Anglicare Australia
in every Community

Response to:

Department of Social Services Commonwealth Home Support Programme (CHSP):

- draft program manual
- Good Practice Guide for Restorative Care Approaches (incorporating Wellness and Reablement)
- proposed Commonwealth Home Support Programme National Fees Policy

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Anglicare Australia

Anglicare Australia is a network of over 40 independent local, state, national and international organisations that are linked to the Anglican Church, and are joined by values of service, innovation, leadership and the faith that every individual has intrinsic value. Our services are delivered to one in 40 Australians, in partnership with them, the communities in which they live, and other like-minded organisations in those areas. In all, almost 13,000 staff and more than 7,500 volunteers work with over 600,000 vulnerable Australians every year delivering diverse services, in every region of Australia.

Ten Anglicare Australia network members provide aged care in the community, five of whom also provide residential care; with more than 3,600 residents, 4,500 clients with community packages and more than 22,000 accessing home support or HACC services.

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This paper

Anglicare Australia supports the introduction of an equitable national scheme to deliver home support as an entry point to the broader aged care system, and welcomes the opportunity for consultation on the Commonwealth Home Support Programme (CHSP) which is due to start on 1 July.

Anglicare Australia sought the views of network members in developing this response to the department's recently released CHSP fee policy consultation paper, draft program manual and best practise notes.

As a member of the National Aged Care Alliance (NACA), Anglicare Australia has had the opportunity to contribute to NACA's thinking on these matters as well.

A few key issues that have emerged in discussion across the Anglicare Australia network are the focus of this paper. They are:

- that the proposed fees structure may adversely impact on the most disadvantaged Anglicare clients and those with complex needs
- the weaknesses in the draft program manual, particularly in terms of support for carers, are counter to the Aged Care Sector principles and the best practise guide
- the unwieldy treatment of allied health services and a proposed simplification
- similar unhelpful and inefficient complexities right across the new system that can be grouped under the heading of red tape.

National Fees Policy – CHSP

As with the introduction of fees and charges in other areas of age care reform, there are both transition issues at the point that the consistent fees and charging regime is introduced, and matters of consequence that would be ongoing if not addressed.

The introduction of the new fees regime

Given the recent public outcry in relation to the introduction of a relatively small GP fee, concern from clients/carers about new charges is expected.

For aged care service providers that have been able to offer Home and Community Care (HACC) type services at very low cost or free of charge until now, the introduction of the new program – with its new fees and charges structure – will particularly provoke their customers. It is important that this industry or system-wide shift is owned by all levels of the system, and be obvious to existing and future customers from the point of first assessment through to contact with providers.

Anglicare Southern Queensland (ASQ) for example has approximately 15,000 active HACC clients who will need to be transitioned within four months from 1 July. The likely impact on those clients will be either that they pay more or that they reduce the level of service that they currently receive.

ASQ, as with other Anglicare network members, supports a higher proportion of vulnerable clients with complex needs and financial disadvantage than the industry average. The level of support required and the cost to ASQ of transitioning these clients is expected to be material.

Anglicare network members are strongly connected to their communities, and have both a mission and a history of working closely with the most disadvantaged and vulnerable members of society. In the interest of equity in the longer term, it is important that the impact of the new regime on access to care and support for these customers is closely monitored, and the consequent impact that this reform has on the capacity of the providers to continue to offer the full range of services to these people.

Eligibility for concessions

As it does not appear to be compulsory for a client to provide evidence of their pension status (or equivalent income) prior to being referred by the Regional Assessment Service/*Myagedcare* gateway for a CHSP service, it would appear that all the risk of debtor management falls back to the provider. If they have to pick up the cost of debtor management, some providers may exercise their right to refuse service to vulnerable clients, leaving them further at risk without any form of care or support. Consideration should be given to making the determination of concession status a clearly defined/compulsory step in the assessment process to prevent unintentional inefficiency and administration being built into service delivery.

There are some across the sector that fear that providers are increasingly distanced from many aspects of the client journey and that the provider role is now one of service delivery only, with intake to system becoming the task of *Myagedcare* and assessment/referral to service becoming the task of Regional Assessment Service/Aged Care Assessment Service. In that sense determination of fees does not belong at service delivery.

Compounding costs

With the maximum (inclusive of supplements) fortnightly Aged Pension rate of $860 per single and $1,296 per couple (combined), the proposed CHSP maximum co-contribution of $10 per session/part thereof for a full pensioner would appear to be both fair and reasonable.

On the face of it, such a co-contribution represents a mere 1.1% and 0.7% respectively of total family income. Given the positive psychological benefits and sustainability outcomes that many recent researchers have identified arising from a client's economic contribution to the provision of their care (See Gilbert, OECD 2005) once they are used to the idea, such a

relatively small co-contribution would, arguably, be an advantageous investment on their behalf.

But of course that assumes there is only one session or service needed. Where someone requires an intensive, short term level of care – for reablement and wellness following accident or illness – the proposed CHSP co-contributions could prove much more significant. Particularly as intensive short term support is not likely to meet the assessment requirements for other funded aged care programs such as Home Care Packages (HCP).

For example, consider a client/patient requiring nursing care (wound management) twice daily (b.d) and personal hygiene support once daily (q.d.) for a fortnight, as a consequence of some health event, in order to maintain their independent living. Under the proposed fee structure, a full pensioner would potentially incur a total co-contribution cost of $420.

For the given fortnight, such a co-contribution could represent 49% of the person's total income and that could place them in extreme financial hardship, leave them seeking benevolent exemption, or inappropriately reducing the level of service. This would seem to be contrary to the Aged Care Sector Committee's guiding principles, and may result in unintended and hidden cost shifting to other areas of the health sector, such as hospitals or GPs, where treatment of acute episodes given would be free.

Anglicare network experts estimate typical Home Care client basic fees at around $2/day regardless of package level (being a true reflection of most recipients' capacity to pay). That's a big gap to the real cost of services on offer, and well above what will be available from CHSP after 1 July.

A cap on fees

The fees schedule is intended to create a cost difference between the services available through CHSP and other packaged care types such as HCP. However, unlike other programs of funded aged care, the CHSP does not provide for a daily, or even annual, cap on fees. The unintended consequence is the removal of any validated and consistent safety net for vulnerable and disadvantaged clients/patients, and risks directly contributing to their economic and ongoing health impoverishment.

The current charge applied by providers such as ASQ is on a per visit basis, not hourly. This means that some visits, such as respite or social support visits which can be up to three hours, are charged at a flat per visit rate irrelevant of the length of the visit. The proposed fees structure may result in less informal carer support being provided and the prioritisation of less time-intensive services in order to reduce the cost burden on client and carer.

Day Therapy Centre (DTC) experience across the network validates this analysis. While DTC hourly charges were low, repeat visits (often multiple in a week) ensured a self-imposed cap became a necessity.

The provision of home care and support is more difficult to people in insecure housing. The absence of a cap on fees and a drift away from longer social and respite visits will make

ongoing independence and inclusion for their older people harder to sustain. They are generally much more financially vulnerable than homeowners, with those in private rental housing in particular unable to absorb unplanned costs, and much less likely to be able to modify their homes should it become necessary.

Fees for group sessions

Anglicare Australia members have noted that no fees have been proposed to date for group sessions within the Allied Health arena or for social support group activities. An hourly rate that is consistent with an individual session would make group activities unaffordable for the majority of our consumers. Group sessions should be included in the fee structure as they are cheaper for customers and permit them to access a wider range of services and activities.

Anglicare Australia members have been encouraged by verbal representations from departmental staff that fees for groups will be included in the revised CHSP. Group fees should be introduced for Home Care and Allied Health, encompassing sessional rates for social support activities and hourly rates for Allied Health support services. Guidance would also be appreciated on the application of the respite 'sessional fee', as respite can be offered on a half day, full day or overnight basis.

The CHSP Manual

Wellness

Anglicare Australia and the aged care providers in the Anglicare network welcome the focus on wellness and reablement in the program. Wellness is well described in the Best Practice Guide as

> "encompassing physical and psychological wellbeing, individual health, community connections, practical support and whatever gives each individual's life meaning and purpose."

The specific mention of community connections and the broader acknowledgment of life's meaning and purpose are particularly helpful and significant.

It is the view of our network that in operationalising such an understanding of wellness, the draft CHSP program manual falls short of the mark. And while we would acknowledge that the program manual by definition is task focussed, the way the tasks are framed will define the focus of services, as the description of wellness in the manual makes clear:

> "Wellness is an approach that involves assessment, planning and delivery of supports that build on strengths, capacity and goals of individuals and encourages actions that promote a level of independence in daily living tasks, as well as reducing risks to living safely at home."

It is important to bear in mind the *use* of a manual, as opposed to the aged care principles or the best practice guide. It is used as a set of directions. And so, while the notion of building on the "strengths, capacity and goals of individuals" might allow for those higher level ambitions relating to community connection and meaning and purpose in life, they will in effect simply feed in to the conduct of daily living tasks and reduced risk to safety, unless further expanded.

Carers

The place and support for carers in the evolving aged care systems around Australia is at best unfinished, with the importance of informal carers recognised at the higher level, but growing uncertainty when it comes to the day to day level of care and support for carers and their work. That paradox is evident in the development of the CHSP to date.

At the highest level, the recently released Aged Care Sector Statement of Principles proposes the direction or goal for aged care where:

- consumer choice is at the centre of quality aged care
- **support for informal carers will remain a major part of aged care delivery**
- the provision of formal aged care is contestable, innovative and responsive
- the system is both affordable for all and sustainable.

These goals complement the 10 key principles of the (national) Carers Recognition Act 2010, which are contained in a statement that sets out how carers should be treated and considered in terms of policy, program and service delivery settings. They are as follows.

1. All carers should have the same rights, choices and opportunities as other Australians, regardless of age, race, sex, disability, sexuality, religious or political beliefs, Aboriginal or Torres Strait Islander heritage, cultural or linguistic differences, socioeconomic status or locality.
2. Children and young people who are carers should have the same rights as all children and young people and should be supported to reach their full potential.
3. The valuable social and economic contribution that carers make to society should be recognised and supported.
4. Carers should be supported to enjoy optimum health and social wellbeing and to participate in family, social and community life.
5. Carers should be acknowledged as individuals with their own needs within and beyond the caring role.
6. The relationship between carers and the persons for whom they care should be recognised and respected.

7. Carers should be considered as partners with other care providers in the provision of care, acknowledging the unique knowledge and experience of carers.
8. Carers should be treated with dignity and respect.
9. Carers should be supported to achieve greater economic wellbeing and sustainability and, where appropriate, should have opportunities to participate in employment and education.
10. Support for carers should be timely, responsive, appropriate and accessible.

The CHSP manual states that it reflects the priorities and principles outlined above and that carer support is seen as a major part of the aged care delivery. However, on close inspection of the manual it would appear that only some of the principles are reflected in it, and indeed that it is mostly silent on carer need and support.

The proposed manual only focuses on the carer through "care relationships and carer support" services, which equate to respite type services. Many providers currently provide supports to carers through Carer Support Groups, individual assistance when issues are discussed and a greater level of service is required, assistance when the caring role ceases and transitioning into further community engagement or vocational training is required for new employment opportunities, and other innovative approaches to meet needs. The possible unforseen consequence of the changes to CHSP is that these more holistic services for the carer will become fragmented, or not provided at all.

The manual indicates that work is still being undertaken for future carer services – currently described as Carer Respite Centre Programs, National Carer Counselling and Carer Information Support services – in conjunction with disability and aged care reforms. It is unclear however how this will be undertaken and whether the aged care sector will contribute to the design of these new services, and what the consequences may be in the meantime of leaving carers behind as the new Home Support Program is implemented.

Furthermore, despite respite type service being in scope there are particular issues around respite care under the new regime, with carers seemingly ineligible for respite in their own right once a care recipient is allocated a HCP.

The target group is explicitly frail, older Australians aged 65 years and over (50 years and over for ATSI people) needing assistance with daily living to remain living independently at home and in the community as the direct service recipients of planned respite services. Carers are considered implicitly as receiving benefit to take a break from their usual caring duties from the planned respite services for the person for whom they care. However, previously under the National Respite for Carers Program (NRCP) the carer was seen as the client and therefore service was organised around the carer's needs, and so provided scope for carers to receive respite whether the care recipient was on a HCP or not. This appears to have been removed from the proposed CHSP.

At a recent Brotherhood of St Laurence Carers' Focus Group, during a discussion on the implications of changes to respite subsidies, it became clear that the HCP is unlikely to be

able to support the care recipient's needs and nor pay a full cost recovery price for respite. Carers considered that this would impact their capacity to continue to provide care, hastening residential placement. Carers also indicated that they could not afford to pay the full cost of respite.

The consequence of these measures and the lack of more comprehensive action on carer support together contradict the principles of carer support and recognition, as legislated and agreed to, above.

Younger Onset Dementia

Another specific area of concern is for people less than 65 years, who currently receive day and respite assistance under HACC and NRCP funding due to younger onset dementia (YOD). They are at risk of disadvantage if they lose the option of access to services under CHSP once the NDIS is fully implemented, as is presently planned.

The NDIS Model is based on a marketised disability sector. Historically the disability sector has emerged to support people with a range of disabilities, but it has not placed a focus on supporting people with dementia, where this is the primary disability. Many people with YOD are currently supported by a YOD key worker, who acts as their primary point of contact. As a result they are linked into aged care services in a timely and coordinated manner. It is of concern that precluding younger people with dementia from the CHSP will limit their access to appropriate services being delivered by the aged care sector.

Aged care providers are employing innovative approaches and programs to engage people with YOD, encouraging them make the most of their capabilities, skills and knowledge to assist themselves and others. It is a true reflection of wellness, reablement and restorative approaches that underpin contemporary thinking. That will be lost if the CHSP and the NDIS between them limit or stop access to these services.

Understanding the role of nurses

The description of a nursing service does not encompass the role nurses play in wellness and re-ablement and is limited by the definition of nursing care as “care directed to treatment and monitoring of medically diagnosed clinical conditions. The care can include recording client observations”. It should be noted that nursing services play a significant role in chronic condition management, education of clients in maintenance of good health practices and the delivery of treatments and care that improve a client’s capacity to self-manage. The definition as it stands is task-focussed and prescriptive and does not acknowledge the nursing profession’s full scope of practice.

Anglicare network members queried how the difference on costing to part pensioners of nurses services as opposed to allied health was arrived at ($32 and $15), and are concerned it will discourage people from drawing on nurses’ skills.

Assessment and allied health

Regional Assessment Services and Allied Health therapies

The draft program manual acknowledges the important role of allied health professionals in providing restorative care, an important principle of the new Commonwealth Home Support Programme.

Tender documents indicate that Regional Assessment Services (RAS) are to train Home Support Assessors in the unit of competency CHCAC318B Work effectively with older people, which is concerned with residential aged care and home and community care. However, no mention is made specifically of (allied) health support services in the unit content which suggests RAS staff will have little or no familiarity with the benefits of allied health support services, nor of the subtle differences between the therapies.

That is generally a concern in terms of assurance that the assessment services share our understanding of the reablement, restorative care and wellness principles of the CHSP. However, it is of particular importance if the assessment process is to require referral to RAS every time a client requires a different service, as the draft program manual presently suggests.

A more general point on assessment relates to quality and standards. The new assessment and admissions systems are dependent on well informed staff with a commitment to continual improvement. There doesn't seem to be that kind of assurance built into these systems yet.

Allied Health therapies as one 'service'

The draft Program Manual indicates service providers have an ongoing responsibility to monitor and review the services they provide their clients to ensure that the client's needs are being met. The manual indicates that where the client requires a different service, the service provider will refer the client to the RAS for a review.

The draft manual does not define 'service' and Anglicare Australia suggests that for the sake of clarity, Allied Health support services (physiotherapy, occupational therapy, podiatry, exercise physiology, massage, dietetics or speech pathology) could be considered one service. With, perhaps, some adjustment to allow for the different unit costings related to providing the various services.

The alternative scenario is that the service provider is required to direct the client to return to the Regional Assessment Service for a re-assessment whenever a new therapy need is identified.

To give an example, AnglicareSA's Allied Health has a client, Mrs X, who was referred for long-term podiatry foot care in 2014. During a session with her podiatrist, Mrs X mentioned she had had some falls so the podiatrist referred her to an exercise physiologist within the

clinic. On assessment, the exercise physiologist recommended Mrs X attend a Falls and Balance group at the clinic for intensive assistance in the short-term and maintenance longer-term. The podiatrist also referred Mrs X for a home visit by one of the clinic's occupational therapist (OT) to assess her home for falls risks. During the OT's home visit, Mrs X mentioned she'd been experiencing back pain. The podiatrist suggested physiotherapy but Mrs X decided on massage at the clinic instead.

The client's best interests are served by ensuring that related Allied Health services can be accessed quickly when the need arises. The possibility that a Mrs X would need to return to the Regional Assessment Service for no fewer than four new referrals seems unnecessarily complex and confusing for clients, slow and expensive overall, and not well informed given our concerns (above) that RAS staff may have inadequate understanding of the Allied Health services.

The growth of red tape

The unwieldy nature of the processes relating to government regulation and funding of aged care services affects every area of care. It is complex of course because these are complex matters; there are issues of safety and quality assurance which cannot be trivialised, and they involve substantial sums of private and public money for which providers and government agencies must be accountable. But it is where the processes are inefficient, unnecessary or repetitive that we think of them as red tape.

While this paper is a response to the draft guides and manuals for the Commonwealth Home Support Programme, the discussion of red tape reduction below has a wider resonance and reads more broadly as a consequence. It is of course particularly relevant to the introduction of CHSP nonetheless.

Red tape reduction

The Australian government has undertaken to improve and simplify process and procedure in transactions between itself and funded agencies as part of its overall endeavour to reduce red tape. This initiative is most welcome. In the aged care sector some advances have been seen, with simplification of grant application processes and documentation; and in the contracting of approved providers and successful tenderers. Again most welcome. However there remains much room for further improvement, especially in light of the major reforms yet to be fully enacted across the aged care sector.

While typically we link red tape to the bureaucratic process associated with one-off occurrences, such as a new funding agreement, the provision of government funded services requires continual (often daily) access to systems, funding claims/payments/reports, and program reporting. As the discussion of access to Allied Health services in the CHSP makes clear above, repetitive, unwieldy and ill-informed decision making procedures can increase the cost and undermine the outcomes our aged care system.

Following are several areas of concern to Anglicare Australia members engaged in the delivery of aged care services.

Transition timeframes

The aged care reform we are in the midst of requires development of new approaches to service delivery, alignment with new program guidelines and adoption of new systems. While it is all part of the challenge arising from change, too often detailed information about the commencement of forthcoming reform is received at short notice and with limited insight to operational practicalities. Change takes time, lead time for commencement of reforms needs to accommodate this, otherwise adoption of change can be rushed not planned, ill-considered, piecemeal and ineffective.

Use of multiple systems

Much has been made of the introduction of the *Myagedcare* website and related initiatives as the doorway to a more accessible and efficient service.

While there is some progress towards common systems and tools, the journey is far from over. Providers are currently working with client records within their existing systems and information relating to new clients in *Myagedcare*. Similarly, client referrals may come from *Myagedcare* or from assessment agencies or from existing wait lists. It is not a good picture. While phased transition sometimes makes sense, in this case it is not at all helpful.

Aged care providers are most concerned about clients and claims, ironically both exist in different systems, one in early stages of development, the other in a dire state of disrepair. It needs to get better. Beyond the immediacy of aged care service provision are client interactions with Centrelink, Medicare, health sector systems all holding information, arguably of relevance to others involved. One of the key pathways to red tape reduction is to ensure the various government agencies can work more effectively with each other.

Manual processes

Approved providers are required to provide to a variety of documents, reports and claims to government agencies in the course of provision of services. Some of this is compliance or contract related, some of it is for purposes of managing payments, in any case it is routine and ongoing. Almost exclusively these requirements involve manual effort and paper based approaches.

There has been little progress in this area since government's red tape reduction commenced. The current state of Home Care claim and payments illustrates the worst-case scenario emerging from a combination of system failures and regression to manual claims procedure. Technological advances should support online lodgement of documentation, interfaces between different systems that consolidate data and pre-populate documents, and provide for point-in-time user access to historical documents or presentation of new documents.

Provider burden

Aged care reforms have uncovered and created new red tape. Introduction of consumer co-contribution, income assessments and fee policies have created an additional burden for providers, with the impact of delays in processing income assessments and determining co-contributions for both consumers and providers well documented. However little attention has been given to the time, effort and cost to providers arising from explanation of income assessment and co-contribution to clients who are unaware, anxious or ill-informed. In a system supported by a website, contact centre and assessment agencies, it makes little sense that relevant matters that affect an client's access to services, such as assessment and fee determination, are not adequately actioned prior to entry to service. The fee process proposed for the start-up of the CHSP adds to the provider burden.

Unnecessary repetition and complexity

Too many transactions require the provision of information that is already known or held by government. Approved provider status should free the provider from providing organisational information and accreditation information on repeat occasions through multiple platforms, and simplify claim and reporting requirements.

We are concerned with unnecessary complexity. AUSKeys, the essential access requirement to government systems, is a good example. While forms, passwords, access levels are to be expected, it cannot be called a simple system if departmentally run user information sessions are required for first time users.

Conclusion

Aged Care providers in the Anglicare network look forward to working with others in the aged care sector and with the department in fine tuning the introduction of the Commonwealth Home Support Programme. We would welcome any opportunity to respond to proposals that might address these and other sector concerns regarding the program's design and implementation.

We would be particularly interested in helping to plan the monitoring and evaluation of the first stages of the CHSP. We have a special interest in the impact the new scheme will have on the ongoing wellbeing and access to services, and support by those older members of our community who are isolated and who live in hardship.