Submission

Aged Care Legislated Review

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Peter Sandeman
Chief Executive Officer

Anglicare SA
159 Port Road
Hindmarsh SA

Telephone: (08) 8305 9229
Email: psandeman@anglicaresa.com.au
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1 Introduction
AnglicareSA thanks the Department of Health for the opportunity to contribute to the Aged Care Legislated Review. AnglicareSA has addressed all elements of the nine-part scope of the review.

2 About AnglicareSA
AnglicareSA has been working for the community of South Australia for over 156 years. Our 1,800 staff and 700 volunteers support nearly 55,000 people each year. AnglicareSA’s diverse community services include aged care, disability, foster care, parenting, financial literacy, new-arrivals, Aboriginal services, emergency assistance and homelessness.

We support older persons, their carers and families at various ‘life junctions’ through the provision of a diverse range of services:

- 590 residential aged care places
- 90 Independent Living Units
- respite care
- 412 Home Care Packages
- palliative care
- dementia care
- A range of Commonwealth Home Support Program services to over 1200 customers annually
- Assistance with Care and Housing for the Aged
- A diverse and holistic range of allied health services to more than 3,300 customers annually

Our customers have the unique opportunity to experience a level of service integration that produces superior health and wellbeing outcomes. Our positive reputation has been built on providing unique service responses to some of South Australia’s most marginalised and vulnerable clients over many years.

We’re here for everyone, even the people everyone else has given up on, and we’ve been doing it for more than 156 years.

3 Overview of AnglicareSA submission and recommendations
The Productivity Commission’s 2011 report Caring for Older Australians and the subsequent reform process have had far-reaching consequences for the provision of aged care to older Australians. The 2016-2017 Aged Care Legislated Review is a timely opportunity to reflect on progress to date and the extent of future changes still likely to occur.
AnglicareSA makes the following recommendations in its submission to the Aged Care Legislated Review.

**Recommendation 1**: That Government prioritises the release of a significant number of new Home Care Packages levels 3 and 4 to address the greatest level of unmet need and allow more people to remain at home longer.

**Recommendation 2**: That Government consider only removing any controls on supply of Home Care Packages once there are sufficient packages in the system to meet the 2021-22 legislated provision ratio of 45 places per 1,000 people aged 70 years and over, and there is a mechanism in place to guarantee that subsequent, rising demand will be met by a corresponding growth in supply.

**Recommendation 3**: Given that market-based reforms may not deliver greater overall wellbeing for older people, the limitations of transactional, market-based arrangements should be explicitly recognised in future policy setting. These limitations should be taken into account when setting policy to ensure older people’s valued relationships remain intact and that they can remain in their own home and community for as long as possible. These relationships include family, friends, carers, care-workers and aged care providers.

**Recommendation 4**: The policy process for changing residential aged care to a market-based arrangement should take into account lessons learned from changes in Home Care and adapted to take into account the heightened vulnerability of consumers entering into a residential care setting and the greater capital and workforce implications for providers.

**Recommendation 5**: Any assessment of means testing arrangements and the alignment of charges across residential care and home care services should take into account the principle of intergenerational equity, to ensure that adult children don’t have to contribute to the cost of their parents’ care and their own.

**Recommendation 6**: That the Department of Human Services’ efforts to improve Centrelink’s means testing continue with a view to reducing the time taken to do assessments and the accuracy with which they are done. Regular public reporting on Centrelink’s performance in this regard may deliver increased confidence to consumers and providers.

**Recommendation 7**: In light of feedback from Anglicare Australia and University of South Australia research about the importance of the aged care workforce, it is disappointing that funding for the majority of aged care workforce programs has been subsumed into wider health workforce funding. Greater funding for aged care workforce programs should be made available to support the structural adjustment underway in the sector.

**Recommendation 8**: That Government retains the current arrangements for protecting refundable deposits and accommodation bonds.

**Recommendation 9a**: Future communications from My Aged Care should focus on how to access aged care and the costs of entry, as these are the most prevalent issues raised by potential consumers with providers.
**Recommendation 9b:** That information about *Increasing Choices in Home Care – Stage 1* is included on My Aged Care’s website, replicating information from the Department of Health’s website. Information for consumers should be available on the consumer gateway’s website.

**Recommendation 10:** That work by the Department of Health to improve consumers’ experience of My Aged Care continue, particularly for people from the cohorts defined as ‘special needs groups’ under the *Aged Care Act 1997*.

**Recommendation 11:** It will be vital for older people and their carers that the Department of Social Services’ proposed integrated carer support service work closely with My Aged Care and the latter places due emphasis on ensuring older people and their carers are provided with the necessary supports.

**Recommendation 12:** It would be valuable if the Department of Health could engage in a conversation with the aged care sector about what mature co-regulation looks like in other industries, in order that Government and providers can better prepare for a future co-regulatory model.

**Recommendation 13:** That consideration is given to ways in which a more integrated service can be provided to people on the disability and aged care continuum to ensure equitable outcomes for people aged 65 years and older, given the commonalities, shared systems and infrastructure increasingly featuring in the aged care and disability provider landscape.

**Recommendation 14:** AnglicareSA recommends that Government commission another independent review of progress to changes made in the aged care system in 3 years’ time, to evaluate the impact and effectiveness of Home Care and Commonwealth Home Support Program changes, and potentially in residential aged care.
4 Response to scope of the Review

4.1 Unmet demand for residential and home care places

4.1.1 Home care
There is still significant unmet demand for Home Care packages in South Australia, particularly for level 3 and 4 packages. The 2015 stocktake\(^1\) ratio of 28.6 places per 1,000 people aged 70 and over in South Australia (an average of 27.8 in metropolitan Adelaide) falls well short of the legislated provision ratio target of 45 places per 1,000 people aged 70 and over by 2021/22.

The integration of CHSP and Home Care Packages as part of *Increasing Choice in Home Care – Stage 2*, and the eventual integration of home and residential care into a single system, should streamline the aged care system and make measuring and responding to unmet demand easier.

**Recommendation 1**: That Government prioritises the release of a significant number of new Home Care Packages levels 3 and 4 to address the greatest level of unmet need and allow more people to remain at home longer.

4.1.2 Residential aged care
There is no longer much unmet demand for residential aged care in Adelaide as evidenced by an oversupply of beds. The 2015 stocktake ratio of 94 places per 1,000 people aged 70 and over in South Australia (an average of 100.5 in metropolitan Adelaide) vastly exceeds the legislated provision ratio of 78 places per 1,000 people aged 70 and over. This is borne out in AnglicareSA’s anecdotal experience as an aged care provider – waiting lists are “a thing of the past” and prospective residents with high ACFI are offered beds within 24 hours. It should also be noted the Department of Health’s annual report on the Aged Care Act suggests only 7 per cent of people aged 65 and over use residential aged care.

4.2 Controlling the number and mix of places for residential care and home care

4.2.1 Home care
In relation to Home Care Packages the primary focus of government should be on addressing a significant under-supply of packages, especially at levels 3 and 4. If controls on supply are to be removed – the Aged Care Sector Committee’s 2016 roadmap (the roadmap) contemplates uncapping supply of Home Care in 5 to 7 years’ time – it would be preferable that this be done when two thresholds are met: sufficient packages are available in the system at a point in time and there is a mechanism which guarantees that growth in demand will be met by a corresponding growth in supply. For the former, a widely understood threshold would be once there are sufficient packages in the system to reach the 2021-2022 legislated provision ratio of 45 places per 1,000 people aged 70 years and over.

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\(^1\) Commonwealth of Australia (2015)
Uncapping supply once the two thresholds have been met will give older persons, their families and carers some assurance in the short- and medium-term that there will be more packages released to fulfil the Government’s policy intent and address growing demand.

**Recommendation 2:** That Government consider only removing any controls on supply of Home Care Packages once there are sufficient packages in the system to meet the 2021-22 legislated provision ratio of 45 places per 1,000 people aged 70 years and over, and there is a mechanism in place to guarantee that subsequent, rising demand will be met by a corresponding growth in supply.

### 4.2.2 Residential aged care

The roadmap refers to removing the Aged Care Approvals Round for residential places in 3 to 5 years’ time. After that time funding would follow the consumer as it will in Home Care from February 2017. The roadmap also refers to removing the distinction between care at home and residential care, creating a single aged care system — agnostic as to where care is received — and uncapping supply in 5 to 7 years’ time.

AnglicareSA supports Government’s cautious approach to deregulation in residential aged care to ensure that people in rural and remote Australia are protected who may otherwise be disadvantaged in a fully deregulated market-based system.

### 4.3 Changing key aged care services from a supply driven model to a consumer demand driven model

#### 4.3.1 Home Care

**4.3.1.1 Is it better for consumers?**

Recent research shows that there is “no discernible differences in overall quality of life” experienced by people receiving aged care services in a traditional, supply driven model and in a consumer-directed environment. (Bulamu *et al* 2016, 1 and 6) However, the same research reported that participants showed “higher levels of self-reported control and independence” and suggested this shows the policy goals of CDC are being achieved. (ibid)

Earlier in 2016, AnglicareSA engaged the Australian Centre for Community Services Research at Flinders University to evaluate its implementation of Consumer Directed Care (CDC) in Home Care. The evaluation found “[I]t is unclear whether clients do actually significantly benefit from being able to say when their services are delivered. This may be an area that requires further consideration.” (Zizzo and Goodwin-Smith 2016, 3) Overall, most clients reported being satisfied with the level of voice, choice and control they are able to exercise over their Home Care Package with AnglicareSA. Many reflected on a high level of satisfaction and indicated that they did not have any improved outcomes based on the transition to CDC, but they did not consider themselves any worse off.

**4.3.1.2 What is important to consumers**

Preliminary findings from recent University of SA research into CDC shows older people place value on the idea of relationships in a Home Care service context. Almost 86 per cent of respondents rated

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the idea of continuity of care worker(s) over time as Important or Very Important (𝑛=848). 90 per cent of respondents rated the idea of care being provided as a partnership between my family, the service provider and me as Important or Very Important. (Beer et al 2016b)

4.3.1.3 Is it better for staff?
Zizzo and Goodwin-Smith (2016) observed that the delivery of CDC has had important implications for AnglicareSA’s workforce and working arrangements which present ongoing challenges to the effective and timely delivery of services. Due to the client having more control of when services are provided, the workforce has to operate in a more challenging and rapidly changing environment that do not mirror Industrial, National Employment Standards and Enterprise Bargaining terms and conditions. Workforce issues are addressed further at 4.7.

**Recommendation 3:** Given that market-based reforms may not deliver greater overall wellbeing for older people, the limitations of transactional, market-based arrangements should be explicitly recognised in future policy setting. These limitations should be taken into account when setting policy to ensure older people’s valued relationships remain intact and that they can remain in their own home and community for as long as possible. These relationships include family, friends, carers, care-workers and aged care providers.

4.3.2 Residential aged care

The transition to a consumer-directed, market-based system in Home Care is a multi-year, staged approach from which many lessons have, and continue to be learned. The risks of undertaking an equivalent change in residential aged care will be magnified by the vulnerability of customers in residential aged care, the capital-intensity of residential aged care and the significant numbers of staff employed to provide year-round care and accommodation.

The roadmap refers to removing the Aged Care Approvals Round for residential places in 3 to 5 years’ time. Government and providers will need to do a great deal of preparation for any such change and the consequences for consumers should be considered carefully and publically before embarking on a consumer driven model in residential aged care.

**Recommendation 4:** The policy process for changing residential aged care to a market-based arrangement should take into account lessons learned from changes in Home Care and adapted to take into account the heightened vulnerability of consumers entering into a residential care setting and the greater capital investment required and workforce implications for providers.

4.4 Effectiveness of means testing arrangements for aged care services

4.4.1 Policy principle of co-contribution

Preliminary findings from recent University of SA research into CDC shows older people agree with government charging fees for Home Care (almost 60 per cent), believe funding for aged care is a joint responsibility between government and individuals (76 per cent) and are happy to pay for services if it means they can remain at home (almost 90 per cent). These results suggest a degree of
willingness to pay that should be considered in reviewing means testing arrangements for aged care services. (Beer et al. 2016b)

AnglicareSA recently undertook market research which had similar findings among older people. More younger people (40 to 49 years of age) disagreed that contributing to the cost of aged care services is reasonable, which suggests their concerns relate to the potential requirement to contributing to the cost of their parents’ care.

**Recommendation 5**: Any assessment of means testing arrangements and the alignment of charges across residential care and home care services should take into account the principle of intergenerational equity, to ensure that adult children don’t have to contribute both to the cost of their parents’ care and their own.

### 4.4.2 Provider experience of means testing arrangements

AnglicareSA acknowledges that the Department of Human Services has made substantial improvement in its income and asset assessments, but reports it is still experiencing too many issues with the time taken by Centrelink to do means testing. Centrelink continues to retrospectively change assessments long after they have been completed, which results in large adjustments (sometimes in the tens of thousands of dollars for people in residential aged care) for consumers and providers. If this situation were to continue into a future market-based environment, providers could have their reputations unjustly tarnished by processes outside their control.

**Recommendation 6**: That the Department of Human Services’ efforts to improve Centrelink’s means testing continue with a view to reducing the time taken to do assessments and the accuracy with which they are done. Regular public reporting on Centrelink’s performance in this regard may deliver increased confidence to consumers and providers.

### 4.5 Effectiveness of arrangements for regulating prices for aged care accommodation

AnglicareSA notes that the current approach to regulating prices for aged care accommodation, in which providers have flexibility in setting prices up to a threshold of $550,000, works well. No recommendations are made in relation to accommodation pricing.

### 4.6 Effectiveness of arrangements for protecting equity of access to aged care services for different population groups

There is still work to be done in protecting equity of access to aged care services for different population groups. AnglicareSA recently conducted a community forum for new and emerging CALD communities and observed a perception among community representatives that aged care is unaffordable, whereas it should be widely known that care is available to all regardless of means.

It is encouraging the Department has acknowledged that key areas for further development in the aged care system include the need for the system to ensure equity of access and services. AnglicareSA makes recommendations at 4.9 in relation to equity of access and services.
4.7 Effectiveness of workforce strategies in aged care services

The Assistant Minister for Health and Aged Care observed recently that aged care funding is growing at a faster rate than the rest of the health sector\(^3\). The present and future workforce will be a key component in providing a consumer-centred, people-centred, flexible system which offers consumers choices and assures budget integrity.

4.7.1 Anglicare Australia’s 2016 submission to Senate inquiry

AnglicareSA contributed to Anglicare Australia’s recent submission to the Senate Community Affairs Committee’s inquiry into the future of Australia’s aged care sector workforce.

In that submission Anglicare Australia wrote that while the demographic changes, and growth in demand for aged care staff are well understood across the community, ageing Australians themselves, and the services and people who provide aged care, are not highly valued.

The existing education and training schemes do not address the needs of this new aged care system, and require significant reshaping – and better performance – and increased funding if they are to do so.

The new model of care is more complex, subtle and demanding for the workforce. It requires a change in culture and a raft of new skills. Not everyone presently working in aged care will fit well, or be interested in, the new system.

One consequence of these changes is that the aged care workforce may become even more vulnerable to depending on, low paid, precarious and part time work. There is not yet a plan to address this inadequacy, and that adds to the risk of enduring shortage of trained, professional and committed workers.

The key message from a recent Anglicare Australia aged care workforce forum was that the onus of steering through the changing models of care, and dealing with the demographic tide appear to be falling on a workforce which is under pressure to be agile and sophisticated, and which is not assured of good pay or working conditions. Similarly, many of the aged care providers that serve isolated communities and people with special needs will find themselves competing for staff on very limited and insecure resources.

4.7.2 University of SA research into aged care employers

The University of SA recently published Ageing in SA research (Beer et al 2016a) which noted that:

- 55% of aged care provider respondents agreed or strongly agreed they are disadvantaged in seeking employees. Providers identified remuneration and limited opportunities for career advancement as the main reasons for being disadvantaged.

- The majority of respondents had no difficulty in recruiting most types of employees, except volunteers.

\(^3\) Commonwealth of Australia (2016)
• Providers supply extra resources to train new staff: close to or well above 60% strongly agreed they do this for all job categories. More strikingly, the need for training did not disappear after induction, with providers needing to continue to invest resources to train existing staff in order to update them on regulations and policies.

• There was little difference in training needs amongst new and existing employees. A greater number and percentage of respondents agreed they need to spend extra resources to train existing staff for virtually all job categories, suggesting that the industry is not dynamic and subject to many challenges.

• Respondents agreed overwhelmingly that “Adapting our workforce to changing government policy has been a challenge; The expectations of the existing workforce has challenged our organisation; Adapting our workforce to the changing demand for aged care services in recent years has been a challenge.”

The research identified future challenges for aged care organisations include paying more attention to career development, induction and skill training for employees to foster a sense of being looked after by the organisation. In addition, the limited adoption of performance-based evaluation and rewards systems should be fully developed among these organisations so clear standards and requirements would encourage individuals to perform well. The final area for improvement is paying more attention to cross-cultural management given an increasingly diverse workforce, as well as clients from different cultural backgrounds, a finding likely to be echoed by Flinders University research into multicultural workforce for residential aged care. This should also be linked with induction and skill training programs, and management/leadership programs to ensure that both managers and employees are well equipped to manage an increasing multi-cultural work environment.

4.7.3 Recommendation

Recommendation 7: In light of feedback from Anglicare Australia and the University of South Australia research about the importance of the aged care workforce, it is disappointing that funding for the majority of aged care workforce programs has been subsumed into wider health workforce funding. Greater funding for aged care workforce programs should be made available to support the structural adjustment underway in the sector.

4.8 Effectiveness of arrangements for protecting refundable deposits and accommodation bonds

The current legislation and compliance requirements for refundable deposits and accommodation bonds provide consumers and aged care providers with good levels of protection. The level of compliance reporting is proportionate with the potential risk to consumers and government.

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4 Developing the multicultural workforce to improve the quality of care for residents. Investigators: Xiao, L, Willis, E, Harrington, A, Gillham, D, De Bellis, A, Morey, W, Jeffers, L. Funded by Department of Social Services (Australian Government); Ageing and Service Improvement Programme
Recommendation 8: That Government retains the current arrangements for protecting refundable deposits and accommodation bonds.

4.9 Effectiveness of arrangements for facilitating access to aged care services.

The Department of Health’s recent research into My Aged Care showed reasonable satisfaction with My Aged Care. AnglicareSA has included two confidential case studies of aged care customers almost entirely deterred from receiving or continuing their services by the experience of using My Aged Care in Appendix 1. Had these customers not had the support of AnglicareSA’s Aged Care Customer Advocate to navigate My Aged Care, they may have faced the following difficulties:

- Increased social isolation as older people become embarrassed to invite neighbours and friends into house as they are not able to manage the housework on their own anymore. The likelihood of this increases the longer it takes for assessments to be completed and for services to commence. Social isolation also increases the risk of mental health diagnoses.

- Increased risk of falls or other accidents as older people try to complete housework on their own whilst waiting for assessment and service commencement. This could lead to premature admission to residential aged care if people sustain significant long term injuries and are unable to access new Short-Term Restorative Care services.

It is imperative that the sole gateway to government-subsidised aged care services function at its peak to ensure that everyone who is entitled to services receives them. AnglicareSA’s confidential case studies are powerful, anecdotal illustrations of less-than-satisfying experiences with My Aged Care.

There is ample evidence that the aged care gateway is complicated and confusing, both for those encountering it for the first time and for those utilising services that are subject to changes arising from reform. More often than not a provider’s initial conversation with a consumer will be about various elements of My Aged Care, income assessments, co-contributions; sometimes debunking myths, sometimes explaining the whys and wherefores; and often not about the care and support available to the consumer.

Data about My Aged Care utilisation and My Aged Care user experience presented to the National Aged Care Alliance Gateway Advisory Group shows care recipient users to have a better experience overall than carer users; and also showed significantly lower registrations amongst ATSI and CALD populations (see also Department of Health et al 2016).

There is evidence that Government communications to consumers contain inconsistent information, lack timeliness and at times are erroneous. Communications to consumers about Home Care Program co-contributions are a good example.

It is important to acknowledge that the My Aged Care system is still relatively new and that communication to date has been about the introduction and commencement of My Aged Care. In

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5 Department of Health et al 2016
thinking about a future communications campaign it is now time to focus more on the function and purpose of My Aged Care, than it’s coming into being. In particular, future communications should focus on “How to Access” and the costs of entry, as these are the most prevalent issues raised by potential consumers with providers. With the February 2017 changes in Home Care imminent, it would also be worthwhile for the My Aged Care website to be updated with information about what the changes mean for consumers.

A lack of confidence among consumers with My Aged Care could result in consumers not accessing services at all if they are unable to self-fund alternative services. This could lead to premature admission to residential care at which time difficulties with My Aged Care will be re-experienced in an attempt to be assessed by an ACAT.

**Recommendation 9a:** Future communications from My Aged Care should focus on how to access aged care and the cost of entry, as these are the most prevalent issues raised by potential consumers with providers.

** Recommendation 9b:** That information about *Increasing Choices in Home Care – Stage 1* is included on My Aged Care’s website, replicating information from the Department of Health’s website. Information for consumers should be available on the consumer gateway’s website.

### 4.9.1 Entry, Screening and Assessment

AnglicareSA is participating in Department of Health consultation on the operation of My Aged Care. As noted above at 4.6, it is encouraging the Department has acknowledged there is a need for the system to ensure equity of access and services. (Department of Health 2016) Some of these difficulties include:

- My Aged Care does not work well for some Aboriginal people. Registering is time-intensive and requires a certain level of spoken English and/or access to someone who can assist with translation. My Aged Care requires consumers to provide a birthdate, which not all Aboriginal people have. It has also been reported that My Aged Care struggles to reconcile the use by some Aboriginal people of more than one name, whereas even Austrac – Australia’s financial intelligence agency with regulatory responsibility for anti-money laundering and counter-terrorism financing – has a flexible approach to identifying Aboriginal people.\(^6\) AnglicareSA has observed elsewhere that the Government provides translating and interpreting services to people from Culturally and Linguistically Diverse communities\(^7\), but not to people from Aboriginal and Torres Strait Islander communities.

- Not all My Aged Care staff are aware it is the first and only point of access to Assistance with Care and Housing (ACHA) services for older people who are homeless or at risk of homelessness. AnglicareSA is aware of situations in which My Aged Care staff have attempted to repudiate eligible prospective ACHA customers because they were unaware My Aged Care is the gateway to ACHA services.

- The Department’s research acknowledges difficulties being experienced by people from Culturally and Linguistically Diverse (CALD) communities. CALD customers “were less likely


to be satisfied with communication with the system. They rated information supplied to the Contact Centre and the sensitivity of their aged care assessment to their cultural background less positively than non-Culturally and Linguistically Diverse consumers.” They were also often less positive about the relevance of the services they received to their Support Plan. (Department of Health et al 2016, 29 - 30)

It is also encouraging the Department has acknowledged that assessment and availability of services does not yet meet the needs of CALD, Aboriginal and Torres Strait Islander peoples and other special needs consumers, particularly those based in rural and remote locations. (Department of Health 2016)

**Recommendation 10:** That work by the Department of Health to improve consumers’ experience of My Aged Care continue, particularly for people from the cohorts defined as ‘special needs groups’ under the Aged Care Act 1997.

### 4.9.2 System Enablers

#### 4.9.2.1 Respite and carers

The evolution of aged care, since the introduction of the *Living Longer Living Better* reforms, has seen minimal advances in respite services. In real terms there has been no expansion of respite services for perhaps 8 years with growth limited to less than CPI equivalent indexations, there are no aspirational service growth targets for respite as there are for the Home Care Program, and until recently, no formal Strategy to inform respite direction.

There is a growing dependence on informal and unfunded care and therefore a growing demand to maintain the capacity of carers to care. Respite service is central to this, and for many carers it is a necessity, especially those who are struggling to balance work, family and friends.

Respite plays an important part in enabling older members of the community, especially those who are frail, with dementia or challenging behaviours, to remain living in their own home. Periodic episodes of respite reduce the prospect of early entry to residential care. Respite can also provide a safe and time limited introduction to out of home care, with increased exposure over time building a bridge to residential care where permanent care maybe an eventual necessity.

The respite service landscape has become less visible with closure of Information Support Service (Commonwealth Carelink Program) in 2014, uncertainty about the status of Commonwealth Respite and Carelink Centres (CRCC) post June 2017, and the incorporation of the National Respite for Carers Program (NRCP) into the Commonwealth Home Support Program. The recently introduced Carer Gateway is a replacement service, not an expansion.

There is evidence that some My Aged Care processes are separating carers and carer recipients e.g. in the registrations and assessments process, rather than treating them collectively in response to respite related needs.

There is also clear evidence that My Aged Care has not made respite a priority as it took AnglicareSA twelve months to have its group respite services listed on My Aged Care as a service that is available for older people. As a result AnglicareSA’s service went for 12 months with no referrals coming through due to this technical glitch in the system. Further, AnglicareSA staff are having to spend anywhere up to 10 hours per client to support potential clients to access its centre based respite
services as direct approaches by clients have been rejected due to the lack of understanding of this type of service by MAC staff.

Proposed future integration of the Home Care Program and Commonwealth Home Support Program raises further uncertainties about continuity and availability of respite services, especially in relation to the emergence of more individualised approaches to funding that threaten viability of services types traditionally reliant on block funding and dependent on availability of built environments e.g. overnight respite.

The Department of Social Services has recently released a draft model for the delivery of carer support services, via an integrated carer support service. The draft model provides some insight into future directions which will inform respite provider planning and preparation for the future. DSS states, “It is proposed that there would be the ability to refer between both services [My Aged Care and NDIS] for carer related supports. Opportunities for information sharing are also being explored to prevent carers from having to repeat their information.” (Department of Social Services 2016, 33) It is hoped that the proposed model and integrated carer support service will address the legacy of under-investment and confusion about respite services for older people and their carers.

**Recommendation 11:** It will be vital for older people and their carers that the Department of Social Services’ proposed integrated carer support service work closely with My Aged Care and the latter places due emphasis on ensuring older people and their carers are provided with the necessary supports.

4.9.3 Other

4.9.3.1 Co-regulation

AnglicareSA supports suggestions there will be changes to the aged care quality system in which providers would face different levels of quality assessment depending on their history of compliance and the nature of their services under changes to the aged care quality system being considered by the Department of Health.  

The Aged Care Sector Committee’s Roadmap suggests aged care providers grow capacity to support co-regulation and earned autonomy in the medium term and government fully implement co-regulation and earned autonomy in the long term (5 to 7 years’ time). The roadmap uses the term ‘co-regulation’ without defining the term further. Changing to a co-regulation model as it is understood in mature co-regulatory environments would involve a transformation in the roles of government and providers, extending well beyond the “earned autonomy” of 5 year accreditation cycles.

**Recommendation 12:** It would be valuable if the Department of Health could engage in a conversation with the aged care sector about what mature co-regulation looks like in other industries, in order that Government and providers can better prepare for a future co-regulatory model.

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4.9.3.2 Nexus between disability and aged care

Aged care and disability service providers are increasingly providing a similar range of personal care, domestic and allied health services to Home Care and National Disability Insurance Scheme (NDIS) customers. More and more providers in these sectors provide care and services to both older people and people with disabilities.

The aged care system and NDIS have been established with some notable differences – the NDIS is more generous and aged care requires co-contributions. The aged care system attempts to cater for those clients who acquire their disability after the age of 65 and in a number of cases aged care specific providers cannot deliver the same range of unique specialist services that are present in the disability system or for those unique organisations, like AnglicareSA, that delivers services in both spaces and can seamlessly support customers as they age.

The aged care roadmap contemplates the eventual integration of home and residential care into a single system. It may be also be worth contemplating a more integrated aged care-disability system or the provision of a seamless gateway between the two systems to enable people who are disabled and over the age of 65 the same opportunities as those under 65.

Recommendation 13: That consideration is given to ways in which a more integrated service can be provided to people on the disability and aged care continuum to ensure equitable outcomes for people aged 65 years and older, given the commonalities, shared systems and infrastructure increasingly featuring in the aged care and disability provider landscape.

4.9.3.3 Next Legislated Review

The scope of this review as legislated in the Aged Care (Living Longer Living Better) Act 1997 focuses on changes introduced in 2013 and 2014. Since that time there have been, and will continue to be, a number of changes to the aged care system which are equally worthy of an independent review. These changes include the 2015 transition to CDC, the 2017 transition to portability in Home Care and the scheduled 2018 integration of Home Care Packages and the Commonwealth Home Support Program. There may also be subsequent changes in residential aged care to move towards a market-based arrangement. These changes should be reviewed in 3 years’ time. In legislating for the proposed future review, it may be worthwhile considering specific terms of reference relating to any other matters which are relevant at the time the review commences to allow for flexibility in the review’s scope.

Recommendation 14: AnglicareSA recommends that Government commission another independent review of further changes made in the aged care system in 3 years’ time, to evaluate the impact and effectiveness of Home Care and Commonwealth Home Support Program changes, and potentially in residential aged care.
5 References


AnglicareSA (2016a) Designing the new integrated carer support service: response to call for written submissions, June

AnglicareSA (2016b) Contribution to ANAO performance audit: Indigenous Aged Care, September


Department of Social Services. 2016. Delivering an integrated carer support service: A draft model for the delivery of carer support services, Australian Government, Canberra.