I would like to make some observations from an Aged Care Assessment Team perspective. I note my comments will be publicly released and give permission.

I have been an ACAT Assessor in country SA for 15 years and have experienced the changes in the program. Although we are a small team, it seems a microcosm of the bigger picture.

Resourcing of ACATs

Commonwealth funding has long not covered our costs, and we are now subsidised from the HACC budget to maintain the historical staffing levels of 1.5 assessors. Staffing levels haven't changed in 15 years, but we now have so many more products to assess for. I endorse the observation that ACATs have been under-resourced for some 10 years (p.96 of issues report) and this plays out in waiting times etc.

Lack of continuity between HACC, CACP ..compared to ageing in place in residential care

We see people in HACC receive more hours than a CACP and a refusal to transfer as care needs increase because the cost of a CACP is so much higher than HACC. We see the gap between a CACP and EACH and not enough of either. So many people are on unsustainable CACP hours and the provider has to cut or the person has to go into residential care.

The nexus between ACAT Ax and funding for facilities

Facilities presently require an ACAT ReAx following the intake ACFI to gain high level funding. I understand many teams simply will not do these due to workload, so this leads to long term financial losses for facilities. Given that facilities assessments are validated, I cannot see any logical reason to place this demand on ACATs. I would also endorse any change that made resident contributions similar whether in high or low care. I am aware of harassment of ACAT staff to change an approval to high level care so that the person does not need to pay a bond. Remove the distinction between high and low for financial purposes and remove the need for ACATs to ReAx – just Ax care needs and eligibility!

Inappropriate admission into residential care

These comments are of concern. I wonder if aged people in hospital are being assessed too soon and this reflects the general lack of restorative and step-down services, as well as pressure on ACATs to Ax. We do our best to wait until the person is medically stable and have rejected referrals where the person is an inpatient, as per the program guidelines. I can see many reasons why assessments could go ahead when teams have time pressures to get the job done. Whether this is an effect of states operation would be interesting to attempt to validate.

Change the focus of ACATs

It would be a shame to lose experienced and competent assessors in the proposed structural changes. ACATs do experience recruitment problems, so it is clear that assessment isn't everyone's cup of tea. It would appear the

new model's recommendation of 'comprehensive assessors' would fit with the work we do at present.

At the low care end

The defunding by the ACFI of people with low care needs and insufficient packages has created a gap for those who have dementia and need assistance with instrumental activities. In country regions, there are also limited people to actually staff packages in the home. There needs to be flexibility for non-metropolitan settings and small stand alone facilities so that they can be financially viable and provide the service for which there is clearly a need.

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The increased ageing of the population is a cause for celebration. Older people are vigorous contributors to their communities and the well-being and care of their extended families