Response to ACFA Respite Care Consultation Paper

Introduction

The Australian Government's original objective in subsidising consumer access to respite services was to delay or avoid the need for more costly permanent residential aged care by giving informal carers a break from caring duties, including relief in case of emergencies, and giving consumers more opportunity for socialisation and a break from their usual care arrangements.

More recently, greater prominence is being given to the complementary policy objective of supporting consumer choice to remain living in the community for as long as possible.

A feature of respite services is that they are linked to the predominant aged care programs, namely residential care, home care packages and the Commonwealth Home Support Program (CHSP). As a result substantially different arrangements apply for respite services, including with regard to funding, eligibility and assessment arrangements and consumer contributions, depending under which program they are accessed, notwithstanding that similar policy objectives apply across all types of respite services.

A key distinction that influences these arrangements is the population being targeted. Residential respite and respite accessed under a home care package (especially higher-level packages) are targeting consumers with higher care needs, whereas CHSP respite is targeting consumers with lower care and support needs.

The following sets out provider responses to the questions identified in the Consultation Paper. This is followed by discussion about the appropriateness of current respite arrangements into the future, including in the context of the Roadmap objectives of greater consumer choice and equity in consumer contributions for respite care.

2. Provider comments on specific questions raised in the Consultation Paper

1. <u>The process for applying for and seeking access to respite care</u>

    - Concerns have been raised about delays in being assessed for respite by MyAgedCare (MAC) and ACATs, especially for emergency respite. This is contributed to by many consumers and their families being unfamiliar with MAC.

    - The MAC process can be confusing for many e.g. if the service sought is respite only, many carers wish to select the location at the time, hence having referrals on the portal does not necessarily work well for any other time other than the first nominated time.

    - Due to occupancy management, many aged care homes have a decreased ability to provide respite that some carers may wish to book well in advance. Most providers do not have dedicated respite places, but instead manage respite in the context of overall occupancy.

    - Many facilities do not accept short term stays because of the high one-off admission costs.

2. Bottlenecks or delays in accessing either residential or non-residential respite care

- Some ACATs will not approve someone for respite care if they are thinking of permanent care. This can limit a family's ability to 'try before you buy'.

- Supply constraints can delay access to respite care, especially in the case of emergencies and for people with a dementia diagnosis.

- The matters referred to in 1) above are also relevant to this question.

3. Whether current provider funding structures for the provision of residential respite care are appropriate

- The work associated with admitting a respite consumer is as high as a permanent resident, hence the majority of aged care homes will not consider anyone for respite unless they have a high respite ACAT approval and the respite duration is for at least one week.

- As well, the funding received does not cover the additional costs incurred by short-term respite arising from the fact that a respite consumer is in a strange environment, surrounded by strangers and away from familiar supports and generally unsettled. As a result, the behaviour management is much higher. Overall, providing respite services for high needs residents is high risk, resulting in many providers limiting numbers in order to limit the risk.

- The disparity between costs and revenues for low care respite residents reduces the availability of low care respite places. Many providers are reluctant to provide respite care for low care consumers.

- The 70% utilisation threshold to attract an incentive payment creates an incentive for some providers to limit their respite places in order to increase the likelihood that the threshold will be achieved, and thereby maximise average bed-day revenues.

- Because respite funding does not reflect the work involved, many providers use residential respite as a flow-through to permanent care, rather than for support to enable consumers to live in the community.

- A factor that influences respite use is the incentive for non-supported residents to maximise their use of respite care because respite care is lower cost than permanent care. Delays in means testing assessments are convenient in this regard.

4. Whether the current system for allocating respite bed days to residential care providers impacts the availability and provision of respite care

- While acknowledging that requests to the Department for variations to the number of approved respite places generally are dealt with reasonably quickly, providers question the need for the process at all. It could be left to each provider to manage the balance of respite and permanent residents based on local demand and overall occupancy.

- In order to maximise the 70% incentive, some providers focus on monitoring and managing approved respite places, including seeking variations from the Department to approved respite places to facilitate retention of the incentive.

5. Costs to consumers and/or carers seeking to access respite care

   - There is an incentive for non-supported consumers to extend their respite status because consumer costs are lower.

   - There is no consistency in fees paid by home care package consumers and CHSP consumers for community-based respite services, and consumers of residential respite are not required to contribute towards their care costs, even though home care packages (suspended while a package holder is in residential respite) are income tested.

   - There is a view that low-income pensioners have difficulty affording the basic daily fee that applies in residential respite.

6. Impact of the current arrangements on equity of access for respite care recipients, including access in an emergency, or to residential respite for periods of less than one week

   - Current funding arrangements can be a barrier to accessing residential respite for the following categories of consumers: low care consumers; consumers seeking short-term respite, emergency respite, or planned respite well in advance of need; and consumers with high care needs associated with a dementia diagnosis. CHSP respite services are either generally not readily available for this these groups of consumers or are not suitable for their needs.

   - Package holders accessing respite services from a CHSP-funded provider are expected to pay any consumer fees associated with the service, as well as the fees associated with the package.

   - Approval processes through MyAgedCare can make timely access difficult in emergencies.

7. Any unintended impacts or consequences of the current arrangements supporting access to residential respite care

   - Many consumers seeking permanent residential care are reluctant to make a final decision until Centrelink assessments are completed, and until financial matters such as unrealised assets e.g. retirement living units, are dealt with by the family. This is resulting in a smaller proportion of residential respite being used to support consumers living at home.

   - The greater transparency and prominence given through the national prioritisation process to the home care packages waiting list has highlighted the option of allowing consumers awaiting the assignment of a package to access residential respite, including using 'unallocated/unfunded places'. Because of the unpredictable operation of the ACAR, many providers have unfunded places in their services.

8. Use of Commonwealth Home Support Program respite care services and the interaction with other programs that deliver respite services, including residential respite care

   - There is anecdotal evidence that the supply of CHSP respite services for lower care need consumers, especially cottage respite and emergency respite, does not meet demand.

- Consumer contributions for community-based respite are not aligned, including means testing arrangements.

- Cottage respite (generally overnight) and day respite are normally not suitable substitutes for residential respite for consumers with higher care needs, including consumers with an advanced dementia diagnosis.

3. Looking ahead

A question that arises is whether the current arrangements for the provision and funding of respite care across the major programs are consistent with the Roadmap objective of creating a more consumer-driven market-based aged care system where consumers have greater choice of services and where to live.

In the Roadmap context, access to respite services assumes greater significance as an essential service for supporting and enabling consumer choice to remain living in the community, rather than permanently in residential care.

Trends in the use of respite care services

In 2016-17:

- 40,720 consumers accessed respite services under the CHSP at a cost to the Commonwealth of $248m. The Consultation Paper does not provide trend data on respite care use under the CHSP. However, given the capped block funding arrangements that apply under the CHSP, and limited growth funds in recent years, it can be assumed that the number of consumers using respite care services funded under the CHSP has remained relatively stable over recent years.

- It is not known how many home care package consumers used their individual budgets to access community-based respite care, including whether they sourced respite directly from their home care provider or from a CHSP respite provider through referral arrangements. It is also not known how many home care package consumers used residential respite.

- 59,228 accessed residential respite care at a cost to the Commonwealth of $287m. At 30 June 2016, respite residents represented 2.8% of total residents. There is no published data on what proportion of allocated residential beds are approved for respite care, or how the proportion may have changed over the years.

A feature of home care package consumer use of community-based respite services is that respite use and choice of respite type and service provider is consumer-driven, within the overall limits of individual budgets and package availability. The absence of individual budgets and funding following the consumer in the CHSP means that CHSP consumers do not have the same flexibility in choosing respite services and providers.

There is greater flexibility in the supply of residential respite services to the extent that providers can apply to the Department of Health for approval to use allocated places for respite services, but choice of provider is limited. However, this greater capacity to respond to respite demand is balanced against competing demand from permanent residents and the economics of respite care compared with permanent residents, which favours the latter.

As the Consultation Paper documents, there has been a steady increase in the use of residential respite over the years, but with sustained higher growth since July 2014. ACFA reports[1] that residential respite care use (measured in bed days) increased by 10% and 7.2% in 2014-15 and 2015-16 respectively, compared with an annual average increase of 4.5% previously. However, because there is no published data on whether providers have been seeking approval for increased respite places, it is unclear whether greater flexibility to increase supply has been important to increasing usage.

It is generally accepted that there has been a long-standing practice for residential respite to be used on a 'try before you buy' basis by consumers contemplating permanent residential care. However, it is unlikely that this factor would account for the sustained increase in residential respite care use that has occurred since July 2014.

While acknowledging the absence of hard data, there is anecdotal evidence that the complexities of the new combined income and assets test for all permanent residents introduced in July 2014 has contributed to consumers and providers choosing respite care pending the completion of means testing processes, and pending financial affairs being settled. The significant increase in the number of permanent residents admitted within seven days of a respite episode documented in the Consultation Paper supports this conclusion.

This explanation for the increased use of residential respite seems consistent with the recent Carers Australia[2] survey that showed that Commonwealth Carer Respite Centres (CCRCs) are reporting difficulty in finding sufficient residential respite vacancies to meet demand, though it is uncertain to what extent such difficulties were present previously.

On balance, it seems that that means assessment timelines, together with 'try before you buy', are combining to reduce the proportion of residential respite places that are being used to support older people living at home.

CHA does not suggest that respite use in these circumstances is inappropriate, but it is a factor to consider when reviewing the appropriateness of current arrangements.

Funding of residential respite services

An unusual feature of residential respite is that, unlike for permanent residents, aged care homes do not receive an accommodation payment, either by way of government payment on behalf of consumers or consumer contribution.

Recognising that this situation, along with the 'churn' costs of managing respite stays, was a disincentive for residential providers to provide respite care, the Australian Government some time ago introduced incentives and supplements to encourage aged care homes to make more respite bed days available, especially for consumers with higher care needs.

How these incentives and supplements were formulated is not clear. However, there is a general view amongst residential providers that the supplements and incentives do not transparently or sufficiently address the costs incurred in providing residential respite care. There is anecdotal evidence that providers are limiting the availability of respite places because of the additional costs of short-term stays and lower returns compared with permanent residents.

Given that demand for residential respite is likely to increase significantly as more consumers choose home care packages (current policy is to double the number of packages by 2021-22 to 140,000 packages), CHA

[1] Aged Care Financing Authority *Fifth Report on the Funding and Financing of the Aged Care Sector* July 2017
[2] Carers Australia *Improving Access to Aged Residential Respite Care* February 2017

recommends that the ACFA review include the following in order to position residential respite for the future envisaged under the Roadmap:

- An analysis of the economics of permanent and respite care in aged care homes to ensure a more 'even playing field' so that one form is not favoured over the other;

    - including an analysis of the current low/high level care payments received by aged care homes to assess whether they are consistent with current ACFI rates, and are sufficiently calibrated to reflect the care needs of respite residents, especially consumers with a dementia diagnosis.

- Replacing the current opaque incentive and supplement arrangements with revenue streams that reflect cost structures. This includes:

    - extending accommodation supplements paid for permanent residents to respite users, and

    - introducing a one-off admission payment to cover the cost of admitting a consumer into respite care for the first time.[3] The latter explicitly recognises the increased admission-related costs incurred in accepting a large number of short-term residents.

    Because respite residents continue to incur accommodation costs, there is a case for extending the accommodation supplement to all residential respite consumers, subject to retaining an annual cap over the number of respite days each consumer can use. The appropriateness of the current cap should also be reviewed.

    Means testing for care contributions for respite care may lead to practical and affordability issues for many older people who are income poor. On the other hand, home care packages (which are suspended for the duration of residential respite) are income-tested. Applying an accommodation payment for respite used as a flow through to permanent residence would be impractical.

    Overall, the judgment for the Australian Government is whether the social and economic outcomes of supporting more people in their choice to remain at home longer outweighs the cost of subsidising the cost of respite care.

- Removal of the current requirement to seek Departmental approval for residential respite places and introducing funding following the residential respite consumer (noting that temporary suspension of packages while a person is using residential respite applies).

    With more consumers expected to remain at home longer, residential providers (and cottage respite providers) should be given flexibility to develop business and service models that cater for this demand. Equally, home care package consumers should have choice of residential respite provider.

    The timing for introducing funding following the respite consumer would need to be coordinated with the removal of the ACAR for residential places.

[3] CHA notes that as part of the current review of residential care funding models, the option of introducing a one-off admission payment for permanent residents has also been floated. This would respond to the anticipated increasing proportion of permanent residents with shorter stays.

Funding for community-based respite services

Funding and consumer contribution arrangements for CHSP consumers and home care package consumers, and hence for providing and accessing respite services under the two programs, bear no similarities or consistency despite, in many cases, similarity in the types of services used.

CHSP respite providers are block funded and are required to seek consumer contributions from those who they assess can afford to pay. Home care package holders, on the other hand, are assigned an income-tested individual budget from which they can decide which support services, including respite, to purchase and from whom.

Funding, care contribution and choice differences concerning respite care are a sub-set of larger reform to achieve greater integration more generally across the two home-based care and support programs. Therefore, consumer contribution policies for community-based respite cannot be considered in isolation. In effect, consumer contributions, along with choice of services and provider for community-based respite care, has to be addressed in this broader context.

Preferably, user contributions for residential respite, where appropriate, should also be aligned with user contributions for community-based respite.

Assessment for respite services

CHA notes concerns that access to residential respite requires a comprehensive (ACAT) assessment. This requirement is appropriate as under current arrangements residential respite targets consumers with higher care needs who become eligible for a care subsidy.

However, assessment processes need to be appropriately resourced, administered and targeted to ensure that access to respite services is not delayed by MyAgedCare eligibility assessment requirements.

Catholic Health Australia
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