5 July 2018

Aged Care Update: Is it time to bring respite services into the reform equation?

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

More recently, the objective of respite services is being expressed increasingly as supporting consumer choice to remain living at home for as long as possible. In the Roadmap[1]context, access to respite services assumes greater significance as an essential service for supporting and enabling consumer choice to remain living at home.

However, respite care arrangements have been largely untouched by the reforms initiated since the *Living Longer Living Better* reform package.

A question that arises is whether the current respite care arrangements are consistent with, and support recent reforms directed at creating a more consumer-driven market-based aged care system where consumers have greater choice of services and where to live.

Current arrangements

Respite services are currently available under one or other of the major 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 is the population being targeted. Residential respite and respite accessed under a home care package are targeting consumers with (ACAT-assessed) higher care needs, whereas CHSP respite is targeting (RAS-assessed) consumers with

fewer care and support needs.

A feature of home care packages is that the package holder may use their individual budget to choose how much community-based respite to use, the type of respite and which provider delivers the service, within the overall limit of each person's individual budget and the local availability of respite services. The only condition is that individual budgets may not be used to pay for any fees or charges that might apply for CHSP-funded respite services.

In contrast, home care package holders may not use their individual budget to purchase residential respite. The package is in fact suspended for the duration of a package holder's stay in residential respite.

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. Instead, CHSP respite services are rationed through block-funded contracted providers.

In theory, there is flexibility to increase the availability 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. In practice, 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. Choice of provider is also constrained because 'funding following the consumer' does not extend to residential care.

Trends in the use of respite care services

The following section discusses respite usage based on available trend data.

- In 2016-17, 40,720 consumers accessed CHSP respite services at a cost to the Commonwealth of $248m, involving about 4% of CHSP consumers. Trend data on respite care use in recent years under the CHSP is not readily available. 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 holders access community-based respite care, either directly through their home care provider or from a CHSP respite provider. It is also not known how many consumers of home care packages use residential respite.
- In 2016-17, 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, or the extent to which providers have been seeking approval to increase the number of allocated places that they can use for respite.

The Aged Care Financing Authority (ACFA) has reported[2]that there has been a steady increase in the use of residential respite over the years, with sustained higher growth since July 2014. 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.

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, as well as to provide respite for family carers. However, it is unlikely that 'try before you buy' would account for the increase in residential respite care use that has occurred since July 2014.

On the other hand, there is some evidence and anecdotal reports that 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. For one, the increase coincided with the introduction of the new means testing arrangements. Second, the significant increase in the number of permanent residents admitted within seven days of a respite episode[3]also supports this conclusion.

This explanation for the increased use of residential respite seems consistent with the recent Carers Australia survey[4]which showed that, notwithstanding the increased use of respite, 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 means testing 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. It is not suggested that respite use in these circumstances is inappropriate, but rather a factor that should to be taken into account.

Other reported characteristics of current respite service use

Anecdotal evidence also points to the following as being characteristic of respite services:

- The work associated with admitting a respite consumer in residential care is as high as for a permanent resident, hence the majority of aged care homes will not consider anyone for respite unless the respite duration is for at least one week.
- As well, many providers consider that the funding they receive 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 support and behaviour management required is often 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 ACAT assessed respite residents in particular reduces the availability of low care respite places. Many providers are more likely to consider high care assessed respite residents.
- Due to priority given 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 instead manage respite in the context of overall occupancy.
- 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. The only consumer contribution for residential respite is the equivalent of 85% of the single pension for everyday living expenses (the same as a permanent resident pays for everyday living expenses).
- There is an incentive for non-supported consumers to extend their respite status prior to becoming a permanent resident because consumer costs are lower.
- Overall, current funding arrangements can be a barrier to accessing residential respite for the following categories of consumers: low care respite consumers;

consumers seeking short-term respite, emergency respite, 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.

Possible reforms to improve access to residential respite

The available evidence suggests that 'try before you buy', means testing timelines and current funding arrangements are impacting the availability of residential respite for supporting consumers wishing to live at home for as long as possible.

An anomalous feature of residential respite is that, unlike for permanent residents, aged care homes do not receive an explicit 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 short-term 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. The value of the supplement and incentive varies depending on whether the consumer has a low or high respite ACAT assessment and the percentage of allocated respite places that are occupied. Under these arrangements, the maximum possible daily payment for a low and high respite resident is $84 and $220 respectively, compared with $270 for a permanent supported resident with the highest ACFI assessment.

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 care, as opposed to using respite for managing means-testing timelines, because of the additional costs of short-term stays and lower returns compared with permanent residents.

However, the demand for residential respite care 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 151,000 packages). There is therefore a case for improving access to residential respite in order to position residential respite for the more consumer-driven future envisaged by the recent reforms and the Roadmap.

To this end, matters that should be addressed include:

- 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. This should include assessing whether the current low/high level care payments received by aged care homes (and potentially following the outcome of the Resource Utilisation Classification Study) are sufficiently calibrated to reflect the care needs of respite residents, especially consumers with a dementia diagnosis, and whether accommodation costs are appropriately recognised.
- 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 residential respite users, and introducing a one-off admission payment to cover the cost of admitting a consumer into respite care for the first time. The latter explicitly recognises the high proportion of admission-related costs relative to total revenue from a short-term stay. Because respite residents continue to incur accommodation costs in their principal place of residence, 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 may use. The appropriateness of the current annual cap on respite days 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.
- Removal of the current requirement to seek Departmental approval for residential respite places. Instead, uncap the number of days that may be used for respite and introduce 'funding following the residential respite consumer' (noting that packages are suspended while a person is using residential respite). 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.

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

Access to community-based respite services

Improving access to community-based respite is more difficult.

As has been noted in earlier Aged Care Updates when discussing the intention to create a single home-based care and support program, administrative arrangements for the CHSP and the home care package program, and hence the arrangements for funding and accessing respite services under the two programs, bear no similarities or consistency.

Improving access to community-based respite services will therefore be a more difficult proposition because change in this area is likely to be co-ordinated with intended reforms to achieve greater integration more generally across the two home-based care and support programs. Because of the complexities involved in achieving greater integration, it is also likely that only incremental change will be possible, focussed on issues such as assessment, access, consumer contributions and consumer choice and control.

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[1] Aged Care Sector Committee *Roadmap for Aged Care Reform* March 2016
[2] Aged Care Financing Authority *Fifth Report on the Funding and Financing of the Aged Care Sector* July 2017
[3] Ibid
[4] Carers Australia *Improving Access to Aged Residential Respite Care* February 2017

Disclosure statement: The author of this Update, Nick Mersiades, is a member of the Aged Care Financing Authority. The opinions in this Update should not be read as being an expression of the views of the Aged Care Financing Authority.

You can read previous Aged Care Updates here.