Comparing aged care and NDIS support:

A funding analysis

Discussion paper

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LASA
LEADING AGE SERVICES AUSTRALIA
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ABOUT LASA

Who We Are

LASA is the national association for all providers of age services across residential care, home care and retirement living/ seniors housing.

Our Purpose

Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion—always.

Our Members

We represent providers of age services of all types and sizes located across Australia's metropolitan, regional and remote areas. We are dedicated to meeting the needs of LASA Members by providing:

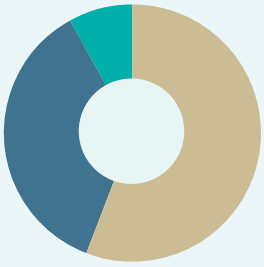
- a strong and influential voice leading the agenda on issues of importance;
- access to valuable and value-adding information, advice, services and support; and
- value for money by delivering our services and support efficiently and effectively.

LASA supports all providers of aged care

54% not-for-profit providers

38% private providers

8% public providers

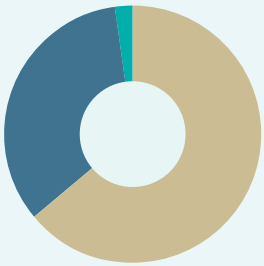


Our Members are located across Australia

64% in major metropolitan cities

34% in regional areas

2% in remote areas



Our Affiliates

LASA Affiliates are proud supporters of the critical role played by the age services industry in caring for older Australians. Their value-adding products and services help age services providers apply innovative solutions that improve the provision of efficient and quality care.

Our Strategic Objectives

1. Be the credible and authoritative voice of aged care representing the views of our Members for the benefit of older Australians.
2. Build sector capability and sustainability by delivering valued services and support to Members.
3. Lead continuous improvement by promoting and celebrating excellence and innovation in age services.
4. Deliver value for money for Members and Affiliates.
5. Be a high performing, respected and sustainable association that cares for our purpose, our Members and our people.

Contents

Key points

Program comparison

- Aged care and disability support both represent about 1.2-1.3% of GDP.
- Aged care programs helped about 1.3 million people over 2019-20 while the NDIS had 400,000 participants as of 30 September 2020.
- NDIS participants receive whatever support is reasonable and necessary (with no cap) whereas people in aged care are classified into programs and bands with capped funding.
- Average annual support utilised in the NDIS equates to about $52,000 whereas the average annualised support for a person in aged care is about $17,000.

Comparison by level of impairment

- Both aged care and disability programs categorise people into levels of support, though there is no straightforward way to compare average impairment between programs.
- For NDIS participants in September 2020, average annual allocated support was about $200,000 for those with high needs (41%) $61,000 for those with moderate needs (42%) and $22,000 for those with low needs (16%).
  - When further broken down into 15 levels of function those with the highest impairment average $493,170 while those with the lowest impairment average $17,144.
- For aged care, about 67% of participants received basic home support that equates to about $3,000 in average annual funding. Providers delivering care in both systems report that many people receiving CHSP would be classified at the moderate level of support under the NDIS.
- A further 10% of aged care participants receive HCPs, with support (including government and participant contributions) ranging between $12,000 to $56,000 annually, averaging $32,000.
- About 19% of aged care participants receive residential care, with average annualised support of about $103,492 (including resident and government contributions) and an estimated maximum level of support of about $139,000 a year.

Comparison of types of services provided

- Based on the limited data that is available there appears to be a high level of consistency in offered supports, with both programs primarily funding supports for daily living.
- Overall aged care appears to offer more support for health needs while the NDIS offers more support for social engagement, community participation and reablement.
- Analysis of individual case studies suggest that the primary difference in support levels across aged care and disability programs relates to the number of hours of personal care available.

Conclusion

- There is a substantial difference in support between aged care and NDIS programs. This appears to reflect differences in the hours of care available, though differences also exist in the level of support for reablement, social engagement, behaviour support, care management and assistive technology.
- Rather than allowing different tasks to be completed, we hypothesise that differences in support levels allow NDIS participants to receive closer monitoring, more social and emotional support and more relationship based care than people receiving aged care.
- Noting the momentum for aged care reform, there must ultimately be funding equity in aged care that is on par with disability to realise reasonable and necessary supports for achieving high quality consumer outcomes.

Chapter 1 – Introduction

Counsel Assisting's final submission to the Royal Commission into Aged Care Quality and Safety highlighted that the National Disability Insurance Scheme (NDIS) offers a higher level of care and a more comprehensive schedule of available supports than the existing aged care program.[1] Understanding the differences across these programs is helpful, noting Counsel Assisting has recommended higher levels of funding are required for aged care relative to what is currently available.

This paper examines the funding and supports available to participants of both the NDIS and three aged care programs comprising the Commonwealth Home Support Program (CHSP), Home Care Packages (HCP) Program and Residential Aged Care (RAC) Program. It considers the allocation of support to program participants based on assessment of individual need, as well as the level of funding and nature of care and supports provided across these programs.

The purpose is to:

- highlight well-known inequities in funding of care for people with similar impairments, and
- identify specific differences in the supports funded for NDIS participants relative to what is provided to aged care recipients with similar impairment.

Many, if not most, of the people receiving aged care have functional impairment similar to those qualifying for the NDIS. Most people in RAC are likely to have needs requiring a higher intensity of support associated with higher levels of functional impairment while many people receiving CHSP services would likely have needs requiring a lower intensity of support consistent with lower levels of functional impairment.

Feedback on the conclusions of this paper are welcome. We are also preparing follow up papers comparing the regulatory requirements in aged care and the NDIS and comparing the relative hourly cost of services and administrative overhead.

1. https://agedcare.royalcommission.gov.au/media/29099

Chapter 2 – Assessment, classification and funding arrangements

There are similarities and difference across both the NDIS and aged care programs, in terms of overall level of funding for each program, participant numbers, and assessment and classification processes used to match funding allocation to need.

National Disability Insurance Scheme

The NDIS funds reasonable and necessary supports that help a participant to reach their goals, objectives and aspirations, and to undertake activities that enable social and economic participation. Costs for all participants are projected to be near 1.3% of Gross Domestic Product (GDP) in 2020-21.[2]

The National Disability Insurance Authority (NDIA) makes decisions about what supports would be considered reasonable and necessary based on the National Disability Insurance Scheme Act 2013 (NDIS Act) and the rules made under this Act.

The NDIA has developed reference packages to support assessments and approvals. Assessors use reference package data to assign Scheme participants a 'typical support package' based on their age, disability type and level of function. This is adjusted during assessment to account for the individual support needs in creating a participant's plan.[3]

The official evaluation of the NDIS reports that implementation of the NDIS has led to increased hours of support, greater frequency of services, and access to a wider range of supports for many people with disability.[3]

At 30 September 2020, there were 412,543 people with a disability supported by the Scheme with a total funding commitment of $24.4b across 2019-20. Average annual funds allocations have increased by 25% over the three years prior, to $71,000 per participant. This corresponds with an average annual utilisation rate of 69% per participant ($52,000 per annum).[2]

Aged Care Programs

Aged care makes a significant contribution to the Australian economy, representing 1.2% of GDP.[4] Funding is tiered to program care and support provision for older Australians extending across three main levels; entry-level care and support, complex in-home care and support and 24-hour care and support that includes accommodation.

The National Screening Assessment Form (NSAF) is used to support aged care assessments and approvals in determining the level of need and care type. Consideration is given to social, physical, medical and psychological needs in assessing the level of need and care type. Assessors work with older Australians to establish a support plan that best meets their needs and goals.[5]

2. https://www.ndis.gov.au/media/2801/download
3. https://www.pc.gov.au/inquiries/completed/ndis-costs/report/ndis-costs.pdf
4. https://agedcare.royalcommission.gov.au/sites/default/files/2020-09/Research%20Paper%202%20-%20Review%20of%20international%20systems%20for%20long-term%20care%20of....pdf
5. https://www.health.gov.au/resources/publications/my-aged-care-assessment-manual

Care and support classification decisions derived from a standardised needs-based assessment include:

- **Entry-level care and support via the CHSP.** There were 829,193 older Australians that accessed CHSP services in 2019-20.[6]
- **Complex in-home care and support** via HCPs. There were 171,797 older Australians that accessed a HCP in 2019-20.[6] There were 162,973 older Australians who had access to a HCP at 30 September 2020.[7]
- **24-hour care and support** via RAC. There were 238,778 older Australians that received permanent RAC in 2019-20 with 65,709 older Australians having received residential respite during the same period. At 30 June 2020, the occupancy rate for RAC was 88.3% – the lowest rate over the previous 10 years of reported data.[6]
- A range of **additional and flexible care** program supports designed to address individual circumstances that require a different care approach.

During 2019-20, total program participants comprised 1,239,768 older Australians across these three levels of supports including CHSP, HCP and RAC at a total cost to Government of $20.4b.[6] This equates to an average annual funds allocation of $16,455 per participant.

Comparison of Program Arrangements

The assessment process for the NDIS and aged care programs have some similarities, both being needs based. The classification of participants for allocation of funds does differ across programs and results in variable funding and support intensity.

NDIS funding is allocated to participants using individualised determinations for delivering reasonable and necessary supports. It is largely uncapped with support needs classified against three funding categories; core supports, capacity building supports and capital supports. Each type of support is funded at a fixed price, set within the Scheme. The volume of support is variable. While reference packages are used to assign participants a 'typical support package' based on their age, disability type and level of function, this is adjusted at assessment to account for individual support needs.

Aged care funding is allocated to participants using individualised determinations classified against funding bands, with funding capped within each band. This includes entry level supports, low level one and two HCPs, high level three and four HCPs, and RAC. The level of funding allocated to people in RAC is subject to further classification using the Aged Care Funding Instrument (ACFI), which divides funding levels into nil, low, medium and high classifications across three separate domains; activities of daily living, cognition and behaviours, and complex healthcare. Each of the ACFI funding bands is capped without adjustment for individual support needs.

The use of capped funding bands in aged care has resulted in participant prioritisation of supports matched to funds available with account for urgency of need. This can leave program participants contending with unmet support needs where funds are insufficient. By design, participants with means to contribute more funds to increase their support intensity are better positioned to respond to any unmet support needs.

Average funding levels differ greatly between the programs with an average annual allocation of $71,000 per NDIS participant that compares with an average annual allocation of $16,455 per aged care program participant.

6. https://www.pc.gov.au/research/ongoing/report-on-government-services/2021/community-services/aged-care-services
7. https://www.gen-agedcaredata.gov.au/Resources/Reports-and-publications/2020/December/Home-care-packages-program-data-report-1-July%E2%80%93-30-

Chapter 3 – Funds allocations by participant level of need

Detailed analysis of funds allocation for program participants by level of need is required to clarify the nature of the difference in participant equivalent funds allocations across the NDIS and aged care programs. Level of funds allocation is broadly based on classification of low, medium and high level support needs with account for accommodation setting.

National Disability Insurance Scheme

Distribution of NDIS participants by level of need in September 2020 indicates 16% of participants have low support needs (having a high level of function), another 42% have moderate support needs (having a medium level of function), and 41% have high support needs (having a low level of function).[2]

This varies when compared to the cumulative distribution of participant support classifications across the three year period prior. Some 27% of participants were classified as having low support needs (having a high level of function), another 45% as having moderate support needs (having a medium level of function), and 28% as having high support needs (having a low level of function).[2]

Comparing the incidental and cumulative distributions, support classification across low, medium and high levels of funds allocation reveals an increasing trend towards higher levels of funds allocation per participant emerging as the Scheme evolves. This may reflect both changes in assessment processes and participants becoming more informed in demonstrating evidence to justify their requirements for reasonable and necessary support.

Noting there are 15 separate levels of function accounted for in the NDIS classification approach for funds allocation, the lowest level of functional impairment currently attracts an average annual funds allocation of $17,144 per participant while the highest level of functional impairment (including access to specialist disability accommodation) attracts an average annual funds allocation of $493,170 per participant.[2]

Distribution of average annual funds allocation by participant level of need is estimated as being:

- $22,363 per participant with low support needs,
- $61,277 per participant with moderate support needs, and
- $199,601 per participant with high support needs.[2]

For NDIS participants with extreme functional impairment requiring intensive support needs and having access to specialist housing solutions via Specialist Disability Accommodation (SDA), package costs for these participants are substantially higher than other scheme participants. These participants accounted for 8% of NDIS participants at June 2017.[3]

NDIS participants having a range of complex support needs comprising mobility and neurocognitive deficits were reported as having the highest levels of average annual funds allocated, near $110,000 per participant. This reduced to near $70,000 per participant when SDA classified participants are excluded.[3] In terms of NDIS funds allocation, the highest 20% of allocations (of which 12% exclude SDA classification) account for 62% of overall scheme costs.[3]

Given this report of impairment specific classification was published in 2017, average levels of annual funds allocation (some three years later) are suggested to be much higher based on trends emerging towards higher levels of support intensity in more recent NDIS publications.[2]

Aged Care Programs

Near 67% of aged care program participants were allocated funds for entry level services through CHSP in 2019-20 while the highest 19% of allocations, via RAC, accounted for 63% of overall aged care funding.[6] This highlights the variability in funds allocations per program participant across aged care programs relative to participant needs.

3.1 Commonwealth Home Support Programme

In 2019-20, average expenditure per CHSP participant was approximately $3,146 pa[8] with considerable variation in funds allocation among CHSP participants.[9]

3.2 Home Care Package Program

HCP funding allocations at 20 September 2020 vary across the four in-home care and support levels. Comprising subsidies[10] and participant contributions[11], they amount to the annualised equivalent of:

- $12,443 for level one HCPs,
- $19, 425 for level two HCPs,
- $38,000 for level three HCPs, and
- $55,731 for level four HCPs.

Supply of HCPs by package level at 30 September 2020[7] indicates that of 149,819 HCP participants:

- 11.1% are accessing level one HCPs,
- 40.8% are accessing level two HCPs,
- 21.8% are accessing level three HCPs, and
- 26.3% are accessing level four HCPs.

Averaging the level of committed HCP funds per participant among the 149,819 HCP participants at 30 September 2020 equates to $32,254 pa per participant (comprising Government and participant contributions). Applying a low level (level 1-2 HCPs) and high level (level 3-4 HCPs) split of HCP participants, average low level HCP funds per participant equates to $17,931 pa and average high level HCP funds per participant equates to $47,701 pa.

3.3 Residential Aged Care Program

ACFA has reported funding estimates across all RAC facilities for the 2018-19 period. The average annualised level of committed funding per resident across 2018-19 was $69,726 with an average annualised cost per resident in the order of $103,492 comprising Government and resident contributions.[9]

Based on the ACFA estimates, Government funds allocation per resident accounts for 67.4% of provider revenue while resident contributions account for 26.6% of provider revenue.

8. https://www.gen-agedcaredata.gov.au/resources/reports-and-publications/2020/november/2019%E2%80%9320-report-on-the-operation-of-the-aged-care-a
9. https://www.health.gov.au/resources/publications/eighth-report-on-the-funding-and-financing-of-the-aged-care-industry-july-2020
10. https://www.health.gov.au/resources/publications/schedule-of-subsidies-and-supplements-for-aged-care
11. https://www.health.gov.au/resources/publications/schedule-of-fees-and-charges-for-residential-and-home-care

LASA also notes the maximum annualised level of ACFI funding that is claimable per resident as of 1 July 2020 is $81,446.[12] This equates to an estimated annualised ceiling threshold cost per resident in the order of $139,291, comprising Government, resident and other contributions.

Accounting for provider revenue sources per resident per day[9], these contributions include:

- Basic care subsidy (ACFI) that funds care expenses (58.5%),
- Resident basic care fees that funds hotel services/daily living expenses (17.7%), and
- Accommodation supplement/payment from residents that funds accommodation expenses (10.3%).

Comparison of Funds Allocations for Program Participants

There is a broad distribution in funds allocation within each program across both the NDIS and combined aged care programs relative to participant needs. Both programs seem similar in that they respond to a mix of low, medium and high level support needs, with responses to low level needs accounting for the majority of participant registrations and responses to high level needs accounting for the majority of funds actually allocated.

Regardless, funding per aged care program participant appears substantially lower when compared with funding per NDIS participant. NDIS participants were reported as having an average annual allocated support of about $200,000 for those with high needs, $61,000 for those with moderate needs, and $22,000 for those with low needs. Aged care participants were reported as having an average annual allocated support of about $104,000 for those with high needs in RAC, $47,000 for those with high needs on level 3-4 HCPs, $18,000 for those with moderate needs on level 1-2 HCPs, and $3,000 for those with low-moderate needs on CHSP. Note that providers delivering care in both systems report that many people receiving CHSP would be classified at the moderate level of support under the NDIS.

12. Based on Daily ACFI Subsidy Rates using high care need ratings across all three ACFI domains: activities of daily living, cognition and behaviour, and complex health care.

Chapter 4 – Support types accessed by participants

Examination of the similarities and differences in types of support accessed by participants across NDIS and aged care programs helps to clarify whether funding differences across programs are due to the funding of different types of supports.

National Disability Insurance Scheme

NDIS funding is classified against three major categories: core, capacity building and capital. Core supports covers four areas:

- **Daily activities:** Having support with everyday tasks that enable participants to live as independently as possible. For example, assistance in getting ready for daily activities, home cleaning, meal preparation, gardening, medication assistance, or assistance with tasks like shopping.
- **Social, community and civic participation:** Getting involved with groups and activities that help participants connect with other people and build their skills in areas of interest. For example, this funding could cover camps, holidays, and membership fees.
- **Consumables:** Support to purchase items participants may use every day, such as continence aids and home enteral nutrition supplies.
- **Transport:** Support getting to and from school, work, or social and community activities. While funding for transport is intended to be limited to people who cannot use public transport for reasons related to their disability. Anecdotal reports from NDIS providers indicates that most people get some form of transport funded in their plan if they access day programs or work in some capacity.

Capacity Building supports are broad, covering nine support categories that are aligned to a participant's NDIS planning goals. The categories are:

- **Improved daily living skills:** Building or developing skills to allow participants to live as independently as possible.
- **Improved life choice:** Assistance with the financial management of participant NDIS supports.
- **Finding and keeping a job:** Support to develop workplace skills through education or professional development, and to find and keep a job. For example, undertaking professional development through a specialist employment/education program.
- **Increased social and community participation:** Support to participate more in the community through social activities.
- **Improved health and well-being:** Support to live a healthy life, including personal training, nutrition advice and any physical therapies that maintain or increase a participant's mobility.
- **Improved living arrangements:** Creating a safe and comfortable home environment.
- **Improved learning:** Assistance to access and maintain employment or higher education.
- **Improved relationships:** Support to build a participant's social connections.
- **Coordination of supports:** Assistance in managing a participant's services.

Capital supports fall into two categories:

- **Assistive technology:** Items for mobility, communication, personal care or transport. These may include prosthetics, walking aids, wheelchairs, hoists or power beds. Capital support funding also covers assessments, set-up and training to use assistive technology.
- **Home modifications:** Changes to building structures, fixtures or fittings that enable people with a disability to live safely and as independently as possible. This support could include stair climbers, elevators or grab rails. The funding can also cover consultations and project management of any modifications.

Research has identified that at 1 July 2016, over half of committed supports for NDIS participants were allocated to provide assistance with daily life while an additional 13% were allocated to provide assistance to improve daily living skills. An additional 19% were allocated to provide social and community programs. Combined, these types of support account for over 82% of committed NDIS supports.[3]

The average number of supports received by participants increased with the time they were in the NDIS from 1.94 supports pre-NDIS to 3.23 in wave 1 (2014-17), and 5.78 in wave 2 (late 2017).[3]

At both wave 1 and 2, the most frequently mentioned types of activity NDIS participants needed assistance with were help doing things at home (87% and 87%, respectively), preparing food and eating meals (75% and 78%, respectively) and help with daily personal activities (60% and 65%, respectively). In both waves, 85% of NDIS participants needed assistance daily and 10% needed assistance weekly with the remainder needing assistance less frequently.

Anecdotal feedback from NDIS providers indicates that in recent years there is a greater flexibility within Core Supports to be used for other things such as assistive technology, as negotiated by participants. Also further to this, unspent Core Supports have been allowed to be used to fund transport related expenses when participants have expended all of their transport budget.

The NDIS has reportedly improved participant satisfaction with the quality of supports among many people with disability and their carers. NDIS participants typically report high satisfaction with their NDIS supports being reasonable and necessary. At both wave 1 and 2, some 75 and 72%, respectively, of NDIS participants reported they were either very satisfied or satisfied.[3]

Currently, there is very little evidence regarding the impact of the NDIS on types of community, educational and employment participation. Given the broad recognition that participation activities often take time to yield concrete results, this is not a surprising finding. Evidence does however indicate that the NDIS has been influencing the building of aspirations and the setting of goals regarding social and educational participation and, to a lesser extent, economic participation.[2] Additionally, the NDIS is now undertaking community consultation to further increase the flexible used of funds allocated to support program responsiveness to participant needs.

Aged Care Programs

Supports for activities of daily living that enable participants to live as independently as possible are common requirements across all aged care program participants. What appears to change as care and support needs increase however is the demand for access to personal, clinical and specialised care and supports relative to decline in function and the emergence of complex care needs and/or complications associated with chronic health conditions.

13. https://www.ndis.gov.au/community/have-your-say/planning-policy-personalised-budgets-and-plan-flexibility

Commonwealth Home Support Programme

The five most common CHSP service types used by participants across 2018-19[14] included:

- Domestic Assistance (39.2% of participants),
- Allied Health (29.1% of participants),
- Transport (20.8% of participants),
- Home Maintenance (18.9% of participants), and
- Nursing (14.3% of participants).

Importantly, these common services exclude social engagement for clients that help maintain social connections and respite services that provide a break to informal carers to ensure the longevity of their caring role.

Home Care Package Program

Research using a sample of near 55,000 HCPs has reported that the most prominent support services provided across all HCP levels during 2018-19 were personal care; cleaning and household tasks; and social support, shopping services, community access services. Collectively, these support services accounted for 48% of all support provided. Care management accounted for an additional 20% of all support services provided.

Changes in support service usage across HCP levels during the same period identified that while these support services remained prominent across HCP levels, there was an increase in the use of personal care services as HCP levels and support needs increased.[15]

Residential Aged Care Program

Among people who were in permanent RAC on 30 June 2019[14]:

- 99.7% had a current ACFI assessment on their record.
- 31.0% had a high care need rating in all three ACFI assessment areas.
- 87.0% were diagnosed with at least one mental health or behavioural condition.
- 49.0% had a diagnosis of depression.
- 53.0% had a diagnosis of dementia.

ACFI assessments classify supports as low, medium and high on three separate categories; activities of daily living, cognition and behaviour, and complex health care. Among residents accessing permanent RAC on 30 June 2019[14], the proportion of residents with ACFI ratings in each of the care domains were as follows:

- Activities of daily living:
  - 60.1% were rated as having high care needs,
  - 29.4% were rated as having medium care needs,
  - 10.0% were rated as having low care needs, and
  - 0.5% did not have any care needs.
- Cognition and behaviour:
  - 63.8% were rated as having high care needs,

14. https://gen-agedcaredata.gov.au/Topics/Care-needs-in-aged-care
15. https://www.health.gov.au/resources/publications/home-care-provider-survey-analysis-of-data-collected

  - 22.1% were rated as having medium care needs,
  - 10.2% were rated as having low care needs, and
  - 3.9% did not have any care needs.
- Complex health care:
  - 51.5% were rated as having high care needs,
  - 31.5% were rated as having medium care needs,
  - 16.3% were rated as having low care needs, and
  - 0.7% did not have any care needs.

Resident case mix, based on this ACFI data, indicates that RAC facilities are often delivering care and support to residents with high acuity and/or complex or chronic health conditions. In doing so, RAC facilities work closely with both primary and secondary health care services to make available a sufficiently skilled workforce to care for people with complex or chronic health conditions.

In terms of direct care hours for RAC, StewartBrown reported that average direct care hours at 30 September 2019 were 3.26 hours per resident per day. This has increased slightly to 3.36 hours per resident per day over the 12-month period to 30 September 2020.[16]

Direct care hours per resident per day were spread across:

- Care management (0.11-0.14 hrs)
- Registered nurses (0.41-0.44 hrs)
- Enrolled & licensed nurses (0.33-0.29 hrs)
- Other unlicensed nurses and personal care staff (2.20-2.22 hrs)
- Allied health and lifestyle (0.18-0.24 hrs)
- Agency care (0.02-0.03 hrs)

Importantly, the relationship between ACFI subsidy received and direct care costs in response to resident need is important in maintaining a sustainable and responsive RAC operational and financial environment.

Comparison of Support Types Accessed by Program Participants

There is a high level of consistency in the supports being accessed by program participants across both NDIS and aged care programs relative to needs. The majority of support services for NDIS participants (82%) are concerned with supporting activities of daily living and engaging in social and community activities. These support types are similar to those identified within aged care programs.

Among in-home program participants, the majority of support is concerned with participants' activities of daily living and social participation. Where support coincides with access to specialist accommodation, supports are also responsive to complex clinical care goals that leverage off specialist accommodation design.

Regardless, the quantum of supports per aged care program participant, being substantially lower when compared with that made available to NDIS participants, appears to exacerbate aged care participant prioritisation of supports matched to funds available with account for urgency of need while contending with unmet needs and thus limiting the scope for lifestyle planning.

16. https://www.stewartbrown.com.au/news-articles/26-aged-care/236-stewartbrown-aged-care-financial-performance-september-2020-survey-sector-report

Chapter 5 – Dual NDIS and aged care service providers

Care providers operating across both NDIS and aged care programs provide a considered case-based account of funding inequities experienced in delivering supports. They have clear line of sight concerning the funding and support inequities that exist, drawing from a similar direct care workforce to deliver funded supports.

Comparison of NDIS and High-Level HCP Participants with Similar Care Needs

Four separate case studies are provided from two different dual care providers who have outlined the support provided across comparable NDIS and HCP participants with similar functional limitations as determined by their support needs. Funding inequities in program supports are markedly apparent.

Case Study One

NDIS Participant

68 year old with acquired brain injury and vision impairment. Non-resident carer is a sister that provides both practical and financial support when required. Participant has two friends who also provide regular social support.

The NDIS care plan includes total committed funding of approximately $181,500 per annum (pa). This includes a:

- CORE SUPPORTS budget that covers:
  - 50 hours per week of personal care and community access support valued at approximately $159,000 pa; and
  - Low level equipment valued at $500 pa.
- CAPACITY BUILDING budget to the value of approximately $7,000 pa for allied health professionals.
- SUPPORT COORDINATION budget for 40 hours to the value of approximately $4,000 pa.
- ASSISTIVE TECHNOLOGY budget for orthotics, commode, pressure cushions etc. valued at approximately $11,000 pa.

Level 4 HCP Participant

72 year old with cognitive impairment, cardiomyopathy and other chronic health conditions. Has a friend who provides practical support with a formal guardian via the Office of the Public Advocate appointed. Was very independent until a significant decline in health, accessing unspent funds to gain additional support to remain at home.

Formal HCP funding is valued at $51,808 pa. This covers high level care management/support coordination and HCP management fees (40% of HCP funds). Two occasions of daily supports (1hr duration each), totalling 14 hours per week. Gardener clean up each quarter. Six podiatrist care services pa. Funding towards meals on wheels service - all meals. Taxis and personal alarm monitoring each month.

Unspent funds balance of $60,000 accessed following health decline to gain additional support to remain at home that if not otherwise available would result in participant admission to residential aged care. Client noted as intentionally accumulating unspent funds knowing the need to prepare for additional supports as health declines.

Case Study One Comparison

The funding deficiency within this case-based analysis for the provision of in-home support to an older Australian when compared with NDIS participant core support funding exceeds $107,000 pa.

When care coordination and assistive technology are also factored in to the total care package this funding deficiency extends to near $123,000 pa, noting some allied health supports will be accessible through alternate Medicare funded primary health care plans that will likely include participant co-contributions. Unspent funds accumulation used by HCP participant appears to have been a key strategy to address funding deficiencies.

It is also noted that the total NDIS core support funding ($159K pa) and direct care hours (50 hrs/wk) for this participant exceeds average RAC care funding ($70K pa) and direct care hours (22.5 hrs/wk) per resident.

Case Study Two

NDIS Participant

63 year old who has vision Impairment. No cognitive impairment. Access to male non-resident relative and friends for social support. Observed to be relatively independent within a known environment, mainly requiring support for meal preparation and medication assistance across multiple times of the day. Has support to access community each week to attend shopping and appointments. Medicare funded medical appointments.

The NDIS care plan includes total committed funds of approximately $250,000 pa. This includes a:

- CORE SUPPORTS budget that covers:
  - $2,000 for assistive technology (basic);
  - Personal care support (for 21hrs per week at weekday/day time, 3hrs Saturdays, 3hrs Sundays, 4hrs each Public holiday);
  - Community access support (for 6hrs per week during weekday, 2hrs per week on Saturday, 2hrs per week on Sunday and 3hrs per public holiday); and
  - A seven-day holiday each year with 24hr care and seven nights of carer sleepover accommodation whilst on holiday.
- TRANSPORT budget to the value of approximately $3,500 pa (taxi travel).
- CAPACITY BUILDING budget to the value of approximately $7,750 pa for allied health care.
- SUPPORT COORDINATION budget to the value of approximately $10,200 pa.
- HOME MODIFICATIONS to be funded via quote supplied.

Total cost for CORE SUPPORTS excluding the holiday to an equivalent of 36 hours per week is estimated to be $117,632 pa.[17]

Level 3 HCP Participant

84 year old who has vision Impairment. No cognitive impairment. Has access to daughter who is non-resident carer. Requires support for meal preparation and medication assistance across multiple times of the day. Requires community access each week to attend shopping and appointments

Formal HCP funding is valued at $34,175 pa. This covers care management/support coordination and HCP management fees (30% of HCP funds), 6 hours per week of personal care and support (53% of HCP funds), $25 per week for taxis and $64 per week for meal preparation and delivery.

17. NDIS Prices - 1 July 2019 https://www.ndis.gov.au/media/1456/download

Case Study Two Comparison

The funding deficiency within this case-based analysis for the provision of in-home care and support to an older Australian when compared with NDIS participant core support funding (excluding the holiday) likely exceeds $86,000 pa.

When care coordination and transport is also factored in to the total care package this funding deficiency extends to near $100,000 pa, noting some allied health supports will be accessible through alternate Medicare funded primary health care plans that will likely include participant co-contributions. If the HCP participant has an equipment need this is not supplied in addition to HCP service funding which is in direct contrast to NDIS participant equipment access, this needs to be paid for by the participant on top of service funding.

It is also noted that the total NDIS core support funding (in excess of $117K pa) and direct care hours (36 hrs/wk) for this participant exceeds average RAC care funding ($70K pa) and direct care hours (22.5 hrs/wk) per resident.

Case Study Three

NDIS Participant

50 year old woman who lives with her husband who provides support. She has multiple sclerosis, blurred vision, weakness in legs and her right arm, fatigue, pain when cold, spasticity. Mobilises with crutches, wheel chair and scooter.

The care provider delivers 5.5 hours of care and support per day from Monday to Friday that assists with daily living activities and access to the community, totalling 27.5 hours per week. Services are estimated to cost approximately $78,000 pa from the NDIS participants core supports budget. The NDIS participant also has another separate budget in their NDIS plan to fund various allied health supports that are supplied by another provider above the core supports budget - value unknown. The support and coordination budget and requirements are also unknown.

Level 4 HCP Participant

80 year old who lives with son who provides limited support. Has fibromyalgia, back pain (surgery 17 years ago), osteoarthritis, hips not aligned, asthma, eczema, weakness if too hot, pressures sores (managed). Requires wheelchair and a lifter.

The care provider delivers one hour of support in the morning as well as in the evening, seven days a week assisting with personal care (shower and toilet) – 14 hours per week. Housework, meal preparation and transport to appointments are also provided.

HCP valued at $51,808 pa. The HCP participant has mid-range care coordination requirements. Care and package management is paid for through HCP funding. The level of support provided exceeds the HCP funded service hours available through the HCP and the participant pays directly for additional support services.

Case Study Three Comparison

The funding deficiency within this case-based analysis for the provision of in-home support to an older Australian when compared with NDIS participant funding likely exceeds $26,000 pa.

When accounting for other NDIS funded supports such as support and coordination, the funding deficiency may be considerably larger. Participant contributions for additional supports are used to address funding deficits where feasible.

It is also noted that the total NDIS core support funding ($78K pa) and direct care hours (27.5 hrs/wk) for this participant exceeds average RAC care funding ($70K pa) and direct care hours (22.5 hrs/wk) per resident.

Case Study Four

NDIS Participant

63 year old diagnosed with schizophrenia (managed by another allied health provider). Has epilepsy, stroke, autism and asthma. Requires a walking stick for mobility. Limited informal care from co-habituating partner. Community nursing provides wound management and community outreach provides mental health care as additional government funded services.

The care provider delivers core supports comprising personal care, assistance for daily living activities and social support. CORE SUPPORTS are estimated to cost approximately $75,000 pa. The NDIS participant also has another mental health care provider delivering support and coordination as an additional budget item in their NDIS plan - value unknown.

The NDIS participant requires high-level care management with significant involvement by the service manager and care co-ordinator. Support and coordination funding does not however cover these costs by the primary provider of core supports and are expected to form part of the actual hourly rate (with this support and coordination component underfunded).

Level 4 HCP Participant

90 year old with polio impacts since a child. Requires mobility transfer assistance in and out of bed. Requires wheelchair for mobility at all times. Pressure sores, cellulitis, oedema and asthma. Participant lives alone and is occasionally visited by niece.

Formal HCP funding is valued at $51,808 pa. This covers care management/support coordination and HCP management fees. Daily support provided across each week. Personal care provided for 2.5 hours on Monday, Wednesday and Friday mornings. Personal care provided for 1 hour on Tuesday, Thursday, Saturday and Sunday mornings. Personal care provided for 1 hour during evenings for 7 days weekly. Total support hours are 18.5 hours weekly at a cost of near $62,000 pa.

The participant's support requirements exceed hours available from package with additional hours paid from the participant's pension. Noting the participant requires daily care management contact and two care manager home visits per month and pays package management fees, total support costs are estimated as being near $107,000 pa.

Case Study Four Comparison

The funding deficiency within this case-based analysis for the provision of in-home care and support to an older Australian when compared with NDIS participant core support funding exceeds $23,200 pa.

When accounting for other NDIS funded supports such as support and coordination, the funding deficiency for the provision of in-home care and support to an older Australian may be considerably larger. Participant contributions for additional supports are used to address funding deficits where feasible.

Thank you to LASA Members who contributed these case studies.

Case Comparison Analysis across Programs

Across the four case studies, estimated funding deficiencies were reported for core supports that ranged between $23,200 pa and $107,000 pa for HCP program participants when compared with NDIS participants with similar support need profiles.

The variance in these funding deficits is marked and is largely accounted for by the individualised classification and funding approach of the NDIS relative to the banded classification and funding approach of the HCP program.

The level of NDIS participant funding appears to exceed not only average HCP funding but also average RAC funding. This further reiterates the dire situation encountered by older Australians without financial means in accessing adequately funded aged care relative to NDIS participant funding for the delivery of reasonable and necessary supports.

HCP funding deficiencies also appear to extend beyond core supports. Both HCP and NDIS program participants have needed access to care management and assistive technologies. While NDIS participants were allocated additional funding for these requirements, HCP program participants did not have access to targeted funding for these requirements and would need to account for these in prioritising supports.

Older Australians who were able to access alternate sources of funding to supplement the cost of their aged care supports relative to need (e.g. co-contributions, accumulated unspent funds, and state-funded health services) would do so in seeking access to reasonable and necessary care and supports for remaining at home.

HCP program participants unable to access alternate sources of funding to supplement support costs are faced with an impending admission to residential aged care.[18] This, however, does not necessarily improve their access to additional supports. Participant contributions via basic care fees in RAC are costed to hotel services and daily living expenses. Additional support requires additional participant contributions above this where afforded.

18. https://www.jamda.com/article/S1525-8610(17)30457-7/fulltext

Chapter 6 – Summary of funding discrepancies

Noting that the types of support provided across the NDIS and aged care programs are largely similar, comparison of average aged care program participant funding allocation relative to average NDIS participant funding allocation by level of need highlights the following issues.

Entry Level In-Home Support

Funds allocation across the NDIS and aged care programs in response to the entry level support needs of program participants suggests that the average annualised allocation of Government funding for entry level aged care is markedly lower than the NDIS. Average CHSP ($3,146 pa) funds allocation account for 14% of average low level NDIS funding ($22,363 pa).

Given CHSP participants account for some 67% of aged care program participants, this amounts to a substantially lower level of overall funding being made available to aged care program participants with entry level support needs relative to the NDIS.

The majority of the variability in funds allocation across CHSP and NDIS participants with a low level need classification may be largely explained by entry level thresholds for access to support and the different need profiles of program participants. For example, many NDIS participants with low level support needs are children with autism or intellectual disability. They have a very different set of needs to CHSP participants. This group accounts for two thirds of all NDIS participants.[19]

However, it is also noted that the most common services accessed by CHSP participants exclude social support activities that help them maintain social connections, as well as respite services that provide a break to informal carers to ensure the longevity of their caring role. This differs from the frequency of service types accessed by NDIS participants. Near one in five NDIS supports were reportedly allocated to facilitate participant engagement in social and community programs.[3] In this respect, some of the variance in funding deficiencies within CHSP when compared to low level NDIS participant funding may be due to the CHSP service system being a capped funding environment with targeted deliverable hours for various service types provided to grant funded programs. This is in contrast to the NDIS allocating supports based on participant need.

The extent of funding variability identified for program participants with higher level support needs also lends support to the possibility that funding inequities exist across program participants with similar low level support need profiles as a result of the capped aged care funding environment.

Low Level In-Home Support

Average low level one and two HCP participant funding comprising Government and participant contributions ($17,931 pa) represents 80% equivalence in average low level NDIS participant funding ($22,363 pa). Any increase in low level HCP participant funding to a level that is more comparable to low level NDIS participant funding should serve to support older Australians as they adjust to their changing functional capacity.

Importantly, anecdotal reports suggest that on many occasions low level one and two HCP participants continue to engage with CHSP funded allied health services to supplement HCP funded supports. Access to these allied health CHSP supports drop off dramatically, however, once HCP participants transition to a high level three or four HCP where access to allied health services is limited to full cost recovery. This requires HCP budgeting and prioritisation alongside essential daily supports such as personal care, domestic assistance or medication assistance.

19. https://www.ndis.gov.au/media/2351/download

Within the NDIS, participant access to allied health services via Capacity Building funding is separated from access to daily living support services via Core Support funding. The trade-off for NDIS participant access to either daily living supports or allied health services is not as prominent an issue as in the high level HCP funding environment. This quarantining of NDIS funding supports, accounting for a more recent trend to relax quarantining of NDIS funds across categories in the context of changing support demands and funds underutilisation, leads to better long term health, wellbeing and independence outcomes for NDIS participants above the supports made available to HCP participants.

Increases in low level HCP participant funding should serve to incentivise participant engagement in wellness programs, reablement services and the uptake of assistive technologies/consumables to support participatory and aspirational goals that support older Australians to remain purposeful, productive and active relative to functional capacity. These early interventions that the NDIS funds relative to there being under incentivised in the aged care system currently may change the comparative trajectories of aged care program participants. More support and funding for aged care participants is required to reable and restore function when decline commences. This can result in extended periods of lower support intensity as progression in decline is delayed.

High Level In-Home Support

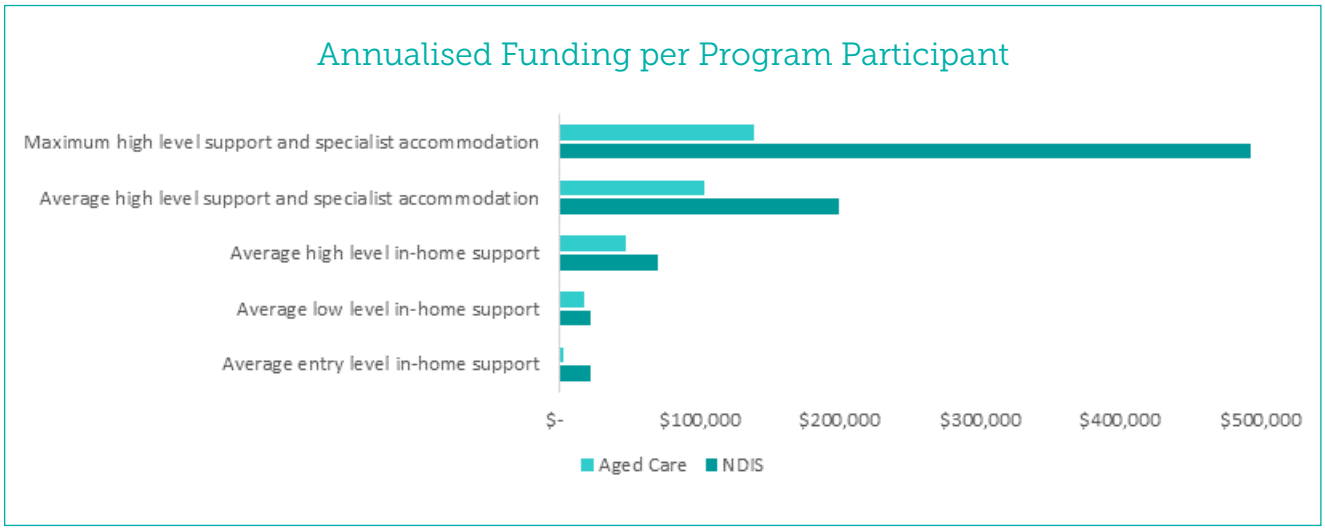
Average high level three and four HCP participant funding comprising Government and participant contributions ($47,701 pa) represents 68% equivalence in average high-level in-home NDIS participant funding ($70,000 pa) for those who are either largely immobile, have mobility deficits and/or neurocognitive deficits.

Noting these estimates are based on earlier reports of average annual funds allocation for NDIS participants[3] and that average levels of annual funds allocation may have increased more recently, it is suggested that there is likely to be a more marked difference in the funding of complex in-home supports across NDIS and aged care programs than suggested here.

Noting the need profiles of both NDIS and aged care program participants at home accessing medium to high level supports may be somewhat different, variability in funds allocation across programs can be expected. However, the extent of funding variability suggests that inequities may exist across programs. Counsel Assisting's recommendation to the Royal Commission into Aged Care Quality and Safety for the provision of higher levels of in-home aged care funding than is currently available is consistent with this conjecture.[1]

Any increase in high level HCP participant funding to a level that is more comparable to high level in-home NDIS participant funding should be sufficiently flexible so as to support older Australians timely access to supports consistent with intermittent changes in functional capacity. High level HCP participant funding flexibility needs to be changeable based on participant health needs at the time – with access to additional funding available to prevent premature admission to RAC if that is what the HCP participant desires.

Many HCP participants state that they accumulate HCP funds when they are well to help plan for provision of support when they are unwell, knowing that their condition will decline and their desire to palliate at home. An 'on demand' system will help shift the mindset of older Australians from accumulating unspent funds.



High Level Support and Specialist Accommodation

Average RAC funding comprising Government and resident contributions ($103,492 pa) represents 52% equivalence in average high level SDA inclusive NDIS participant funding ($199,601 pa).

RAC ceiling threshold funding comprising Government and resident contributions ($139,291 pa) represents 70% equivalence in average high level SDA inclusive NDIS participant funding ($199,601 pa). This extends out to 28% when compared to maximum SDA inclusive NDIS participant funding.

Noting the profiles of both NDIS and aged care program participants accessing specialist accommodation with high to extremely high level support needs may be somewhat different, some level of variability in funds allocation across programs can be expected. However, the extent of average funding variability suggests that inequities may exist across programs. These inequities become more evident with regard to program participants assessed as having extremely high level support needs, where funding variability may exceed that of average funds allocation.

Counsel Assisting's recommendation to the Royal Commission into Aged Care Quality and Safety for the provision of higher levels of residential aged care funding than is currently available is consistent with this conjecture.[1] Any increase in RAC participant funding to a level that is comparable to both average high level and extremely high level SDA inclusive NDIS participant funding needs to be based on a classification approach at the higher end of the spectrum of functional impairment that is sufficiently sensitive to facilitate funds allocation for provision of reasonable and necessary supports among this resident cohort.

Funds allocation should target both RAC facilities and in-reaching primary/secondary health care services to support a RAC staffing/service mix that is multidisciplinary and sufficiently skilled to respond to variations in resident case mix.

Chapter 7 – Conclusion

Disparity in funding and support intensity reported across NDIS and aged care programs, and alluded to through the Royal Commission into Aged Care and Quality, are made evident in this paper.

The estimated participant equivalent allocation of total Government funding for the aged care program is suggested through this analysis to be near one quarter of that allocated through the NDIS. Research on older people in the NDIS further confirms this disparity, reporting that funding levels under the NDIS are higher than within the aged care and state disability systems.[20]

Differences in classification approaches and the corresponding funds allocation process across NDIS and aged care programs are suggested to be key drivers of this discrepancy. NDIS funding is allocated to participants using individualised determinations for delivering reasonable and necessary supports, being largely uncapped with fixed pricing for each support type. The volume of support is variable. Aged care funding is allocated to participants using individualised determinations matched to funding bands, capped within each band. The use of capped funding bands in aged care has resulted in participant prioritisation of supports matched to funds available with account for urgency of need. This can leave program participants contending with unmet support needs where funds are insufficient.

Without aged care program participant access to alternate sources of funding to supplement the cost of their aged care needs, the level, quality and outcomes of care and support can suffer. This subsequently places pressures on the operations of workforce and regulation. Reliance on these drivers of quality and safety in the absence of a robust funding environment is deficient at a population level. System settings need to be calibrated with a focus on the basic human right for access to reasonable and necessary supports matched to assessed need.

Counsel Assisting has recommended to the Royal Commission into Aged Care Quality and Safety for the provision of higher levels of aged care funding than is currently available.[1] This will be fundamental to future aged care reforms.

The NDIS provides a benchmark for an uncapped classification and funding approach in respect to the requirements for higher levels of aged care funding matched to an individual program participant's assessed needs.

20. https://www.dss.gov.au/disability-and-carers/programs-services/for-people-with-disability/national-disability-insurance-scheme/ndis-evaluation-consolidated-report

Please contact LASA if you would like to know more about us and how we can assist you in the age services industry. We look forward to hearing from you.

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