providers across all elements of the home care program, and it especially should not lead to the dismantling and destruction of the core elements of a program that has been successful for decades.
 - Rather, there needs to be a specific and distinctive policy and program focus on people with low external support needs (who are the vast majority of home care users), with systems for entitlements, funding, and regulation that are appropriate to the needs and circumstances of these people, and that best maintains their social connections and capacity for independent action.
 - This parallels other human service sectors where there is are clear distinctions between basic 'primary' services and other more complex services in ways that still allow for an overall integrated system (e.g. as with primary, secondary, and higher education; or with primary, specialist, and acute health care).
- b) *Retain block grant funding to providers as the basis for funding services for people with low support needs (i.e. current CHSP services), at least for locally-based non-profit providers.*
- This would (as now) be subject to agreed outputs and unit prices, and be sufficient to ensure the viability and smooth operation of efficient providers.
 - It is important to ensure that each community has a stable non-profit or public provider committed to the public interest.
 - This would not involve more funding than would be spent under a total fee-for-service model, but would ensure the stability and continuity of quality services for all communities and older people.
 - As a fall-back option this may only apply to selected locally-based, non-profit or public providers with a proven record of quality services, with full fee-for-service arrangements applying to larger 'chain' providers whose current CHSP services are only a minor part of their overall operations.

- c) *Introduce a fee-for-service arrangement to apply above the level of block grant funding for services for low need users (as in [b] above) in order to enable providers to increase their activity to respond to additional demand.*
- A related alternative to this could be the UoW/ACSA model²⁹, whereby the fixed (or capacity) costs would be covered by a block grant, with the variable (or ‘activity’) costs covered by fee-for service. A key design issue for that model is where the dividing line between fixed and variable costs needs to be set (e.g. providers tend to regard a higher proportion of their staff costs as fixed, compared to the view of an economist).
 - Again (as in [b]), this may only apply to selected locally-based non-profit or public providers with a proven record of quality services.
- d) *For people with more complex and extensive needs (i.e. current Package holders), retain the current arrangements for their entitlements to a government subsidy.*
- That is, reject the DoH Proposal to change to totally individualised entitlements (as per the NDIS) for users
 - The current HCPP arrangements involve (i) four groupings (levels), with a maximum amount of funds for each level (ii) users being allocated to one of the four levels following an ACAT assessment such that they have a set of approved services and a maximum financial amount, and (iii) the detailed services then being worked out between the user, their family, and providers.
 - The number of levels of packages could also be increased (e.g from 4 to 6), with an extra level above the current top level, or finer gradations between levels.
- e) *Introduce a common maximum entitlement (e.g. \$5000) for people with relatively low needs (i.e. current CHSP clients).*
- This would be integrated into the system in [d] above as the lowest level of ‘package’
 - Anyone using services at a level above the limit would move to a higher level of package.
 - This does not preclude providers receiving their funding via block grants.
- f) *Maintain (or even tighten) the current regulation of the entry and capability of providers of more complex services where care staff are needed*
- Do not introduce ‘risk-proportionate regulation’ in regard to the entry and exit of providers for these services.
 - This approach is consistent with the concerns expressed by the RCAC about the increase in poor quality home care providers entering the sector in recent years.
- g) *Introduce a limited form of ‘risk-proportionate regulation’ for proven high quality providers in relation to their ‘service behaviour’.*

²⁹ A model developed by staff at the University of Wollongong in conjunction with ACSA (ACSA 2022).

- The aim of this measure is to give good providers greater flexibility to innovate and to adapt services to individual user needs.
 - The tighter the regulation of entry, the more this is possible given that there can be a greater level of confidence in the capability and motivation of all providers.
- h) *Introduce the two Indigenous-specific proposals contained in the DoH Proposals, subject to clear statements about the basis of the relationship of these services with Indigenous service users and providers.*
- In addition, seek to embed Indigenous navigators within local providers in rural and remote areas.
- i) *Explicitly recognise the importance of the social capital and community development role played by CHSP and locally based providers, with additional funding and measures to enable locally-based providers to continue and strengthen this role.*
- For a relatively small amount of additional funding a network of Local Aged Care Information Centres (LACICs) could be established in many communities based on current local providers. This would be more accessible to users and more effective than the proposed system of care-finders; alternatively, the two measures could complement each other.
 - It perhaps needs to be noted here that this is *not* looking back to return to some cottage-based industry using only locally-based providers. That would be quite inappropriate for a system that has to effectively and efficiently meet the diverse needs of over one million older people across a nation as large as Australia. However, the presence of vibrant and well-supported local non-profit providers in each community *is* an essential element of an optimum home and community care system.
- j) *Additional funding and measures to assist locally-based providers to identify and support socially marginalised older people who may not otherwise seek assistance.*
- k) *Retain payments in advance, subject to acquittal of the use of funds as agreed.*
- There is no need for funding in arrears, especially if block grant funding is retained.
- l) *Accept in principle the broad goals of the other DoH Proposals affecting all services and expanding services (i.e. Rows 5-14 in Table 6 and paras 176-191), with further clarification and/or development necessary for each of these.*
- They may all ultimately be acceptable if designed appropriately.
- m) *The arrangements for co-payments should ensure*
- the financial viability of quality services for all older people
 - people are not deterred from using services that are essential for their well-being,
 - both horizontal and vertical equity between services and users.
- n) Support some of the further Indigenous-specific measures as proposed by NAGATSIAC.

243. There are also possible additional measures particular to services for Indigenous people that could be adopted. In particular, DEG is likely to support the following proposals from NAGATSIAC (2022b), subject to further development and clarification of what is intended and how they will affect DEG's independence and viability:

- annual access targets (to drive the creation of more aged care places for Indigenous people);
- an aged care capacity building program;
- extending NATSIFACP³⁰ to support more aged care hostels for Aboriginal Elders;
- closer integration of aged care and primary health care; and
- expansion and development of the Indigenous direct care workforce (e.g. more positions, mandated minimum qualifications).

244. Finally, there needs to be more funding for home care in general if the support needs of older people are to be adequately met. From DEG's perspective, they need additional funds to (a) be able to provide their current services to all eligible Aboriginal Elders in Walgett (paras 80-83), and (b) to expand the range of services they are able to provide (as set out in Table 3).

³⁰ NATSIFACP is the National Aboriginal and Torres Strait Islander Flexible Aged Care Program.

G. Action Required by DEG

245. Given that there will almost certainly be some changes in the funding and regulatory systems for home and community care, DEG needs to consider action at four main levels, namely to:

- review its service offerings over the intermediate and longer terms;
- determine organisational development action that may be necessary;
- determine its position on issues concerning the future design and key features of SAHP (as in Section F above); and
- determine action it might take to influence decisions about the final form of SAHP.

246. We now briefly look at what DEG might do under each of these four levels of action.

247. *First, review its service offerings over the intermediate and longer terms.*

- This involves reviewing (a) its current services and the way it plans and delivers those services (b) possible additional services it could provide, and (c) alternative approaches to planning and delivery, with a particular focus on how to retain the strengths of its community and cultural roles.
- Flowing from such a review it can determine (a) if there is a need to vary how the current services are provided, and (b) what additional services it wants to provide if more funds were available.
- Ultimately, DEG's continuing viability and success as a service provider *under any system* will depend on its capacity to retain and increase the number of people who use its services and the frequency they use those services.

248. *Second, determine organisational development action that may be necessary.* This could include action to:

- ensure that all potential clients from the Elders in Walgett are formally assessed as soon as possible;
- identify how it can establish an adequate financial reserve (e.g. to cover the exigencies of fee-for-service and payment in arrears model should they come to be adopted);
- review the organisation against the DoH 2021 Provider Readiness survey;
- review staffing policies and contracts (given that funding will be less secure);
- establish systems to monitor the weekly/monthly usage of services and resulting revenue;

- introduce new IT systems that may be necessary (e.g. from individualised funding);
- enable implementation of long-term plans to expand services (as in Table 3); and
- establish relationships with the two parallel Indigenous services (assessment, navigators).

249. *Third, determine its position on issues concerning the key features of SAHP that will come under discussion.*

- DEG has the opportunity to influence the final form of SAHP, the design of which is far from finalised and which will be subject to consultation and change.
- Section F above contains a suggested approach on what DEG's position could be on various aspects of the new program.

250. *Fourth, determine action it might take to influence decisions about the final form of SAHP.*

- This essentially involves (a) establishing processes to keep informed about ongoing developments with the design of SAHP, and (b) deciding what, if any, forms of advocacy it can most effectively undertake
- Possible forms of advocacy include direct approaches to politicians and DoH, attendance and presentations at aged care forums, and ongoing contacts with media outlets (including the aged care media).
- An important aspect is to establish and maintain ongoing linkages with a range of other organisations in the sector (e.g. government, Indigenous, peak bodies) so as to advocate for its needs and to participate in joint action with those organisations.

H. Future Development of SAHP

251. DoH has set out a schedule for future consultation about the development of SAHP on a range of issues, with the aim of SAHP ultimately beginning in July 2023. The RCAC had recommended (Rec 25) that a new overall aged care program (encompassing Residential Care, HCPP, and CHSP) should begin in July 2024.

Concern about the Proposals

252. However, as outlined above, the DoH Proposals are very problematic with concerns ranging from the overall philosophy of the proposed changes through to the mechanics of the proposed processes for the funding and regulation of home care services. This has led to widespread concern about the Proposals in the sector from service users, practitioners, providers, and researchers. The problem is not one of detail or process, but the fundamental model that the proposals represent, a model for which no justification has been given on key aspects in spite of the ample evidence over many years in many human services in many places of the problems the Proposals will inevitably bring.
253. The concern about the DoH Proposals has largely remained under the public radar, but has been raised strongly within industry forums and media. For example, an alliance of peak bodies and service providers wrote to the former Prime Minister outlining their concerns and calling for a pause in the development of the current SAHP model which they described as 'misconceived'. Evidence of concern about the DoH Proposals can be found, for example, in Morgan (2022), Skatsssoon (2022), and Fine (2022).
254. There has been an attempt by supporters of the DoH Proposals, both in public forums and in DoH discussions with stakeholders, to characterise these concerns as an attempt by service providers to protect their vested interests. That is quite wrong and simply ignores the extensive evidence showing the problematic and potentially damaging nature for service users and providers of some of the Proposals - including evidence in the RCAC Report and the many recent revelations about the failure of some of the key mechanisms in the NDIS. It also ignores the many commercial vested interests that would benefit from a more marketised system, substantially increased IT requirements for most providers, and a host of inexperienced providers whose principals and staff have had little experience in human services, let alone home care. It would be better if the supporters of the DoH Proposals actually presented some arguments for the major changes rather than simply assuming them as a *fait accompli*.

Concern about the Consultation

255. There is also concern about the nature of the consultation by DoH. The DoH Proposals involve some major changes to the philosophy and mechanics of home care services and funding, but DoH has simply assumed they will happen and has given no justification for these proposals or indicated any intention to consult further. Public consultation thus far has been largely limited to questions of detail and implementation, while DoH has closely controlled the format of public consultation. This was clear, for example, in the DoH Webinar on 8 March 2022 which kept the 1204 questions hidden from public view, while presenting only one question in relation to the major issues noted in this paper.
256. However, indications are that consultation may be less of a problem with proposals affecting Indigenous issues given that (a) so far there appears to have been reasonably close consultation by DoH with NAGATSIAC and other Indigenous bodies on these issues (b) the time period for the initial consultation about Indigenous issues was the most extensive, going out to August 2022 (whereas all others were scheduled to end between March and June 2022), and (c) a number of NAGATSIAC proposals have been accepted.

Future Steps

257. Given all of the issues outlined in this paper, there have been calls from a number of key stakeholders to, at the very least, pause the development of SAHP to enable a more thorough consideration of the design of the program.
258. Notwithstanding the many potential problems with the DoH Proposals outlined in this paper, we can expect that the four major changes in the proposals will in fact lead to better services and outcomes for *some* older people, by giving them access to more responsive and higher quality providers than previously, as is envisaged in the sorts of rationales that are usually given for such changes.
259. The point, however, is that there is now a mountain of theory and empirical evidence from many human services in many places over many years - including in the RCAC Report - to show that while some limited and strategic use of market mechanisms in human services is desirable, indeed essential, excessive marketisation can lead to poorer services and outcomes for *many and often most* service users. **This evidence needs to be properly assessed in the determining the final design of SAHP.**

260. Moreover, with the change of government after the May 21 election, the incoming government needs time to determine its position on the future of SAHP. No government would want to face the problems that the current DoH Proposals will inevitably bring. Alongside this (and towering over any actual problems specific to home and community care), are major and urgent issues on multiple fronts in other areas of aged care that require immediate and whole-hearted government attention and resources and for which there are no easy or obvious short-term answers. This is especially so in regard to the workforce, residential care, and COVID. Why would a new government wish to open up another front of change on matters for which even the need for major change is hotly disputed?
261. In the above context, it is important that (a) the development of SAHP should be paused, and (b) that there then be significant change in both the parameters for SAHP as set out in the DoH Proposals and the proposed timetable for consultation and the start of the new program. A traditional government Green Paper,³¹ developed with significant stakeholder input, and canvassing the full range of evidence and issues, would be a valuable first step.
262. This would mean that the current DoH timetable for consultation would be substantially revised and the start of SAHP deferred from July 2023, probably at least until July 2024 as the RCAC recommended for the start of the single overall aged care program. That would not preclude the earlier introduction of some of the features in the DoH Proposals that are less controversial and properly developed.

³¹ <https://guides.library.uq.edu.au/how-to-find/parliament-government-information/white-green-papers>

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Bob has held senior positions in national and state government agencies and government business enterprises, and as an adviser to ministers. This included periods as the national director of various human service programs; five years as an adviser to national ministers in economic, industry, employment, social, and science portfolios; and senior roles at a state level in fields as diverse as investment promotion, state development, community services, Aboriginal affairs, and energy. He has also been heavily involved in the community sector, as a volunteer, a member of the management committees of a range of local and regional service providers, and a consultant. Through all of the above, he has had a long background in working with Indigenous people and organisations from community to national level over many years.

For the last two decades, his research interests and consultancy work have centred on the intersection of economics, social policy, and organisational theory and practice, with a particular focus on economics of the provision of human services, human service markets, and service providers within these markets, especially in home and community care. His publications have examined the assumptions and logic of market theory where the product is a human service, with a particular focus on aged care. His PhD thesis, *Contestability in human services and its impact on service providers: A case study of community aged care in NSW* was one of the first economic analyses of the home care industry in Australia.

He also has close and ongoing personal contact with aged and disability care services through close family members who have been receiving these services for a number of years.

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