BAPTISTCARE
Finance & Public Administration Committee
Inquiry into Residential and Community Care

Perth Hearing

Questions on Notice to Baptistcare

Question 1

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Senator HUMPHRIES – We have had a few variations on those sorts of themes suggested in the course of today. What would be useful from my point of view is if someone could sit down and nut out how that system would actually work. Imagine that you were drafting not necessarily a full bit of legislation but drafting the structure of this brave new world of aged care. Describe how that would work. We may choose to put that kind of thing forward as a possible model of how to proceed, and having some flesh on those bones would be quite helpful in that respect.

Baptistcare's Response to the Question on Notice

Baptistcare is a not-for-profit organisation whose Vision is to be known as a person-centred organisation regarded for its integrity, compassion and diverse range of holistic support services and programmes. This Vision has shaped the way we see the 'brave new world of aged care'.

Our perspective is based on being holistic, so that people can access services to assist with the experience of ageing without having to jump through wide ranging, disconnected, incoherent service options, with different funding structures and with different standards, regulations and Visions, that provide instead for connected, holistic services that see each individual and that each ageing person is able to make their own choices and they sit at the centre of the system. So, with this in mind, we want to strip away much of the clutter of the various bits of the system, provide for a single entry point, a point at which people are identified and which enables them to come and go as their needs require; and which enables service providers to provide a suite of services, or be niche providers as they choose. It also requires Government to be very active in making sure the ageing services sector provides support services where the market is not developed, where providers struggle to make ends meet, or where people do not have enough resources, such that they can access services that meet their needs irrespective of their condition. The Governments' role is critical in this environment in ensuring that there is equity of service access and that people do not fall through the gaps; that the system ensures follow-up and accountability for the delivery. Organisations like Baptistcare will continue to seek to be active in some of these hard-to-serve places as we are currently doing, as well as being a significant provider in the wider range of services.

With this context, Baptistcare envisages a single system of care accessed at a single point of entry and, once accessed, the client maintains their place within the system without having to leave and re-enter as their care needs change. The system would differentiate

between domestic, personal and clinical care needs and would operate irrespective of a client's accommodation circumstances, needs or preferences. The somewhat artificial differentiation between high and low care and the changes in funding and restrictions between community and residential care would be removed. People live in communities and these connections need to be maintained, irrespective of where the services are provided. The aim would be to provide care initially in the client's home, recognising that the best outcomes are likely to be achieved in an environment in which the client feels most comfortable and familiar. However, the system also recognises that at a certain point, the level of care could increase to where it is no longer possible to provide cost effectively those services in the client's home, or there might be an aspect of the care need that dictates that it cannot be provided safely in the client's home, either for the safety of the client or the safety of the care giver. Nonetheless, one of the underpinning principles of aged care is its social inclusion model of care, that remains connected to community with the option for individuals to return to their own home after periods in residential care.

Access

Initial entry to the system would be simple and easy for people to activate; it would be via a telephone assessment (perhaps a 1300 number) to a central assessment agency. Ideally, the assessment agency would be independent of any service provider to reduce any possible conflict of interest arising. An assessment instrument would have to be developed for this initial assessment, however, it is understood that such instruments currently exist, such as that used by Veterans' Home Care.

At the completion of the assessment and having identified the need, the assessment agency would provide the client with a unique ID, which would remain with the client throughout their time within the system (see the Job Network system for examples), including possible periods when they are not in the system, together with their care plan, which would have a value as determined by the elements within it and provides the purchasing power and choices to the client, and a list of potential providers that the client may wish to approach for their service. (This is being practiced by Disability Services in WA). The WA Disability Services Commission provides a wide range of funding options to suit individual and family needs, the options and choices for people are significant and has returned much more control to their lives as they purchase services and acknowledges differences that exist.

If the care plan identified a need for domestic services only or other social supports (currently provided through HACC services), the value would be low and the range of providers might be quite localised. However, this market should be opened up and remove the geographical borders and the caps on what services can be provided. The plans never match the demands and if clients have money allocated, they should be able to purchase the services they want from the providers that they prefer. It would be one way of being more person-centred, if providers had the capacity to be licensed and operate wherever services are needed and if their services are not meeting the clients' demands, clients are able to choose another operator. The government's role will include the monitoring of the marketplace and would need to ensure there are services where the market is too small or too hard to access, such as in rural and remote regions.

If the care plan identified a combination of both domestic and personal care needs, hence more hours (again provided currently by HACC services), the list of potential providers might be larger, because the combination of services might necessitate a larger provider able to deliver more complex services. However, while the client is able to choose their service provider and purchase services on their own behalf, service providers will respond to the demand. The Government will need to include the need to ensure that connections and partnerships exist between providers and across the service system to ensure that once a client has been assessed, that this person is followed up and service provided.

If there are clinical needs identified within the initial assessment (current CACP, residential care), a referral would be made to an Aged Care Assessment Team (ACAT) for a more comprehensive assessment. Like the assessment agency, after assessment, the ACAT would provide both a care plan which had a particular value, based on the assessed need, and a list of potential providers for the required services. Naturally, as occurs within the existing system, there will be clients who have no needs until a critical health event occurs and they then need clinical services. The current system where Doctors, Hospitals and other Allied Health Services can refer a client straight to an ACAT for assessment would need to be maintained for such occurrences.

In addition to the choices of living in their own home or moving into residential care, that currently are available to the ACAT, a further choice of rehabilitation should be available. This choice would provide a higher level of funding for a predetermined period of time during which the service provider would be expected to improve the client's health to such a level that they can return home, thus avoiding the need for ongoing residential care. This level of service is currently provided by Transition Care but is only available to small numbers of clients in specific locations, whereas it should be part of the mainstream care choices and residential facilities able to offer this as part of their suite of services. Due to the specialised nature of such care, there may be fewer potential service providers, but that should be determined by the service providers who choose to offer such services, rather than a limiting tender process as occurs currently.

Similarly, the system needs to acknowledge that the provision of both short and long term respite services, be they residential or home-based, can be positive contributors to maintaining clients in their homes for longer than would otherwise be available. Accordingly, the system needs to incorporate the provision of such respite care.

In all cases listed above, the choice of service provider rests with the client, their families, or their advocate. It would not be determined by the assessors.

Accommodation

From the description provided above, it is clear that there is no accommodation element in any of the assessments carried out. The choice of accommodation, unless it is neither cost effective nor safe, remains entirely with the client, their family or advocate. If a client does not believe they should receive their services in their own home, it is up to them to choose to move into alternative domestic accommodation, which they prefer or is safe, or in the case of high clinical needs, into residential aged care.

In the event that a service provider believes it is no longer safe for a client to receive services in their home, the service provider should advise the client accordingly. In the event the client does not wish to change their accommodation to meet their needs as assessed by the provider, it should be the prerogative of the service provider to withdraw the service and allow the client to arrange an alternate provider.

As occurs in every other change in an individual's circumstances throughout their life, a change in their wellbeing which necessitates a change in their accommodation, will require them to obtain their new accommodation using their own resources. The public policy objective should not be to 'protect the children's inheritance'.

Naturally, where a client does not have the resources necessary to move into accommodation to meet their new care needs, there will need to be a safety net available, similar to the existing rental assistance model. However, in recognition of the higher costs of providing residential aged care accommodation, a higher level of funding would be required than the rental assistance model.

In addition, because with a small capital outlay, a client might be able to remain in their home for considerably longer, or perhaps not require residential aged care if there are physical changes made to their home, a system of capital grants should be in place to facilitate such changes.

As can be seen from the above, the choice of accommodation and in other than the rental assistance type model, the funding for that accommodation, remains with the client. Just as the Commonwealth does not specify what accommodation someone using rental assistance should take up, there is no place in this model for the Commonwealth to become involved in determining the standard or type of accommodation in which a client should choose to live.

The ACAR

The Commonwealth currently uses two methods to control the demand for aged care services.

Through the ACAT, it determines the level of services required by a client. The ACAT can direct clients into, or away from, either home or residential services. This method should continue as part of the system as outlined earlier.

Through the ACAR, the Commonwealth determines the number of aged care places within a region based on the number of persons within that region over the age of 70. This is meant to ensure there is an equitable distribution of services throughout the country. However, because of a range of reasons, be they socio-economic or in smaller urban and rural areas where the actual numbers of people over 70 in the region do not make it possible to provide cost effective services, such ratios are not always achieved.

As the assessment system and the proposed funding model are driven by care needs and are not accommodation needs, there should be no requirement for the Commonwealth to continue with the ACAR process, just as there is no requirement to continue with a

prescriptive accommodation standard. This suggests that the certification instrument and policies such as the 2008 privacy standards would no longer be applicable.

Accordingly, an Approved Provider would make its own determination about whether it would invest in residential aged care in a particular region and would also determine what type of accommodation that it might construct to provide that residential care. This will lead to a range of different services, from large institutional type facilities to smaller boutique facilities. To assist providers to determine whether they should build in a region, a central database of what facilities exist within a region should be maintained by the Department, but that would be the extent of the Department's role in determining accommodation provision.

There might be concern that in leaving the determination of what is built where, to the market, that there would be an underinvestment in a particular region, or for that matter an over investment. However, that should not be the Commonwealth's concern and such types of investment decisions are made currently anyway. In the regions of low service provision, the types of capital stimulus the Commonwealth currently uses, to attract investment, could continue. Hence, there will be a need for capital grants in rural and remote areas and loans for the establishment of facilities in urban areas with low levels of service provision. The open marketplace carries its own perils and we request a shift in the perspective rather than complete deregulation and removal of all current perceived limitations.

Community

People who are ageing and need more services live in communities. Irrespective of whether or not they have families still around providing support or they live alone, there are connections with service providers, friends and acquaintances and support systems that are in place, generally. As people move through the existing processes of aged care services they lose control over what is happening to them and their lives, and they become more and more passive; they also lose their connections. While we focus on the providers' issues, it is more important to focus on the client who will be choosing support services into the future. At the moment, the choices are regulated by a range of Government stakeholders, the choices are limited and concentrate on managing risk and reducing cost. The emphasis needs to change if it is going to continue to meet the needs of the clients and their families and communities.

Conclusion

The description of the system proposed by Baptistcare here has been kept to a minimum level of detail, but offers the basis of a new way of approaching aged care within Australia. It ***must be*** person-centred and provide choices for the clients in the system and, therefore, for the providers within the system, enabling people to make choices at every level and step along their care journey without being over-burdened with regulation, restrictions and risk management. The Governments' role is to ensure that the system works and that the person who is ageing is enabled to maintain their sense of choice and able to access the services they need; and that where there is a gap or insufficiency, action is taken to ensure the safety net exists. This approach also acknowledges that the Commonwealth does not need to maintain a strong control over the accommodation needs within the system, however, in those areas that, for whatever reason, would not easily attract providers of

services, there will still be a need for Commonwealth intervention in the form of some sort of capital injection.

I would like to refer you back to Baptistcare's original submission and to the point that we made in the Hearing; we would rather the funds came to assist providers to pay the interest on capital, rather than in the form of capital.

Thank you for the opportunity to follow up with this response.

Yours sincerely

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