Current Respite Care Arrangements

ACFA Annual Report
Each year ACFA provides the Minister responsible for aged care with a report on the funding and financing of the aged care sector.

In recent annual reports, ACFA has noted the increasing use of residential respite care since the 1 July 2014 reforms. ACFA’s 2017 report is published on the Department of Health’s web site: Aged Care Financing Authority | Ageing and Aged Care. That report contains background information regarding residential respite care in pages 53 to 57.

In addition, on 31 July 2017, Mr David Tune AO PSM, as the independent reviewer, provided the report of the Legislated Review of Aged Care 2017 | Ageing and Aged Care, to the Minister for Aged Care, the Hon Ken Wyatt AM, MP.
Recommendation 8 of the legislated review report was: “That the government:

a) in the short-term, review the existing respite arrangements to ensure that its objectives are being met.

b) in the medium term, in discontinuing the Aged Care Approvals Round for residential care (Recommendation 3), review how best to ensure adequate supply and equitable access to residential respite care.”

Current Arrangements
Carers play a vital role in supporting older people to remain living at home and in the community. To help maintain the caring relationship, carers and their care recipients may choose to access respite care. Respite care is available through a number of programs funded by the Australian Government, including:

- Commonwealth Home Support Programme (CHSP)
- Home Care Packages Program
- Residential respite care.

The pathways to accessing respite care, and the types of care available, can vary depending on the number of providers and respite programs available in the area, and the approval processes for those programs.
Commonwealth Home Support Programme (CHSP)
CHSP supports the carer relationship through the provision of a range of planned respite services. These services include flexible respite such as in-home respite and host family respite, cottage respite, including overnight community respite, as well as centre based respite.

These services, which are targeted to the care recipient, support and maintain the care relationship between the carer and care recipient, allowing regular carers to take a break from their caring responsibilities.

CHSP respite services are targeted to frail older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) who live in the community and who have difficulty performing activities of daily living without help due to functional limitations.

Emergency respite care can be arranged by calling the Commonwealth Respite and Carelink Centre.

Home Care Packages Program
Care and services provided under a home care package are developed in partnership between the client and provider and are outlined in the client’s care plan, based on the client’s assessed care needs. Home care package funds cannot be used to cover any care recipient contribution costs.

Respite care can be supplied under a home care package if the need for respite care is identified in the client’s care plan and the supply of respite services can be achieved within the home care package budget.

A home care package is temporarily suspended if the care recipient enters residential respite care.

Residential Respite Care
Residential respite care is short-term care delivered within an aged care home on either a planned or emergency basis. An assessment by an Aged Care Assessment Team (ACAT) is required to access residential respite care. Eligible care recipients are approved for either high or low level residential respite care.

A noticeable difference in respite care compared with permanent residential care is that respite residents do not make any means-tested accommodation or care contributions. They can however be asked to pay the basic daily fee for living expenses, which is at the same rate as permanent residents. Respite residents can also choose to purchase additional services, in the same manner as permanent residents.
Providers of residential respite care do not have a separate allocation of residential respite places. Rather, a portion of each permanent allocation of residential care places may be used for the provision of respite care and it is up to the provider to decide what mix of permanent care and residential respite care they provide. Access to respite services will depend on a person’s need/choice to access this type of care and on an approved provider’s willingness and ability to provide such care at that point in time.

**Eligibility for non-residential respite**

Since 1 July 2015, entry and assessment for the CHSP has been through My Aged Care, the identifiable entry point to the aged care system for older people, their families and carers.

My Aged Care incorporates a website and contact centre. The My Aged Care contact centre registers clients and provides a preliminary assessment of the client’s circumstances via a phone-based screening process.

My Aged Care also incorporates the Regional Assessment Service (RAS). The RAS operates in all states and territories across Australia (except Western Australia) and assesses a client’s needs and eligibility for CHSP services via a face-to-face assessment.

From 1 July 2018 all eligible WA Home and Community Care (HACC) services, including respite services for older people, will transition to the CHSP. From 1 July 2018, WA assessment services will also transition into the national My Aged Care RAS arrangements.

**Eligibility for residential respite**

The primary purpose of residential respite care is to give a carer or care recipient a break from their usual care arrangements.

Residential care providers may receive respite subsidies and supplements for eligible residential respite care recipients. Residential care providers do not have a separate allocation of residential respite places. Rather a portion of each permanent allocation of residential care places is used for the provision of respite care, known as respite days.

Care recipients must have an ACAT approval for government subsidised residential respite care. The ACAT approval will specify whether the care recipient is eligible for low or high level respite care, depending on the person’s care needs. A person who is approved for respite care can have up to 63 days of subsidised respite care in a financial year. This can be extended by up to 21 days at a time if approved by an ACAT.

Where a care recipient accesses residential respite care, providers are responsible for checking the care recipient’s remaining respite care allowance. Respite care subsidies and supplements are not paid if the care recipient has used up their annual allowance of respite care days.
To receive the respite care subsidies and supplements, a residential care service must have an allocation of respite days. A service cannot claim respite subsidies for a day if the service’s respite allocation is exhausted.

Services can request changes to their allocation of respite days. The process to be followed for this change depends on whether or not the number of respite days to be delivered by the service is linked to a condition of allocation.

**Funding Arrangements**

**CHSP**

Funding for the delivery of services provided under the CHSP is provided directly to CHSP service providers through the administration of grant agreements.

In the 2016-17 financial year:

- 579 CHSP providers were funded to deliver respite care
- 40,720 care recipients received respite care from a CHSP provider
- Total expenditure for CHSP respite care was $248 million.

CHSP respite care includes centre-based day respite, cottage respite and flexible respite.

Client contributions towards services delivered under the CHSP (including respite services) are governed by a principles-based Client Contribution Framework (the Framework) which was released by the Department in October 2015. Under this Framework, CHSP clients are expected to contribute to the cost of the services they receive if they can afford to do so. CHSP providers are required to adhere to this principles-based approach to the charging, collection and reporting of client contributions. This includes having in place a documented and publically available client contribution policy to inform clients of possible costs associated with accessing their services.

**Home Care**

Respite care can be supplied under a home care package if the need for respite care is identified in the care recipient’s care plan and the supply of respite services can be achieved within the home care package budget.

Home care package funds cannot be used to cover any care recipient contribution costs, such as the basic daily fee for residential respite care.

Home care recipients can be asked to pay a basic daily fee. The maximum basic daily fee is equivalent to 17.5 per cent of the basic rate of the single age pension. Depending on a care recipient’s income, they may also be asked to pay an income-tested care fee in addition to the basic daily fee.

A home care client can agree to pay for additional services not covered by the home care package funds.
Residential care

A residential care service may be paid a subsidy and supplement for providing respite care to an eligible care recipient on an allocated respite day.

Low level respite care

- a basic subsidy for low level residential respite care; and
- a low level respite supplement for a care recipient approved for low level respite care.

High level respite care

- a basic subsidy for high level residential respite care; and
- a high level respite supplement for a care recipient approved for high level respite care.

Respite incentive supplement for high level respite care

An additional amount is available for eligible providers if they use an average of 70 per cent or more of their respite allocation during the 12 months up to and including the current month providing respite care. If the 70 per cent target is met, a payment is made at the end of the month for each of the high care respite days provided during that month.

Care recipient fees

Residential respite care recipients are required to pay a basic daily fee of 85 per cent of the single basic age pension. Residential respite care recipients are not required to pay any accommodation costs.

Chart 1: Comparing the amount of respite care basic subsidy plus respite care supplement to the maximum permanent care ACFI basic subsidy and potential accommodation supplement – daily rates at 20 September 2017
Other supplements
Other supplements that may be payable on behalf of an eligible residential respite care recipient are:
- Oxygen supplement
- Enteral feeding supplement
- Viability supplement in residential care
- Hardship supplement in residential care

Payment of these supplements for respite care recipients is the same as for permanent residential care recipients.

**Respite Program Data**

**Residential Respite Care Data**

**Number of residential respite care recipients**

The residential care reforms introduced on 1 July 2014 made no changes to residential respite care, yet the usage of respite care increased noticeably in the year following those reforms.

A total of 59,228 people received respite care in 2016-17, and approximately 54 per cent were later admitted to permanent residential care.

There is a strong seasonal pattern to the use of respite care, with the peak generally occurring in August/September.

**Length and frequency of stay in residential respite care**

59,228 people received residential respite care during 2016-17. Of these, on average each person had 1.4 respite care stays with each stay being an average of about 26 days. The average length of stay has increased slightly from around 24 days since 1 July 2014.

A high proportion of residential respite care recipients have only one episode of respite care per annum (75 per cent counted by discharge year). This trend has remained relatively stable over the past few years.

A clear pattern of respite care use is the length of stay. Residential respite care is most commonly accessed in weekly units. A fortnight is by far the most common residential respite care length of stay. One, three and four weeks are the next most common lengths of stay (Chart 2).
Admissions to permanent residential care after respite care

The number of residents entering permanent care within a week of a respite care stay has been increasing since 2010 (Chart 3). The increase has been noticeably more significant since 1 July 2014. This may indicate that care recipients who intend to enter permanent care are first accessing respite care while they arrange their financial affairs or await the completion of aged care means testing.

**Chart 3: Number of permanent residential care admissions, by use of respite care prior to entry into permanent care, 2010-11 to 2016-17**
The number of people admitted to permanent residential care within a week of being discharged from respite care increased from 25,320 in 2015-16 to 27,794 in 2016-17 (an increase of 9.7 per cent).

Since 2014-15, care recipients who are admitted to permanent care within a week of being discharged from respite care are more likely to have received their latest respite care stay at a “High” level rather than at a “Low” level. By contrast, the majority of people who entered permanent care within a week of being discharged during the preceding four years received their latest respite care stay at a “Low” level respite care.