Aged care in MPS:

Response to the Australian Government Terms of Reference

21 October 2019

CHERE
CENTRE FOR HEALTH ECONOMICS RESEARCH AND EVALUATION

UNIVERSITY OF TECHNOLOGY SYDNEY

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Abbreviations

Abbreviation	Full title
ACFA	Aged Care Financing Authority
ACFI	Aged Care Funding Instrument
ACHSE	Australian College of Health Service Executives
ACSA	Aged and Community Services Australia
AHHA	Australian Healthcare and Hospitals Association
AIN	Assistant in Nursing
BPSD	Behavioural and Psychological Symptoms of Dementia
CHERE	Centre for Health Economics Research and Evaluation
CHSP	Commonwealth Home Support Programme
COTA	Council on the Ageing
CREA	Concessional Resident Equivalent Amount
DOH	Department of Health
DVA	Department of Veterans' Affairs
EN	Enrolled Nurse
HCP	Home Care Package
MBS	Medicare Benefits Scheme
MPS	Multi-Purpose Service/s
NATSIFACP	National Aboriginal and Torres Strait Islander Flexible Aged Care Program
NDIS	National Disability Insurance Scheme
NHTP	Nursing Home Type Patients
NRHA	National Rural Health Alliance
PCA	Personal Care Assistant
PHN	Primary Health Network
RHWA	Rural Health Workforce Australia
RN	Registered Nurse
TCP	Transition Care Program
UTS	University of Technology Sydney

Key Points

Access to, and delivery of, health and aged care services to rural and remote communities has many challenges. The joint Commonwealth / State Multi-Purpose Services (MPS) Program has been a longstanding and successful response to these challenges, commencing in 1993. In 2019 there were 180 MPS, located in all States, the Northern Territory and Norfolk Island.

The core objective of the Program is for each MPS to provide innovative, flexible and integrated health and aged care services through Pooled Funding. State governments are predominantly the approved providers and contribute health funding (the majority of overall funding), while the Commonwealth contributes aged care funding for an allocated number of residential high care and low care places, and home care places.

The delivery of aged care services through the MPS is a sound model. Within the limits of the terms of reference and information provided to this study, the research concludes that MPS deliver integrated health and aged care services that flexibly meet the needs of individual rural and remote communities. The benefits include the following:

- The joint funding enables each community to retain highly valued local health and aged care services.
- The degree of certainty of funding helps overcome the limited economies of scale and high fixed overheads of many MPS.
- The funding is applied flexibly across health and aged care by MPS providers from the one funding pool. The services aim to address the contemporary needs of the local area in accordance with a Service Delivery Plan and providers have the opportunity to develop innovative models of integrated care.
- MPS are the provider of last resort for home care in the absence of other HCP and CHSP local providers.
- There are economies of scope. For instance, nursing staff can deliver health services and supervise or deliver services to aged care residents who live in the same facility, and those residents can at times be 'admitted' for acute care within their own room.

There are barriers to the greater effectiveness of the Program:

- Not all States are equally committed to the MPS model in the delivery of rural and remote heath care.
- The Commonwealth does not fund infrastructure and yet requires the availability of suitable facilities or capital support as a criterion for allocating places to establish or expand a multi-purpose service. Some States actively fund infrastructure but communities in some areas may be missing out.
- The issue of improving access for Aboriginal and Torres Strait Islander people to culturally appropriate health and aged care is an ongoing priority across these service delivery modalities.
- MPS, in common with many other small rural and remote providers, are generally not able to meet the needs of people with significant behavioural and psychological symptoms of dementia.
- Flexibility in the delivery of care from the pooled funding may be reduced as a result of implicit care categorisation and inadequately defined accountability of service providers to the Commonwealth and the States for the use of their funding contributions.
- MPS have not adopted all aged care reforms:
- The lack of means-tested care and accommodation contributions can provide a financial advantage for some MPS aged care residents and home care clients over those receiving mainstream services. This is also contrary to the principle of competitive neutrality for local mainstream providers.
- Funding according to annually approved high care and low care places does not respond to the cost of providing care according to the acuity of current residents, unlike the Aged Care Funding Instrument.

There is a lack of transparency and accountability of MPS providers to the Commonwealth which limits its ability to assess the efficiency of MPS service delivery and effectiveness in achieving Program objectives.

The Commonwealth's contribution could be reformed to retain a level of funding certainty through the approved places approach but apply an assessment of the cost of funding care for residents and home care clients to better address rising acuity of needs. The replacement to ACFI may be fit for this purpose.

The assessment criteria and approval processes for MPS establishment and expansion do not adequately promote the model design, which could be of benefit to many other rural and remote communities.

Executive summary

Introduction

Regional, rural and remote communities face many challenges in accessing health and aged care services, as do governments and other providers in delivering those services. This Report examines one of the longstanding policy and program responses to these challenges – the Multi-Purpose Services (MPS) Program, though it only does so from the perspective of the Commonwealth's delivery of aged care.

The Report concludes that the delivery of aged care services through the MPS is a sound model. Within the limits of the terms of reference and information provided to this study, MPS are seen to flexibly meet the locally identified health and aged care needs of individual regional, rural and remote communities through the integrated delivery of State and Commonwealth services by a single provider, a cohesive workforce and a single undifferentiated pooled fund.

The MPS Program was first established by the Commonwealth and State and Territory Governments as a collaborative response over two and a half decades ago, in 1993. As of 2019 there were 180 MPS facilities located in all States and the Northern Territory (henceforth 'the States'), together with one on Norfolk Island. The primary objective of the Program has been to provide innovative, flexible and integrated health and aged care services in regional, rural and remote communities that could not support stand-alone hospitals or residential aged care services.

The Commonwealth, through its Department of Health, has commissioned this Report of the delivery of aged care in MPS Program to inform ongoing planning, development (including service establishment) and continuous improvement. It has requested the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology (UTS) Sydney to address three issues.

1. Ascertain the extent to which the MPS Program objectives are being achieved and identify and examine any unintended outcomes.
2. Examine the impact of broader aged care policy and regulatory changes in MPS Program related contexts.
3. Determine whether the MPS Program funding model is an effective use of Commonwealth funds to deliver aged care services in regional, rural and remote (henceforth 'rural and remote') areas.

CHERE was also requested to respond to matters relating to appropriateness, effectiveness, efficiency and equity. The Terms of Reference are set out in Chapter 1.

While this review has been commissioned by the Commonwealth and addresses issues that are Commonwealth specific (aged care policy and effective use of Program funds), the Program is inherently a collaboration with the States. Therefore, to assess whether MPS objectives are being met requires a whole-of-MPS perspective. In similar manner, given the core importance of pooled funding for each MPS, questions of effectiveness and efficiency of one component (aged care) requires an assessment of the inputs, outputs and outcomes of the pooled funding as a whole.

Accordingly, the review has reached out to all States and, to the extent possible with the information they have provided, sought to provide insights into these broader issues.

This Executive Summary has drawn on the various findings and recommendations arising from the analyses contained in this Report to provide considered responses to each of the three issues identified above.

Achievement of the MPS Program objectives

The first of the three issues for this review is to "assess the extent to which the MPS Program objectives are being achieved and identify and examine any unintended outcomes".

The Program objectives

The Terms and Conditions for Multi-Purpose Service Agreements made under the *Aged Care Act 1997* state, in part, that the MPS Program seeks to achieve the following objectives for small rural and remote communities:

- improved access to a mix of health and aged care services that meet community needs;
- more innovative, flexible and integrated service delivery;
- flexible use of funding and/or resource infrastructure within integrated service planning;
- improved quality of care for clients; and
- improved cost-effectiveness and long term viability of Multi-Purpose Services.

To the extent that such findings could be made with limited access to state data, this Report found the following in relation to the objectives:

Table 1: Findings in relation to MPS Program objectives

Objective	Findings in relation to objectives
Improved access to a mix of health and aged care services that meet community needs	Access to a mix of services is being achieved in most instances. A small number of MPS either deliver only aged care or do not offer residential aged care places. Access to dementia specific care (for severe psychological / behavioural symptoms) is not available in many MPS, nor in many other small rural and remote facilities. The extent to which MPS meet community needs is unclear as current activity reports to the Commonwealth do not elaborate on progress against service delivery plans.
More innovative, flexible and integrated service delivery	This objective is being achieved within the MPS. However there are challenges in some cases for older people to access CHSP and HCP from external providers which can place additional demands on MPS flexible and integrated service delivery. Poorly defined accountability for use of the funding for high and low level residential aged care and home care may also inhibit flexibility.
Flexible use of funding and/or resource infrastructure within integrated service planning	This objective is being achieved. However infrastructure improvements are dependent on State budgeting decisions and local philanthropy as MPS do not have access to Commonwealth infrastructure and capital funding programs
Improved quality of care for clients	Achievement of this objective is uncertain. Until recently, it was not mandatory that MPS meet Aged Care Quality standards.

Objective	Findings in relation to objectives
Improved cost-effectiveness and long term viability of Multi-Purpose Services	This objective was unable to be assessed as complete Service Provider data on inputs, outputs and outcomes was not available either to the Commonwealth or to this research. Commentary has been provided on issues of efficiency.

Stakeholder attitudes to achieving the objectives

A related issue is whether the objectives remain the most appropriate for the Program. Reviews of the MPS Program and other work that has referenced the Program have generally supported its underlying intent.

At a workshop involving a wide range of stakeholders there was a common view that, at its core, the Program was about Commonwealth/State collaboration to enable the delivery of innovative, flexible and integrated health and aged care services that meet the communities' needs, supported by local level planning and the flexible use of funding and resource infrastructure. This was seen as a sound foundation for the Program.

There was broad agreement that the remaining objectives could be expanded and re-stated as more concrete goals. Should a joint Commonwealth / State governance committee be established for the Program as a whole, this matter may warrant inclusion in its considerations.

Demand and supply

Although rural Australia is, on average, facing minimal population growth (0.4%), data from the 2011 and 2016 Censuses indicated wide variation in population growth at case study MPS sites. While this may explain some variation in the demand for local health and aged care services, underlying drivers are likely to be that resident populations are ageing faster and have a lower socioeconomic profile. There are strong preferences for ageing in the local community.

MPS catchment area populations for case study sites (as defined by Statistical Area Level 2 where relevant) are generally less than 7,000 and more likely between 3,000 and 5,000. MPS facilities were mainly established in communities which had an existing community hospital providing sub-acute care for their elderly and, in many cases, some form of de facto residential aged care through long stay or nursing home type categories of frail older patients. Many had (and some still have) a hostel-style facility that was no longer viable on its own.

MPS offer a range of services including residential and home-based aged care, inpatient and hospital care and community health care. Of the 89 MPS which responded to the survey, 73% had between 11 and 30 total beds, with 80 % having up to 20 long term aged care residents on the night of the survey census. Two thirds of the MPS did not use their funding to support aged care for people living in their own home. Almost all MPS provide some level of health and hospital care, with inpatient beds ranging from two upwards and hospital services ranging from sub-acute care through to procedures and obstetrics, emergency departments and community health services.

The benefits and limitations of the Program

The longevity of the Program (now 26 years) and its ongoing operation in 180 regional, rural and remote communities is testimony to its relevance to local communities and their general satisfaction with its flexible delivery of integrated health and aged care services.

Discussions with community members during the review's site visits reinforced the importance of being able to be cared for in a local hospital and being able to remain in the community in their old age – either at home or in the aged care home. These facilities are integral to the histories of the towns. Generations have been cared for, have volunteered for, and have worked at their local MPS.

Most MPS stakeholders were able to recall the community activism that led to the decision to establish an MPS in their town or to upgrade the existing facilities. This included direct bequests or large donations from local residents for buildings or infrastructure, fund raising for specific improvements and direct lobbying of politicians.

Flexibility is a cornerstone of the MPS model – in the use of health and aged care places to deliver integrated care within the facility and in the associated delivery of care to help people remain at home. MPS are expected to develop flexible services in response to identified community needs. The MPS workforce is multi-skilled to deliver emergency, acute care, community nursing and aged care and there were many examples of staff who developed rewarding career paths at their facility. The ability of nursing staff to work flexibly across health and aged care was perceived to increase efficiency and quality of care, but such economies of scope were only available in co-located facilities.

Staffing and training in MPS is dominated by the requirement to provide safe, high quality healthcare. While this has resulted in a rich nursing skill mix to meet residents' clinical needs, in many MPS there is limited capacity to employ care staff with the time and appropriate skills to attend to residents' daily living and social needs, or to provide adequate diversional activities.

Most MPS also use their funds flexibly to deliver services to older people living in their own homes through community nursing. Community nursing plays a central role in integrating health and aged care services, identifying and meeting the needs of older people living in their own home, and in easing the transition from home to residential aged care. Some also deliver personal care and domestic assistance. In many cases, the MPS is the provider of last resort in community aged care where external providers of Home Care Packages (HCP) and Community Home Support Programme (CHSP) are deterred by poor economies of scale and long travel times from regional hubs.

The artificial division of Commonwealth funding into residential high and low care and home care places may be reducing actual flexibility in care delivery in some MPS by potentially shaping how the manager conceptualises and is held accountable for the delivery of services against specific funding inputs rather that against pooled funding.

Overall, the case studies and the survey found that most MPS residents had good access to medical care but in some cases very poor access to medical practitioners threatened the viability of the MPS.

Integrated services for ageing in place were enabled by co-location where the richer nursing staff skill mix, staffing flexibility, medical support and clinical infrastructure allowed aged care residents to be 'admitted' for treatment for acute conditions and palliation while remaining in their own room. Bed flexibility was highly valued by MPS managers for providing rehabilitation and respite to help older people in the community age in place. However, hospital accommodation was often unsuitable for prolonged stays.

Individual States have implemented the MPS Program and govern their respective MPS in different ways according to their own policies and operational frameworks. Several States have invested significantly in their MPS and see it as an essential element of their strategy in delivering health and aged care to their smaller communities.

Barriers to achieving the objectives

One of the greatest barriers to the delivery of the benefits of the MPS Program is the ambivalence of some States towards its implementation. The Department has advised of a lack of applications received in MPS allocations rounds for the last four years. There may be many other communities which could benefit from the MPS model (or some variant of it) and enable their elderly to remain at home or at a local aged care home and receive flexible and integrated care.

A second significant barrier for some communities in accessing the Program is the requirement that the State and/or community provide the aged care infrastructure. The Commonwealth's Applicant Guide sets out assessment criteria for responding to applications for new or expanding MPS which include whether the premises used (or to be used) is suitably planned and located for the provision of aged care and whether the places will be made operational in a timely manner. A related issue is the limitation on delivering integrated care to aged care residents where the health facilities are not co-located and the health workforce is not able to be deployed across both areas of need.

A further potential barrier is where the MPS does not adequately meet the cultural needs of some members of the local community. In three communities there is a co-existence (and in one at least, an integrated delivery) of both MPS and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP), but this may not be the appropriate solution in other communities. The MPS Program attracts a higher proportion of Aboriginal and Torres Strait Islander aged care recipients than mainstream aged care services, but the issue of improving access to culturally appropriate health and aged care remains an ongoing priority across these service delivery modalities.

Most MPS case study services provided residential care for people with dementia. However, most also noted that they did not have dementia-specific facilities and were not able to retain residents who displayed severe psychological and behavioural symptoms of dementia. This situation applies to many small aged care providers in rural and remote areas, represents a significant barrier to enabling older people to remain resident in their own community and is likely to be an increasing issue in the light of the growing incidence of dementia. The majority of MPS reported in the survey that their aged care residents did not have timely access to allied health professionals.

The current assessment criteria for approving MPS establishment or expansion do not adequately identify the characteristics of communities that could benefit from the MPS model of flexible and integrated health and aged care service delivery. These have been identified in other research as:

- Service planning based on population health planning principles and local health needs
- Strong local relationships and engagement with local communities
- Strong local governance, management and leadership
- Commitment to continued funding of a range of basic acute, aged care, community care and community health services under the single service entity
- Accountability mechanisms.

A lack of transparency and accountability

A lack of detailed information about the finances and activities at the whole-of-MPS level has meant that any complete assessment of the achievement of MPS objectives in the delivery of aged care (and in overall health and aged care) could not be made. The pooling of funds has meant that a

comparison of the Commonwealth's funding inputs and the MPS aged care outputs could not be naively made to assess the effectiveness and efficiency of this MPS set of activities without bias.

Impact of broader aged care policy and regulatory changes in MPS Program related contexts

The second issue which this review has addressed is to "examine the impact of broader aged care policy and regulatory changes in MPS Program related contexts".

Mainstream reforms

Since the inception of the MPS Program in 1993 there have been significant reforms in mainstream aged care, starting with the introduction of the *Aged Care Act* 1997. There have been more extensive reforms since 2011 following the *Caring for Older Australians* Inquiry with a focus on consumer choice and control within a more market-based system and a stronger aged care quality and safety standards regime. In addition, a Royal Commission into Aged Care Quality and Safety is currently in progress.

Some of the challenges in aligning the MPS service delivery model as administered by the various States with mainstream aged care stem from the pooled funding and flexible delivery model as well as the limitations of delivering residential and home-based services in rural and remote Australia given their isolation, cost structures and 'thin market' characteristics.

In some communities the market-based system for home care through HCP and CHSP has resulted in inequity in access to home-based aged care through the absence of providers willing to service the smaller and more remote localities. This has the potential to place further demand on MPS operations, both in terms of the use of flexible pooled funds to provide home-based aged care through their community nursing services and also avoidable early entry into residential aged care due to poor access to HCP and CHSP.

MPS aged care consumer contributions and payments

There are several mainstream reforms which have not generally been carried through to the funding and delivery of aged care services in MPS by the States as approved providers. Two of these have led to the inequitable treatment of aged care residents and home care clients in mainstream services relative to those receiving aged care services from MPS.

- First, the States do not require MPS residents with higher incomes/assets or home care clients with higher incomes to make a means tested care contribution. MPS residents are able to have their income/assets assessed by DHS and receive a letter with the outcome of that assessment. However, this process is not system generated as it is in mainstream aged care and does not have the flow on effect to funding.
- Second, the States set their own fees for MPS and there is no requirement for partially and non-supported residents in MPS in many States to make an income and asset tested contribution towards, or pay for, their accommodation.

In some cases there is a lack of competitive neutrality in that the inequitable treatment of MPS aged care consumers places some current (and prospective) non-MPS providers operating in the same region as an MPS at a disadvantage and impacts on their viability. In other cases, there is strong complementarity between an MPS and separately operated older style hostels, particularly with ageing in place and the rising care needs of those residents.

As part of an overall realignment of MPS aged care, the Commonwealth should consider consulting with the States to remove the current misalignment between MPS and mainstream aged care relating to means tested contributions by residents and home care clients. This would need to be subject to the preservation of current arrangements for existing residents and clients and implementation after a period of advanced notice and community education.

ACAT assessments

Currently there is no formal requirement for residents and home care clients of MPS to have an ACAT assessment, though it has become standard practice across most MPS. Formal alignment with the mainstream reforms would improve transparency and help overcome any local concerns about the inequitable allocation of places to older members of the community.

Quality and Safety

MPS that deliver residential care are required to comply with the Aged Care Quality Standards introduced on 1 July 2019. One of the significant issues regarding quality and safety for MPS emerging from the review was that it can be challenging for MPS to create a homelike environment within an integrated hospital/aged care facility, especially where the MPS is housed in an ageing hospital building. However, the States are taking steps to address this with some States developing and rolling out formal programs and investing in more homelike accommodation for residents.

Access to other Commonwealth programs

This review has documented several Commonwealth programs, including those specifically targeted to rural and remote providers, to which MPS are not eligible. Each should be re-examined with the default decision being inclusion of MPS unless there is a clear net benefit to the contrary.

Assessment of the funding model

The third of the issues for this review is to "Determine whether the MPS Program funding model is an effective use of Commonwealth funds to deliver aged care services in regional, rural and remote areas".

The Pooled Funding for each MPS is required to be used to meet both health and aged care needs as set out in Service Delivery Plans. The States' contributions represent the majority of the pooled funding. The Commonwealth's contribution to the pooled funding for the care component of aged care is calculated according to a determined number of high care and low care residential places and home care places and does not vary according to occupancy. The Commonwealth also contributes to the States for the health care service according to the funding model determined by IHPA.

Benefits and disadvantages of the pooled funding model

The MPS pooled funding model allows the flexible allocation of resources and integrated service delivery by MPS to best meet community needs as expressed in Service Delivery Plans. It also has the advantages of administrative simplicity and reasonable funding certainty (based on pre-determined levels of occupancy). Analysis of trends in occupancy and waiting lists, within the limits of the available data, supports the conclusion that there is a high and ongoing demand for higher levels of care for residents. There is also a higher level of variability in occupancy in small facilities, and funding arrangements should recognise the implications for meeting their higher relative fixed costs.

Calculating the Commonwealth's aged care contribution to pooled funding based on annually determined residential high and low care places and home care places means that the costs of

providing care in response to the acuity of current residents and MPS home care recipients are not necessarily closely aligned with levels of funding or reflective of actual service delivery. The division between different categories of care places is artificial in the context of the MPS flexible use of pooled funding to address local health and aged care needs. There is also an anomaly in the delivery of MPS funded home care (by the MPS) as opposed to the delivery of HCP and CHSP (delivered by approved providers) where MPS are not approved providers but are attempting to fill gaps due to an absence of actual delivery of these services in their locality. It may be possible to better integrate the full range of aged care services in MPS in towns which are experiencing market failure.

The Commonwealth's expenditure on the aged care component of residential aged care in MPS is estimated to be broadly comparable to the level of expenditure if that was based on resident assessment according to the Aged Care Funding Instrument. The confidence in this assessment is limited by the lack of acuity data of MPS aged care residents and by the use of occupancy data which applies to the number of funded places rather than the physical bed capacity of the MPS.

There would be benefit in the Commonwealth undertaking (or commissioning) research into developing a Commonwealth funding model for aged care services in MPS which: retained its current advantages of reasonable funding certainty and administrative simplicity; addressed concerns about adequate care funding for both resident and home care acuity; and addressed the issue of market failure in the delivery of HCP and CHSP in small isolated communities.

The significance of adequate infrastructure

The Commonwealth is not responsible for capital funding under the MPS Program. Infrastructure (or commitment thereto) is a pre-requisite for the establishment of an MPS and differences in the local availability of facilities or capital funding may result in inequity of access to the MPS service delivery model between communities. Access to high quality contemporary infrastructure is important in ensuring the effectiveness and efficiency of operating an MPS. Several States have embarked on significant projects to rebuild or refurbish facilities while other MPS rely more heavily on local philanthropy which, in itself, represents a voluntary contribution by many, together with the benefit of building social capital

Many legacy hostels are becoming inappropriate for delivering care to residents who have increasing acuity of needs. In some cases, renovation is not a practical proposition and capital injection will be required.

Transparency and accountability for the Program as a whole could be improved by strengthening the reporting provided by the States to comply with the underlying intention of the reporting arrangements in the Agreement. This would enable a more complete assessment of the effectiveness and efficiency of the Commonwealth's funding of aged care in MPS and in the overall achievement of the Program objectives.

Recommendations

The Multi-Services Program is a joint Commonwealth / State program (in bipartite or tripartite forms). As such the recommendations arising from the research has been grouped according to whether the matter requires joint Commonwealth / State consideration or is primarily the responsibility of the Commonwealth.

Further, by constructing the report according to the three matters set out in the terms of reference, rather than by policy issue, findings which conclude several chapters are repeated or closely related. The following recommendations consolidate these matters.

Part A: The Commonwealth should approach the States to jointly undertake the following:

1. Develop a standing working group of Commonwealth and State officials, with a view to establishing collaborative governance of the MPS Program.
2. Review the overarching vision for the MPS Program, taking note of stakeholder feedback contained in this report.
3. Identify constraints on the greater deployment of MPS by the States and seek opportunities for mutual resolution of those constraints (noting recommendation 9 below).
4. In the context of evolving models of delivery of health and aged care in rural and remote areas, review the definition of an MPS under Section 104 of the Subsidy Principles.
5. Examine the impact that state-based minimum nurse staffing standards have on limiting the budget capacity of MPS to employ appropriately trained care and diversional activities staff who are more skilled at meeting the daily living and social care needs of aged care residents.
6. Review the funding of MPS for home based care for older persons, including the care delivered through community nursing, home care recognised in the funding of Home Care places by the Commonwealth and funding sourced from the Commonwealth Home Support Program, with a view to ensuring the delivery of flexible, high quality home care and home-based palliative care and to reducing avoidable residential aged care.
7. Consider amending the MPS Agreement along the following lines:
    a) Introducing means testing of MPS residents and home care clients by the Department of Human Services, with the States aligning consumer care contributions and accommodation payments/contributions with mainstream care recipients, subject to the preservation of current arrangements for existing residents and clients and implementation after a period of advanced notice and community education.
    b) The States aligning their charging of basic daily fees for residential and home care with payments made by mainstream care recipients, noting that in most cases this would require minimal adjustment.
    c) The States formally undertaking ACAT assessments for all incoming MPS recipients of aged care services (home care clients and residents), noting that this would differ little from current practice in most circumstances.

Part B: The Commonwealth should initiate action to:

8. Require Service Providers to comply with the underlying intention of the MPS Agreement reporting arrangements, including, in a format agreed with the Commonwealth:
    a) reporting on all service provider activity and all revenue and expenditure from the pooled funding
    b) reporting on progress of the activities specified in the Service Delivery Plan
    c) reporting on matters referred to elsewhere in this report such as more complete reporting on complaints and the achievement of a homelike environment.
9. Review the Commonwealth's approach to the funding of accommodation and other aged care infrastructure in MPS with the aim of increasing the number of co-located health and aged care services and the provision of facilities which meet contemporary standards and expectations (noting recommendations 3 and 10).
10. Review all Commonwealth rural and remote health, aged care and related programs (operational and capital) that currently exclude MPS, assessing the rationale for that exclusion and assuming future inclusion of the MPS unless there is a public net benefit in retaining the current policy. This review would include the recent Commonwealth initiative to enhance Medicare payments to cover travel costs for GPs visiting a residential aged care facility, the National Residential Medication Chart program and Commonwealth capital programs.
11. Explore a model for the delivery of private provider Home Care Packages which retains consumer choice but might allow community-supported selection of a 'preferred provider' through a periodic open process. That provider (which may be the MPS) may be able to develop sufficient economies of scale to ensure more efficient and effective service delivery to local residents.
12. Undertake (or commission) research into developing a Commonwealth funding contribution model for aged care services in MPS which reflects prevailing acuity and numbers of aged care residents while maintaining medium term certainty, administrative simplicity and the effectiveness of the pooled funding arrangements. Suggested lines of enquiry include:
    a) Retaining, for the purposes of its funded contribution for residential care to the MPS pooled fund, the determination of a number of places funded at 100% occupancy (irrespective of the MPS MMM classification).
    b) Reviewing the number of funded residential aged care places on a regular basis (including where there is a reducing demand and/or an alternative residential aged care provider) and ensuring the MPS Allocations Rounds and periodic reviews of existing MPS have clear and transparent criteria, assessment processes and reporting of outcomes.
    c) Replacing the current residential high and low care funded contributions to the MPS pooled funding with funding to reflect the care needs and cost of caring for current MPS residents. The residential care funding level could be assessed at a census date annually, averaged across all aged care residents and applied to the number of funded flexible residential care places for the following 12 months.
    d) Assessing whether the replacement to the ACFI funding model, or some variation of that model, would be fit for purpose.
    e) Noting the joint review of funding of home care at recommendation 6.

1 About the Report

This Report responds to the Terms of Reference set by the Commonwealth Department of Health (the Department) in relation to its ongoing planning, development and continuous improvement of aged care services provided through the Multi-Purpose Service Program (MPS Program) across regional, rural and remote Australia.

It is important to note that this Report does not purport to be a holistic review of MPS. Such a review would require terms of reference developed and delivered collectively by the States and the Northern Territory (hereinafter, the States) and the Commonwealth and review the governance, funding and delivery of health and aged care services under the MPS Program.

This review of aspects of aged care in MPS was commissioned by the Department and undertaken by the Centre for Health Economics Research and Evaluation (CHERE) at the University of Technology Sydney. The review commenced on 17 September 2018.

1.1 Background to the report

This review had its genesis in an internal review undertaken by the Department in 2016-2017. That review confirmed the importance of the MPS Program for delivering aged care services in regional, rural and remote Australia. It concluded, however, that the Program may need to be updated in light of significant changes within broader aged care policy.

Subsequently, the Legislated Review of Aged Care 2017, recommended:

> *"That the government engage with state and territory governments and service providers to review the MPS Program to better align its service delivery model with mainstream aged care programs, where appropriate, to ensure greater consistency of services for aged care consumers and providers, and to consider the location of services to ensure that MPS funding is properly targeted."*[1]

1.2 Summary Terms of Reference

The Official Order from the Department set out the requirements for undertaking this review, including the following summary terms of reference:

> *[CHERE] will plan and undertake a review of the Multi-Purpose Services (MPS) Program to assess the Program's appropriateness, effectiveness and efficiency to inform ongoing planning, development (including service establishment) and continuous improvement. The objectives of the review are to:*
>
> - *ascertain the extent to which the MPS Program objectives are being achieved and identify and examine any unintended outcomes*
> - *examine the impact of broader aged care policy and regulatory changes in MPS Program related contexts*
> - *determine whether the MPS Program funding model is an effective use of Commonwealth funds to deliver aged care services in regional, rural and remote areas.*

The Department also set out the following series of questions to be answered in relation to each of Appropriateness, Effectiveness, Efficiency and Equity:

[1] https://agedcare.health.gov.au/reform/aged-care-legislated-review

Appropriateness

- Is the MPS Program still the right response to meet the aged care needs of older people living in outer regional, rural and remote locations?
- Are current locations still appropriate and processes and eligibility criteria adequate to ensure that funding is targeted to appropriate locations?
- What is, or should be, the impact of broader aged care policy and regulatory changes within MPS Program contexts:
    - on MPS providers?
    - on other local aged care service providers?
    - on consumers?

Effectiveness

- How well is the MPS Program service delivery model being implemented (in a manner that optimises effectiveness)?
- To what extent is the MPS Program resulting in improved access and quality of care for aged care clients?
    - what are the barriers and enablers?
    - are there any unintended outcomes (positive and negative)?

Efficiency

- How cost effective (efficient) is the MPS Program funding model in delivering aged care services in outer regional, rural and remote areas?
    - what are the advantages of the pooled funding model?
    - are there any disadvantages or unintended outcomes (positive and negative) of the pooled funding model?
    - are there any deficiencies in the funding model?

Equity

- Are there groups missing out on MPS services due to social determinants or inequity of access?

1.3 Review design

A convergent mixed methods research design was used to address the complexity and diversity of the review's objectives, within the timeline available. In convergent mixed methods designs, quantitative and qualitative data are collected concurrently, and the integration of the different data occurs at the stage of analysis and presentation of the results. The review design is provided in Figure 1

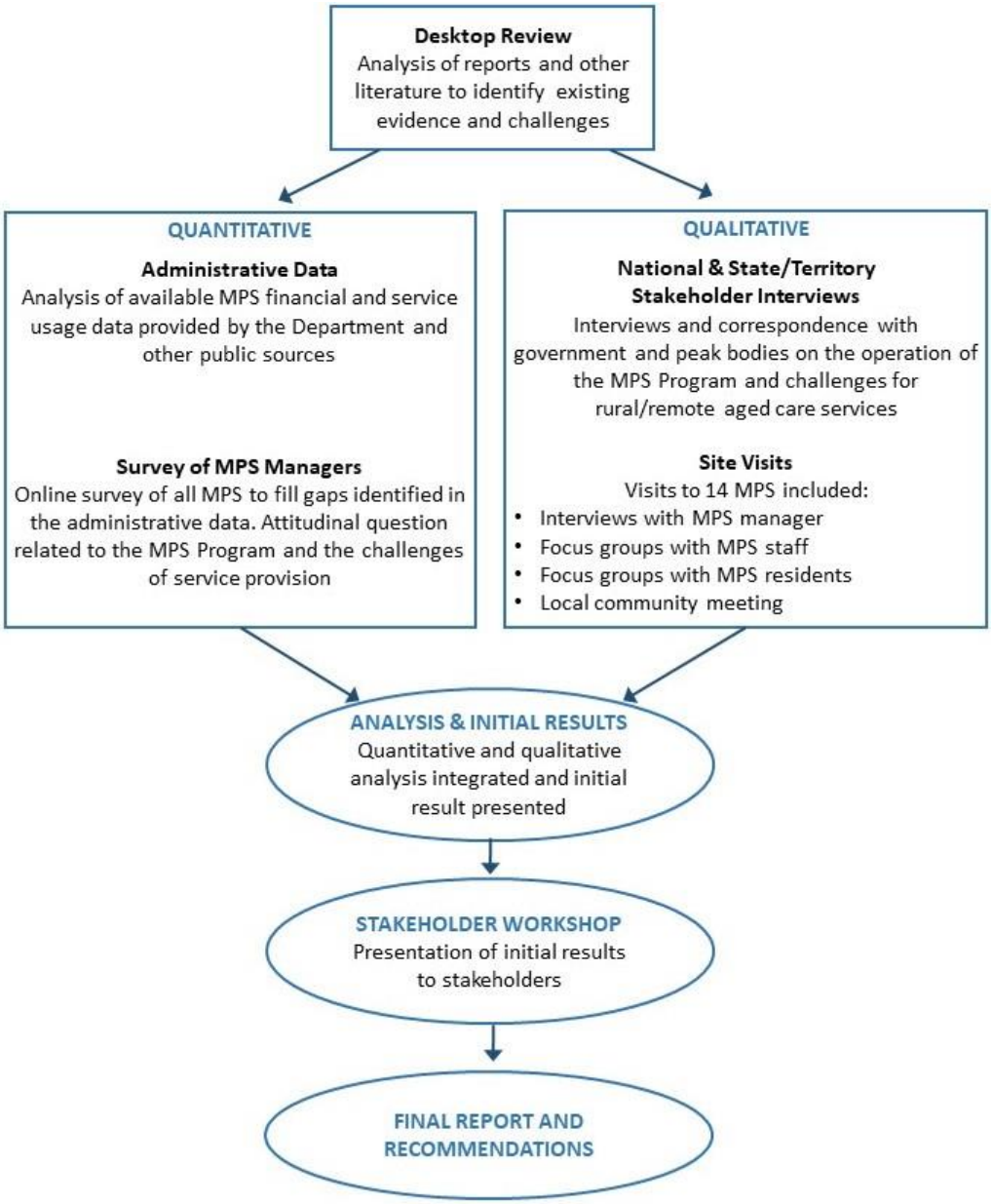

Figure 1: Review design

The following subsections provide information on three components of the review process: ethics approvals, desktop review and interim reporting. Greater detail is provided on the other components in chapter 3.

1.3.1 Ethics approvals

At the commencement of the review, the review Team prepared and submitted a multi-site ethics application through Hunter New England Human Research Ethics Committee and was formally advised of its approval on 25 January 2019. Following receipt of the multi-site ethics approval, site-specific ethics applications (SSA) (and jurisdiction-level overarching applications as necessary) were developed prior to undertaking site visits. The final set of approvals was not obtained until 12 April 2019. The ethics approval processes proved to be complex and cause significant delays.

1.3.2 Desktop review

The desktop review included publicly available reports, internal reports provided by the Department and other stakeholders, grey literature, peer reviewed literature and relevant organisational websites. The purpose of the desktop review was to obtain a current view of:

- The evidence related to the provision of MPS type services in regional, rural and remote communities
- The current policy environment for the provision of aged care in regional, rural and remote communities
- Examples of current and alternate models of aged care provision in regional, rural and remote communities

The desktop review provided informed the development of the data collection methods and the context for the review findings and recommendations.

1.3.3 Interim reporting

A progress report on the Review of the Multi-Purpose Services (MPS) Program as at 21 February 2019 was provided to the Department. It included early observations from the initial analysis of quantitative data and outlined the processes for the subsequent site visits, surveys and analyses.

A report on the Review of the Multi-Purpose Services Program was provided to the Department in August 2019.

1.4 Structure of the Report

This Report responds to the Terms of Reference and the remaining chapters are structured as follows:

1.4.1 Chapters 2 – 4

These chapters provide important contextual analysis to inform both the findings from this review and future policy deliberations.

Chapter 2 provides a brief contextual history of the MPS Program and its legislated definition. Chapter 3 expands on some of the key sources of evidence drawn on for the policy analysis. Chapter 4 identifies the drivers of current and future demand for health and aged care in regional, rural and remote areas.

1.4.2 Chapters 5 - 8

The remainder of the Report responds to the terms of reference for this research. First is an analysis of the degree to which the MPS Program is meeting its objectives. This is set out in chapter 5, with chapter 6 focussing in particular on the contribution of the health workforce in meeting the Program objectives. Chapter 7 compares and assesses the delivery of aged care in MPS with the broader reforms in mainstream aged care. In conclusion, Chapter 8 draws on the limited available data to assess whether the MPS Program represents an effective use of Commonwealth funds to deliver aged care services in regional, rural and remote areas. Report references are provided at the end of the document.

2 Background to the MPS Program

The MPS Program is a joint initiative of the Commonwealth and State (including the Northern Territory) Governments. One of its primary objectives is to provide integrated health and aged care services in all States to regional, rural and remote communities that could not support stand-alone hospitals or residential aged care services. It is one of a variety of responses to meeting the challenges of delivering services to these communities. The Program is jointly funded by the Commonwealth Government (recognising its aged care responsibilities) and the State Governments (health service responsibilities).

2.1 The challenges of accessing health and aged care in rural and remote Australia

For people living in regional, rural and remote (henceforth 'rural and remote') communities, access to health and aged care services can be very challenging. The AIHW's report *Australia's health 2018* (AIHW 2019) identifies the poorer health outcomes experienced by people in these communities. Compounding factors include the limited availability of nursing staff and general practitioners, intermittent access to allied health professionals and medical specialists, and the time and costs of travel.

The Aged Care Financing Authority (ACFA 2016) reports that on the supply side, service providers face high cost pressures from geographical isolation, including: the costs of attracting and retaining staff; the time and costs of travel for staff and families; freight costs and delays; and the limited internet coverage in many areas. The ageing of the populations and the limited and ageing infrastructure create additional challenges for both health and aged care.

From an aged care perspective, many rural and remote communities without a critical mass of older people have not had an aged care home in their area. Consequently, people requiring residential aged care have been required to leave their community, and often their family, to live in an aged care home elsewhere. Even where these facilities – often former low care hostels – have been locally available, the councils (or charitable organisations) that managed them have been divesting from these services due to high costs and poor viability. Likewise, rural hospitals have experienced viability issues due to increasing costs of health care and a greater emphasis on primary health care. Indeed, many rural hospitals have had "nursing home type patients" (NHTP) living long-term in sub-acute wards for want of another option.

2.2 Establishment of the MPS Program

One of the responses to these challenges was the joint establishment of the Multi-Purpose Services Program in 1993 by the Commonwealth and the States. The MPS Program was intended to offer a solution by enabling a more innovative, flexible and integrated approach to the delivery of health and aged care services and the flexible use of funding and resources in a way that addresses the specific needs of each community. MPS facilities were often established in communities which had an existing community hospital providing sub-acute care for their elderly and, in many cases, some form of de facto residential aged care through long stay or nursing home type categories of frail older patients. Many communities had (and still have) hostel-style accommodation.

More than 25 years after the first MPS was established there are now 180 MPS nationally (as at February 2019): 64 in NSW; 38 in Western Australia; 36 in Queensland; 26 in South Australia; 11 in

Victoria; 3 in Tasmania; 1 in the Northern Territory and 1 in Norfolk Island. Data used in this report is based on 179 MPS as at June 2018 and excludes Norfolk Island.

The Program has changed little over these two and a half decades. A review of the program overall would be timely as aged care has undergone transformational change over this time and health care has had a similar experience. The NSW Multi-Purpose Service Program website summarises the situation as follows:

> *"The demographic and social profile of rural and remote Australia has changed over the last 20 years. These changes have influenced the way health care is delivered and funded. For example:*
>
> - *hospital stays are shorter*
> - *use of technology has expanded*
> - *more services are delivered in the community or close to home*
> - *older people are increasingly choosing to be cared for at home.*
>
> *Traditional hospital structures and models of care have changed to reflect evolving health needs in regional and remote environments. There is now a greater emphasis on primary health care, including health improvement and prevention programs, delivered in an integrated way. In small communities, more flexible service models are being delivered as part of a more client-focused approach, responsive to community needs."*[2]

Importantly, however, this report is largely limited to the Terms of Reference set by the Commonwealth and is focussed on aged care.

2.3 MPS Program definition

MPS are administered under the Flexible Care provisions of the *Aged Care Act 1997* (the Act) and the associated *Aged Care Principles 2014* (the Subsidy Principles). Section 49-3 of the Act defines flexible care as follows:

> ***Flexible care** means care provided in a residential or community setting through an *aged care service that addresses the needs of care recipients in alternative ways to the care provided through residential care services and home care services.*

Section 104 of the Subsidy Principles 2014 defines MPS as follows:

> *104 Multi-purpose services*
> *A multi-purpose service is a flexible care service in relation to which the following requirements are satisfied:*
> *(a) residential care is provided through the service;*
> *(b) at least one of the following services is also provided through the service:*
> *(i) a health service;*
> *(ii) a home and community care service;*
> *(iii) a dental service;*
> *(iv) a transport service;*
> *(v) a home care service;*

[2] http://www.mps.health.nsw.gov.au/

(vi) a service for which a Medicare benefit is payable under the Health Insurance Act 1973;

(vii) a service that provides a pharmaceutical benefit under the National Health Act 1953;

(viii) a service that the Minister nominates, in an agreement with the responsible Minister of the State or Territory in which the service is located, as an appropriate service.

2.4 Roles of the Commonwealth and the States

Multi-Purpose Services are administered under the Aged Care Act 1997. Under the Subsidy Principles 2014 the Secretary of the Commonwealth Department of Health can enter into a Multi-Purpose Service Agreement with a State where they satisfactorily demonstrate that their services will:

a) improve access to care
b) increase coordination, flexibility and innovation in the delivery of care in the area
c) provide care that is cost-effective
d) provide care that is culturally appropriate

Further, each service is not to be in a major city, must be in an area that is able to sustain a viable multi-purpose service, and has, or is likely to have, the broad support of the community within the local area.

The MPS Agreements may be bi-partite between the Commonwealth and the State Governments (as approved providers and service providers), or tri-partite between the Commonwealth, the States (approved provider) and a third-party service provider (which may include a State regional health service or private organisation).

Under the Agreements, the allocation of resources from the pooled funding of an MPS is to be guided by a Service Delivery Plan. The Plan details the community's health and aged care needs and the services to be delivered by the MPS to meet the identified priority needs, including the necessary infrastructure and resources as agreed by the Commonwealth, the States and their agencies (where they are separate service providers).

2.4.1 MPS service building blocks

The services to be delivered in accordance with the Service Delivery Plan can include: aged care (residential, respite and home care); acute care; emergency care 24/7; sub-acute care; primary care; allied health care; community care; and other health services.

In practice, the three core building blocks in nearly all MPS are:

- a health service comprising acute and/or sub-acute in-patient care and community health services
- emergency medical care (including triage, stabilization and transfer)
- a residential care service which is focused on high care needs

In addition, some MPS have:

- direct responsibility for, or a close working relationship with, a legacy 'hostel' in the community which was originally supporting residents with low care needs but increasingly is providing care for residents with higher levels of need

- delivery of MPS home care places (additional to community health services), and/or as providers of HCPs or CHSP (formerly Home and Community Care)
- a more comprehensive range of health services that includes surgery and maternity

MPS generally also work very closely with other health and social support services in the community.

There is diversity between the States (and their regional organisations) in terms of the MPS models of operation. Local contexts such as population size, service capacity and community activism (including substantial local philanthropy) also play a part, giving concrete expression to the underlying objective of delivering flexible care which meets the needs of each individual community.

2.4.2 Role of the Commonwealth

Under the Act, the Commonwealth has determined a set of Aged Care Principles. These Principles impose a set of requirements on the States as approved providers. The Principles range from matters of quality and complaints procedures to allocation, accountability, reporting and funding.

In relation to funding, the amount of the Commonwealth flexible aged care contribution for each MPS is calculated according to the provisions of the MPS Agreements. It is based on the allocated number of places and the daily funding amount which is set by Ministerial Determination each year. The Commonwealth's funding is contributed to the MPS Pooled Funding. The Aged Care (Subsidy, Fees and Payments) Determination 2014 sets out the subsidy amounts (expressed as a number of points, which are then converted to monetary values).

2.4.3 Role of the States

State Governments, either directly or through their agencies, deliver health and aged care services, contribute health services funding, manage and report on the Pooled Funding and provide the necessary capital and infrastructure for MPS (supplemented by community philanthropy).

Under the MPS Agreements, State funding contributions are unspecified other than to note that they are the amounts as notified by their governments to the Commonwealth by 31 December in each year over the Funding Period. This funding is contributed to the Pooled Funding.

As approved providers of aged care services, the States are subject to a series of requirements which are set out in both the Aged Care Act 1997, the Aged Care Principles and the Terms and Conditions of their MPS Agreement with the Commonwealth.

For instance, the Accountability Principles 2014 require that as Service Providers, the States (or their agencies) provide the Commonwealth and the State (if requested) with Annual Statements of Financial Compliance and Income and Expenditure and Annual Activity Reports.

2.5 International comparisons

The MPS Program model encompasses a broad range of strategies to address health and aged care access in rural and remote communities. There is very limited evidence internationally for other similar models.

A number of countries have considered integration strategies to support improved health, with or without specific targeting of health and aged care services. For example, strategies on integrated primary care (not necessarily related to integration of health and aged care) have been considered in the United States, the United Kingdom, New Zealand, Canada and The Netherlands (Powell Davis, G. et al, 2008). In the UK, approaches to integrated care have included health and social care services,

through health, local government and other social care providers, however this has proved challenging (Humphries, 2015).

The systematic review by Powell Davis. et al. (2008) found that in the context of aged care and chronic conditions, international strategies most commonly focused on communication and support for providers and patients, such as case conferencing; and structural arrangements to support coordination - including co-location, case management, multidisciplinary teams or assigning patients to a particular primary health care provider. The authors found that integrated care strategies were broadly comparable with the relevant parts of the existing framework for successful integration and coordination of care and these models were associated with improved health and/or patient satisfaction outcomes in more than 50% of studies. Interventions using multiple strategies were more successful than those using single strategies.

While that systematic review focused on the broader population and without any geographical distinctions, an important conclusion was that Australia has had a largely incremental approach to improving coordination of care, using a broad range of strategy types and while this has served to improve health and patient satisfaction, it has also perpetuated existing structural problems. As is well understood, one of the most significant issues is the distribution of responsibilities across Australia's federated structure.

3 Review methods

3.1 Review design

As noted in Chapter 1, a convergent mixed methods research design was used to address the complexity and diversity of the Report's Terms of Reference, within the timeline available. In convergent mixed methods designs, quantitative and qualitative data are collected concurrently, and the integration of the different data occurs at the stage of analysis and presentation of the results. The review design is set out in Figure 1 of Chapter 1.

At the request of the Department, further detail of some of the data results has been brought together into this one chapter. The relevance of this evidence to the analysis of the policy questions, and data limitations, are dealt with in each of the substantive chapters that follow. This chapter therefore profiles:

- Administrative data
- Survey of MPS Managers
- National and State/Territory stakeholder interviews
- Site visits
- Stakeholder workshop
- Comparative profiling of MPS survey respondents and MPS case study sites with all MPS.

3.2 Administrative data

This Report makes extensive use of a number of administrative data sources provided by the Department. Rather than including a (necessarily lengthy) synopsis of that data here, it is set out in relevant detail in the policy analysis chapters. The administrative data sets used for this research have included the following:

- MPS Activity Reports for 2016-17 and 2017-18
- MPS Client data (de-identified) for 2016-17 and 2017-18
- Service profiles for MPS in locations where RACF also exist
- MPS maps
- Departmental reports
- Final Report MPS Program Pre-review stakeholder engagement meeting May 2018
- MPS Funding Information
- 2016-17 and 2017-18 Income and Expenditure Statements & Financial Compliance
- ACFI data, home care data and residential aged care data.

Data from other sources has also been used in undertaking analyses for this Report, such as the demographic data which is included in chapter 4. The range of sources include the following:

- Publicly available demographic data sourced through the Australian Bureau of Statistics (ABS).
- Publicly available data in relation to selected MPS sample sites, e.g. Local Government websites, accreditation reports
- Data available from AIHW GEN Aged Care Data.

3.3 Survey of MPS managers

3.3.1 About the Survey

The online survey of MPS managers was designed to capture the capacity of, and challenges for, MPS facilities across Australia and complements administrative data provided by the Department of Health.

The online survey was piloted with four MPS, refined and emailed directly to the manager of each 179 MPS. The survey was distributed on 29/04/2019 (03/05/2019 for Western Australian facilities) with follow up reminder on 09/05/2019. A final reminder was sent on 13/05/2019 and the survey was closed by close of business that day.

Out of 179 MPS sites that were invited to participate in the survey, 50% percent (n=89) responded. Table 2 below shows the number of MPS in each State that responded to this survey.

Table 2: Online survey responses by State

	Survey responses (n)	Total MPS (n)	Response rate (%)
New South Wales	33	64	52%
Western Australia	13	39	33%
Queensland	13	35	37%
South Australia	20	26	77%
Victoria	5	11	45%
Tasmania	3	3	100%
Northern Territory	1	1	100%
Norfolk Island	1	1	100%
Total	**89**	**179**	**50%**

The following summarises the survey results. Care should be taken in interpreting these results due to the under-representation of Western Australian and Queensland MPS in the sample and the presence of potential bias in some MPS characteristics compared to the 50% of MPS which did not respond to the survey.

However, as section 3.7 demonstrates, an analysis of a range of characteristics of MPS which responded to the sample, compared to all MPS (178 - excluding the one in each of the Northern Territory and Norfolk Island) shows no statistically significant differences in such matters as funding, size, remoteness and occupancy.

3.3.2 Residential Aged Care Capacity

The survey asked for the total number of beds in the MPS (including health and aged care beds), the number of residential and respite aged care residents occupying beds on the day they completed the survey, and the number they could admit.

Table 3 describes the MPS responding to the survey categorised by the combined number of health and aged care beds in their facility. The smallest MPS in the survey provided no in-patient or residential aged care, while the largest had a total of 76 beds. The mean number of total beds across the sample was 23.6 beds. The proportion of MPS with 11 to 30 beds in total was 73% (n=65), with a much lower proportion being smaller (10 beds or less, n=8) or larger (31 beds or more, n=14).

Table 3: Total number of MPS beds, health and aged care combined

	%	n
None	1%	1
1 to 10 beds	8%	7
11 to 20 beds	35%	31
21 to 30 beds	38%	34
31 to 40 beds	7%	6
41 to 50 beds	7%	6
Over 50 beds	4%	4

The survey asked managers how many of their MPS beds would be occupied by long-term and respite aged care residents at midnight on the day they completed the survey. The table below shows that two MPS had no long-term aged care residents, while two had over forty residents, the highest number of residents was 41. Of the MPS responding to the survey, 47% had between 11 and 20 long-term residents, and the mean average was 14.4 residents. The average number of respite aged care residents was one, and six was the highest.

Table 4: Number of long-term aged care residents at midnight

	%	n
None	2%	2
1 to 10 long-term residents	33%	29
11 to 20 long-term residents	47%	42
21 to 30 long-term residents	10%	9
31 to 40 long-term residents	6%	5
Over 40 long-term residents	2%	2

To estimate the aged care capacity of the MPS, the survey asked managers how many aged care residents they could admit on the day they completed the survey. The mean number of vacant beds for was 1.3 for long-term aged care, and 0.5 for respite care. Of the MPS responding to the survey, 46% (n=41) reported they had no vacant aged care beds. Several managers commented that, while there was spare bed capacity in their MPS, they did not have the staffing budget to operate those beds.

3.3.3 Aged Care in the Community

Managers were asked the number of older people they supported to live in their own home using MPS funding, and other sources of funding they received to deliver community aged care services (in addition to the MPS Program).

Table 5: Number of older people supported in their own home with MPS funding

	%	n
None	66%	59
1 to 10 people	22%	20
11 to 20 people	5%	5
21 to 30 people	1%	1
31 to 40 people	1%	1
Over 40 people	3%	3

Around two-thirds (n=59) of survey respondents reported that they did not support older people to live in their own home using MPS funding. Of the remaining respondents, around a quarter (n=25) supported between one and 20 people at home with MPS funding, while four MPS reported they used their funding to support more than 20.

The wide range in responses (from no people supported at home, to 165) may reflect differences in how the respondents interpreted the survey question. Some may have counted all those supported by MPS funding, including health-funded community nurses, while others may have included those receiving specific aged care services (e.g. personal care or domestic assistance).

Table 6 below shows the number of MPS receiving additional sources of funding to support older people living in their community. Of the MPS responding to the survey 42% (n=37) received CHSP funding, while 22% (n=20) delivered HCPs, and 17% (n=15) received funding from the Transition Care Program. However, 47% of the MPS respondents (n=42) said they did not receive any additional funding to deliver community aged care.

Table 6: MPS receiving community aged care funding from other sources, % n

	%	n
Commonwealth Home Support Program	42%	37
Home Care Package Program	22%	20
Transition Care Program	17%	15
Short Term Restorative Care	2%	2
NONE of the above	47%	42

Managers were also asked if there were other, external providers delivering aged care services to older people in their community, including residential and respite care. Table 7 shows that 64% (n=57) reported that external providers delivered HCP in their community, while 37% (n=33) reported there was another provider of the CHSP.

There were 21 cases of another residential aged care facility in the community, and 23 where respite care was provided by service other than the MPS. However, 16 managers reported that the MPS was the sole provider of aged care serviced in the community.

Table 7: External providers of aged care services in the community, % n

	%	n
Home care packages	64%	57
Commonwealth Home Support Program	37%	33
Residential aged care	24%	21
Respite care	26%	23
MPS sole provider	18%	16

A few of the MPS facilities indicated the following services were available in their community, in addition to above: Palliative Home Care, Department of Veterans' Affairs (DVA) domestic assistance, independent living units, National Disability Insurance Scheme (NDIS) services, RSL care, Transition Care Program (TCP), and Veterans Home Care.

3.3.4 MPS Staffing

3.3.4.1 Nurse Staffing

Managers were asked to provide the nursing staff budget for their facility in full-time equivalent (FTE) for RNs, ENs and care staff (AIN or similar). The mean average total FTE for the 79 MPS that completed this question was 16.8 nurses, comprising an average of 7.6 RNs, 4.4 ENs and 4.8 care staff.

Table 8: Mean nursing budget – FTE and skill mix

	FTE	Skill Mix
Registered Nurses	7.6	46%
Enrolled Nurses	4.4	29%
Care Staff (AIN, PCA or similar)	4.8	25%
Total	16.8	100%

Missing n=10

Represented as skill mix, RNs made up 46% of total FTE, while the average skill mix for professional nurses (i.e. RN and EN combined) was 75%.

Table 9 gives the results of the set of questions on manager' perceptions of the availability of skills for the provision of aged care in their facility. It confirms that the majority (76%, n=65) felt the nursing skill mix met the *clinical* needs of aged care residents.

In contrast, just 50% (n=42) reported they felt staff were able to meet residents' emotional and lifestyle needs, and 52% (n=43) said staff had access to training on the care of aged care residents in a home-like environment.

Table 9: Managers' assessment of the availability of skills for aged care - % (n)

	Agree	Neutral	Disagree
The nursing **skill mix** meets the clinical needs of our aged care residents	76% (65)	13% (11)	1% (8)
Staff are able to meet the **emotional and lifestyle needs** of our aged care residents	50% (42)	38% (32)	12% (10)
Staff have access to training opportunities in the care of aged care residents **in a home-like environment**	52% (43)	40% (34)	8% (7)
Our aged care residents have **timely access to the allied health services** they need	27% (23)	36% (30)	37% (31)
Our aged care residents have access to **a medical practitioner** to make timely decisions about their medical care	85% (71)	13% (11)	2% (2)

Missing n=5

3.3.4.2 Diversional/Activities Workers

The limited ability of some MPS to meet the lifestyle needs of their aged care residents was confirmed by the reported budgets for Diversional/Activities Workers. While 40% (n=31) of respondent MPS had a budget of 0.5 FTE or more, a third (n=26) had a less than 0.5 FTE while 27% did not employ such workers.

Table 10: Budgeted FTE for Diversional/Activities Workers

	%	n
None	27%	21
Part-time - 0.1< 0.5 FTE	33%	26
Part-time - 0.5< 0.9 FTE	15%	12
Full-time – 1 FTE or more	25%	19

Missing n=11

3.3.4.3 Allied Health Professionals

Just 27% (n=23) of survey respondents agreed with the statement that *"Our aged care residents have timely access to the allied health services they need"*.

Table 11: Budgeted FTE for Allied Health Professionals

	%	n
None	78%	62
Part-time - 0.1< 0.5 FTE	4%	3
Part-time - 0.5< 0.9 FTE	0%	0
Full-time – 1 FTE or more	17%	14

Missing n=10

3.3.4.4 Medical Staffing

Of the MPS responding to the survey, 85% (n=71) agreed with the statement that *"Our aged care residents have access to a medical practitioner to make timely decisions about their medical care"*.

The survey also asked managers to describe the access that aged care residents had to medical practitioners. The majority described access as being '24/7' due to on-call arrangements with local GPs to cover MPS health facility. In terms of regular GP care, while not every community had a full-time GP practice, obtaining an appointment was generally described as being unproblematic. GPs either attended the MPS facility or more mobile residents might attend a practice in town.

Seventeen respondents reported there was a GP clinic co-located with the MPS. Some GPs provided regular 'clinics' dedicated to residents, either in their practice or at the MPS. Six MPS respondents described GPs being involved in three or six-monthly reviews of residents' ongoing care.

> *We have a medical practice onsite and residents can be booked for appointment if needed. GPs have a dedicated morning that they visit any resident unable to attend the practice. Residents also have a regular 3 monthly review.*

In terms of responding to emergencies or a sudden deterioration in residents' condition, most MPS responding to the survey could rely on the on-call Visiting Medical Officer (usually the local GP). Some managers also described residents being included in 'ward rounds' when required. The survey did not collect information on whether such occasions of care were billed as GP care under Medicare, or subsumed under VMO hospital costs. In MPS where there was no doctor on-call, managers reported that the nurses could access emergency phone and/or telehealth services.

While overall the medical coverage of MPS was described in positive terms, there were seven MPS in the survey which described limited or problematic access to doctors for their residents. In these cases, GP care in the community was predominantly provided by locums or was so limited that the community would go two weeks where there was no access to a doctor.

In two cases the local GPs "refused" to provide services to MPS residents, in which case hospital medical officers employed by the State provided acute and ongoing care for residents, including three-monthly reviews.

3.3.4.5 Recruitment and Retention

Table 12: Number of MPS with recruitment and retention difficulties, % (n)

	Difficult to **recruit**	Difficult to **retain**
Registered Nurses	76% (68)	36% (32)
Enrolled Nurses	40% (36)	12% (11)
Medical Practitioners	31% (28)	13% (12)
Care Staff (AIN, PCA or similar)	25% (22)	11% (10)
Auxiliary staff (e.g., cooks, cleaners, maintenance)	25% (22)	12% (11)
Allied Health	20% (18)	6% (5)
Managers and administrators	16% (14)	10% (9)
Diversional/Activities Worker	15% (13)	15% (13)
Nurse Practitioner	7% (6)	0

The scale of recruitment and retention for nursing staff was reflected in the actual vacancy rates reported by managers. The mean average vacancy rate for RNs was 0.9 FTE, for ENs 0.3 FTE and care staff 0.5FTE.

Table 13: FTE Vacancies for nursing staff, % (n)

	RN	EN	Care Staff
None	39% (30)	66% (52)	67% (53)
0.1< 0.9 FTE	15% (12)	15% (12)	6% (5)
1 to 2 FTE	35% (27)	18% (14)	23% (18)
Over 2 FTE	11% (9)	1% (1)	4% (3)

Missing 11, 10

3.3.5 Physical and Financial Resources

Table 14: Managers' assessment of MPS physical and financial resources - % (n)

	Agree	Neutral	Disagree
We are able to deliver quality health and aged care services within budget	46% (39)	30% (25)	24% (20)
We have the physical infrastructure required to deliver quality **aged care services**	35% (29)	32% (27)	33% (28)
We have the physical infrastructure required to provide a **home-like environment for aged care residents**	42% (35)	32% (27)	26% (22)
We have the appropriate physical infrastructure to provide residential aged care for **people living with dementia**	4% (3)	32% (27)	64% (54)

Missing n=5

3.3.6 Access to Aged Care Services

Table 15: Managers' assessment the access to aged care services - % (n)

	Agree	Neutral	Disagree
We are usually able to accept **new referrals** for aged care services in a timely manner	56% (47)	26% (22)	18 (15)
We often have to accept clients referred from other services due to their **higher care needs**	28% (23)	32% (27)	40% (34)
Residential care at this MPS is the **only option** for the elderly who wish to remain in this community	46% (39)	13% (11)	41% (34)
We have **strong relationships** with other health and community services to help us deliver quality aged care services	61% (51)	28% (24)	11% (9)
We have access to any **language services** we need to care for our aged care residents	61% (51)	30% (25)	9% (8)
We are able to provide **culturally appropriate** services for all our aged care residents	56% (48)	39% (33)	5% (4)

Missing n=5

3.4 National and State/Territory stakeholder interviews

Interviews with MPS stakeholders from the Commonwealth and State/Territory governments, as well as national aged care and health bodies were undertaken by telephone phone or face to face. Interviews were based on a semi-structured template and ran for 30 minutes to one hour. Some interviews were recorded and transcribed for accuracy, or notes were taken. A list of stakeholder groups that participated in the review is given in the table below.

Table 16: List of stakeholder groups interviewed

Australian Government Department of Health	**State jurisdictions**
Chief Medical Officer	Country Health South Australia
Chief Nursing and Midwifery Officer	West Australia Country Health Service
Health Systems and Primary Care	Ministry of Health NSW
Health Financing	Department of Health and Human Services Victoria
Ageing and Aged Care	Department of Health and Human Services Tasmania
Corporate Operations	Department of Health Queensland
State Officers	
Health regions	**Primary Health Networks**
Murrumbidgee Local Health District	Murrumbidgee PHN
Hunter New England Local Health District	Western NSW PHN
Western NSW Local Health District	Murray PHN
Tasmanian Health Service (Northern and Southern Regions)	Western Queensland PHN
Regional Managers West Australia Country Health Service	Primary Health Tasmania
	Central Queensland, Wide Bay, Sunshine Coast PHN
Peak bodies	
Aged and Community Services Australia	
Council on the Ageing	
National Rural Health Alliance	
Dementia Australia	
Victorian Health Care Association	

South Australian and Victorian consultations included representation from state-wide MPS Manager forums.

3.5 Site visits

Fourteen site visits were undertaken during the period February-April 2019 to provide in-depth qualitative case study data. While operating within these constraints, there were visits to sites in all jurisdictions: New South Wales (n=4), Victoria (n=3), Queensland (n=3), Western Australia (n=2), and South Australia (n=2). To capture the diversity of MPS service models, the sites selected include very remote, remote, outer regional and inner regional locations, one MPS operated by a non-government organisation, and six where there is a mainstream RACF in the same town.

There are differences in characteristics between the total population of MPS and the 14 selected for the site visits (refer Table 19). The sites visited, on average, had more places, more high care places and subsequently greater Commonwealth funding (all statistically significant). This is partially explained by the selection of the sites for visiting which were based on visiting all States and the range of sizes, rather than being a representative sample. There was also a higher occupancy in the visited sites (but this was not statistically significant).

Challenges in obtaining site-specific approval within the study's timeline meant the review team could not complete a planned site visit in Tasmania, however MPS Managers from the Northern region attended a teleconference with regional executive, held in Launceston. A third site in Western Australia could also not be visited, however, a telephone interview with the manager of this MPS was conducted.

Table 17: List of MPS site visits

NSW	Victoria	Queensland	Western Australia	South Australia
Barraba	Bright	Barcoo Living Blackall	Exmouth	Kangaroo Island
Coolamon-Gainman	Myrtleford	Childers	Plantagenet	Waikerie
Gundagai	Ouyen	Clermont		
Nyngan				

Focus groups or one-to-one interviews were conducted at each MPS with managers, staff and community stakeholders. As per the ethics-approved protocol, the local MPS assisted the research team with participant recruitment by distributing the study advertising material to staff and the stakeholders in the local community.

The number and type of focus groups conducted in the site visits are described in Table 18. In most sites a focus group with residents and family members was also conducted, but this was not always possible.

At one site, an unplanned visit from a neighbouring MPS delegation was received. This involved a presentation by the visiting MPS manager and staff. These stakeholders were not interviewed.

Table 18: Number and type of focus groups

Focus Group/Interview	Type of participants	Number conducted	Total Participants
Manager	MPS Manager, often the Director of Nursing. In some sites, others such as regional and community health managers also participated in a focus group	14	32
Staff	Focus groups always contained registered nurses, enrolled nurses and care staff. Some sites included allied health professionals, social workers, administrative and hotel services staff	16	91
Community	Participants in the community focus groups varied but could include local government services, MPS volunteers and advisory group members, emergency services and other local health professionals	13	76

Qualitative data from the site visits was managed using the software program NVivo 12. Transcripts and notes in Word format were imported into NVivo and analysed using a thematic analysis approach, while being focussed on addressing the review's objectives. The large body of evidence collected during these site visits has not been repeated here, but is referred to in the analytical chapters where relevant.

3.6 Stakeholder workshop

A workshop was held with key stakeholders on the 5th July 2019, to introduce the key points and issues for discussion from the review to date, and receive feedback. Some participants offered detailed commentary on several matters. The document below summarises the outcomes of the workshop. Some commentary reported may conflict with other commentary, as this document reports on the range of views expressed.

3.6.1 The drivers of demand and supply

Participant feedback

- The guidelines for MPS need to be updated to be more responsive to changing demography and population needs and address inappropriate submissions that are largely politically driven.
- The locations of the MPS have been driven by advocacy and community activism as well as the local demand but this has created some level of inequity where areas with the "loudest voice" have been more successful in establishing an MPS. Community engagement should be included in the drivers of demand, as this is different to activism and is considered a positive attribute.
- Moving to a system of only high-care subsidies would make sense given the current state of frailty of MPS residents across the board.
- Some communities have peak populations that are higher than ABS reporting would indicate, due to tourist influx and seasonal workers.

- In terms of planning (such as new locations, expansion, alternative funding and delivery), the MPS Program should work more closely with mainstream aged care programs within the Department of Health. This would also help smooth the transition to mainstream for MPS that have become too large in response to increasing demand.

3.6.2 Changing aged care landscape, challenges for MPS

Participant feedback

- Income tested care contributions are needed to increase equity across the board. There were many examples quoted by workshop participants where they thought a means tested system could increase equity across neighbouring regions.
- Aged Care Quality Standards should include MPS in their scope to increase equity. However, some workshop participants were worried this might add to the administrative burden for MPS.
- ACAT assessment should become mandatory across the board.
- MPS providers should be eligible for a range of other Commonwealth programs, including those specifically targeted to rural and remote providers.
- MPS generally have to report comprehensively to their State and would be happy to report in a similar way to the Commonwealth if required. Reporting should include statements of progress towards achieving a home-like environment for MPS aged care residents. The activity reports presented by MPS to the Commonwealth should significantly increase their information on consumer complaints and their resolution as well as information on all the other activities that MPS undertake. A small number of participants did not hold these views.

3.6.3 Workforce

Participant feedback

- There have been innovative activities to increase workforce flexibility and skills (e.g. rotating community nurses and practice nurses, Rural and Isolated Practice (Scheduled Medicines) Registered Nurses, and interdisciplinary training of allied health professionals).
- There are many programs and sufficient opportunities for the education of the nursing workforce in the care of older people in a home-like environment. However, the challenge remains in engaging the nursing staff in MPS in this training.
- Virtual allied health programs can be expanded and are helpful in rural and remote areas.
- Personal care staff are under-represented in some MPS due to the cost of meeting minimum nursing staff standards for inpatient care.
- Telehealth is an important factor for access to medical and allied health services.

3.6.4 Service flexibility and integration

Participant feedback

- Bed flexibility is central to the MPS model, especially for delivering respite care for older people in the community.
- Many MPS in rural and remote areas offer community nursing.
- In many rural communities it makes sense for MPS to expand through home care places, CHSP and/or HCP.

- The extended delivery of health and aged care to older people living in their own home, especially through community nursing, should be properly recognised in the MPS Activity Reports and should play a role in funding (possibly through appropriate supplements).
- Transport in rural and remote communities is an important factor affecting people's access to local and appropriate health and aged care.

3.6.5 Operational and capital funding

Participant feedback

- The Activity Reports received by the Commonwealth should include all financial and performance information about the health component as well as the aged care component of an MPS. Possibly, since the MPS already provide more extensive reports to their States, all members of the Agreement can jointly produce the Activity Reports. A small number of participants did not hold these views.
- Given the increasing level of acuity, it makes sense for MPS subsidies to move to the high-care level only, or to take acuity into account in other ways.
- The block funding is essential for the MPS. However, a system of reviewing health and aged care activities every three to five years to adjust the block funding would make sense.
- Potentially a hybrid system for larger MPS could be beneficial. One option could be a system with a certain minimum number of block funded places and additional ACFI style funded places with annual review.
- ACFI funding brings with it a resource cost in compliance activities.
- Access to capital funding for infrastructure is an issue. Several workshop participants suggested that having a system for access to capital programs through the Commonwealth, (e.g. charging RADs/DAPs using a means tested methodology) could help MPS to use that money for infrastructure. However, this money needs to be earmarked for infrastructure. Currently, even in places that charge for accommodation, this is not the case. Means tested accommodation charging will increase equity from the perspective of the residents.
- A mechanism for determining when an MPS should be transitioned into a mainstream residential facility and health service should be developed.

3.6.6 Program objectives and Governance

Participant feedback

- There should be an overarching vision for MPS, with practical objectives sitting below.
- The Program objectives need to be updated to reflect the current needs and address:
    - Appropriateness of access to health and aged care (rather than improvement)
    - Reference to the Aged Care Standards
    - Outcomes-based measurement of success such as collection of PROMs and PREMs
    - A flexible and agile workforce.
    - More transparency from all parties to the Agreement is needed to ensure better accountability.

3.7 Comparison of MPS qualitative data sources

Table 19 provides comparative profiles of all MPS, MPS which responded to the survey, and MPS which hosted site visits for the in-depth collection of qualitative data.

Table 19: Comparison of MPS qualitative data sources

	NSW	VIC	QLD	SA	WA	TAS	All included MPS	Survey	Site visit
Number of MPS	64	11	34	26	40	3	178	86	14
					Funding (2017/2018)				
Mean Commonwealth Contribution	$952,567	$1,366,660	$772,812	$1,239,101	$742,045	$1,423,421	$946,302	$1,040,765	$1,510,735
Mean State Contribution	$2,621,333	$4,172,545	$5,352,573	$2,672,082	$3,037,431	$1,674,901	$3,316,035	$3,221,695	$4,146,608
Total Commonwealth Contribution	$60,964,265	$15,033,262	$26,275,602	$32,216,635	$29,681,815	$4,270,263	$168,441,840	$89,505,806	$21,150,292
State/Commonwealth Contribution	2.8	3.1	6.9	2.2	4.1	1.2	3.5	3.1	2.7
					Funded places				
Mean High Care Places	14.4	22.2	9.1	17.9	8.3	22.0	13.2	14.6	22.9
25th percentile High Care Places	10.0	10.0	6.0	10.0	4.5	16.0	7.0	9.0	15.0
75th percentile High Care Places	16.5	35.0	12.0	26.0	10.0	28.0	16.0	18.0	32.0
Mean Low Care Places	2.1	10.5	3.8	4.9	7.8	5.0	4.7	4.9	8.9
Mean Home Care Places	1.9	1.7	4.1	0.5	4.0	7.0	2.7	2.6	3.6
Mean Total Aged Care Places	18.4	34.4	17.1	23.3	20.1	34.0	20.5	22.0	35.4
25th percentile of Total Care Places	13.0	22.0	8.0	12.0	11.0	30.0	11.0	13.0	16.0
75th percentile of Total Care Places	22.0	45.0	23.0	31.0	24.5	38.0	27.0	29.0	58.0
					Occupancy (%)				
High care occupancy: mean (25th percentile – 75th percentile)	89.8% (87% to 98%)	82.2% (74% to 100.0%)	82.5% (77.0% to 96.0%)	82.3% (69.3% to 95.8%)	74.0% (50% to 98.0%)	91.3% (85.0% to 97.2%)	83.4% (74.9% to 98.0%)	84.7% (77.0% to 98.0%)	89.9% (96.0% to 100.0%)
Low care occupancy: mean (25th percentile – 75th percentile)	88.3% (74.7% to 100.0%)	62.7% (56.5% to 70.1%)	59.9% (33.6% to 85.0%)	76.9% (69.0% to 93.9%)	61.0% (27.0% to 87.0%)	96.3% (91.6% to 100.0%)	71.5% (50.2% to 97.3%)	70.5% (43.6% to 99.0%)	69.2% (59.0% to 96.0%)
					Health service location (mean)				
Modified Monash Model Categories	5.3	5.0	6.0	5.8	5.7	5.0	5.6	5.6	5.6
Remote Classification	4.0	3.2	6.8	5.5	5.2	2.9	4.9	5.0	5.1

Notes: Northern Territory was excluded from all calculations. The survey response is one less in this Table than for this reason.

Data for the Places, financial contributions and remoteness were sourced from the Department of Health data provided, the occupancy was calculated using the activity reports.

3.8 Data limitations

This report presents evidence-based policy analysis on the governance, funding and delivery of aged care in MPS and develops policy recommendations that are in the best interests of the community as a whole. As such, it is not limited to identifying a data set to be analysed and written up as findings, discussion and conclusions. Instead, as with public policy analysis generally, it starts with an issue of public importance and relevance to government. The report draws on a wide range of data of varying quality (quantitative and qualitative) together with the results of consultations with stakeholders (consumers, providers, workforce, funders and regulators). Analyses and findings were tested with a range of parties and a set of evidence-based recommendations have been finalised and included in the report.

Accordingly, the body of evidence that has been drawn on is extensive, as indicated in the preceding sections. Throughout the report the limitations of the various sources of data are made known. By way of illustration, the following are four examples relating to different sources of data:

Demographic data (chapter 4)

> *'The ABS has defined the purpose of an SA2 as being to represent a community which interacts together socially and economically. However, given the size of many SA2 regions, SA2 data is of limited value in understanding the direct hinterlands of MPS. Accordingly, this analysis should only be treated as providing contextual information for the more relevant MPS case study site data. The SA2 results are not generalizable to MPS sites across Australia.'*

Activity Reports (Chapter 8)

> *'Data from the Activity Reports submitted by each MPS were used to analyse the level of activity in MPS. The data on home care places contained a large number of missing items, so was not considered valid for further analysis. Further, Activity Reports on MPS do not cover health service delivery. However, occupancy rates can be estimated for residential care places. The limitation to this analysis is that it is comparing the number of aged care residents with the number of Commonwealth funded residential aged care places, not the number of places allocated by MPS to meet their intake of aged care residents. As such, the results must be treated with caution and are indicative of trends only.'*

Survey of MPS (chapter 3)

> *'The [89] MPS which responded to the survey, were on average, similar to the total population of MPS in funding, size, remoteness and occupancy (no statistically significant difference). However, there were differences between the MPS who responded to the survey and the total population of MPS based on state location, with MPS Western Australia and Queensland less likely to provide responses, while MPS in New South Wales and South Australia more likely to provide responses.'*

The Report also records instances where the data was of such a limited and poor quality that highly relevant econometric benchmarking techniques (DEA and SFA) could not be employed. By way of example:

> *'While the necessary data should be available to the Commonwealth through the annual financial and activity reports, it was not possible to employ these approaches with the data in its currently available form:*

- *the data on aged care service provision only relates to the input of the Commonwealth's contribution to the pooled funds*
- *the data on input funding by the States for their health funding that is contributed to the pooled funds is not clear*
- *the many outputs across health and aged care delivery in each MPS are unknown to the Commonwealth and to the review, and the resources allocated to each of these outputs is equally unknown.*

Accordingly, technical efficiency could not be validly estimated using these econometric benchmarking techniques. Therefore, the review is unable to calculate the efficiency of the delivery of the respective health and aged care outputs, nor the efficiency of MPS overall.'

4 The drivers of demand and supply

As a prelude to the ensuing policy analyses, this chapter examines the various drivers of demand and supply in the delivery of aged care services in rural and remote communities. To ensure sufficient depth of understanding, it draws heavily on integrating both quantitative and qualitative data relating to the case study sites and the regions within which each of the MPS are located as well as the survey data. Demographic profiles were not undertaken for all MPS-related regions as, by itself, this data is of limited value as explained below. In contrast, and within the limits of the budget available for the research, the survey of MPS and the 14 sites visited provide important MPS-relevant data. In particular, the selection of the sites and associated collection of qualitative data was based on carefully designed sampling and estimated data saturation points (approximately 60 interviews / focus groups across all visits), as described in chapter 3.

4.1 Demographic drivers of demand

A demographic analysis of the regions where case study MPS sites are located was undertaken to provide contextual understanding for the data obtained during the site visits. It was based on 2016 Census data from the Australian Bureau of Statistics (ABS), using site location data mapped to the Australian Standard Geographical Classification Scheme. Each MPS site was mapped to the Statistical Area Level 2 (SA2) in which the service is located.

The ABS has defined the purpose of an SA2 as being to represent a community which interacts together socially and economically. However, given the size of many SA2 regions, SA2 data is of limited value in understanding the direct hinterlands of MPS. Accordingly, this analysis should only be treated as providing contextual information for the more relevant MPS case study site data. The SA2 results are not generalizable to MPS sites across Australia.

For instance, the ABS 2016 Census populations for three towns with MPS, and the relevant SA2 populations, are as follows:

- Coolamon and Ganmain 2,798, Wagga Wagga Region SA2 14,819
- Barraba 1,410, Tamworth Region SA2 18,472
- Childers 1,584, Bundaberg Region South SA2 9,837

The population of SA2s which most closely reflect direct catchments of MPS are less than 7,000 and generally around 3,000 – 5,000.

Table 20 reports a range of demographic characteristics for the regions containing case study MPS as well as the averages for both rural and metropolitan Australia. Based on Census 2016 data these regions were on average more aged than rural Australia generally, with one in five residents aged 65 and over, compared to 16.9% for average rural Australia. Moreover, 2% were aged 85 and over.

Demand for aged and health care services in these regions is likely growing, with an average 3.5% growth in the population aged 65 and over. There was little change in the proportion of residents aged 85 and over although this may change as the cohort currently aged 65+ grows older. Generally, around half the population aged 65 and over were female across these regions, however several had distinctly lower proportions of women over 65 – Childers (45.2%), Clermont (42.1%), Mallee Track (46.7%) and Exmouth (40.2%).

A distinct socioeconomic characteristic of these regions was the high proportion of residents aged 25 and over who had not completed Year 12 high school (32.1%). This proportion reached as high as 40% in Barcaldine – Blackall, Waikerie and Mildura Region SA2s, and compares to a benchmark of

30.4% in rural Australia (and 21.3% in metropolitan areas). The low level of educational attainment may present additional challenges in navigating the complex systems of access for aged and health care services.

Despite the lower educational levels, lower levels of functional need were observed in these regions, compared to rural Australia. Around 14.4% of older residents reported needing assistance with daily core activities (compared to 16.7% and 19.3% in rural and metropolitan Australia, respectively), while 35.4% lived alone (compared to around 38% more broadly).

These regions had fewer Aboriginal and/or Torres Strait Islander residents, or residents who spoke a language other than English at home. On average, 5.1% of residents reported an Aboriginal and/or Torres Strait Islander background, although almost one in five residents in the Nyngan-Warren SA2 in NSW had an Aboriginal and/or Torres Strait Islander background. Similarly, 3.4% of residents spoke a language other than English, compared to 9.3% and 23.5% in rural and metropolitan areas.

Data from the 2011 and 2016 Censuses indicated wide variation in population growth/decline in these regions, ranging from a decline of 12% in Barcaldine – Blackall SA2 to an increase of 9.7% in Exmouth SA2(average of 2.4% growth). This compares to virtually no growth overall in rural Australia (0.4%), and growth of 9% in metropolitan areas. The data is reported in Table 19. While there was significant variation in the demographic profile of these regions, key drivers of demand are likely to be resident populations ageing faster, and with a lower socioeconomic profile, than rural Australia overall.

Based on the qualitative data there is no uniform perception of the demographic criteria for an MPS across different States, and any criteria applied are likely to be influenced by State policy. During the review's site visits, some MPS in one State were ceasing to operate as MPS in response to demographic changes, with a perception at regional level that declining populations no longer justified the expense of maintaining hospital and residential aged care services. In other localities, case study MPS argued strongly for the continuation of their local MPS as their ageing populations not only increased the demand for residential aged care but also increased the challenges for older partners and friends travelling across country roads to visit them.

Table 20: Census demographic profile of MPS sites visited by ABS Statistical Area Level 2, 2016

Service Name	SA2	SA2 Population	% aged 65 and over	% aged 85 and over	% female[1]	% did not complete Year 12[2]	% needs assistance[3]	% lives alone[4]	% ATSI status	% Non-English language at home
Nyngan MPS	Nyngan - Warren	4,971	21.0	2.4	51.3	36.2	15.1	41.8	18.6	2.5
Coolamon-Ganmain MPS	Wagga Wagga Region	14,819	17.1	1.8	48.6	29.6	12.9	33.1	3.9	2.2
Gundagai MPS	Tumut Region	4,715	22.1	2.4	51.0	33.2	11.7	38.3	3.7	4.9
Barraba MPS	Tamworth Region	18,472	20.7	2.1	49.6	31.3	15.1	35.6	8.1	1.5
Churches of Christ Care Barcoo Living MPS Blackall	Barcaldine - Blackall	4,765	19.7	1.8	49.1	39.5	15.5	41.3	6.1	1.8
Childers Multipurpose Health Service	Bundaberg Region - South	9,837	26.3	1.6	45.2	36.6	16.1	29.5	3.3	2.9
Clermont Multipurpose Health Service	Central Highlands - West	8,139	13.4	0.7	42.1	32.5	13.4	43.6	3.9	2.8
Kangaroo Island MPS	Kangaroo Island	4,702	23.3	2.5	50.5	31.1	13.4	31.9	1.6	3.8
Waikerie MPS	Waikerie	6,608	23.2	2.6	50.1	38.8	15.9	33.3	2.7	4.7
Alpine - Bright MPS	Bright - Mount Beauty	8,147	23.5	2.6	50.1	22.5	10.6	35.3	0.8	6.6
Alpine - Myrtleford MPS	Bright - Mount Beauty	8,147	23.5	2.6	50.1	22.5	10.6	35.3	0.8	6.6
Mallee Track - Ouyen MPS	Mildura Region	3,722	20.1	3.2	46.7	40.5	16.7	38.9	2.0	4.5
Exmouth MPS	Exmouth	4,326	12.9	0.7	40.2	23.5	13.7	39.9	7.5	6.3
Plantagenet MPS	Plantagenet	5,078	20.8	1.9	50.0	29.7	15.8	32.8	3.3	6.4
All sites	Total	98,307	20.4	2.0	48.4	32.1	14.4	35.4	5.1	3.4

Service Name	SA2	SA2 Population	% aged 65 and over	% aged 85 and over	% female[1]	% did not complete Year 12[2]	% needs assistance[3]	% lives alone[4]	% ATSI status	% Non-English language at home
Rural Australia	Total	2,461,919	16.9	1.8	50.0	30.4	16.7	38.4	11.0	9.3
Metropolitan Australia	Total	20,889,076	15.6	2.1	54.1	21.3	19.3	38.1	2.0	23.5

1. Population: Aged 65 and over
2. Population: Aged 25 and over; includes individuals whose highest educational attainment was Year 11 and below, or a vocational Certificate I or II.
3. Population: Aged 65 and over; includes individuals who reported needing assistance with core activities.
4. Population: Aged 65 and over; we have assumed that those not married or living in a de facto relationship are living alone.

4.2 Burdens of disease in rural Australia and case study sites

The health status of rural Australians is lower than the urban population after taking into account various health indicators. Rural Australians experience an approximately 20% increase in disease relative to those living in urban areas (National Rural Health Alliance, 2016). This is attributed to the prevalence of risk factors such as smoking, alcohol, low physical activity, and insufficient nutrition. Another contributing factor is the socioeconomic status of those living in rural and remote areas as well as their level of access to health services. The Australian Institute of Health & Welfare (2018) reports that those living in outer regional and remote areas are more likely to have long term health conditions such as arthritis, asthma, back problems, deafness, long-sightedness, diabetes, heart, stroke and vascular disease compared to those living in major cities.

As has been noted, the SA2 regions containing case study sites were on average more aged than rural Australia more generally. Demand for aged and health care services in MPS catchment areas is likely to grow over time, with a higher average growth in the population aged 65 and over compared to metropolitan Australia.

Table 21: Population ageing in MPS sites visited by ABS Statistical Area Level 2, 2011 to 2016

Service Name	SA2	Population	Aged 65 and over	Aged 85 and over
		% change	percentage point change	percentage point change
Nyngan MPS	Nyngan - Warren	-4.6	2.6	0.6
Coolamon-Ganmain MPS	Wagga Wagga Region	5.9	2.3	0.1
Gundagai MPS	Tumut Region	1.5	2.6	0.7
Barraba MPS	Tamworth Region	6.5	2.8	0.4
Churches of Christ Care Barcoo Living MPS Blackall	Barcaldine - Blackall	-12.0	4.2	0.6
Childers Multipurpose Health Service	Bundaberg Region - South	4.8	7.1	0.5
Clermont Multipurpose Health Service	Central Highlands - West	-8.5	2.6	0.0
Kangaroo Island MPS	Kangaroo Island	6.5	6.1	0.2
Waikerie MPS	Waikerie	4.4	4.2	0.3
Alpine - Bright MPS	Bright - Mount Beauty	5.4	2.8	0.3

Service Name	SA2	Population % change	Aged 65 and over percentage point change	Aged 85 and over percentage point change
Alpine - Myrtleford MPS	Bright - Mount Beauty	5.4	2.8	0.3
Mallee Track - Ouyen MPS	Mildura Region	-2.3	2.8	1.0
Exmouth MPS	Exmouth	9.7	0.8	0.2
Plantagenet MPS	Plantagenet	4.0	4.2	0.0
All sites	Total	2.4	3.5	0.4
Rural Australia	Total	0.4	2.8	0.3
Metropolitan Australia	Total	9.0	1.6	0.2

4.2.1 Dementia

Dementia is increasing across Australia as the population ages. Based on public data provided by Dementia Australia[3] the number of people with dementia is projected to increase to 589,807 by 2028 and 1,076,129 by 2058. Providing sufficient care for people with dementia in a rural and remote region is additionally challenging due to outdated infrastructure and difficulty in accessing appropriately trained health professionals.

Despite the prevalence of dementia in older people, most case study MPS did not have purpose-built facilities to support residents who exhibited high level behavioural and psychological symptoms of dementia. In most cases though, MPS were home to residents with dementia who did not require a specialist residential and staffing environment.

4.2.2 Frailty

Most case study MPS had noticed a significant increase in the frailty of new aged care residents compared to when the MPS Program first commenced. Most attributed this to the introduction of the aged care reforms, resulting in increased accessibility of community-based aged care and a greater focus on supporting people to remain at home for as long as possible. Some case study MPS (supported by regional health authorities and/or States) were actively working through MPS Allocations Rounds to change their allocation of low care places to high care places so that funding reflected the increased effort required to provide care for their typical residents. MPS generally reported that the average length of stay for residents was decreasing as frailty and care needs at entry increased.

[3] https://www.dementia.org.au/statistics

Most stakeholders in MPS case study sites stated they needed more aged care places, citing the need to reduce waiting lists and reduce the temporary relocation of people needing residential aged care to other towns. Jurisdictional stakeholders in one State suggested a regional allocation of MPS places that could then be moved to where there was identified need. On the other hand, in a small number of case study MPS, stakeholders believed there was a sufficient allocation of aged care places in their town and were worried that additional allocations to private providers might create an oversupply and competition.

4.3 Preference for ageing in the local community

A strong theme arising from focus groups with community members, residents and MPS staff in case study sites was the value of the MPS in enabling people to remain in their hometown. In some cases, people had moved back after a period away to regenerate old acquaintances and to age in a comfortable and familiar environment.

A significant proportion of residents had lived in the town their entire lives and could not imagine having to move away. In one MPS site, all the residents in the low care facility had known at least one other person in the facility before they moved in.

> *"…if they've got to go somewhere this is where they want to go because they're still in (town), they've still got their family around them, they've still got their friends around them, they can – if they can be put in a car they can be taken for a drive to see what's happening in the community, drive down the street and see the changes that have been made in the street and all these sort of things, you know, the school kids come up and sing to them and they might be their great grandchildren or something like that and they just, you know, it's – it means so much to them, it just means so much to them."* Community member

4.4 Community drivers of demand at MPS study sites

Stakeholders in case study sites where community aged care was also provided through the MPS noted the value of being able to stay at home for as long as possible due to community-based support. The local community organisations and councils at case study sites saw not only the health and social benefits of ageing in place in the town but also the economic benefits in establishing the MPS.

In relation to the latter, there were reports in some smaller towns that people were moving to town because of the MPS facility, either for employment or to take up residence. This included people who were attracted to lower house prices and a perceived safer environment. One community advised that the local council had made a strategic decision to become an 'aged care town' – an attractive destination for older people to live. Other stakeholders expressed the view that people moved to their town partly because of the MPS.

Generally speaking, MPS were significant employers in case study sites. In some smaller communities they were the largest employer in the community or in the district. In larger communities, they were amongst the largest employers. Their economic contribution to the town was recognised by community members and MPS staff and Boards.

For some communities, the creation of the MPS was an opportunity to integrate local separately established aged care services, particularly CHSP (former HACC) services and low care residential aged care services. Many of these services had been established originally by local government or community groups. The general view was that the integration of the services had been a positive change. In some communities, the separate governance structures remained although in one or two cases there were emerging viability issues for the separate services.

4.5 Drivers of supply

4.5.1 MPS Allocations Rounds

The Commonwealth Department of Health receives competitive applications through Flexible Aged Care Places (Multi-Purpose Services) Allocations Rounds[4] generally on an annual basis. Through these rounds, existing MPS facilities (with the support of their State and/or regional health authorities) can apply for additional flexible aged care places or change the level of care of an existing place from low care to high care. Through the same rounds, new services can apply to receive funding for new flexible aged care places.

If the proposed MPS aligns with the Multi-Purpose Services Program objectives (including improved access to a mix of health and aged services that meet community needs, improved cost-effectiveness and long-term viability of services, and improved quality of care for clients), and the State supports the proposal, the Commonwealth will grant approval in principle. Further steps required to establish the MPS involve community consultation, the commitment of infrastructure by the State or community (where existing infrastructure is insufficient), successful development of a Service Delivery Plan and an allocation of places in an MPS Allocations Round.

While the Program objectives relate to performance, they do not overly assist in establishing criteria for assessing whether a particular location would be suitable for an MPS or for the expansion or retention of an existing MPS. The specific criteria by which applications for MPS Allocations Rounds are assessed as set out in the Application Guide are based on the requirements specified in the Aged Care Act 1997 and associated Principles, specifically the Allocation Principles 2014 and the Subsidy Principles 2014.

Part of the assessment focuses on needs identified in ACAR heat map and reviews of other services in the area, including occupancy and ACFI data. In addition to reviewing service plans the Department accesses and analyses all available aged care data in its assessment of applications to establish whether there is a need in a particular location.

However, and notwithstanding the wider range of factors considered by the Department, the review considers the formal criteria focus heavily on the performance of the applicant provider, the availability of suitable premises and the timeliness of commencement. The only region-specific criterion is "whether, if the application is approved, the allocation will increase diversity of choice for current and future care recipients, their carers, and families, having regard to the different kinds of services offered in the region".

[4] For more information, please check https://agedcare.health.gov.au/programs/flexible-care/how-places-are-allocated-to-a-multi-purpose-service

The review had expected a more developed set of community and regional criteria along the lines of the critical success factors identified in earlier reviews (see earlier section 2.3 for more detail). These are summarised below:

- Service planning based on population health planning principles and local health needs
- Strong local relationships and engagement with local communities in planning and health decision-making, delivery and evaluation
- Strong local governance, management and leadership
- Commitment to continued funding of a range of basic acute, aged care, community care and community health services under the single service entity
- Accountability mechanisms

4.5.2 Community activism

Most case study MPS stakeholders were able to recall elements of community activism in the decision to establish an MPS in their town or in renovating existing facilities and adding additional places. The key areas of activism were:

- Direct bequests or large donations from local residents for buildings or infrastructure
- Fund raising for specific purchases or improvements
- Direct lobbying of politicians

As a corollary to this, people living in 'safe seats' noted it was harder for them to successfully lobby politicians for capital investment. Poorer communities or those with a lower level of community altruism were less likely to have benefited from bequests or donations.

> *"But there's not many philanthropists around (town)."* Community member

> *"…if the community hadn't got behind it and decided it was a really good idea and so forth, we'd still be sitting with nothing."* Community member

4.5.3 State level planning

Decisions regarding which communities will apply for an MPS are heavily influenced by the position that the States have taken regarding MPS. Demographic data might indicate communities where an MPS would be desirable and appropriate, but application to the Commonwealth requires support from the State and/or (in some cases) its regional health authorities.

4.5.4 Challenges of supply

MPS facilities face challenges in relation to both workforce and infrastructure funding. Workforce issues are covered extensively in chapter 6. Access to funds for physical infrastructure was an ongoing issue in many case study MPS visited in this review and was brought up during meetings with stakeholders. Many of the MPS need to update their facilities to address increasing frailty levels and also provide care for residents with dementia. Capital and infrastructure funding are examined in chapter 8.

A further potential challenge is where the model does not adapt to the cultural needs of some members of the local community. In three communities there is a co-existence (and in one at least, an integrated delivery) of both MPS and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP), but this may not be the appropriate solution in other communities. The MPS Program attracts a higher proportion of Aboriginal and Torres Strait Islander aged care recipients than mainstream aged care but the issue of improving access for Aboriginal and Torres Strait Islander people to culturally appropriate health and aged care remains an ongoing priority across these service delivery modalities.

4.6 Other aged care services in rural and remote areas

4.6.1 Other residential aged care services

The internal review undertaken by the Department in 2016/17 reported there were 42 locations where MPS and private residential aged care providers were both operating.

In case study visits, the smaller MPS were more likely to report the existence of another residential aged care provider in the community. Those with 20 and lower aged care places were frequently in a collaborative, often co-located, relationship with a longstanding community-owned facility, usually a low care provider in an older hostel type facility. In these cases, the MPS was generally providing complementary higher level care, even when the other facility was providing some degree of high level aged care. This is also in line with the review data analysis. As shown in Figure 2 below, very small MPS that have low inpatient activity (more than 200 admissions per year) have the highest number of collocations with another aged care service (25 MPS out of total 43 in this category).

MPS in category 3 and 4 (those with more than 20 funded aged care places) are less likely to have a second residential aged care provider in the town. Based on case study visits if there was such a provider, it might be a private provider, and not a community-owned provider. In these cases, there was more of a competitive relationship.

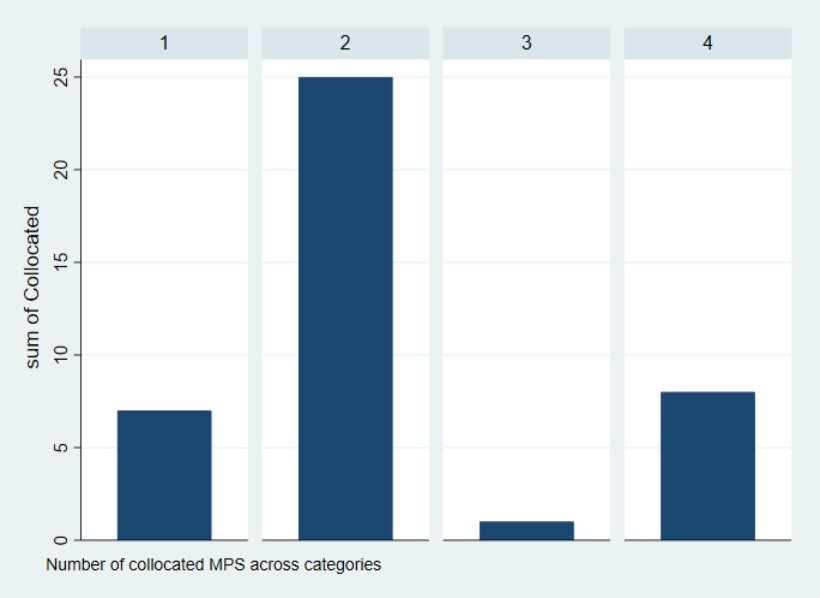

Figure 2: Number of MPS that are collocated with another residential aged care facility across categories.
Note: Category 1 refers to very small aged care-very low admissions to hospital, category 2 refers to very small aged care- low admissions to hospital, category 3 refers to small aged care- very low admissions to hospital, and category 4 refers to small aged care and low admissions to hospital.

4.6.2 Other community aged care services

Of the MPS responding to the online survey (n=89), 16 reported no other aged care services delivered by other providers in their community. Where other community aged care services were reported, 57 were Home Care Package (HCP) providers, 23 respite care and 33 the Commonwealth Home Support Program (CHSP) (refer Table 22).

One issue repeatedly discussed in case study visits to small or isolated communities was the misalignment between the community-based aged care providers that were advertised on My Aged Care as servicing that town, and the actual provision of care by those providers to eligible and approved individuals in the town. It is not possible from the survey results to determine if the HCP providers reported were in fact providing services locally in response to individuals' needs.

Table 22: External providers of aged care services in the community, % n

	%	n
Home care packages	64%	57
Commonwealth Home Support Program	37%	33
Residential aged care	24%	21
Respite care	26%	23
MPS sole provider	18%	16

A few of the MPS facilities indicated that one or more of the following services were available in their community, in addition to the above: Palliative Home Care, Department of Veterans' Affairs (DVA) services, domestic assistance, independent living units, National Disability Insurance Scheme (NDIS) services, RSL care, Transitional Care Program (TCP), and Veterans Home Care.

5 MPS Program objectives: are they being met and are there any unintended consequences

5.1 Defining the objectives

Chapter 2 defines an MPS as set out in the Aged Care Act and Subsidy Principles. In terms of the Program's objectives, the MPS Agreements between the Commonwealth and the States identifies the following, for small rural and remote communities:

- improved access to a mix of health and aged care services that meet community needs;
- more innovative, flexible and integrated service delivery;
- flexible use of funding and/or resource infrastructure within integrated service planning;
- improved quality of care for clients; and
- improved cost-effectiveness and long term viability of Multi-Purpose Services.

The Application Guide for the MPS Allocations Rounds makes a similar statement on the role of MPS Program and states the objectives of the allocation process in the following terms:

> "*The MPS Program is a joint initiative of the Australian and state and territory governments, and provides integrated health and aged care services for small rural and remote communities. MPS have an important role in small rural communities and allow services to exist in regions that could not viably support a stand-alone hospital or aged care home.*
>
> *New MPS are not established in locations where there is an existing Residential Aged Care Facility.*
>
> *The broad objectives of the allocations process are to identify community needs, including people with special needs, and to allocate places in a way that best meets the identified aged care needs of the community*."

5.2 Implementation of the MPS Program by the States

The Commonwealth and the States have agreed to standardised Terms and Conditions under the MPS Agreement. There is, however, a degree of variation on how the individual States have implemented the Program and how they govern their respective MPS.

On the one hand, this has an impact on MPS responsiveness to the key objectives of the Program, including on workforce, consumer fees and charges available to the MPS, and State Government funding. On the other hand, as is the case with a number of other jointly shared responsibilities across the Federation, this diversity enables:

- States to incorporate these services into their pre-existing governance, administrative and funding arrangements
- States to undertake innovative practices which may also lead to beneficial change at a national level

- States and the Commonwealth to demonstrate ways in which they can cooperate for the common good.

Some of the major differences between the States, as identified in the analysis of quantitative data and qualitative data from sites visits and survey, are discussed below to illustrate the range of variation.

5.2.1 State and regional administration and accountability

The Agreements signed by the States are either bipartite or tripartite agreements. The latter provide direct accountability at the regional health network level as well as at the State level. In addition, even in the case of bipartite agreements, where regional networks exist, most States devolve responsibility for the operation of MPS to that lower level.

This 'regional' level varies from a single regional entity that covers all country areas in a State (the WA Country Health Service and, until 30 June 2019, the Country Health SA Local Health Network – since replaced by six regional LHNs) to multiple regional entities within a State (e.g. NSW Local Health Districts, Queensland Hospital and Health Services and Tasmanian Health Service Regions).

Victoria does not have regionally governed networks, with MPS generally comprising several sites within a single region. In this context, for example, Alpine Health operates MPS in three towns as part of the overall Alpine Health organisation, with the MPS in these three towns being considered by the Commonwealth for the purposes of the MPS Program as separate services managed by the one provider.

5.2.2 Impact of different governance arrangements

Based on case study site visits, MPS had a level of accountability to their community through local committee structures. However, the extent to which this governed their daily operations and service planning varied with their degree of local autonomy. In Victoria, for example, some MPS have responsibility for a range of local services beyond the scope of health and aged care in response to local needs and under the auspice of local Boards of Management.

5.2.3 Workforce

As MPS are, in most cases, an integrated health and aged care service, they are required to be staffed in a manner that allows safe and high-quality care across all elements of their operations, including emergency, inpatient and community healthcare. In Victoria, nursing ratios for MPS are determined by State policy, which is generally based on a typical 'hospital' environment. Workforce issues are described in more detail in Chapter 6.

5.2.4 Consumer fees and charges

Each State has determined a set of fees and charges for MPS that are embedded in policy and practice and these are not consistent across the nation as is evident from Table 27 in chapter 7. As an example, MPS aged care residents and home care clients are not required to pay the same sets of fees and charges mandated for consumers of mainstream aged care services.

5.2.5 Government funding

MPS operational funding arrangements are outlined elsewhere. On case study visits, the extent to which managers were aware of the proportion of their Commonwealth and State contributions to the funding pool varied considerably. The opacity in relation to how States determine their contributions to the pooled funding or how that pool is spent derives from their individual systems of internal budgeting and performance accountability and the limited financial and activity reporting to the Commonwealth.

MPS are not eligible to apply for Commonwealth capital funds for new or renovated infrastructure, as this is considered a State responsibility under the MPS Program. The review found that NSW and Queensland have made significant investments in capital works for MPS.

Several other States are more of the view that the provision of residential aged care infrastructure in MPS should be a Commonwealth matter. On site visits the review team found situations where services were grappling with providing safe and high quality contemporary residential aged care in ageing hostel style infrastructure and/or unsuitable hospital buildings. Local philanthropy has played a significant role in some communities.

5.3 Variations in services delivered by the MPS in different States

The services delivered in MPS varies across States and between MPS. In part this may be in response to local community needs and in other instances it may reflect issues of financial sustainability and/or State policy. The analyses in this section provide an important insight into whether the Program's objectives are being achieved.

Under the Aged Care Subsidy Principles 2014 Act (section 104), the one mandatory service for meeting the requirements of being a multi-purpose service is that it provides residential care, as well as at least one aged care or health service. However, the review has identified instances of limited adherence to either the regulatory requirement or the intent of flexible and integrated health and aged care delivery. For instance, one MPS does not offer residential care and two other MPS recorded nil residential occupancy for their MPS in their 2017-18 Activity Reports.

In at least two other cases, the MPS delivers only aged care – which is centred on residential care but may include a form of home and community care listed in Section 104 (b). One of the sites has a long-term arrangement where the local community hospital and health services are managed separately.

5.3.1 State level variations

Almost all MPS in the States provide acute and emergency care. Victoria has MPS that are more likely to deliver the Commonwealth Home Support Programme (CHSP), while South Australian MPS are less likely to deliver community health care (reflecting the separate management of that program prior to 1 July 2019), transition care or short-term restorative care. Western Australia and Queensland have a lower number of Commonwealth funded high care places per MPS and a higher number of home care places. While this information is available at a high level, it does not allow a comparison of service activity with the needs of the local community as set out in the Service Delivery Plans. Such an analysis could be undertaken as part of a joint State/Commonwealth review of the MPS Program.

5.3.2 Variations in services delivered across MPS

The following analysis of the current services available under the MPS Program is based on a combination of qualitative data gathered in case study visits and quantitative data received on all MPS from the Commonwealth Government and publicly available at My Hospital. Challenges in undertaking this type of analysis for MPS included a lack of access to comprehensive data, particularly access to reliable data from the States on detailed MPS expenditure overall and on health care activity (inpatient, outpatient and community-based). In particular, in the absence of detailed aged care resident usage data, the following analysis has sourced data on funded (not 'occupied') places from official Activity Reports.

As would be expected from a program designed to support health and aged care in small rural and remote communities, most MPS are small services relative to mainstream aged care and to district level hospitals and above. Flexibility in the use of MPS beds/places is a cornerstone of the MPS Program.

The following analysis of MPS sizes and services divides the MPS into four categories based on the mix of the number of funded aged care places and hospital admissions[5]. Two groups relate to aged care places and two are based on health care admissions.

Aged care places

MPS can be divided into two groups based on the number of funded aged care places: very small aged care, and small aged care. The very small aged care category refers to MPS services with 20 or less funded aged care places. There are 114 MPS sites in this group (about 64% of MPS facilities). The small aged care category refers to MPS with more than 20 funded aged care places. The remaining 65 MPS are in this category, with places ranging from 21 to around 60 places (with 6 MPS around that higher level).

Health care

Almost all MPS provide some level of health and hospital care, with inpatient beds ranging from two upwards, and hospital services ranging from sub-acute care through to procedures and obstetrics. The hospital inpatient component of the MPS is relatively small compared to those in regional and urban Australia. The MPS also usually provides emergency department and community health services.

Therefore, the MPS facilities are also divided into two groups in line with the definition from AIHW (2015): the hospitals that had more than 200 admission per year[6] are assigned to small hospital group[7] and hospitals with lower than 200 annual admission are assigned to very small hospital group. 79 of MPS facilities that data was obtained for[8] fall into the very small hospital category versus 86 MPS that are in the small hospital group which had admissions ranging from 200 to 1,500 with one outlier having around 2,500 admissions per year. About 11 MPS have more than 1000 admissions in a year.[9]

[5] Admissions can include same-day or overnight stays
[6] According to admission data for 2016-2017 downloaded from https://www.myhospitals.gov.au/ Note: this site does not report community health activity data.
[7] AIHW (2015) calls this group Public acute group D hospitals.
[8] We were able to obtain admission data from the https://www.myhospitals.gov.au/ for 165 of MPS facilities.
[9] Source: MyHospitals.gov.au

These two cross categories are used to divide the MPS into four main groups as depicted in Figure 2:

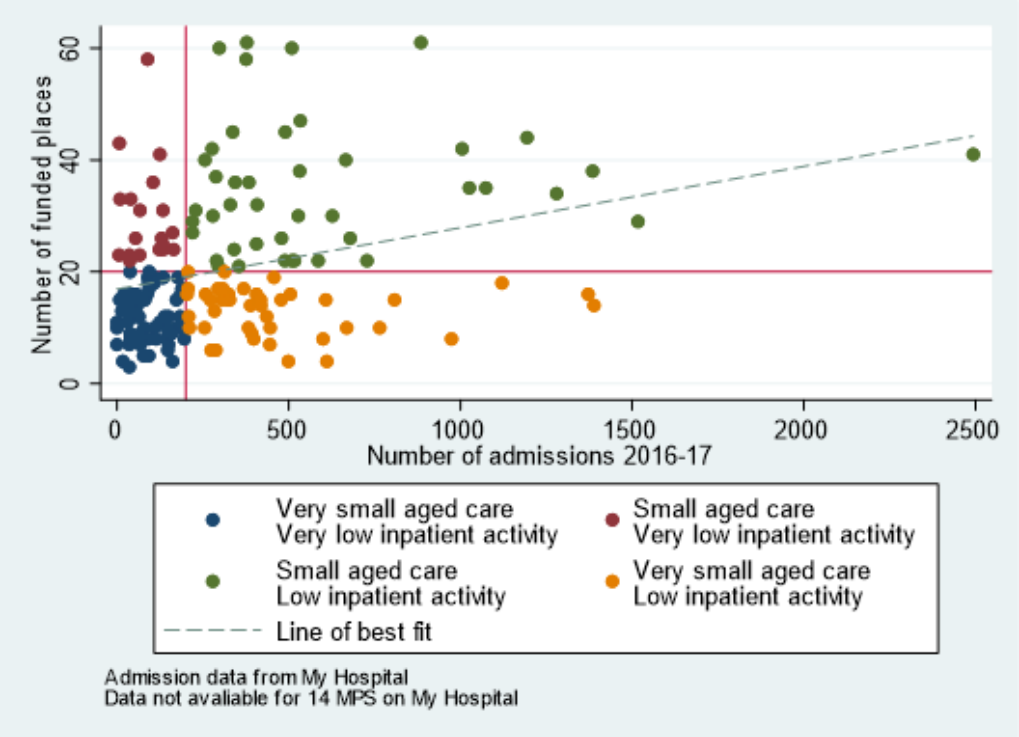

Figure 3: The number of funded aged care places versus the number of inpatient admissions for MPS facilities across Australia

1. Very small aged care-very low admission hospital

There are 60 MPS in this category (coloured blue in Figure 3). These MPS with 20 or less aged care funded places and very small hospital services are particularly vulnerable to variations in funding and rely on the flexibly applied to pooled funding from both Commonwealth and the States to remain viable. These MPS have a relatively high emphasis on high care funded places and about 64% of the funded places in this category are allocated to high care. (Figure 4)

2. Very small aged care- low admission hospitals

There are 43 MPS in this category where the number of funded aged care places are 20 or less but the hospitals have more than 200 admissions per year (low but significant inpatient activity). This category of MPS has the highest percentage of high care funded places at about 83 % of the total.

3. Small aged care- very low admission hospitals

There are 19 MPS that fall into this category (colour red in Figure 3). This group has the lowest percentage (55%) of high care funded places relative to the other categories. This group has more than 20 funded aged care places with very low inpatient activity (less than 200 admissions per year).

4. Small aged care- low admission hospitals

There are 43 MPS that have more than 20 aged care places combined with low but significant inpatient activity. This group has the highest percentage of low care funded places relative to other categories.

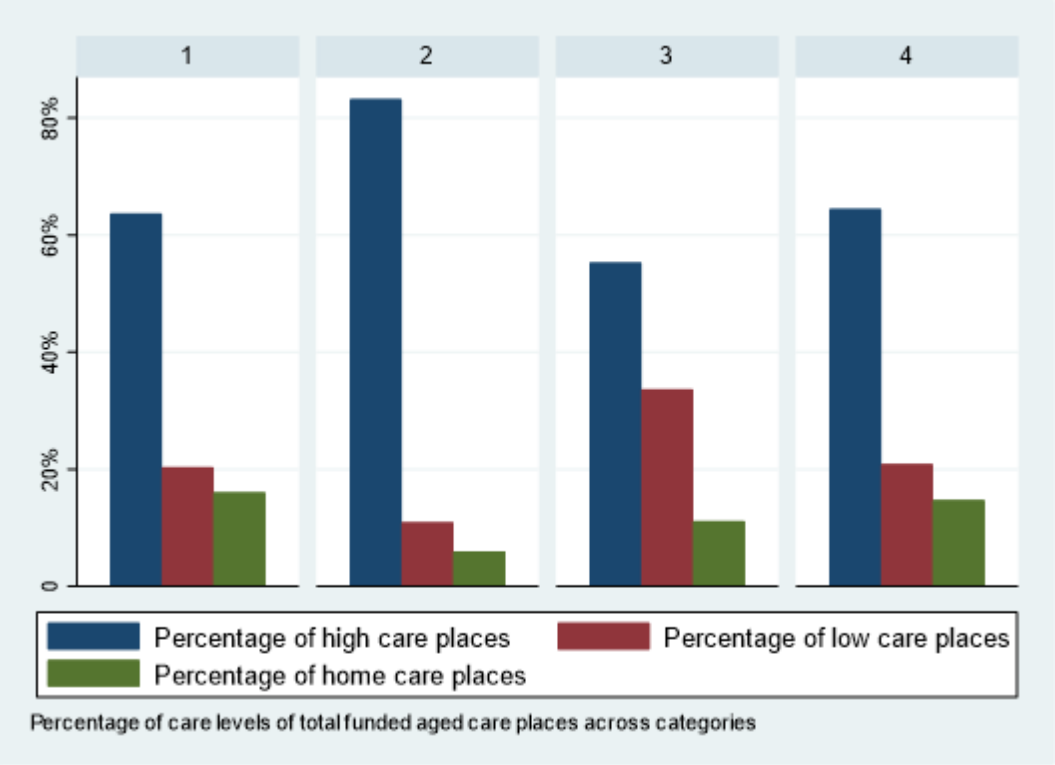

Figure 4: Care levels across MPS categories

Note: Category 1 refers to very small aged care-very low admissions to hospital, category 2 refers to very small aged care- low admissions to hospital, category 3 refers to small aged care- very low admissions to hospital, and category 4 refers to small aged care and low admissions to hospital. Vertical axis refers to percentage of the funded places.

Community health and home-based aged care

Caring for the elderly is core business for health services (within their delivery of health care) and most MPS survey[10] respondents provide some level of locally managed community health services (especially community nursing) supplemented by visiting services. The majority of the case study MPS provided aged care services to older people living in the community, through their community nursing services, flexible home aged care places, HCP, or through CHSP.

[10] For a full overview of the survey please refer to chapter 3.

In the MPS survey, managers of MPS were asked the number of older people they supported to live in their own home using MPS funding, and other non-MPS sources of funding they received to deliver community aged care services. (Table 23)

Table 23: Number of older people supported in their own home with MPS funding

	%	n
None	66%	59
1 to 10 people	22%	20
11 to 20 people	5%	5
21 to 30 people	1%	1
31 to 40 people	1%	1
Over 40 people	3%	3

Around two-thirds (n=59) of survey respondents reported that they did not support older people to live in their own home using MPS funding. Of the remaining respondents, around a quarter (n=25) supported between one and 20 people at home with MPS funding, while five MPS reported they used their funding to support more than 20. The wide range in responses may reflect differences in how the respondents interpreted the survey question. Some may have counted all elderly people supported by MPS funding, including community health nurses, while others may have included only those receiving specific aged care services (e.g. personal care or domestic assistance). The survey did not ask MPS to identify whether they were drawing on funds that would have otherwise been directed to residential care (it is a pooled funding model) nor whether the older people also had a separately funded HCP.

While there may be a number of CHSP and HCP providers advertised on the My Aged Care website as providing services to these communities, a number of case study MPS in smaller, more isolated communities reported difficulties for their elderly population accessing CHSP and HCP packages unless the MPS was providing this service itself (either as a HCP/CHSP provider or from its flexible care places) or the town was located close to a larger centre. A small number (four) of case study sites provided HCPs themselves, while managers at two reported they were exploring the option of their MPS becoming an HCP provider. In the absence of stable HCP providers in MPS communities, most delivered community nursing, personal care and domestic assistance through the flexible use of community health services, MPS aged care places, and/or CHSP.

5.4 Transparency and accountability within a pooled fund: the MPS reporting requirements

While flexibility is the cornerstone of the MPS Program's success, it does present challenges for assessing the effectiveness and efficiency of the Commonwealth's contribution, and for making an overall assessment on whether the MPS Program objectives are being met. In part, this tension can be reduced through sound standards of transparency and accountability.

The MPS Agreement requires the Service Providers (which are mostly the Stares or one of their agencies) to provide the Commonwealth and the State (if requested) with the following reports, in a format agreed by the Commonwealth and the State:

> *Annual Statements of Financial Compliance and Income and Expenditure*
>
> An annual statement of financial compliance and income (including Other Income) and expenditure, including a completed declaration, to provide details of the income and expenditure managed by the Multi-Purpose Service over each financial year of the funding period.
>
> *Annual Activity Report*
>
> An annual activity report to detail the activities of the services provided by the Multi-Purpose Service over each financial year and report progress of the activities specified in the Service Delivery Plan. The MPS Agreement provides for the Commonwealth and its authorised representatives to have access to records or materials for purposes associated with the Agreement or any review of a Service Provider's performance under the Agreement.

However, as set out in more detail later, the current Activity Reports do not comply with the underlying intention of the MPS Agreement reporting arrangements. Analyses undertaken on policy issues for this Report were limited by the inadequacy of the information. For instance, the data on aged care service provision only relates to the input of the Commonwealth's contribution to the pooled funds. The data on home care places contained a large number of missing items, the reporting on complaints and their resolution was minimal and there was little reporting on the achievement of a homelike environment. The reports are not providing detailed information on progress on each of the activities specified in the Service Delivery Plan.

The many outputs across health and aged care delivery in each MPS are unknown to the Commonwealth, and the resources allocated to each of these outputs is equally unknown, resulting in a major shortcoming in assessing whether the MPS objectives are being achieved in terms of the effectiveness and efficiency of those MPS.

5.5 Prior reports on the MPS Program

Several reports have attempted the development of performance criteria that would be most appropriate for an MPS model of care.

The 2009 Report of the National Health and Hospitals Reform Commission (27 July 2009) supported the MPS model, noting that flexible funding arrangements and locally designed and flexible models of care are required in remote and small rural communities to enable the configuration of health service delivery which achieves the best outcomes for the local population. The Commission recommended the expansion of the multi-purpose service model to towns with catchment populations of approximately 12,000.

In 2009 a joint Australian College of Health Service Executives (ACHSE) and Australian Healthcare and Hospitals Association (AHHA) National Multi-purpose Services working group published an Issues Paper which supported the recommendation of the National Health and Hospitals Reform Commission to

expand the MPS Program nationally, as a delivery strategy for integrated health and services (AHHA/ACHSE 2009).

The report drew attention to the diversity of MPS in terms of their range of services, and the structural, funding and legal mechanisms that have been established to secure those services in accordance with community expectations. The working group concluded that the MPS demonstrated innovation in service design and delivery and that this was attributable to the ability to pool funds, design and deliver flexible services, and forge strong local relationships. However, as a consequence, this diversity had led to inconsistencies across the MPS Program nationally in key areas of service planning, governance and accountability, funding and accreditation. The findings of the report raise an important policy issue: how to achieve the benefits of flexibility, innovation, improved health and aged care, together with opportunities for broader learning, while maintaining consistency, to the extent necessary, in such areas as governance and accountability.

The AHHA/ACHSE Issues Paper proposed a national evaluation of the Program and identified a set of critical success factors (p.3):

- 'service planning based on population health planning principles taking into account local health needs as defined by local communities including Indigenous people
- strong local relationships and, in particular, structures and processes for engaging local communities in planning and health decision-making (governance), health services (delivery and management) and evaluation (governance)
- strong local governance, management and leadership – in effect creating a strong local health service entity with which the community can identify and therefore the establishment of single health service entities protected by legislation with corporate and health governance responsibilities
- commitment from the Commonwealth, States and territories to continued funding a range of basic acute, aged care, community care and community health services under the single entity
- accountability mechanisms that include prescribed and streamlined reporting of financial, service and quality outcomes as well as accreditation'

Additionally, the Issues Paper noted that MPS are not immune to the health workforce shortages experienced across Australia, that they face particular challenges around recruitment and retention and flexible use of staff across roles and that any evaluation should look at innovative staff employment and development practices for wider adoption across the Program.

A 2016 review of the MPS Program by NSW Health (Sheehan, J. 2016), building on early guidance from the Australian Health Ministers Advisory Council National Rural Health Policy Sub-Committee, identified a broadly similar set of characteristics of rural communities and service delivery which would best support the implementation of the MPS model. They included:

- 'insufficient catchment populations to sustain separate acute hospital, residential care, community health and home care services (generally around 1,000 to 4,000 persons)
- inability to access the mix of health and aged care services appropriate to the needs due to isolation

- complementary, rather than competing, services
- service catchments which reflect a common sense of community
- consumer and community involvement in, and commitment to, the MPS model
- Support for the MPS from existing services, including local health professionals such as GPs;
- capacity to achieve financial viability under MPS funding arrangements
- willingness and capacity to participate in the change management processes essential to gaining the most benefit from the flexibility of the model
- no adverse impact on services in nearby towns'

In 2016 ACFA produced a report*: Financial Issues Affecting Rural and Remote Aged Care Providers*. The report concluded that providers operating in rural and remote areas generally have higher cost pressures and lower financial results. Expenditure pressures included: the costs of engaging and retaining staff; travel; freight; access to allied health professionals; limited internet coverage in some areas and limited catchment areas resulting in smaller scale facilities/services. This was a provider focussed study, but it did include MPS providers.

As noted in Chapter 1, there was an internal review undertaken by the Department in 2016-2017 which confirmed the importance of the MPS Program for delivering aged care services in regional, rural and remote Australia, but noted the necessity to re-align it with contemporary aged care policy.

The Legislated Review of Aged Care 2017, as part of its remit, undertook an assessment of equity of access to aged care, including the challenges facing consumers and providers of aged care services in rural and remote areas relating in particular to geographical isolation. Those challenges were seen to include the operation of small services that may be remote from professional assistance and support, have limited internet availability and incur higher infrastructure and supply costs. As also noted in Chapter 1, that review was part of the genesis of this report.

5.6 Stakeholder views on the Program objectives

The MPS Program objectives establish the criteria for assessing the appropriateness, effectiveness, efficiency and equity of the current MPS operations. The review, in conducting its analysis, questioned whether the objectives remain as relevant now as when the Program first commenced over two decades ago. This issue was also discussed at the workshop of stakeholders which took place on 5 July 2019 in Sydney.

The core objectives would appear to focus on an overarching vision of having

> *Commonwealth/State collaboration to enable the delivery of* ***innovative, flexible and integrated*** *health and aged care services that meet the communities' needs, supported by local level planning and the flexible use of funding and resource infrastructure.*

At the workshop it was considered that the remaining objectives may be better re-stated as more concrete goals rather than be prefaced by 'improved' and could be reformulated along the following lines:

- access to appropriate health and aged care services that meet community needs, with regular reporting of outcomes-based measures of performance, including the consumer, resident and carer experience
- delivery of a quality of care for clients that, as a minimum, fully meets the Aged Care Standards
- recruitment, development and retention of a flexible and agile workforce that meets all relevant professional standards
- effective and efficient service delivery that supports the long-term viability of MPS

It is recognised that reconsideration of MPS objectives would best be undertaken as part of a joint Commonwealth and State review of the Program as a whole.

5.7 Meeting the Program's objectives: a summary

The longevity of the Program (now 26 years) and its ongoing operation in 180 regional, rural and remote communities is testimony to its relevance to local communities.

5.7.1 The benefits

Discussions with community members during the review's site visits reinforced the importance of being able to be cared for in a local hospital and being able to remain in the community in their old age – either at home or in the aged care home. These facilities are integral to the histories of the towns. Generations have been cared for, have volunteered for, and have worked there. The MPS are an embodiment of local social (as well as physical) capital.

Most MPS stakeholders were able to recall the community activism that led to the decision to establish an MPS in their town or to upgrade the existing facilities. This included direct bequests or large donations from local residents for buildings or infrastructure, fund raising for specific improvements and direct lobbying of politicians. Individual States have implemented the MPS Program and govern their respective MPS in different ways according to their own policies and operational frameworks. Several States have invested significantly in their MPS and see it as an essential element of their strategy in delivering health and aged care to their smaller communities.

Flexibility is fundamental to the MPS model –in the use of health and aged care places to deliver integrated care within the facility and in the associated delivery of care to help people remain at home. MPS are expected to develop flexible services in response to identified community needs. The MPS workforce is multi-skilled to deliver emergency, acute care, community nursing and aged care and there were many examples of staff who developed rewarding career paths at their facility.

The ability of nursing staff to work flexibly across health and aged care was perceived to increase efficiency and quality of care and enabled aged care residents in many MPS to be 'admitted' for treatment for acute conditions and palliation while remaining in their own room. Overall, the case studies and the survey found that most MPS residents also had good access to medical care the viability of those MPS with only poor access to medical practitioners was under threat.

Economies of scope were only available in co-located facilities. It has also meant that in many MPS there is limited capacity to employ care staff with the time and appropriate skills to attend to residents' daily living and social needs, or to provide adequate diversional activities.

Most MPS use their funds flexibly to deliver services to older people living in their own homes through community nursing. Community nursing plays a central role in integrating health and aged care services, identifying and meeting the needs of older people living in their own home, and in easing the transition from home to residential aged care. Some also deliver personal care and domestic assistance. Bed flexibility was highly valued by MPS managers for providing rehabilitation and respite to help older people in the community age in place. However, hospital accommodation was often unsuitable for prolonged stays.

5.7.2 Barriers to achieving the objectives

One of the greatest barriers to the delivery of the benefits of the MPS Program is the ambivalence of some States towards its implementation. The Department has advised of a lack of applications received in MPS allocations rounds for the last four years. There may be many other communities which could benefit from the MPS model (or some variant of it) and enable their elderly to remain at home or at a local aged care home and receive flexible and integrated care.

A second significant barrier for some communities in accessing the Program is the requirement that the State and/or community provide the aged care infrastructure. The Commonwealth's Applicant Guide sets out assessment criteria for responding to applications for new or expanding MPS which include whether the premises used (or to be used) is suitably planned and located for the provision of aged care and whether the places will be made operational in a timely manner. A related issue is the limitation on delivering integrated care to aged care residents where they are not co-located with the health facilities and the health workforce is not able to be deployed across both areas of need.

Third, a focus on reporting against Commonwealth inputs for high and low residential care places and home care places may be reducing flexibility in care delivery in some MPS. This can occur by potentially shaping how the manager conceptualises and is held accountable for the delivery of services against specific funding inputs rather that against all health and aged care outputs from the pooled funding.

A further potential barrier is where the MPS does not adequately meet the cultural needs of some members of the local community. In three communities there is a co-existence (and in one at least, an integrated delivery) of both MPS and National Aboriginal and Torres Strait Islander Flexible Aged Care Program (NATSIFACP), but this may not be the appropriate solution in other communities. The MPS Program attracts a higher proportion of Aboriginal and Torres Strait Islander aged care recipients than mainstream aged care services, but the issue of improving access to culturally appropriate health and aged care remains an ongoing priority across these service delivery modalities.

Most MPS case study services provided residential care for people with dementia. However, most also noted that they did not have dementia-specific facilities and were not able to retain residents who displayed severe psychological and behavioural symptoms of dementia. This represents a significant barrier to enabling older people to remain resident in their own community and is likely to be an increasing issue in the light of the growing incidence of dementia. The majority of MPS reported that their aged care residents did not have timely access to allied health professionals.

5.7.3 In conclusion

The Report concludes that the delivery of aged care services through the MPS is a sound model. Within the limits of the terms of reference and information provided to this study, MPS are seen to flexibly meet the locally identified health and aged care needs of individual regional, rural and remote communities through the integrated delivery of State and Commonwealth services by a single provider, a cohesive workforce and a single undifferentiated pooled fund.

5.8 Findings

The Commonwealth should consider approaching the States to jointly undertake the following:

- Develop a standing working group of Commonwealth and State officials, with a view to establishing collaborative governance of the MPS Program.
- Review the overarching vision for the MPS Program, taking note of stakeholder feedback contained in this report.
- Identify constraints on the greater deployment of MPS by the States and seeking opportunities for mutual resolution of those constraints.
- In the context of evolving models of delivery of health and aged care in rural and remote areas, reviewing the definition of an MPS under Section 104 of the Subsidy Principles.

The Commonwealth should consider initiating action to:

- Require Service Providers to comply with the underlying intention of the MPS Agreement reporting arrangements, including, in a format agreed with the Commonwealth:
    - reporting on all service provider activity and all revenue and expenditure from the pooled funding
    - reporting on progress of the activities specified in the Service Delivery Plan
    - reporting on matters referred to elsewhere in this report such as more complete reporting on complaints and the achievement of a homelike environment.

6 The MPS Program objectives: are they being met through a flexible workforce delivering integrated care?

This chapter examines the evidence for whether the Multi-Purpose Services Program is achieving its key objective of providing more innovative, flexible and integrated service delivery for small rural and remote communities. Drawing on observations and qualitative data from the MPS case studies and the survey of MPS managers, this chapter explores the enablers and barriers to the flexibility of, and integration between, health and aged care services which is needed to achieve accessible, sustainable and quality services.

6.1 MPS Workforce

The success of the MPS Program hinges, in large part, on overcoming the significant ongoing challenges of recruitment and retention of a health workforce for rural and remote Australia. The efficiency and quality of MPS services depends on the ability of that workforce to work flexibly across health and aged care settings.

6.1.1 Nursing and care workforce

The nursing and care workforce is central to the delivery of the MPS services and comprises registered nurses (RNs), enrolled nurses (ENs), and care staff such as assistants in nursing (AINs) or personal care assistants (PCAs). Recruiting and retaining the right number and mix of staff needed to provide safe and quality care in a facility that may contain an emergency department, hospital ward, community nursing, home-based aged care and residential aged care is a significant challenge for local managers and State health departments. Furthermore, staffing budgets must incorporate state-based industrial agreements or legislation that may require a minimum number of professional nurses (RNs and/or ENs) to be on duty (i.e. separate from care staff).

The extent to which minimum nurse staffing standards apply to health services of the size and scope of an MPS varies between States[11] (see Table 24).

Table 24:Minimum nurse staffing standards applicable to MPS in States

State	Commentary on minimum nurse staffing standards
NSW	The industrial agreement sets minimum nurse staffing numbers for small hospitals based on the type of ED in the facility.
Victoria	Legislated nurse-to-patient ratios that apply to MPS. Legislated ratios for professional nurses based on the number of high-care and low-care *funded places* (rather than actual residents).

[11] The Victorian government has a useful resource comparing minimum nurse staffing standards for each state: https://www.parliament.vic.gov.au/publications/research-papers/download/36-research-papers/13887-safe-patient-care-nurse-to-patient-and-midwife-to-patient-ratios-amendment-bill-2018

State	Commentary on minimum nurse staffing standards
Queensland	Small hospitals such as MPS are excluded from nurse-to-patient ratio standards
South Australia	Industrial agreements that set various levels of nursing hours per patient day according to the type of patient or ward (based on patient acuity and complexity), and these may apply to health services in some MPS. *Care* hours per resident day apply to MPS residential aged care. Hours worked by unregulated care staff can be included to meet those standards
Western Australia	Industrial agreements set various levels of nursing hours per patient day according to the type of patient or ward (based on patient acuity and complexity), and these may apply to health services in some MPS.
Tasmania	Industrial agreements that set various levels of nursing hours per patient day according to the type of patient or ward (based on patient acuity and complexity), and these may apply to health services in some MPS.

These various standards produce a very different staffing cost base between States. Managers in States with high RN staffing requirements noted their inability to recruit sufficient permanent RNs to meet those standards. This meant they relied on expensive agency staff, which increased budget pressure.

One consequence of professional nurse staffing in health facilities is that MPS have a much richer nursing skill mix (i.e. a higher proportion of care provided by professional nurses) than other residential aged care facilities. The survey asked for the MPS nursing staff budget in full-time equivalent (FTE), for RNs, ENs and care staff. The mean average total FTE for the 79 MPS that completed this question was 16.8 nurses, comprising an average of 7.6 RNs, 4.4 ENs and 4.8 care staff. Represented as skill mix, professional nurses account for 75% of FTE (RNs=46%, ENs=29%) while care staff account for 25% of FTE. In contrast, the Commonwealth's most recent survey of the aged care workforce found that professional nurses comprise 24% of FTE in residential aged care (RNs=15%, ENs=9%) while care staff account for 71% of FTE (Mavromaras, K. et al 2017, p.13)[12].

Table 25: Mean nursing budget – FTE and skill mix

	FTE	Skill Mix
Registered Nurses	7.6	46%
Enrolled Nurses	4.4	29%
Care Staff (AIN, PCA or similar)	4.8	25%
Total	16.8	100%

Missing n=10

[12] Note this survey included allied health and nurse practitioners in their calculation of skill mix which accounts for the remaining 5% of FTE.

Not only did RNs account for the highest proportion of MPS nurse staffing budgets, but they were also reported to be the most challenging occupational group to recruit and retain. As Table 26 shows, 76% (n=68) of survey respondents reported that RNs were difficult to recruit. The survey also found that 61% (n=30) reported they had vacancies for RNs, with 9 MPS reporting they have more than 2 FTE vacant RN positions.

Table 26: Number of MPS with recruitment and retention difficulties, % (n)

	Difficult to **recruit**	Difficult to **retain**
Registered Nurses	76% (68)	36% (32)
Enrolled Nurses	40% (36)	12% (11)
Care Staff (AIN, PCA or similar)	25% (22)	11% (10)

The professional and personal barriers to RN recruitment cited by MPS managers and nurses in the case studies are common to health services across rural and remote Australia (Francis and Mills 2011). Professionally, there were concerns about access to training and ongoing professional development, and the generalist nature of rural health practice whereas RNs' career advancement is increasingly linked to specialisation in acute care environments. Managers also reported that some RNs worried about losing their clinical skills when residential aged care comprised the majority of the facility's activity, and that younger nurses' career ambitions were more likely to be in acute areas such as emergency and critical care. Misunderstandings about the complex nature of nursing work in aged care, and the undervaluing of this work both within and beyond the nursing profession is a barrier to RN recruitment and retention across the aged care sector (Chenoweth et al. 2014). However, some nurses in the case studies regarded the challenges of caring for older people in a residential setting as an opportunity to develop their skills:

> *"I actually find aged care more challenging than any other area that I've worked in because it is so complex. It's not a quick fix. Aged care is not a quick fix. …Whereas, in emergency and ICU you can fix problems, whereas in aged care it's just far more complex and far more challenging."* Registered Nurse

Personal barriers to RN recruitment included employment opportunities for partners, the quality of education for children, as well as the availability and standard of accommodation in the local community. Some MPS provided staff accommodation by repurposing existing buildings or constructing new buildings. However, these were intended for temporary nursing and medical staff, rather than a housing solution for permanent staff. Some MPS had recruited overseas-trained RNs with varying success in terms of long-term retention.

The recruitment and retention of ENs and care staff was reported as less problematic than for RNs (Table 26), though this may be partly attributed to the lower number of ENs and care staff within the MPS staffing profile. Some of the managers interviewed reported they could recruit to these positions relatively easily, while other face significant challenges in the local labour market. For care staff in particular, the MPS could not compete with the higher wages offered by supermarkets and other retailers for less demanding work.

While MPS faced significant challenges in recruiting nursing and care staff, managers and nurses reported that once recruited, many did come to embrace the rural lifestyle and the MPS work environment. This perception is reflected in the lower proportion of survey respondents reporting that staff were difficult *retain* compared to difficult to recruit (Table 26). There were also several examples in the case study sites of 'grow your own' approaches to recruitment and development. Staff recruited locally had successfully transitioned from entry level positions (cleaner, personal care assistant) through to EN, and from EN to RN, facilitated by partnerships with local vocational and higher education institutions with a specific focus on rural workforce needs.

6.1.2 Nursing staff flexibility and training across health and aged care

In addition to recruiting and retaining the right number and mix of nursing and care staff, a key challenge for MPS is ensuring that the workforce is able to work flexibly across health and aged care. Despite the poor perceptions of rural and aged care nursing practice noted above, nursing staff and managers commented on the high level of skills and experience needed for the diversity in MPS patients and residents. Effective MPS nurses had extended scopes of practice to deliver emergency care (often in the absence of a medical practitioner), the knowledge and skills needed for the long-term care of older people, and the ability to switch between different work environments.

> *"…to be able to go from a triage two chest pain in the ED to managing a fall of a resident while also monitoring a couple of sick people… Their skills are pretty impressive"* MPS Manager

Managers and staff perceived that efficiency and quality of care were improved when nursing and care staff could work flexibly across the health and aged care areas of the MPS. Where health and aged care beds were co-located (i.e. in separate areas of the same building), there was one roster for RNs, ENs and care staff. In larger facilities, staff were assigned to either the health or aged care area for a shift but moved between areas according to demand and to cover breaks. In smaller MPS, staff worked across both areas for the whole shift.

> *"…so our average occupancy in our acute ward sits between 2 and 3 occupied bed days per month, up to 5 in winter. We have minimum staffing for the acute, but if there is no one in the acute ward then the expectation is that the nurses go down and help with the 22 residents."* MPS Manager

Participants considered this ability to allocate staff according to demand allowed the efficient use of limited staff resources and improved the quality of clinical care for aged care residents who benefited from the richer skill mix associated with hospital nurse staffing. However, these benefits only accrued when staffing standards could be applied flexibly. Moreover, facilities where residential aged care beds were located offsite (i.e. on a different campus to the hospital, often in legacy hostels) could not benefit from staff flexibility. Managers of those services noted that their cost base was higher, despite their skill mix for aged care being lower (i.e. provided by more care staff) since they had to duplicate, rather than share, staff and supervisors (Malone and Anderson 2014). Managers and staff were also concerned about the staffing levels and the skill mix in these former hostels since the acuity and complexity of

residents had substantially increased in recent years. The manager of an MPS which had moved its aged care function from an off-site hostel to a purpose-built co-located facility explains:

> *"… now we are co-located, it's broken down a lot of challenges where we had people working offsite; the governance over what they were doing there was difficult, because even although it was only a kilometre up the road, it might as well have been 10 kilometres when it comes to keeping an eye on staff."* MPS Manager

The flexible use of staff across health and aged care in co-located facilities was viewed positively by managers and staff, but there were challenges. Some raised concerns about maintaining an adequate staffing presence in the aged care area when the ED and inpatient areas were busy (Malone and Anderson 2014). Even with normal levels of patient activity, nurses commented it was difficult to 'shift gears' between the more familiar intensive hospital environment with its focus on timely task completion, to the home-like environment of residential aged care. For example, that it was not only acceptable, but desirable, to take time providing care for aged care residents, or to 'sit on the bed and have a chat'. In MPS that employed care staff to focus on aged care residents, managers commented that those workers were able to spend time with residents, to understand their needs and preferences, and to form strong relationships.

In addition to the time taken over care, MPS managers commented that, because professional nurses were mainly trained and experienced in the acute care environment, they were not well-prepared in knowledge, skills and approach to delivering aged care. This finding is in line with other research in MPS, and other rural aged care facilities (Malone and Anderson 2014; Henderson et al. 2016). Most States have instituted quality improvements that include ongoing education of MPS nurses such as by sponsoring staff to attend training, employing a nurse educator (shared between multiple facilities), mentoring programs for junior staff and hosting graduate nurse placements. One MPS mentioned the Aged Care Chanel as a source of education for staff. In one case study, care staff with a Certificate III in Health Care Assistance were supported to complete a Certificate III in Aged Care. However, most training interventions were focussed on maintaining nurses' clinical skills with only around half (52%, n=43) of survey respondents agreeing that *"Staff have access to training on the care of aged care residents in a home-like environment"*.

The survey found that 27% (n=21) of respondent MPS did not employ an activities worker or diversional therapies worker. Many MPS rely on volunteers and partnerships with local councils and others, but those services are also under funding pressure. It is therefore unsurprising that the majority (76%, n=65) of survey respondents felt the nursing skill mix in their MPS met the clinical needs of aged care residents while only 50% (n=42) reported they felt staff were able to meet residents' emotional and lifestyle needs. These findings are in line with one previous study of skill mix in residential aged care that found higher RN staffing was associated with better clinical outcomes (pressure ulcers, infections, complaints of pain and hospitalisation rates) but poorer outcomes in relation to continence and activities of daily living.

6.1.3 Medical workforce

The medical workforce is crucial for the operation and sustainability of the MPS Program, both in the provision of inpatient and emergency health care, and in aged care residents' ongoing and emergency medical care. Indirectly, MPS services can come under pressure when the community has insufficient access to local GP services. Overall, both the case studies and the survey found that most MPS aged care residents had good access to medical care: 85% (n=71) of survey respondents agreed with the statement that *"Our aged care residents have access to a medical practitioner to make timely decisions about their medical care".*

Managers described a variety of arrangements with doctors, with the majority referring to a contracting arrangement with local GPs to cover the MPS on a regular and on-call basis as a Visiting Medical Officer (VMO). Some MPS employed doctors directly but allowed them a right to private GP practice. Not every community had a full-time GP practice but most managers in the survey and the case studies reported that MPS residents could obtain an appointment for ongoing care relatively easily. Some GPs attended the MPS facility, but more mobile residents might attend the GP's practice (located in town, or on the MPS campus). Some GPs allotted time each week for a clinic dedicated to addressing MPS residents' medical needs. A small number of managers also described GPs involvement in multidisciplinary reviews of residents' ongoing care every three to six months.

In terms of responding to an emergency or a sudden deterioration a resident's condition, most MPS responding to the survey stated they could rely on the on-call VMO (usually the local GP). In facilities where health and aged care were co-located in the one building, managers and nurses described the flexible use of medical staff. When nurses raised a concern about a resident the doctor would include them the ward round. Interviews with managers suggest that these occasions of care could either be billed as GP care under Medicare or were subsumed under VMO hospital costs.

Overall residents' access to medical care was described in positive terms but there were a small number of MPS in the survey and case studies which described problems accessing to medical care. In these cases, GP care in the community was predominantly provided by locums or was so limited that the MPS could go for several weeks without access to a doctor. MPS were highly dependent on the cooperation of local GPs to provide services to both the health and aged care areas, including inpatient admissions. In a small number of cases, managers reported that local GPs would not to travel to the MPS to provide services to residents. MPS are not eligible for the recent Commonwealth initiative to enhance Medicare payments to cover travel costs for GPs visiting a residential aged care facility. When GPs would not visit the MPS, hospital medical officers employed by the State provided ongoing care for residents, including three-monthly reviews. Managers also noted that some local GPs did not want to be on-call or assume hospital admitting rights which meant that the MPS could not function as a health facility:

> *"When there's no doctor around then the ambulance has to go on by-pass…not having regular doctors who are prepared to emergency on-call means they can't really admit somebody to hospital… that patient has to go somewhere else."* MPS Manager

Even where there was good access to medical care, nearly all the managers in the case studies and survey said that continuity of care for aged care residents was a problem. Many MPS relied on locums

for hospital medical officer positions and/or the local GP practice. Despite the high costs of locums, the long-term failure to attract and retain permanent GPs willing to be on-call 24/7 meant many MPS managers sought stability within their cohort of locums as a means to improve continuity of care:

> *"I don't think stable GPs are out there willing to do what the GPs of 20 years ago did. It's a big commitment that you're asking people for and the whole landscape has changed. So we've been working really hard to on trying to get continuity of locums, we've got two signed up to the end of the year."* MPS Manager

Problems for MPS and their communities in recruiting and retaining a local medical workforce reflect the chronic national shortage of doctors in remote and rural Australia. Personal and professional barriers to recruitment and retention described by MPS managers and community members are consistent with those found by previous research: longer and more unsocial working hours in rural practice due to after-hours and on-call duties in facilities such as the MPS; problems of professional isolation including lack of peer support and development opportunities; burnout due to lack of locum coverage for leave; financial stress of managing a small practice; and the lack of education and employment opportunities for families (Buykx et al 2010). Despite numerous incentive strategies by governments over a number of years, the recruitment and retention of doctors in rural practice remains a significant challenge, and there is little robust evidence of which incentives actually work (Grobler et al 2015).

Just one manager said their MPS was involved in rural medicine education, hosting registrars of the Rural Generalist program[13]. Instead, strategies to attract and retain doctors described by MPS managers and community members centred on reducing the financial risks of rural practice by providing the buildings, and sometimes administrative support, needed to run a GP practice. In some communities the local council built and ran the practice, with an 'easy entry, easy exit' policy for taking up a room. In others the State government undertook this landlord function, especially where the practice was co-located with the MPS. There were also examples of the MPS, councils and Primary Health Networks working in partnership to provide infrastructure and other incentives to ensure local medical workforce coverage, though with limited success.

The recruitment and retention of doctors to work in rural practice remains a significant challenge for the sustainability of the MPS Program, and many health services had developed alternatives to a permanent medical workforce. In MPS where there was no doctor on-call, managers reported that the nurses could access telehealth over the phone and using video technology for ongoing and emergency care.

> *If we don't have a doctor for two days then we've got a remote medical consultation service where we can have a GP on the phone 24 hours a day. They can access to electronic medical record to read the notes… and they will able to prescribe when we get electronic prescribing [later this year]. We also have a critical care camera, so we have 24-hour access to an intensivist or cardiologist or a paediatrician, simply amazing…* MPS Manager

[13] Australian College of Rural and Remote medicine prepares rural GPs as Rural Generalists to deliver medical care across the lifespan and acuity spectrum, including the knowledge and skills needed for MPS health and aged care services https://www.acrrm.org.au

Telehealth was also increasingly used to allow aged care residents to access specialist medical care, including gerontology, without the disruption and discomfort of lengthy travel to a regional centre. Some MPS reported that one of the challenges in establishing telehealth services was convincing specialists that clinical consultations could be provided remotely, including routine follow-ups. Effective telehealth was also dependent on local infrastructure such as point of care testing, imaging and pathology, as well as appropriate video technology and nursing capacity to facilitate those consultations.

One of the specialist areas which did not lend itself to telehealth is the procedural aspect of dentistry. In line with the shortage of dental professionals in rural areas, the case studies suggest that MPS residents' access to dental care is highly variable. In some MPS, residents had access to mobile or visiting dental services funded by State health departments. In others MPS had entered a partnership agreement with local dentists in private practice so that residents could receive basic oral health services in the MPS, with more complex procedures provided in the dentists' clinic. In one MPS governance barriers were reported to prevent private practice dentists from providing basic oral care in a State health facility. In other MPS the limited range of dental services within the community, or a lack of co-operation with local dentists, meant access to oral health services was a significant problem for aged care residents

Just one MPS was actively recruiting a nurse practitioner (NP) to complement the limited medical workforce coverage. While managers perceived an NP would make valuable addition to the MPS workforce, few had the demand for, or could accommodate a full-time NP in their staffing budget. Any 'right to private practice' arrangement offered by the MPS would be of limited utility since a concession obtained by the Australian Medical Association means NPs in private practice must be in a 'collaborative arrangement' with a named medical practitioner in order to access the MBS and PBS. There are few GPs willing or able to enter such an agreement. Despite the potential for NPs to fill critical service gaps in both rural primary care and MPS, the development of NP practice in remote and rural areas in Australia has been very slow, when compared to health systems internationally (Schadewaldt et al 2016).

6.1.4 Allied health workforce

The allied health services relevant to aged care services MPS include physiotherapy, occupational therapy, dietetics, speech pathology, and podiatry, as well as the critical role of local pharmacists. Many MPS experienced challenges in accessing adequate allied health services for clients, patients and residents. Just 27% (n=23) of MPS survey respondents agreed with the statement that *"Our aged care residents have timely access to the allied health services they need".*

MPS managers described a variety of employment and contracting arrangements for accessing allied health services. In one State, where MPS had permanent allied health positions shared between local health facilities, access to services was reported to be good. In other States, MPS were serviced on an out-reach basis from a larger regional community health service, but those positions were often difficult to fill, limiting MPS access to those services. In one State, managers perceived that a policy to separate the management of community health services from the MPS resulted in poorer access to allied health services. Some MPS reported that they had a contracting arrangement with private providers in the local community, but again this relied on the presence of a stable, co-operative allied health practice in town. Regardless of the type of arrangement, there was a reported shortage of allied health professionals to meet patients' and residents' needs in remote and rural areas (Keane et al. 2013).

In common with nursing and medical staff, rural allied health professionals must have a broad range of knowledge and skills to treat a wide variety of conditions across the life course, in community health, inpatient and residential aged care settings. The Allied Health Rural Generalist pathway is a multi-jurisdictional strategy to ensure rural allied health professionals have these broad skills, and to increase access to allied health services for rural and remote populations[14]. The strategy includes: the implementation of telehealth for allied health; the use of allied health assistants; and extended scopes of practice including skill-sharing across disciplines (e.g. between physiotherapists and occupational therapists). In the case studies, the MPS in Queensland reported the highest level of engagement with this strategy for the allied health professionals and employed on-site allied health assistants to help rehabilitation patients and aged care residents continue their therapies under supervision.

> *"We find it is really beneficial to have an allied health assistant down in the aged care section, if there's a resident whose mobility has deteriorated, they'll actually see them daily for a week to ensure they are mobilising and doing what [the physios] have put in place safely."* MPS Manager

Finally, local pharmacists also play an important role in supporting MPS services. While access to pharmacy services was not raised as a problem in the case studies, current Commonwealth policy means MPS are excluded from accessing the National Residential Medication Chart (NRMC) [15] developed for the residential aged care sector. The NRMC enables the prescribing and supply of most medicines and streamlines PBS/RPBS claims by pharmacists where applicable. The NRMC aims to improve medication safety and to reduce the administrative burden of prescribers, aged care staff, and pharmacists by combining the medical 'prescription' and 'medication chart' functions. Residents' details, including their photograph and known adverse drug reactions, relevant pathology and medical practitioners' instructions are visible from each page of the NRMC to enable correct identification by pharmacists when supplying the medications, and to nursing staffing when administering the medication. This important quality, safety and efficiency initiative is not available to MPS because they do not have a Residential Aged Care Service ID.

6.2 Facility-based services for ageing in place

Allowing older Australians to age within their own community is central to the MPS model. Ageing in place was facilitated in co-located MPS facilities and enabled residents to receive acute care and palliation. However, many case study MPS struggled to meet the demand for dementia-specific care. MPS used their beds flexibly to support the community's need for respite care.

6.2.1 Acute care in MPS aged care

Managers and staff in co-located facilities reported that residents in need of acute care due to illness or injury were, as far as possible, treated for that condition in their own room, thus minimising the disruption and discomfort of bed transfers. The resident was administratively "admitted" to the hospital, and the treating doctor classification changed from a GP to a hospital medical officer, though

[14] https://sarrah.org.au/ahrgp
[15] https://www.safetyandquality.gov.au/our-work/medication-safety/national-residential-medication-chart

this was often the same person. If the resident required a more complex procedure, or more frequent vital signs or neurological observations they may be moved to an acute bed within the facility.

> *"So we can do all sorts of things in people's rooms, we can do IV antibiotics… but sometimes they have to bring them round to the ED for their own benefit. We just had a resident who had a fall, in fact it turns out he had a significant cardio-vascular event, so he spent four or five days in acute care then we put a really good plan to get him back in his own room…."* MPS Manager

> *"One of the things that I love about us being co-located is, aged care residents they get sick as well. In the past [when aged care was off-site] we had to package them up and send them to hospital, now we have the skill mix that we can treat them in their room. We don't need to send them to the ward to have IV antibiotics."* Registered Nurse

As the above comments highlight, MPS operating physically separate aged care facilities did not have the same access to the staffing or clinical infrastructure required to provide acute care in residents' rooms and would often have to phone an ambulance to transfer residents to the 'hospital' part of the MPS, even for a very short distance. One MPS overcame this problem by building an adjoining corridor between the hospital and the 'hostel' so that staff and beds could move freely within the 'one' building. In contrast, in another MPS where the on-site (but separate) aged care facility was community-owned, ambulance staff had to transfer residents less than 100 metres to receive acute care.

6.2.2 Palliative care

Another strength of co-located health and aged care facilities was the ability of nurses to provide advanced palliation in residents' own room, and (in most MPS) for the resident to have regular access to a doctor to manage this care. MPS also provided palliative care to patients in the acute beds due to limited access to community palliative care, or because the end of life phase followed an acute episode. During one case study visit a patient at the end of life, together with her partner, made a considerable effort to impress on the review team the importance of being able to die in her community.

Overall, managers and staff reported that access to specialist palliative care support had improved in recent years. However, some communities still lacked adequate access to GP and community nursing to support palliation in older people's own homes, or in off-site aged care facilities (MPS or mainstream).

6.2.3 Dementia care

The ability of the MPS to care for residents with behavioural and psychological symptoms of dementia (BPSD) which were impacting on their care, was limited due to inadequate infrastructure, staffing and staff training. 64% (n=54) of managers responding to the survey disagreed with the statement "*We have appropriate infrastructure to provide residential aged care for people living with dementia".* Most MPS managers reported their service did not offer places to those with more challenging behaviours and/or were prone to wandering. Those who had (or developed) those symptoms were placed in mainstream facilities with dementia care units, often a significant distance from their home community. Three of the case study MPS said they did care for residents with more significant dementia symptoms, but they also had to send residents to other facilities when their behaviours became more challenging, or there were too many such residents for the level of staffing.

Many managers felt they did not have the staffing numbers and training to provide appropriate care for residents with a level of BPSD which was impacting on their care. There was a widespread perception among the managers interviewed that such residents required a "secure facility" to assure their, and other residents', safety and this was too difficult to achieve in their MPS without significant infrastructure investment.

> *"It is not a secure facility here and with our staffing profiles and things like that, we are very reluctant to take wanderers. If someone has got dementia and they are bedridden or poor mobility, that's fine. But, if they are an active wanderer, we can't…"* MPS Manager

However, in line with current best practice in dementia care, another MPS manager noted that while safety was paramount, solutions should focus on staffing and training, especially with so many older people in residential aged care experiencing dementia symptoms.

> *"Our vision is that we do not have a locked dementia unit because the only people that get locked up in our society are those people that have done wrong. It should be staffed and open, we have residents that are in a secured dementia unit that are no more confused than the people that are sitting in the hostel or high care."* MPS Manager

Other managers noted that other aspects of the MPS physical environment were not suitable for residents with dementia, including providing quiet spaces for residents, other than their own room.

> *"The environment is really lacking for dementia, and we had Dementia Australia come and do an environmental report on us and told us exactly, from doorframes to toilet seats, what we needed, but then we don't have any money to do that."* MPS Manager

6.2.4 Bed flexibility for respite care

In line with the principle of pooled funding, MPS managers reported they used their health and aged care beds/places flexibly. Most MPS in the study were at full capacity in residential aged care, and younger patients with injuries and conditions that were stabilised locally were generally transferred to larger regional hospital. The flexibility usually involved using hospital beds to provide rehabilitation and/or respite to support ageing in place.

> *"I can't emphasis enough that the bed flexibility in managing this facility, it's so important"* MPS Manager

Managers and community staff commented that older people and their carers were encouraged to plan for respite in the MPS, but that respite was mainly provided in response to a crisis at home or following an admission for acute care. While managers referred to such unplanned episodes as "respite" they were often managed as a hospital admission (and therefore not charged daily living fees) until the maximum number of 'free' days was reached, and then switched to respite aged care.

> *"We do have that flexibility, for example we have people sitting in acute beds awaiting [residential aged care] placement, we can keep them for 6 months, 12 months as respite funding whereas if we weren't an MPS we would be restricted to the 63 days"* MPS Manager

Many also noted that older people could spend prolonged periods in a hospital bed awaiting higher level of support for the HCP, or home modifications to allow them to return to the community, or for

placement in residential aged care (in the MPS or elsewhere). However, some managers raised concerns that MPS hospital accommodation was not suitable for prolonged stays.

> *"…there are cases where community members may be in crisis and need residential care, and we don't have the vacancies. We can use our beds on the ward for care awaiting placement, which we do frequently. It just means that they sit there on a hospital ward and it's not always ideal."* MPS Manager

A further aspect of MPS managers' flexible approach to support ageing in place was when some older people had to be sent to a mainstream facility in another town due to lack of vacancies in the MPS, managers kept them on the waiting list and brought them back to the MPS when possible, if this was their preference.

> *"We do have people that get admitted and then are unable to go home and so they're awaiting placement. Now we work hard to make sure that they get into an environment that's more conducive for them other than the acute hospital so that might not be here but in [another town] with a view to get them back here as soon as we can. We do from time-to-time have people awaiting placement and we can't force them to take a bed somewhere else but it's not good for someone to be sitting in a hospital bed."* MPS Manager

6.3 Integrating health and aged care services in the community

The majority of MPS are involved in providing community health and aged care services to older people in the community. The case studies provided many examples of the MPS using their pooled funding flexibly to deliver integrated home-based services. MPS-based community nurses played a central role in identifying needs, integrating services, and in easing the transition between home-based and residential aged care. In many cases, the MPS was filling gaps in community aged care caused by limited access to external providers of HCP and CHSP.

6.3.1 Access to external providers

The survey asked managers which community aged care services were delivered by external providers in their area. Sixty-four per cent of the 89 respondents (n=57) reported that HCP were delivered in their community, while 37% (n=33) reported there was another provider of the CHSP. Sixteen managers reported that their MPS was the sole provider of aged care services, of any kind, in the community.

In the case studies, community members and staff in most sites complained of problems accessing community aged care services, especially HCP. National waiting times for the release of HCP was compounded by the problem of the thin market with limited economies of scale and long travel times for private providers. Community and staff members commented that, while My Aged Care listed several potential providers, none would actually travel to their community.

> *"So there might be two or three service providers that say, yes, we come into [this town], but it might not be the service I want. Or it might be the service says, no, they're not coming here at this point in time because we've got no other clients in [this town]. We're based in [regional centre] if we have to travel an hour each way to get there,*

that's going to come off the package, and, so it's not worthwhile." Community Nursing Manager

Consequently, the model of consumer-directed care, in relation to HCP Program service delivery, was not a reality in many MPS communities. Instability in private HCP and CHSP providers also created problems for the continuity of care, which was perceived to have been less problematic when providers, mainly public or religious organisations, were previously funded to service the local area and were based there. In the absence of stable external providers, the MPS filled the gap in community aged care services.

> *"Consistency, I think, is the big one because all rural towns, we have providers come in and they do a bit for a couple of months, then they get sick of travelling to the towns and then they drop off … they don't stick around, there's no getting them embedded into the community."* Social Worker

People lose eligibility to access supported transport once they become RAC or MPS residents. The MPS is not required to provide transport, although a small number reported raising funds to purchase a bus. The lack of public transport was raised by staff and community members in case study sites as a barrier to accessing health and aged care services, both those within the community and those located in larger regional centres. Some communities did not have a taxi, and council-operated bus services were severely curtailed (often attributed to CHSP funding cuts). Many noted that the community bus or car service relied entirely on volunteers and that there were fewer people in the community willing or able to contribute to the service. The lack of transport also impacted older peoples' ability to engage in social activities and visit family and friends who may have had to move to an aged care facility in another town.

6.3.2 Flexibility in MPS community aged care

MPS may deliver a variety of community health and aged care services including community nursing, personal care, domestic assistance, as well as Meals on Wheels. The survey found that, in addition to MPS funding, 42% of the services (n=37) received CHSP funding, while a fifth (n=20) delivered HCP, and 15 received funding from the TCP. However, 47% of the MPS surveyed (n=42) said they did not receive any additional funding to deliver community aged care. The survey did not ask MPS to identify whether they provided home-based services using funds that would have otherwise been directed to residential care (it is a pooled funding model) nor whether the recipients of MPS home-based aged care also had a separately funded HCP.

The survey did not seek information on community nursing services specifically, though based on the 2017-18 activity reports, 89% of MPS deliver "community care". The MPS in one larger community in Western Australia reported they planned to stop delivering services under the CHSP to allow another local provider to become more viable.

Most MPS in the case studies were the main, or only, community care provider in town and were filling gaps in services formerly provided by local councils whose CHSP funding had been frozen or cut. Four of the fourteen case study MPS delivered HCPs, two others reported that they were exploring the option of their MPS becoming an HCP provider.

6.3.3 Role of community nurses in service integration

Community, staff and residents from across the MPS spoke of the benefits of living in a small community for integrating community health and aged care services. While older people did not necessarily want to accept the services available, service providers (MPS, council and other aged care providers) and the broader community could easily identify those in need. Many contrasted this with larger towns and cities where, they perceived, there was greater potential for older people to 'fall through the cracks'.

MPS that provided community nursing services reported working closely with facility-based staff to ensure older peoples' needs in the community were identified and addressed and that care was escalated where required, including those who were at 'maximum services' and in need of respite or residential care. Community nurses also encouraged and supported older people to complete an ACAT assessment. In some cases, nursing staff worked across community and facility-based services which allowed them to build knowledge of, and relationships with, individuals in community.

> *"… one of the things we do well in the MPS is we are a community and we work well across the whole community… we share staff around. We support our clients in the community quite well through the process."* MPS Manager

Managers reported that formal communication channels (i.e. multi-disciplinary meetings) were complemented by informal communication, enabled by the co-location of the community and facility-based nurses and other professionals.

> *"We have a weekly case conference meeting, so [the community nurses] have come and said look, we're worried about Mrs Blogs, this has happened and if I say yes, "we're pretty much just about at max services there" we come back to this meeting. It's a multi-disciplinary meeting with all of our allied health team, doctors, ambulance, basically whoever we can get there and then we would talk about that as a group and come up with a plan… It might include beginning the process of a residential aged care application, then their families would also be involved …. Usually grandma or granddad, they're not too keen!"* Community Nursing Manager

Integrating community services was thus easier when community nurses providing health and aged care were based in the MPS facility. That said, managers in the small number of MPS with a well-established external provider delivering HCP and CHSP (often NGO or community-owned) reported they worked in a similar, cooperative manner to ensure individuals' health and aged care needs were met. Where there was no local provider and/or a lack of continuity in providers, such service integration could not be developed.

The central role played by community nurses was common across the case studies, except where the community nursing function has been removed from local MPS and centralised to regional centres. In those circumstances the MPS reported similar problems with access to community services as that experienced with private providers.

The integration of health and aged care services delivered by MPS was also reported to smooth the transition for older people moving from community-based to residential aged care. Older people in need

of residential aged care were usually known to MPS staff, likewise older people were familiar with the facility and its staff.

> *"Very rarely do we see someone come into the MPS that we haven't supported in the community"* MPS Manager

Where the older person in need of residential aged care was in an MPS hospital bed following an acute episode or for respite, and the MPS had a vacant aged care place, the transition could be very straight forward.

> *"From the client's point of view, it's seamless. They go into hospital, they go into the nursing home, they're seeing the same staff, the same process, the paperwork's being filled in while they're in the hospital to transition into the nursing home, so it's far easier for those people, and their families."* Community Nursing Manager

> *"…it's happened quite a few times with older isolated people that are just not quite well enough to go home, and once they've been here and they've stayed as a sub-acute patient they've said to me, 'It's not like I thought it would be and I think I'd like to stay.' "* MPS Manager

MPS communities with a retirement village or supported living facility in town commented that this offered a staged transition for older people living in their own home to residential aged care. One MPS that delivered the full range of community and residential aged care services with a community-owned retirement village in town reported they worked towards a smooth transition between each level of care.

> *"This service means they don't have to move out of the community where they've lived all their life. Once they can't manage their home, they go into the village, which gives them a level of care as well, that they don't have to worry about any of their maintenance to their home. They've got people keeping an eye on them. And once they can't manage there, the next step's in here and they get all the service they need."* MPS-based community aged care manager

6.4 Findings

The Commonwealth should consider approaching the States to jointly undertake the following:

- Examine the impact that state-based minimum nurse staffing standards have on limiting the budget capacity of MPS to employ appropriately trained care and diversional activities staff who are more skilled at meeting the daily living and social care needs of aged care residents.
- Review the funding of MPS for home based care for older persons, including the care delivered through community nursing, home care recognised in the funding of Home Care places by the Commonwealth and funding sourced from the Commonwealth Home Support Program, with a view to ensuring the delivery of flexible, high quality home care and home-based palliative care and to reducing avoidable residential aged care.

The Commonwealth should consider initiating action to:

- Remove barriers to MPS entitlement to Commonwealth programs which aim to improve the access to, and quality of, medical care for aged care residents. This includes the recent Commonwealth initiative to enhance Medicare payments to cover travel costs for GPs visiting a residential aged care facility as well as the National Residential Medication Chart program.

7 Broader aged care policy and regulatory changes: what are the impacts on the MPS Program context?

Since the inception of the MPS Program in 1993, there have been significant reforms in mainstream aged care. These include the introduction of the *Aged Care Act* 1997 and the more recent comprehensive reforms undertaken following the *Caring for Older Australians* Inquiry conducted by the Productivity Commission in 2011. Recommendations from that inquiry resulted in the introduction of new service delivery models through *Ageing in Place* and; L*iving Longer Living Better* (LLLB), which focus on consumer choice and control within a more market-based system. Subsequent reforms have included a range of initiatives such as *More Choices for a Longer Life* and the 2018-19 Commonwealth Budget's *Better Access to Care*. More recently, the Commonwealth has reformed the aged care quality and safety standards regime.

In addition, the Royal Commission into Aged Care Quality and Safety, as required under its Letters Patent, is inquiring into the future challenges and opportunities for delivering accessible, affordable and high-quality care services, including in remote, rural and regional areas. An interim report is required by 31 October 2019, and a final report by 30 April 2020.

There are challenges in aligning the MPS service delivery model as administered by the various States with mainstream aged care. Some of these challenges stem from the objectives of the MPS Program (the pooled funding and flexible delivery model), as well as the inescapable costs and limitations of delivering services in rural and remote Australian and their 'thin market' characteristics. In addition, MPS are excluded from several requirements that apply to mainstream aged care. These matters are addressed, where relevant, in the following sections of this chapter.

Against the backdrop of the current policy environment, a recent Departmental internal policy review identified a number of immediate issues. The following analysis draws on and extends the findings of that review. In relation to funding, the focus of this chapter is primarily on consumer contributions and payments. Details relating to the Commonwealth's funding of care and accommodation are explored in greater depth in the following chapter, which draws policy conclusions about whether the MPS program is an effective use of Commonwealth funds.

7.1 Aged care funding

The MPS Program funding model has not kept pace with reforms to aged care mainstream funding. The differences mainly relate to the MPS consumer contributions to care and the Commonwealth's contribution to the Pooled Funding for care, and funding of accommodation supplements.

Infrastructure costs – primarily the costs of accommodation –are met either by the States (or their local health agencies) and/or local councils or charitable organisations in the communities. There is a considerable level of local fundraising and other philanthropy directed to the MPS in most communities and this represents a voluntary contribution by many, together with the benefit of building social capital.

The major forms of funding of aged care are discussed as follows.

7.1.1 Consumer funding of basic daily services

From the evidence available, there is general comparability between MPS and mainstream residential care in the consumer payment of basic daily fees to contribute to the costs of food, cleaning, laundry, power and similar services. For mainstream residential care the maximum fee is 85% of the single basic aged pension, while for HCPs it is 17.5%, though this latter fee is not universally applied in either mainstream or MPS flexible home aged care places. Table 27 shows the average daily fees charged to residents and home care consumers in MPS across different States. The final column also notes whether a refundable accommodation deposit or former bond is charged. The data used to create this table is from the activity reports received by the Commonwealth Department of Health.

Table 27- Fees charged by MPS 2017-2018

State and Territory	Fees charged (for basic daily services)				RAD charged
	Flexible high care	Flexible low care	Flexible home care	Respite	
New South Wales	$56.29	Varies with 12.11/hr average		$47.87	No
Victoria	Varies with average of $54.60	Not reported		Varies with average of $52.02	Yes
South Australia	Varies with average of $50.83	varies		Varies with average of $50.16	Yes
Western Australia	$60.05 or 85%-87.5% of pension	$8 per hour to a weekly cap of $64		Not reported	No
Northern Territory	Not reported				No
Queensland	Varies with average of $51.69	Varies with average of $10		$50.16	Varies
Tasmania	$56.94 or 85% of pension	$5/$10 per visit up to $10/$20 per week if a pensioner/non-pensioner.		$56.94 or 85% of pension	Yes

7.1.2 Consumer contributions for care

Many residents in mainstream aged care homes are fully supported by the Australian Government for their costs of care, but some are required to pay an income and assets tested care fee in addition to the basic daily care fee (section 4.1.1). For home care clients, in addition to the basic daily fee there is an

income tested care contribution. There are also annual and lifetime caps that apply to these care contributions and once a cap has been reached, no further care fee is payable for the relevant period.

The research for this report did not identify any service in any State which applied an income tested care fee in its MPS. This aligns with the situation applying to fully supported aged care recipients receiving mainstream services. There is associated evidence of the lower income and asset levels of many residents in most rural and remote communities except where there is a stronger economic base such as mining, tourism or retirement living. However, there is a lack of equity between those in mainstream residential care who have higher incomes/assets and their MPS counterparts.

7.1.3 Government funding of care

Whereas providers of mainstream residential care are funded by the Commonwealth according to residents' ACFI classifications (which adjusts daily to the resident profile), people who receive care through an MPS do not receive an ACFI classification. Further, they do not need to be approved people as a precondition for the approved provider to receive a care subsidy from the Commonwealth (Chapter 4 of the aged care Subsidy Principles 2014). Instead it is sufficient for the provider to hold an allocated (high or low care) place for the provision of care, irrespective of whether a resident is occupying that place and irrespective of the care needs of any such resident.

In an MPS, there is also a loading for respite care. Allocations for respite care no longer exist in mainstream aged care. Services are free to deliver respite care as they choose.

As a consequence, the Commonwealth's contribution of care funding to an MPS provider is determined annually. It does not change according to whether the pooled funds are used for health or aged care services, or according to the level of aged care residential occupancy, or the number of home care services delivered by the MPS, or the daily adjusted cost of meeting the care needs of current residents in a MPS. The Commonwealth contribution to pooled funding is a foundation element of the efficient provision of flexible care in MPS.

7.1.4 Consumer contributions and Commonwealth subsidisation for accommodation

In mainstream aged care, the Commonwealth pays an accommodation supplement to providers for eligible residents assessed as low means, with a higher rate applying to new or recently refurbished accommodation and a lower rate if less than 40% of residents are fully supported. Fully supported residents make no accommodation payment and partially supported residents make an income and assets tested contribution which reduces the level of the Commonwealth's payment. Non-supported residents pay for their accommodation. Contributions and payments can be by way of a lump sum refundable accommodation deposit (RAD) or a daily accommodation payment (DAP) or a combination of the two.

For the MPS Program, while MPS do not receive an accommodation supplement from the Commonwealth, (residents are not means tested) they do receive the concessional resident equivalent amount (CREA), which was replaced in mainstream aged care by the accommodation supplement in 2008.

The costs of accommodation and other infrastructure are met by the majority of the States, their agencies and/or through funds raised by communities themselves. The Commonwealth makes no funding contribution for accommodation, not even for residents who would be classified as fully supported under mainstream aged care. This creates a misalignment between some residents in MPS in those States and their counterpart residents elsewhere in mainstream aged care homes, sometimes even within the same community. As Table 25 shows, however, MPS aged care residents in several States are required to make an accommodation contribution or pay for their accommodation.

7.2 Co-existence of services creating competitive environments

At the time of this research, non-MPS residential aged care facilities co-existed with MPS in 42 communities.

The lack of a uniform policy on MPS charging care contributions and accommodation contributions or payments for those with higher incomes/assets places non-MPS providers of aged care services who operate in the same region at a disadvantage in terms of needing to require their residents and clients to pay a higher overall charge. This can influence choices made by potential residents as to whether to apply for entry into an MPS or a mainstream aged care provider, as well as impact on the viability of mainstream providers and create waiting lists at MPS sites.

In some cases, there is a co-operative and synergistic relationship, particularly where the MPS provides acute aged care and the non-MPS provider operates a legacy hostel. However, because of differences in required fees and more immediate access to specialist services, MPS may be preferred – reducing the viability of the private services.

It is understood that the original model for MPS was not intended to result in co-existence with private providers, and the current MPS Allocations Rounds Application Guide still clearly states “New MPS are not established in locations where there is an existing Residential Aged Care Facility”. Accordingly, the current situation of extensive co-existence adds an additional degree of urgency to resolving the disparities between the two systems.

The introduction of the consumer directed care model and consumer fundholding for HCPs has the potential for an increasing number of providers to offer the delivery of home care services in the same regions where MPS deliver flexible (home care) places. While this can generate benefits of competition, this research has raised anecdotal evidence that some non-MPS providers who advertise services on MyAgedCare and other sites are based in larger regional centres and do not have staffing and support to adequately deliver services to the smaller outlying communities. This presents an opportunity for the Commonwealth and the States to explore a model for HCP which retains consumer choice but might allow community-supported selection of a ‘preferred provider’ through an open and revisited process. That provider may be able to develop sufficient economies of scale to ensure more efficient and effective service delivery to local residents.

7.3 Aged care needs assessments

In mainstream aged care, under the *Aged Care Act 1997*, an Aged Care Assessment Team (ACAT) assessment and approval is a requirement before older people can access any subsidised residential

aged care and HCPs. With the advent of My Aged Care, information regarding a client's assessment is accessible to registered providers through an on-line portal. All MPS providers have access to My Aged Care and the provider portal. All MPS are set up on My Aged Care. It is up to each service to set their service as "available" in the service provider portal in order to receive referrals, however, this does not apply in all States.

There is no legislative requirement for an older person to obtain an ACAT approval prior to accessing any aged care service offered by an MPS. However, the review noted many instances of the MPS managers seeking an ACAT assessment and working closely with community nurses and other care organisations to prioritise access to aged care – particularly residential care – based on greatest need. Nonetheless there may not always be sufficient transparency in the prioritisation decision-making process, and the absence of an ACAT assessment could reduce that transparency.

7.4 Quality, accreditation and complaints reporting

The Aged Care Quality Standards in force for mainstream aged care providers from 1 July 2019 identify the following:

- residential care
- home care
- flexible care in the form of short-term restorative care

The department's web-site states that the Aged Care Quality Standards also apply to MPS that deliver residential care. This requirement has been communicated to all State and Territory governments and MPS providers, and is specified in the MPS Agreement that commenced on 1 July 2019.

For those MPS that deliver acute or sub-acute hospital and community health care, it is also mandatory for the service to be accredited to the National Safety and Quality Health Service (NSQHS) Standards. These standards currently address some, but not all, of the specific safety and quality issues for aged care.

MPS have been excluded from reporting requirements for Aged Care Quality Indicators, including use of restraints and other reportable events.

7.4.1 Aligning the two systems

The ACSQHC is currently developing an Aged Care Module, with a view to assessments commencing in January 2021. Under the MPS Agreement, an MPS accredited under the NSQHS Standards which also meets the requirements of the Aged Care Module will be considered to have met the requirements of the Aged Care Quality Standards.

MPS which are not accredited under the NSQHS Standards are now required under the MPS Agreement to obtain accreditation under the Aged Care Quality Standards. The Agreement also permits the ACSQHC to provide the Department with any reports created as a result of any assessment undertaken by the Commission in connection with the accreditation of a Multi-Purpose Service under the NSQHS Standards.

7.4.2 Complaints reporting

Standard 6 of the Aged Care Quality Standards requires an organisation to have a system to resolve complaints. The system must be accessible, confidential, prompt and fair. It should also support all consumers to make a complaint or give feedback. The Standard covers key elements of an effective complaints management system that:

- encourages consumers to give positive and negative feedback to their organisation about the care and services they receive
- responds to feedback and complaints consumers and others make formally and informally, written or orally to the organisation
- helps organisations keep improving, informs improvements to care and services and
- resolves issues for consumers and others

Organisations are expected to demonstrate open disclosure. This is in line with up-to-date practices of open communication and transparent processes. It includes acknowledging and apologising when the organisation has made mistakes.

Although MPS may not currently apply Standard 6, of the Aged Care Quality Standards, the States have advanced systems which capture and record all complaints and incidences. The Australian Commission on Safety and Quality in Health Care would review complaints processes and management as part of the NHQSHC Accreditation process.

A condition of the MPS Agreement is that MPS are required to manage complaints through the State government complaints process, which must be publicised. If the client is dissatisfied with the results following this process, the State government must refer the client to the Aged Care Complaints Commissioner for further investigation. The State government must publicise the existence of the Aged Care Complaints Commissioner to deal with aged care complaints and must assist in the investigation of any complaint made or referred to the Commissioner. The Aged Care Complaints Commissioner can receive complaints of abuse or neglect of an aged care resident. It also allows people to raise concerns about the quality of care or services being delivered to people receiving aged care services subsidised by the Commonwealth, including MPS.

Under the Aged Care Act 1997 – Section 63 1(AA) approved providers are required to report instances or allegations of reportable assaults to both the police and the department within 24 hours of the allegation being made, or from the time the approved provider starts to suspect, on reasonable grounds, that a reportable assault may have occurred. This requirement extends to MPS providers.

MPS Activity Reports received by the Commonwealth report on the numbers of complaints and numbers of matters resolved but do not provide detailed advice on action taken or on the outcomes of the complaints. The Department can access other complaints information.

7.4.3 Homelike environment

Establishing a home-like environment is integral to quality of life in a residential aged care facility. The concepts of choice, dignity, independence, respect and safety underpin the Aged Care Quality

Standards. It can be challenging for MPS to establish and maintain a homelike environment in a facility (often itself ageing) that may have started life as a hospital. It can be similarly challenging for an MPS operating a former low care hostel to bring it up to contemporary standards for residents with a higher level of frailty. Where the establishment of the MPS has involved a renovation or new build, the physical environment can be purpose built.

Similarly, the staffing mix of smaller MPS is primarily driven by community health, inpatient and emergency care and therefore dominated by registered and enrolled nurses. Chapter 5 sets out the challenges for nursing staff in changing their practice frameworks when moving from inpatient and emergency care to residential aged care.

Most States have undertaken some form of action to support MPS in creating a homelike environment. This includes independent assessments against the Aged Care Quality Standards (not for accreditation) and the implementation of quality improvement programs.

As an example of these initiatives, NSW has implemented a state-wide quality improvement program titled "Living Well in MPS"[16]. This was driven by a 2014 Australian Commission on Safety and Quality in Healthcare (ACSQHC) consultancy which identified the following gaps between the NSQSHC and the Aged Care Quality Standards:

- Provision of a Homelike Environment
- Role of the Person in their own care
- Cognitive Impairment
- Hydration and Nutrition
- Leisure activities and lifestyle.

The quality improvement program commenced with 25 selected MPS participating in a structured program, using the Institute for Health Care Improvement Collaborative model. It is now being rolled out across all MPS, led by the Agency for Clinical Innovation (ACI). There are comprehensive guidance materials and toolkits to support MPS to drive the changes locally. "Living Well in MPS" was cited by all NSW case study MPS as driving changes in culture and practice to increase the homelike environment within their facility (within the limitations of physical infrastructure). Living Well in MPS Principles of Care are designed to assist MPS to meet NSQHS V2, Standard 5 - Comprehensive Care, within an MPS.

Activity Reports are required to report progress of the activities specified in the Service Delivery Plan, and this can include progress on creating a homelike environment.

7.5 Availability of other rural and remote funding

The Commonwealth has a range of programs and payments to support the delivery of aged care in regional and remote communities. For instance, under the Flexible Care umbrella, the Government delivers the National Aboriginal and Torres Strait Island Flexible Aged Care Program. There are only limited instances where communities which receive funding under this program also have an MPS, such

[16] Accessed at: https://www.aci.health.nsw.gov.au/resources/rural-health/multipurpose-service-model-of-care-project/living-well-in-multipurpose-service

as at Gilgandra, Ceduna and Coober Pedy, and even then, there can be integration or collaboration in the town.

There are also infrastructure grants. The Rural, Regional and Other Special Needs Building Fund facilitates equitable access to residential aged care where access is impeded by geographic location, inadequate supply of residential care, or lack of access to sufficient non-grant funding by the approved aged care provider. This program is not available to MPS. In the 2018-19 Budget the Government announced funding of $40 million for infrastructure investment in regional, rural and remote aged care. Funding was available up to a maximum amount of $500,000 (per aged care service) to upgrade old or unsuitable infrastructure, improve or upgrade existing buildings or associated staff housing.

Other programs which exclude MPS include the National Residential Medication Chart (NRMC). This program enables the prescribing and supply of most medicines, and PBS/RPBS claiming by pharmacists where applicable, directly from the NRMC. The review was advised that the reason this key quality and safety mechanism is not available to MPS is because they are not issued with a Residential Aged Care Service ID.

GPs attending patients in an MPS are not eligible to claim the recently announced additional Medicare payment to cover travel time and costs when attending a patient in a residential aged care facility. This additional payment was introduced facilitate increased attendance by GPs to patients residing in a residential aged care facility.

7.6 Findings

The Commonwealth should consider approaching the States to jointly undertake the following:

- Consider amending the MPS Agreement along the following lines:
- Introducing means testing of MPS residents and home care clients by the Department of Human Services, with the States aligning consumer care contributions and accommodation payments/contributions with mainstream care recipients, subject to the preservation of current arrangements for existing residents and clients and implementation after a period of advanced notice and community education.
- The States aligning their charging of basic daily fees for residential and home care with payments made by mainstream care recipients, noting that in most cases this would require minimal adjustment.
- The States formally undertaking ACAT assessments for all incoming MPS recipients of aged care services (home care clients and residents), noting that this would differ little from current practice in most circumstances.

The Commonwealth should consider initiating the following:

- Explore a model for the delivery of non-MPS private provider Home Care Packages which retains consumer choice but might allow community-supported selection of a ‘preferred provider’ through a periodic open process. That provider (which may be the MPS) may be able to develop sufficient economies of scale to ensure more efficient and effective service delivery to local residents.

- Review all Commonwealth rural and remote health, aged care and related programs (operational and capital) that currently exclude MPS, assessing the rationale for that exclusion and assuming future inclusion of the MPS unless there is a public net benefit in retaining the current policy.

8 MPS Program funding model: is it an effective use of Commonwealth funds?

The focus of this chapter is primarily on Commonwealth funding of MPS aged care services, unlike chapter 7 which deals mainly (though not exclusively) with consumer contributions. The data used in this chapter is mainly drawn from annual activity reports and financial statements submitted by the States to the Commonwealth Department of Health, as well as site visit qualitative data which adds contextual understanding.

8.1 Operational funding

The broad outline of the MPS funding arrangements is set out in chapter 2. Given the subject of this chapter, a greater level of detail of Commonwealth funding is first provided.

The methodology used to calculate the *Commonwealth's aged care contribution to the MPS pooled funding* is specified in the Schedule to the MPS Agreement. The funding is directed to the care component of aged care and is calculated according to a determined number of high care and low care residential places and home care places. It does not vary according to occupancy or type of care provided. The Commonwealth also provides funding to the States for the health care service component through the National Health Funding Pool according to the model determined by the Independent Hospital Pricing Authority. The Schedule to the Agreement does not specify how the States are to calculate their contribution to the MPS pooled funding.

8.1.1 Commonwealth rates of funding

The Commonwealth's base rate for high care places in 2017-2018 was $126.66 per day, the low care places $33.29 a day, home care places $38.21 a day, the concessional resident equivalent amount was up to a maximum of $19.77 per place per day and the viability payment could be up to a maximum of $51.40 per place per day. There are other supplementary payments as shown below.

An example of the funding calculation is given below in Table 28 for an MPS with five high care places, five low care places (ten total places) and two home care places. For this small MPS the Commonwealth funding would be approximately $400,000 pa.

MPS can charge residents basic daily care fees (as do mainstream residential providers). For mainstream residential facilities this is set at 85% of the single person rate of the aged care pension.[17] MPS charge generally similar amounts for basic daily fees. MPS can charge a means tested Refundable Accommodation Deposit (RAD) or Daily Accommodation Payment (DAP) from residents. In practice this varies between States. Almost all MPS reported charging a basic daily fee (96%), while a minority reported charging a RAD/DAP/bond and maintaining a register (21%).

[17] https://agedcare.health.gov.au/programs/flexible-care/funding-for-multi-purpose-services

Table 28: Example of the Commonwealth MPS funding calculation

Category	N	Funding per unit	Total funding per day for the MPS	Annual funding	Notes
High care places	5	$126.66	$633	$231,155	Based on the number of agreed high care places
Low care places	5	$33.29	$166	$60,754	Based on the number of agreed low care places
Daily concessional resident equivalent amount	10	$12.01	$120	$43,837	Depends on facility location and multiplied by total number of high and low care places
Veterans supplement	10	$0.08	$1	$292	Dependant on the number of high and low care places
Viability supplement	10	$10.51	$105	$38,362	Depends on facility location and multiplied by total number of high and low care places.
Respite amount per day for facility		$51	$18,440	Depends on facility size	
Home care places	2	$38.21	$76	$27,893	Dependant on the agreed number of home care places
Dementia and Cognition	2	$1.19	$2	$869	Dependant on the agreed number of home care places
Remoteness (MMM 5)	2	$2.29	$5	$1,672	Depends on facility location
Total funding				$423,272	

There are several legacy issues in the MPS funding (such as classifying care as high or low), one of which revolves around the high care S-bed places (otherwise known as the adjusted subsidy reduction) which were allocated to district hospitals to deliver aged care services prior to the establishment of the MPS Program. S beds still exist in some hospitals that are not MPS. An adjusted subsidy was based on the ratio of S-beds to total high care places. The subsidy for S-beds is lower than the high care place subsidy.

8.1.2 Current funding contribution shares

The combined State/Commonwealth funding of MPS differs between States and between MPS. Figure 5 uses data provided by the Commonwealth to show the relationship between the State contribution (on the x-axis) and Commonwealth contribution (on the y-axis) from the 2017-2018 financial year. To illustrate the relationship, a line of best fit (the dashed line) and a line where the State funding is twice the Commonwealth funding (the solid line) have been placed on the figure. (The Commonwealth contribution to the States for health (small rural hospitals) as calculated by IHPA is not separately identified in the State funding in this analysis.)

MPS to the right of the solid line are dominated by State funding (State funding makes up at least two-thirds of the funding) while MPS to the left are less so (State funding makes up less than two-thirds of funding). The MPS in the Northern Territory has not been included because the data did not report the Territory contribution independently.

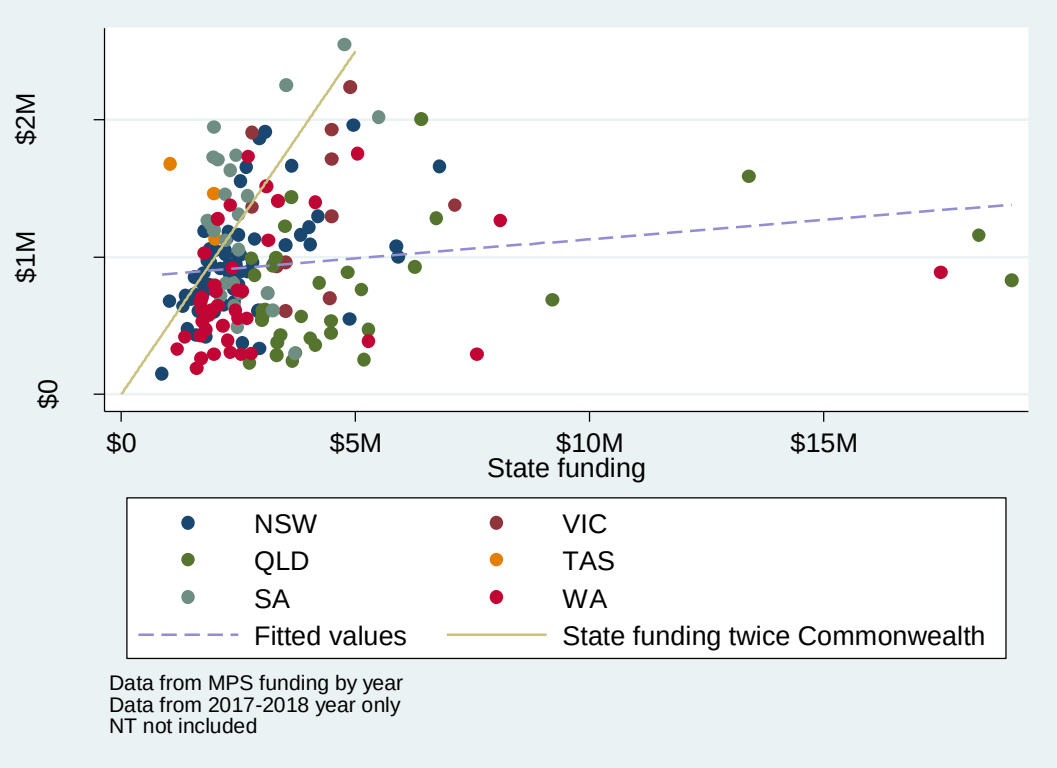

Figure 5: State and Commonwealth funding of MPS

There are differences between the MPS within each State, as well as some state-wide trends. There are a small number of MPS with substantial State funding (four MPS with over $10 M). Three are in Queensland and one in Western Australia. The next three largest are also in those two States. Western Australia also has a greater number of MPS with a lesser amount of total funding. Tasmania has no MPS that has more than two-thirds State funding and has a lower State contribution per MPS on average.

Five MPS have a relatively larger quantum of Commonwealth funding (over $2 M), with three being in South Australia. On average the contribution of the Commonwealth is approximately $1 M per MPS. The average State contribution is over three times this value. There is a weak but statistically significant association between increasing State funding and increasing Commonwealth funding.

8.2 Capital funding

Commonwealth funding to the MPS Program does not include a contribution for infrastructure, with this being the responsibility of the States. The condition of the physical infrastructure and associated plant and equipment for the residential aged care component of the MPS varies between States and between MPS. This section first examines the current state of the infrastructure before analysing the relevant policy issues.

8.2.1 The current state of the MPS facilities

MPS inherited a range of infrastructure when they were first incorporated into the MPS Program. Only a minority of the managers who responded to the review survey (chapter 3) assessed that their MPS had the physical infrastructure required for delivery of quality aged care services (46%) or a home like environment (42%). The majority of managers disagreed that that the MPS had the appropriate infrastructure for residential aged care residents with dementia (64%).

The MPS Allocations Rounds Application Guide identifies a range of operational criteria for approving allocations, two of which specifically relate to infrastructure: “if applicable, whether the premises used (or to be used) is suitably planned and located for the provision of aged care” and “whether, if the application is approved, the places allocated are made operational in a timely manner”. The Department advised that the response to the Application Guide was but one of several inputs taken into account when makings new allocations of places.

Upgrading of infrastructure has been variable between the States over the life of the Program. Some States have invested significantly in the redevelopment of their MPS, either directly or through their regional health organisations. The site visits demonstrated this difference, and State Governments such as New South Wales and Queensland are engaging in extensive capital works programs.

Several other States are more of the view that the provision of residential aged care infrastructure in MPS should be a Commonwealth matter. Some MPS have been able to access private funds, bequests and community donations through targeted fund raising for infrastructure development, however this cannot be assumed as a source of funding. As noted earlier, MPS can raise a RAD/DAP from residents but this is not compulsory. A small group (21%) reported having a refundable accommodation deposit (bond) register.

In the site visits the importance of access to funds for physical infrastructure was emphasised as crucial to allowing MPS to operate effectively and efficiently. Ageing and inadequate infrastructure can lead to higher maintenance costs which lower the amount of funding available for resident care and activities. Poor facility design and functioning can impede the ability to efficiently allocate and share staff and services. Physical design may not support contemporary quality care in either residential aged or health service provision.

The review found that there was often spare capacity available for low care residents but relatively less demand. Some MPS (or collaborating councils/community organisations) operate legacy hostels which often cannot care for high care residents because the old buildings cannot accommodate lifters or wide beds. There can be limited ability to decommission some of these facilities under the current funding of the MPS Program. Further, by leaving these facilities 'on the books' even if only partially occupied, the States receive operational funding contributions for the places from the Commonwealth – calculated on the basis of full occupancy.

Inefficient infrastructure can limit the ability to gain the economies of scope[18] from the integration of aged care services and health care services. Again, with reference to legacy hostels, those that are in the same town but not under the one roof with a health facility have little capacity to use staff across both aged care and health services. MPS are unable to reclassify residents in non-co-located facilities as 'admitted patients' while remaining in their 'home' when they suffer an acute health episode or gain economies of scale in providing services such as meals.

Another very common example is the lack of infrastructure appropriate for residents living with dementia who have challenging behaviours or wander. MPS that have access to infrastructure funding may be able to repurpose their facility and therefore upgrade their places from low to high care via the Allocations Round, with an attendant increase in funding from the Commonwealth's MPS contribution.

As noted in Chapter 7, the Commonwealth conducts programs of infrastructure grants. For example, the Rural, Regional and Other Special Needs Building Fund aims to overcome issues of remoteness, lack of supply of aged care or difficulties in accessing financing from capital markets. In the 2018-19 Budget, the Government announced funding to upgrade old or unsuitable infrastructure, improve or upgrade existing buildings or associated staff housing. These programs are not available to MPS, nor are ACAR allocated capital funding grants available to State government entities.

8.3 Trends in occupancy

Data from the activity reports submitted by each MPS were used to analyse the level of activity in MPS. The data on home care places contained a large number of missing items, so was not considered valid for further analysis. Further, activity reports on MPS do not cover health service delivery. However, occupancy rates can be estimated for residential care places. The limitation to this analysis is that it is comparing the number of aged care residents with the number of Commonwealth funded residential aged care places, not the number of places allocated by MPS to meet their intake of aged care residents. As such, the results must be treated with caution and are indicative of trends only.

[18] See 6.8.3 for a discussion of economies of scale versus economies of scope as applied to MPS.

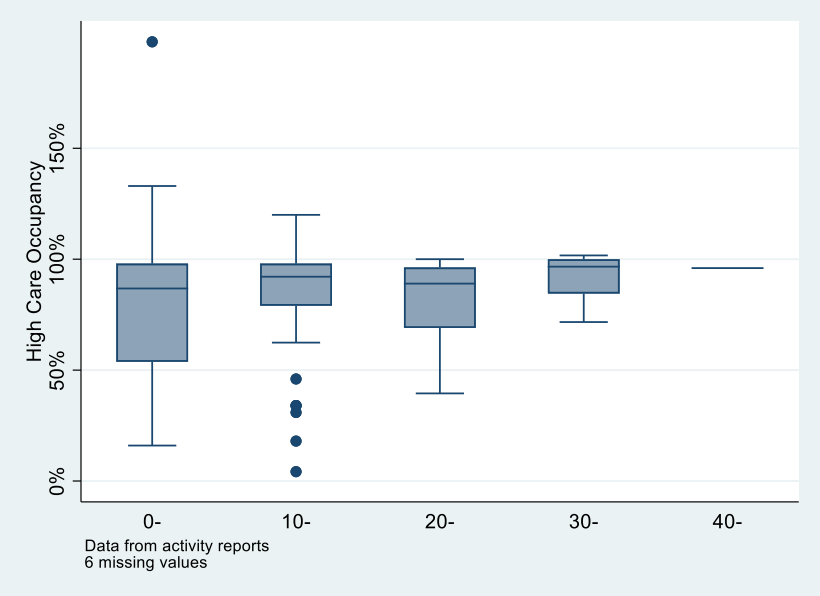

Figure 6: High care occupancy associated with total number of funded high care places

A box and whisker plot is shown in Figure 6. The box demonstrates the median as well as the 25th and 75th percentiles of the high care occupancy in MPS of different sizes (of high care places used to calculate Commonwealth funding).

Several features are evident. First, increasing numbers of Commonwealth funded high care places are associated with decreasing variability in occupancy. Second, the mean occupancy increases with an increasing number of funded high care places. Third, some small aged care facilities have a very high occupancy rate, the highest being 197%, and some very low occupancy rates. The extreme outlier was associated with an increase in high care places late in 2017-2018.

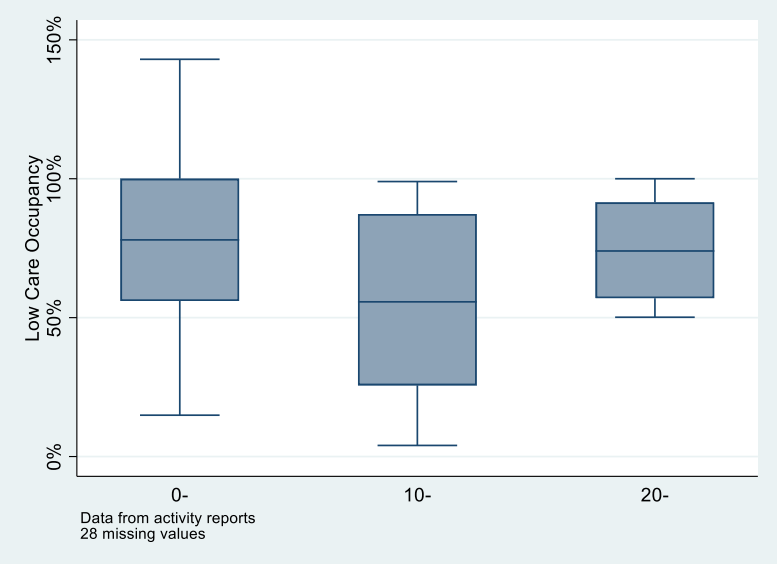

Figure 7: Low care occupancy associated with total number of funded low care places

A different pattern is seen in the occupancy of the Commonwealth funded low care places, with an overall decrease in occupancy compared to the high care places (t-test, $p<0.05$). There is no correlation between an increase in the occupancy rate and an increasing number of funded low care places.

This difference between high care and low care place occupancy is also reflected in the waiting lists for high care and low care. Eighty-one MPS reported at least one person waiting for high care (with an average of six persons on a list), whereas only 29 reported at least one person wating for low care (with an average of six persons on a list). The total number of people on a high care place waiting list is greater than the equivalent waiting list for low care.

Overall, this analysis, recognising its limitations, suggests that high care places have a higher average occupancy than low care places and waiting lists for high care places are greater. The analysis supports the conclusion that there is a high and ongoing demand for higher levels of care for residents. There is also a higher level of variability in occupancy in small facilities and funding arrangements should recognise its implications for meeting higher relative fixed costs.

8.4 Addressing increasing acuity: comparison with Aged Care Funding Instrument

An issue regularly raised during the review and supported by earlier analysis of the demand for high care is that the acuity of aged care residents is increasing, with greater support available for older people to assist them to remain in their own homes for longer. Although the Commonwealth's MPS residential funding is based on high and low care places, it is not sensitive to changing acuity and care needs compared to ACFI funding.

8.4.1 The analysis and underlying assumptions

To assess the potential implications of introducing ACFI funding into MPS, the review undertook a hypothetical analysis which illustrates the relationship between the two funding models. This has necessarily relied on the number of residential aged care occupants recorded in MPS Activity Reports and a set of assumptions on resident characteristics.

The Aged Care Financing Authority estimated that Commonwealth funding for mainstream rural and remote mainstream services was $56,834 per resident per annum for 2014-2015 financial year (Aged Care Financing Authority, 2016a). This was based on a review of 311 mainstream residential facilities in rural and remote areas. To compare this to the 2017-2018 MPS funding, this figure was inflated by the ratio between the payments from July 2014[19] and July 2017[20]. This resulted in a funding rate of $58,436 for the 2017-2018 financial year. This is a funding of approximately $160 per day per resident provided by the Commonwealth.

The funding rate of $58,436 was applied to the total number of patient years of the occupied high and low care places in MPS. The number of patient years was calculated by applying the occupancy rate

[19] https://agedcare.health.gov.au/sites/default/files/documents/06_2014/att-e-published_rates_from_1_july_2014_0.pdf

[20] https://agedcare.health.gov.au/sites/default/files/documents/10_2017/aged_care_subsidies_and_supplements_new_rates_of_payment_from-1-july_2017.pdf

contained in the activity reports[21] to the number of places used by the Commonwealth to calculate its contribution to the pooled funding. This data was taken from the detailed funding breakdowns provided by the Department of Health. Data was available for 178 MPS but three facilities recorded nil days of occupancy (at least one of those MPS is known to have no residential care service) and therefore the comparison was made for 175 MPS.

Resident-based funding for the MPS was estimated using the combined sum of the block funding for the high care places, the low care places, the concessional resident equivalent funding, the viability supplement and the veterans supplement. Although all MPS receive respite funding as a cashed-out sum based on the number of places allocated, respite funding was excluded from the analysis as not all MPS reported accurately on this item [22]. Also excluded from the analysis were home care places, the supplement for the dementia and cognition and the remoteness supplement associated with the home care places. The resulting amount is referred to as the MPS resident funding.

8.4.2 Results of the analysis

The comparison between the two types of funding is shown in Figure 8.

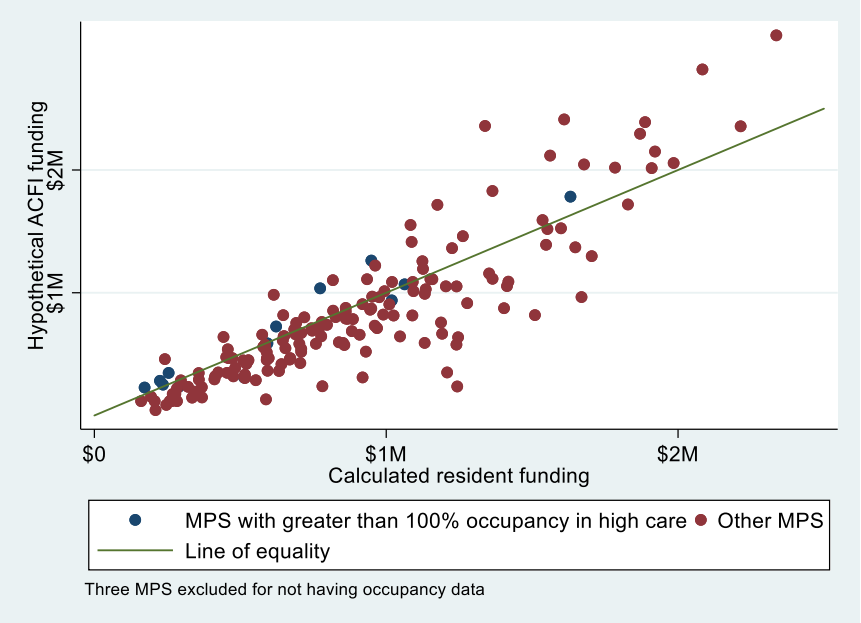

Figure 8: Unadjusted estimate of Federal Government funding for MPS compared to Commonwealth MPS funding

[21] Information was taken from activity reports as de-identified data did not break occupancy down into type, which might then be used for further analysis. This results in a small difference only from using de-identified client data.
[22] Respite was excluded because there were 40 MPS that did not report any respite days in the activity reports. The inclusion of respite would therefore have increased variation.

On the basis of these estimates, and accepting its limitations, approximately 30% of MPS may receive greater funding from ACFI under these assumptions. In general, the larger MPS are more likely to obtain higher funding under ACFI.

In addition, the MPS that reported a greater than 100% residential care occupancy (and are assumed to be utilising State contributions to the pooled funding for aged care services) are more likely to gain some benefits from moving away from the MPS model to an ACFI model for aged care residents, while also losing some of the flexibility, integration of care and funding certainty of the MPS model. The benefits are an expected result of ACFI funding rewarding higher occupancy (activity levels) while MPS is block funding of pre-determined places.

MPS with variable occupancy levels are expected to benefit from the funding certainty afforded under a block funding model. In particular, the smaller the scale of the MPS, the less capacity to benefit from economies of scale and less ability to absorb the impact of reduced revenue to meet high fixed expenditures.

8.5 Assessing efficiency

This review attempted to assess the efficiency of the MPS Program.

Determining the relative technical efficiency of the MPS units can be achieved by benchmarking. There are two widespread approaches to the measurement of technical efficiency using benchmarking, data envelopment analysis (DEA) and stochastic frontier analysis (SFA).

DEA is a non-parametric linear programming method while SFA uses statistical regression. Although the two techniques require different assumptions to hold, both require valid and robust data and a well-defined framework of the production process (i.e. a model of how inputs are transformed to outputs).

The review explored in some detail whether the data from the Activity Reports were sufficient to apply either of these approaches.

The data underwent a series of internal validation checks to identify missing data and outliers. Consistency and reasonableness were assessed by comparing alternative sources of data. Information from site visits was used to assess whether key assumptions were reasonable. As the review had been provided with no data for the health-related outputs associated with the MPS, it investigated the use of My Hospital data as a publicly available source of hospital activity data. This data source does not report community health services, such as community nursing and allied health.

While the necessary data should be available to the Commonwealth through the annual financial and activity reports, it was not possible to employ these approaches with the data in its currently available form:

- the data on aged care service provision only relates to the input of the Commonwealth's contribution to the pooled funds
- the data on input funding by the States for their health funding that is contributed to the pooled funds is not clear

- the many outputs across health and aged care delivery in each MPS are unknown to the Commonwealth and to the review, and the resources allocated to each of these outputs is equally unknown.

Accordingly, technical efficiency could not be validly estimated using these econometric benchmarking techniques. Therefore, the review is unable to calculate the efficiency of the delivery of the respective health and aged care outputs, nor the efficiency of MPS overall.

8.5.1 Addressing the lack of transparency and accountability: the key to improved performance assessment by the Commonwealth

The paucity of data described above contrasts with the provisions on reporting set out in the Commonwealth/State Agreement. The Schedule specifies that each Service Provider must provide the Commonwealth and the State (if requested) with annual reports on the details of the income and expenditure managed by the MPS as well as details of the activities of the services provided by the MPS and reported progress on the activities specified in the Service Delivery Plan. There is no provision for the reports to only address a sub-set of services (such as aged care) provided by each MPS.

The key means by which the Commonwealth is able to assess the performance of the MPS is through these annual statements. Based on an analysis of a series of these Activity Reports, the review considers that they do not provide a clear line of sight for the Commonwealth between its contribution to the pooled funding and the ways in which overall expenditure from the pooled fund is producing a flexible, locally integrated aged and health care service that addresses community needs.

This lack of data limits both transparency and accountability, and the Commonwealth's ability to assess the performance of the MPS overall or its delivery of aged care and health services.

8.6 Review of the current MPS funding model

There are two core features of the current MPS funding model which warrant review from the Commonwealth's perspective.

- The first is how the Commonwealth determines its contribution for the delivery of aged care, and funds that contribution as part of each MPS pooled funding.
- The second is how the pooled funding (which also includes the State's funding relating to health care) is allocated and expended on the delivery of all MPS services.

In both cases there are issues of effectiveness, efficiency, equity and sustainability.

8.6.1 Commonwealth funding of aged care services

Effectiveness.

The two issues of concern relating to effectiveness are the responsiveness of the funding model to the acuity of residents and to the number of residents requiring care.

In terms of acuity, there has been a general increase in the care needs of residents entering and residing in aged care homes. The Commonwealth's MPS model has reflected this to an extent by converting some low care places to high care funding status. However, there is not necessarily a nexus between this funding and the actual acuity of current residents.

In relation to the quantum of care being funded, the Commonwealth's calculation of its funding contribution, being dependent on a number of allocated places and an assumption of full occupancy, may not be sufficiently responsive to the changes in community needs as expressed through the Service Delivery Plans and as reflected in actual admissions.

As demonstrated earlier in this Chapter, preliminary analysis by the review suggests that larger MPS may receive greater funding under an ACFI-type model. Site visits reinforced this preliminary conclusion as at least one larger facility in one State is planning to withdraw from the MPS model and fund its residential care under mainstream arrangements. In addition, this facility has had limited control over community health services and therefore does not benefit from maximum MPS flexibility in delivery of community-based care to keep people well at home. Two facilities in another State are undertaking similar analyses.

The issue at hand is whether it could be possible to overcome the limitations of the Commonwealth's current model of calculating its aged care contribution within its block funding approach while still retaining the advantages of MPS pooled funding for the flexible and integrated delivery of health and aged care services. To an extent, resolution of this issue hinges on the question of efficiency.

Efficiency

The three most significant efficiency issues are the extent to which the Commonwealth's care contribution arrangements: provide incentives to MPS and State management for the Commonwealth's funding to broadly reflect the level of need for delivery of aged care; promote efficient delivery of care; and are administratively simple.

In relation to the first, the current process of pre-determining the number and level of places creates an incentive to lobby for more places (potentially greater than actual occupancy needs) or retain funding of places not necessarily currently occupied, and for as many of those places to be classified as high care as possible (potentially ahead of acuity needs).

In terms of the second, the current arrangements respond to the small scale of MPS operations and their high levels of fixed overheads. Any change to the calculation of the contribution which introduced greater variability to funding levels could reduce certainty and allocative efficiency for only minor gains in aligning Commonwealth funding with aged care need.

The third issue relating to the current arrangements is that it involves an administratively simple calculation for MPS and again enhances medium term certainty of funding outcomes.

There may be benefit in undertaking more detailed research into developing a contribution model which is more responsive to contemporary levels of acuity and resident numbers while maintaining medium term certainty, administrative simplicity and the effectiveness of the pooled funding arrangements (as discussed below).

Equity

There are several equity issues relating to aged care funding, as noted in other parts of this report. For instance, there are differences in the approach to care contributions and accommodation contributions and payments (including means testing) between MPS and mainstream services and between MPS in

different States. These differences result in the potential for unequal treatment of those residents with similar needs and resources.

Similarly, the lack of infrastructure funding is a weakness of the current funding model, resulting in inequity in the availability of a facility and the standards of accommodation (and operational efficiency) for residents in different MPS.

8.6.2 MPS pooled funding of Commonwealth and State contributions

There are substantial advantages to the MPS pooled funding model.

Effectiveness

The pooled funding model is effective in meeting the MPS Program's core objectives of innovation, flexibility and service integration. The model allows MPS to allocate resources between services (health and aged care) in response to changes in Service Delivery Plans and prevailing needs, thus optimising the benefit to the community. The largest effectiveness-related disadvantage of the pooled funding model for the Commonwealth is a lack of clarity about whether the Program objectives in relation to aged care are being achieved.

Efficiency

MPS generally have high fixed costs, especially for smaller facilities. In particular, the need for a minimum roster of registered and enrolled nurses for the health services of an MPS can result in underutilisation of that workforce. Under the pooled funding model, and where health and aged care services are co-located, those staff are also able to be employed in the delivery of care to aged care residents. Pooled funding also aids the efficiency of the MPS by reducing reliance on variable residential aged care occupancy and is particularly relevant to smaller MPS who do not have the benefit of economies of scale.

The combination of the aged care and health activities allows a greater scale in staff hiring and in purchasing some inputs, again increasing the efficiency of services in rural and remote regions. Pooled funding also has benefits for staff development, allowing MPS to invest in staff training that aligns with the broad scope of work undertaken by the MPS. Overall, this level of efficiency promotes the sustainability of health and aged care services in small rural and remote communities.

The pooled funding model is administratively simple for MPS and does not impose a substantial reporting burden on the MPS to the State supervising entities. However, there is minimal provision of those reports to the Commonwealth. As with effectiveness as noted above, the largest disadvantage of the pooled funding model for the Commonwealth is a lack of clarity about the efficiency of the MPS from the perspective of the Commonwealth's contribution for aged care services.

Equity

Ideally, MPS would not crowd out the private provision of aged care. Currently 42 MPS are recorded as co-existing with private providers. In some cases, there is a co-operative and synergistic relationship, particularly where the MPS provides acute residential care and the non-MPS provider is a legacy hostel catering for residents with lesser (though rising) levels of acuity.

However, because of differences in required resident contributions (for care and, in some States, for accommodation) as well as differential access to GP and specialist medical/allied health services, MPS may be preferred. This reduces the viability of current or potential private competing services. This research has concluded that there is no private/public competitive neutrality between MPS and co-existing mainstream residential aged care facilities in the same catchment area. This development is contrary to the original intent of not having an MPS in a community where there was an alternative provider of residential aged care.

8.6.3 The concepts of economies of scope, economies of scale and addressing market failure

Economies of scope, economies of scale and market failure

Economies of scope refers to the joint production of health and aged care services being less expensive than the production of each individually. The source of potential economies of scope come from the shared use of fixed costs or excess capacity (indivisibilities) related to size. The qualitative analysis and site visits suggested economies of scope do occur, particularly in the allocation of fixed staffing costs across a wide range of services.

Economies of scale refers to the decrease in average costs as the scale of production increases. The purchase of a greater number of meals to achieve a lower unit price is an example, as is the ability to improve the productivity of staff.

In relation to **market failure**, the demand for aged care in small rural and remote communities will often be limited and/or unpredictable. This makes the communities an unattractive market for independent providers, due not just to diseconomies of scale but also the challenge of remaining financially viable, particularly where funding is determined by activity. A similar challenge is faced for health care delivery. This has been addressed under the MPS Program by providing annually determined and pooled contributions where more responsive activity funding is not feasible.

The concepts of economies of scope, economies of scale and overcoming market failure all coincide to justify the use of Commonwealth/State pooled funding for the MPS to enable the ongoing delivery of innovative, flexible and integrated health and aged care services in rural and remote communities, supported by local level planning and the flexible use of funding and resource infrastructure.

8.6.4 Can acuity be better incorporated into a model while retaining its underlying strengths

This review has given consideration to how to retain the funding model of annually determined Commonwealth contributions for residential care, given its certainty of occupancy revenue (especially for smaller MPS), the operational benefits of flexible and integrated care, and the administrative simplicity of the arrangements, while being responsive to the cost of providing ever higher levels of care.

There would be benefit in the Commonwealth undertaking (or commissioning) research into developing a Commonwealth funding contribution model for residential aged care services in MPS.

One approach would be to retain the current processes whereby a number of places is approved and there is a funding provision for 100% occupancy.

It would be appropriate, however, for the number of funded places to be reviewed on a regular basis (including where demand is declining and/or there is an alternative provider). This would require clear and transparent criteria for establishing and maintaining/dissolving MPS which should be carried through to the MPS Allocations Rounds, together with equally clear and transparent assessment processes and reporting of outcomes.

In relation to resident acuity, it may be possible to replace the current high care, low care (and high care S-bed) contributions to the MPS Pooled Funding with funding for a single category of flexible residential places which reflects the care needs and cost of caring for current MPS residents. The funding level (drawing on ACFI or successor) could be assessed at a census date annually, averaged across all aged care residents and applied to the number of funded places. Home care places could be replaced with ACAT assessed funding for individual Home Care Packages.

There may well be other approaches that retain the underlying benefits of the pooled funding model while being more responsive to the cost of caring for the residents and dispensing with the current sub-categories of flexible residential care places. For example, the AN-ACC funding proposal currently under investigation by the Department has similar characteristics of having both fixed and variable components in certain specified rural and remote regions

Competitive neutrality between co-existing MPS and other providers could be achieved by MPS requirements for means tested contributions from aged care recipients being aligned with mainstream arrangements. An alternative would be to review the need for Commonwealth aged care funding for an MPS where an alternative provider co-exists, but this would need to be subject to that provider being able to adequately meet community needs and there being no significant adverse impact on the ongoing provision of health services in the community.

8.7 Findings

The Commonwealth should consider initiating the following:

- Review the Commonwealth's approach to the funding of accommodation and other aged care infrastructure in MPS with the aim of increasing the number of co-located health and aged care services and the provision of facilities which meet contemporary standards and expectations.
- Undertake (or commission) research into developing a Commonwealth funding contribution model for aged care services in MPS which reflects prevailing acuity and numbers of aged care residents while maintaining medium term certainty, administrative simplicity and the effectiveness of the pooled funding arrangements. Suggested lines of enquiry include:
- Retaining, for the purposes of its funded contribution for residential care to the MPS pooled fund, the determination of a number of places funded at 100% occupancy (irrespective of the MPS MMM classification).
- Reviewing the number of funded residential aged care places on a regular basis (including where there is a reducing demand and/or an alternative residential aged care provider) and ensuring

the MPS Allocations Rounds and periodic reviews of existing MPS have clear and transparent criteria, assessment processes and reporting of outcomes.

- Replacing the current residential high and low care funded contributions to the MPS Pooled Funding with funding to reflect the care needs and cost of caring for current MPS residents. The residential care funding level could be assessed at a census date annually, averaged across all aged care residents and applied to the number of funded flexible residential care places for the following 12 months.
- Assessing whether the replacement to the ACFI funding model, or some variation of that model, would be fit for purpose.
- Noting the joint review of funding of home care referred to in chapter 6.

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