POSITION PAPER: 
RESHAPING THE 
MULTIPURPOSE SERVICE 
(MPS) MODEL IN NSW 

Health System Planning and 
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## Document History

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1. INTRODUCTION

The purpose of this Position Paper is to guide future planning in the development of MultiPurpose Services (MPSs) in rural NSW.

In rural and remote communities there are many complexities in providing health services due to community characteristics. Many communities are geographically dispersed, have an ageing population, have low population density; limited and ageing infrastructure and higher costs associated with health care delivery. In contrast, some rural communities are experiencing rapid growth associated with resource and mining development, tourism or lifestyle migration. In this context, it is essential that services are well planned with the flexibility and capacity to respond to evolving changes to meet community need.

The Strategic Directions in the NSW Rural Health Plan: Towards 2021 recognise that it is not possible to deliver the full range of health services in all settings and emphasise the importance of robust links between emergency, community, primary, specialty and supra-Local Health District (LHD) specialty services to ensure patients receive the care they need, when they need it.

Network and partnership arrangements have the potential to enable additional services to be provided locally; improve access through the use of technology; support improvements in service cohesion; and result in greater efficiency in the use of resources for rural health services.

The NSW Rural Health Plan: Towards 2021 identifies investment in further MPSs as an initiative to meet the Plan’s goals. The MPS model where the hospital and residential aged care are integrated has been a successful default model for small rural health services for some time. However, opportunities exist for innovative responses to further extend integration and coordination of health services to people in rural communities through new partnerships.

Over the last 25 years, MPSs have been able to survive multiple challenges through economic, social, technological, educational and policy change. They have proven to be a sustainable model of integrated health service delivery based on population health planning and primary health care service delivery models. They have enabled smaller rural and remote communities to retain basic services and expand those that are relevant to local communities. The most obvious feature across the State is their diversity in terms of the range of services they provide to meet the individual community needs.

This Paper has been developed using feedback from the Chief Executives of Rural Local Health Districts (LHDs) and other stakeholders. The Paper acknowledges MPSs are well established in the community and the positive impact they have had on delivery of services in small rural and remote communities. The Paper proposes that the model is now ready to be reshaped particularly given the stronger approach to delivery of care in the home reflected in the current Australian Government Aged Care Reforms and that the way forward can embrace and encourage the development of locally integrated health care solutions, based on local needs, which could consider incorporating the provision of some of the service delivery through a third party provider.

1.1. Background

The MPS program was designed as a national health service delivery strategy in the early 1990s to address the specific health and aged care needs of certain rural and remote communities. The MPS program offered the opportunity to regional communities to work in new ways – principally to expand community care and integrate health and aged care settings to support individual well being in the community, away from a predominantly traditional hospital services based model.

NSW has embraced the MPS model and has established the highest number of MPSs, compared to other States and Territories.

The implementation of the MPS program in NSW in the early 1990s sought to ensure continued access to health and aged care services where hospitals were closing; infrastructure had aged and there was no longer a functional facility; health and aged care services were limited; there were shortages in the health workforce; and populations were small and ageing. As the MPS model has evolved, innovation in service design and delivery has been possible and is attributable to the ability to pool state and Australian Government funds. This innovation has also been enhanced through greater networking supported by further investment in eHealth and technological initiatives, flexible delivery of services in a range of settings, and strong local engagement in health priorities. This has seen community attitudes to the MPS model develop from early resistance and a fear of downgrading services, to a positive acceptance resulting in a rejuvenation of health services and attracting new service providers in rural and remote communities.
From an Australian Government perspective, the main services funded on a recurrent basis through the MPS model are residential aged care and the Home Support Program (formerly known as Home and Community Care (HACC)) services. MPSs offer opportunities to integrate a range of publicly funded NSW government health services, including acute care, subacute care, emergency department, allied health, primary health and community services. Private and non-government services might also be included in the service delivery model.

The NSW government has also funded the capital redevelopment of these small rural health services, including the residential component. In recent years the Australian Government has provided capital funding as a co-contribution, through a one-off budget initiative, to a small number of MPS redevelopments in NSW through the Health and Hospital Fund (HHF).

The MPS operating framework\(^1\) is defined by the following core elements:

- **Health service needs** – determined by the local community and contained in an integrated health services plan, taking into account regional demography, epidemiology, socio economic status, culture, environment, health service infrastructure and availability of service providers
- **Governance** – management committee appointed under legislation to oversee the MPS with members drawn from its geographic catchment area
- **Funds** - commonwealth, state and local government funds pooled and directed to purchasing health and aged care services according to the agreed service plan
- **Flexible use of funds** - health and aged care service types and levels adjusted or redirected according to changing needs rather than specific program funding targets with flexible and responsive working arrangements for staff
- **Reporting arrangements** - streamlined reporting against services plan replacing reporting against multiple programs
- **Accreditation** - a single accreditation process replacing multiple processes

### 1.1.1. Definition of a MultiPurpose Service

MPSs are administered under the *Aged Care Act 1997* and the *Flexible Care Subsidy Principles 1997*.

The underpinning funding model by the Australian Government is the flexible funding payments made to MPSs to deliver aged care. The Aged Care Act defines flexible care as 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 service. The principles state that the flexible care service must provide, or propose to provide, an integrated service that includes residential care and at least one other health or community service.

MPSs receive payments from the Australian Government, called a flexible care subsidy, to provide aged care services. An MPS can charge a resident who has entered care on or after 1 July 2014 an accommodation payment. However, the legislation does not allow a MPS to charge a partially supported low means resident an accommodation contribution\(^2\).

There are two key points of difference for access to aged care places between mainstream aged care providers and an MPS.

1. **ACAT assessments** - Aged Care Assessment Teams (ACATs) help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. An ACAT assessment and approval is required before people can access Australian Government subsidised residential aged care and Home Care Packages delivered by an aged care provider recognised under the Aged Care Act 1997. MPSs are not aged care providers under the Aged Care Act 1997, therefore there is no legislative requirement for an Aged Care Assessment Team (ACAT) approval to access any service. However, undertaking an ACAT assessment is good practice and should ensure residents are receiving the right level of care and support to match their level of functionality.

2. **Allocation process** - The Aged Care Approvals Round (ACAR) is a competitive application process that enables prospective and existing approved providers of aged care to apply for a range of new Australian Government funded aged care places and financial assistance in the form of a capital grant. Every November residential places are allocated to applicants that demonstrate that they can best meet the care needs of older Australians. MPSs have not in

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the past had to compete in this process for access to aged care places. However, recent changes, as advised by the Australian Government Department Health, involves the introduction of an annual MPS Program Funding Round for new funded flexible aged care places which will be accessed through a competitive application process. An invitation to approved providers will be extended when additional places. Aged care places for the MPS and mainstream aged care provider are sourced from the same allocation pool. The difference in the subsidy payment though is that the flexible funding for MPSs is allocated for an agreed number of allocated places whereas mainstream aged care providers are funded by occupancy.

1.1.2. Aged Care Legislation Changes

Recent changes in the Aged Care legislation - Increasing Consumer Choice - as part of the Aged Care Reforms, may see some relaxing in the restrictions around approved aged care providers that may support the development of partnerships between Local Health Districts (LHDs) and those providers. This Reform initially focuses on the home care and support component of Aged Care funding. From February 2017 these changes include, but are not restricted to:

> Funding for a home care package will follow the consumer, allowing the consumer to choose a provider that is suited to them and to direct the funding to that provider;
> No ACAR (Aged Care Assessment Round) for home care packages meaning allocation of funding for a client can occur any time throughout the year when they need it rather than the one off annual allocation process;
> The concept of ‘home care places’ will no longer exist, removing the current regulation associated with management of places, e.g. transfers and variations;
> A consumer will be able to change their provider if they wish, including if they move to another area to live.

While these changes are specifically targeted at home care packages these Reforms are planned to continue through to full implementation by 2022, where the long term vision for Australia’s aged care system will incorporate residential aged care services and will aim to:

> be sustainable and affordable, long into the future;
> provide diverse and rewarding career options;
> encourage aged care businesses to invest and grow;
> offer greater choice and flexibility for consumers;
> support people to stay at home, and part of their communities, for as long as possible.

1.2. Integrated Models of Care

Diverse models of integrated care have been introduced across Australia and internationally. Health and aged care consumers require health services that meet their needs, are connected and well integrated. They want access to services regardless of service structure, funding or governance - this finding was at the forefront of the 2009 National Health Reforms across Australia.

Evidence from a systematic review of the literature relating to care coordination across Australia, the US, the UK, NZ and the Netherlands suggests that the types of integrated care initiatives that demonstrate the highest proportion of significant positive outcomes for patients are those that enable strong relationships between service providers both internal and external to the health organisation. These strategies can be divided into:

> factors relating to communication and support for both providers and patients (including continuing medical education, case conferences, health literacy and self-management, audit and feedback);
> structural arrangements to support coordination (including, multidisciplinary teams, new roles in the workforce, care plans, case management approaches, physical environment/co-location, shared care, discharge planning);
> information technology resources to promote integration (including electronic health records, telemedicine and telehealth).

From a service delivery perspective, integrated care is a priority for patients where service delivery gaps or poor care coordination negatively affects their experience of the health service and their care outcomes. The implementation strategy should tackle barriers, centre on the factors that enable and reinforce providers to engage in activities and adopt procedures that make care as seamless as possible.

All delivery models going forward should consider and address these aspects in their implementation to ensure a successful transition.
2. RESHAPING THE MULTIPURPOSE SERVICE MODEL

2.1. MultiPurpose Services (MPS)

An MPS provides residential aged care and hospital services. A range of health services, including acute care, subacute care (including respite and palliative care), emergency, allied health, oral health, primary health and community services can be all included when establishing an MPS.

The MPS model delivery uses a funds pooling approach from the State and Australian governments, to service the assorted NSW Health program areas and Australian Government aged care services/resources available to rural and remote communities. This is undertaken under one management structure - either formal (Contracted) or informal (Memorandum of Understanding), to deliver easily assessable and sustainable health, aged and community services.

The Australian Government approves the number of aged care places to be allocated to an MPS before providing recurrent funding, and after assessing the current and projected need of the community.

The NSW Ministry of Health coordinates the formalised agreement through a three yearly Tripartite Funding Agreement between the LHD, the Ministry and the Australian Government.

The characteristics of rural communities and service delivery which best support the implementation of the MPS model includes:

- 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.

Community participation and engagement is essential to successful health planning and ongoing service delivery in an MPS. An MPS committee is usually established in the earliest stages of planning and continues to function as part of the operation of the MPS. NSW Health tends to use a Local Health Advisory Committee model - this should be a forum where all aged care providers come together along with other key health and primary care stakeholders to develop and implement priorities for services delivery in the town or community.

2.2. MPSs in Australia

There are 178 MPSs operating across Australia - South Australia 26; Western Australia 44; Victoria 11; New South Wales 60; Queensland 33; Tasmania 3; Northern Territory 1.

These MPSs differ on many dimensions predominantly reflecting the history and culture of towns covered by each MPS and the service planning based on local needs assessment. Each jurisdiction governs and has developed their MPSs in their own way. For example, Western Australia Country Health (WAC Health) uses a ‘virtual’ model whereby services in different towns are linked together under the one networked structure - one site may deliver community health and it is “linked” to an aged care facility in another location and both are linked to a hub providing inpatient care. This can be done as all aged care funds

are pooled centrally and then allocated to regions, where the WA Country Health Service’s regional management teams determine specific MPS sites. More recently WAC Health is working towards establishing an aged care management function in each of its country regional networks in order to better coordinate the planning and delivery of aged care services, minimise duplication of processes and better up-skill and support staff. The objective of this planning for WAC Health will be to have a number of external providers (e.g. Silver Chain Nursing Association, local government, church-based agencies and the private sector) called Health Partners who deliver this aged care alongside WA Health staff, or under a contracted arrangement. Silver Chain Nursing currently manages five of the services which are called Multi-purpose Centres.\(^5\)

Victoria Health (Vic Health) has taken a different approach to the implementation of MPSs. Vic Health uses a single Board of Management made up of representatives of health services that form part of the MPS, and other relevant stakeholder and community members. The Board replaces all other governance arrangements and has sole authority and accountability for all aspects of the MPSs operations. One of the benefits sought through this governance arrangement is that the traditional model of health care service delivery can be challenged and innovation made possible from pooled funding that could be used flexibly, along with flexible roles and use of staff, which has resulted in the range and number of services offered to the community increased from health service facility that had previously been considered unviable.\(^6\)

### 2.3. Policy Changes in NSW Since MPSs Were Introduced

It is important to note that aged care is only one service component of the MPS model although the focus of planning may appear to concentrate on a particular service area rather than the broader health needs of the local community. The NSW Rural Health Plan’s directions emphasises improvement in prevention and early intervention health initiatives, the health of rural children, young people and families, rural oral health and rural mental health, and so in going forward these services should also be a focus of the MPS model delivery.

The traditional MPS model, where the hospital and residential aged care are integrated, has been a successful default model for small rural health services for some time. As the health care system faces growing pressure from the needs of an ageing population and the rise in chronic health diseases, opportunities now exist for innovative responses and alternate delivery models. For the MPS model, this may include partnering with private and not-for-profit organisations for the delivery of aged care, to further extend integration and coordination of health services to people in small rural communities. Some emerging changes and considerations in the development of a new model of health and aged care delivery in rural areas are discussed in the following sections.

#### 2.3.1. Health Partnerships

The NSW Government has used Public Private Partnerships (PPP) as an option to procure infrastructure and services\(^7\) over a number of years and has used PPPs to facilitate the larger discussion around reform and the reshaping of services within number of sectors. A PPP provides an opportunity to consider a private entity as a possible sector participant.

PPPs that can demonstrate an alignment of interests, can offer significant benefits to local communities through efficient use of local health infrastructure, decreased overheads and greater patient choice. Nationally, a growing trend is that partnerships between government agencies, non-government and private organisations, primary, specialist and multi-disciplinary professionals and home, community and hospital settings should be explored and fostered in the development of new approaches to service delivery and models of care.

#### 2.3.2. A Growing Aged Care Sector

From an economic perspective the aged care sector is projected to be one of the highest growing investment areas. Not for Profit organisations currently make up the majority of operators (64%) nationally, interestingly there has been reported an increasing trend of for-profit organisations purchasing Aged Care places in the last 5 years. Through the Aged Care reforms private investors are being encouraged to participate by the Australian Government and as a result attracted to the aged care

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\(^5\) WA Country Health: Strategic Directions 2015–2018: Healthier Country Communities through Partnerships and Innovation

\(^6\) Australian Healthcare and Hospitals Association: Issues Paper 2009 - Multi-purpose Services

sector because of the high growth forecasts, underpinned by the projected ageing population and their increasing care requirements and wants particularly in regard to modern facilities and lifestyles. This increasing interest in the aged care sector is likely to present many opportunities for investment in some rural and regional areas where aged population growth is projected.

2.3.3. Primary Health Networks

Primary Health Networks (PHNs) can play a key role in supporting older people to lead healthy, productive and connected lives, ensuring they enjoy greater social and economic participation in society.

The Australian Government decision to transfer greater regional responsibility of primary care planning, using a population health approach, and commissioning responsibilities to PHNs is an important consideration in meeting the aged care needs of rural LHD residents. This requires all stakeholders to ensure they have a clear strategic direction for how services are most efficiently provided and effectively delivered across rural areas.

Demand for health services is forecast to increase, and the efficient and effective use of resources is crucial. Therefore LHDs are challenged with having to balance the provision of core health responsibilities against the ability to deliver a broader range of services in the aged and primary care areas. LHDs working with PHNs have the potential to create the catalyst to develop networks and systems that connect providers across health and aged care services, thereby aligning services to the needs of older residents.

2.3.4. Aged Care reform changes through Living Longer Living Better

The new Aged Care reforms are aimed at encouraging healthy ageing so as to enable people to continue to productively contribute to the economy and to reduce the burden on the health care system. Further, the reforms seek to “create a better system to give older people more choice, more control and easier access to a full range of aged care services”. Service providers will be expected to offer to do more ‘with’ clients, than just ‘for them’.9

The reforms provide significant additional Australian government funding in the form of home care packages (combines all programs - home support, respite and day care) which are easier to access and will follow the client, and removal of the high care/low care distinction for accommodation payments for concessional residents in aged care facilities. The reforms also allow aged care providers some freedom to negotiate accommodation payments with those residents who can afford to pay. In regard to access to capital funding, there may be less incentive for residents to pay lump sum accommodation bonds but rather they can negotiate periodic rent - style payments or a combination of both periodic and lump sum payments for their residential aged care accommodation.

The Australian government has also introduced a number of workforce initiatives to attract a higher level of skilled workforce in the delivery of care - these initiatives include moving nursing salaries in the aged sector to that on parity with acute nursing. Therefore, the Australian governments’ Living Longer Living Better (LLL) reforms will likely encourage additional investment into the aged care sector via the provision of extra services through more of a ‘user pays’ or ‘the money follows the person’ model10. This should raise new opportunities for aged care providers being able to provide a broader base of aged care responses from infrastructure investment in supportive home environments through to improved technology reach in the role of care provision along with a strong home care base, and may mean that the LHDs no longer remain the default aged care provider in rural communities where there are high aged care needs.

2.4. Local Health District Planning

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8 Thornton, Grant: "An Instinct for Growth" March 2015. (Dealtracker publication for the Aged Care Sector: Growing with Age)
9 AHHA PHN Discussion Paper Series: Paper Seven. Primary Health Networks and Aged Care. 2015
10 Thornton, Grant: "An Instinct for Growth" March 2015. (Dealtracker publication for the Aged Care Sector: Growing with Age)
Chief Executives from rural LHDs are reporting that the majority of their MPSs have larger numbers of residential aged care beds in proportion to other inpatient services\(^{11}\). While the MPS model was developed to ensure viability and sustainability of health services in small rural communities by incorporating aged care into the mix, it is now appropriate to consider whether further health capital and recurrent funding should be used to invest in facilities where the majority, or all of the beds, are planned for residential aged care. In communities where there is a viable residential aged care (RAC) service there is considerable scope for greater links between the two providers to avoid competition and possible impact on sustainability and choice.

Some rural LHDs are also reporting that there are increasing viability issues arising for some not for profit providers with low bed numbers, and not being able to access additional places where an MPS may be located or proposed, and that it would be in the best interest of the LHD to look at broader options to ensure the viability of residential aged care for the community.

Some rural LHDs have found they have reached a proportion of residential aged care need that outnumbers their inpatient requirements or are looking at services that comprise only aged care.

In communities where an aged care provider already exists LHDs are now investigating the delivery of an integrated health service along the lines of the MPS model of care, but without the residential aged care component. Local aged care providers in some of these towns have indicated to the rural LHDs that they would be amenable to maintaining and/or expanding the aged care services in their communities.

As recent planning has progressed in the current MPS capital strategy a number of health services have recommended that they transition to a new service delivery approach for their proposed MPS. The service strategy is to establish a facility to complement, rather than incorporate residential aged care services.

Some LHDs have submitted Clinical Service Plans (CSP) that exclude residential aged care and are progressing discussions with those private aged care providers to work together and identify opportunities to share resources such as staff, linen and food services.

\(^{11}\) Issues Log: Consolidated Comments on the MPS Discussion Paper and Planning Framework (MOH 2016)
3. **A WAY FORWARD FOR RURAL NSW**

The challenge to design, deliver and support rural and remote health services requires a flexible, innovative and locally appropriate solution, which does not compromise the quality and safety of care. Collaboration, commitment, partnerships and the shared objective to place the patient or client at the centre of all activities ensuring continuity of care will support the delivery of more effective and appropriate care. It is now time to review the approach to delivery of new and expanding MPS in NSW enabling the model to respond over the coming years to 2022 to the changes being introduced through the Australian government’s Aged Care Reforms.

The integrated model of care, and in this instance specifically the MPS, has proven to be the most effective model to support sustainable health and aged care services in rural NSW. The models proposed in the rural LHDs CSPs offer a different approach, but support the tenets of the MPS model. The operating framework of an MPS is still relevant to today’s planning and service provision and is not proposed to change.

The continued use of the nomenclature MPS may need further discussion with the Australian Government, although as long as the MPS is receiving some form of flexible funding the definition applies. An alternative if the MPS does not receive any flexible funding is to use a similar name such as MultiPurpose Centre (MPC) or MultiPurpose Health Service (MPHS). However, the current Aged Care reforms aim to “encourage aged care businesses to invest and grow” and “offer greater choice and flexibility for consumers” and under these objectives it would appear to support the partnering in the delivery of aged care services. While these services may not receive the flexible funding, their proposed model does support the delivery integrated service that includes residential care and at least one other health or community service as described under the Aged Care Act and Flexible Care Principles.

Where there is an adequate supply of health and aged care services, planning for future MPSs should focus on an integration model of care which considers the key strategies (see section 1.2) to ensure successful implementation. The LHDs should be encouraged to enter into formal ‘type’ partnership arrangements with other providers in the community such as aged care providers and PHNs that promotes case sharing and co-ordination and allows sharing of clinical and clinical support resources such as visiting allied health services, clinical education and professional development, clinical nurse specialists, telehealth, information management/IT systems, transport, food, linen and stores.

The Aged Care reforms have removed the distinction between high and low care funding for residential places. Therefore all providers are able to develop their services to meet the needs for people assessed as eligible to access residential care anywhere along the continuum. This allows the client or their family to seek or request a place from any provider listed on the myagedcare portal - MPSs are included on these lists for each State and Territory. This change in care level distinction could facilitate a significant increase in demand for places from an MPS or undermine the viability and sustainability of other aged care providers already established, or those wishing to establish a new service, in a rural town. Therefore, there are parity and access factors that need to be addressed in the forward planning for the MPS model in NSW.

3.1. **Accommodation Fees**

There should be some consideration given to the application of Refundable Accommodation Deposit (RADs) and Daily Accommodation Payment (DAPs) to any individual accessing a residential place in an MPS, and deemed as eligible, under the new fee arrangements introduced through the Australian Government Aged Care reforms. A NSW Health policy change would be required to introduce this payment

Under the new Aged Care reforms RADs and DAPs based on income and assets testing carried out through Department of Human Services (DHS - Centrelink)), will be charged to non concessional people accessing residential care from any aged care provider across Australia. As of 1 July 2014 these entry payments could have been introduced and applied to any new MPS residents. Currently MPSs in NSW are not requesting accommodation deposits from eligible residents and this has the potential to create an inequitable and unfair competitive advantage to aged care providers in the same town or community with clients opting to be admitted to the MPS where there is no RAD required.

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3.2. Access Criteria

The aged care access portal myagedcare operates under the premise that an individual has undergone an aged care assessment to determine the appropriate level of care. Under the current MPS Operational Guidelines access to an MPS does not require an ACAT assessment. This practice, if continued, has the potential to create inequity in access to an appropriate level of residential aged care, particularly in communities where there are options for aged care provision. Operators previously labelled Low Care or Hostel providers can offer the complete range of aged care once accredited, therefore being encouraged to develop their capability and capacity while expanding their services. The ACAT assessment introduces a quality based, standard access criteria, for home and residential aged care services. An MPS should operate in collaboration with all aged care providers, therefore in the absence of an ACAT assessment there is the potential for the MPS to be put in a position of having to operate under a ‘first in’ basis in response to direct requests for care from individuals, rather than ensuring those individuals who may have a higher level of health care need or very low functional capability can access the most appropriate care when they need it. Formalising the requirement for an ACAT assessment prior to admission to residential aged care in an MPS should be considered.

3.3. Partnership Models

3.3.1. MPSs with no Provider in town

As indicated earlier the MPS model can be developed to take a number of shapes. It is proposed that in very small communities where there is no aged care provider and the number of aged care places are low and not projected to increase, that the traditional MPS model apply and the LHD continue to operate as the aged care provider. However, there may be instances where the LHD could contract an aged care provider to manage their MPS or a group of MPSs across the LHD that only have residential aged care beds. The WAC Health model, where Silver Chain Nursing has been contracted to provide this care on behalf of the health service is one example.

While a residential aged care benchmark is used by the Australian Government to inform planning, it is not recognised as the sole justification for the need for residential aged care. Additional supporting evidence includes waiting lists, aged care assessments and numbers of residents having to leave town to access aged care.

3.3.2. MPSs with another Provider in town

The Australian Government has detailed its intent to significantly increase the number of aged care places available by 2022 across Australia, along with more providers coming into the market to meet the home care support needs. Where early planning, using the aged care planning benchmark has shown the number of residential aged care places is projected to increase; consideration should be given to undertake market testing to determine whether there is interest from any providers, locally or new, to deliver this care.

While the LHD cannot apply for these aged care places on the providers behalf a collaborative approach to planning may see the MPS develop a ‘specialist’ aged care role, complementary to the services planned by the aged care provider. This arrangement can be formalised by an MOU which is already accepted by the Australian Government, with the MOU outlining the shared and collaborative components of the relationship. The specialist role of the MPS may be to provide residential aged care to very high need dementia clients, or if not providing a bed based service establishing the MPS as a high level (nursing) home care support provider.

The possibility of this ‘boutique’ MPS model had been the subject of discussion around Oberon MPS in 2005/06 where there was strong representation from the local community for the MPS to expand however a not for profit provider was interested in developing services in the town. Rather than developing competing services, it was agreed that the MPS would maintain the number of places it held and take on the role of providing the very high, nursing intensive, level of residential care that the new aged care service was not in a position to provide. While this has developed informally and the LHD did not go to the market looking for a provider or a partner this was a win-win solution for all parties. A more formal arrangement could be used if this marketing and partnership arrangement is adopted in rural and regional LHDs across NSW.