

Australian Government  
Aged Care Financing Authority

# Report on respite for aged care recipients

31 October 2018

# Executive Summary

## Background

The Minister for Senior Australians and Aged Care, the Hon Ken Wyatt AM, MP requested that ACFA undertake a study of respite care, including its use and the appropriateness of current arrangements and funding structures.

Respite Care is defined in the *Aged Care Act 1997* as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short break from the care arrangements.

Many older people receive care from their partner, family member or friends supporting them to remain living at home and in the community. Respite care can provide a necessary break for carers from the caring role, helping carers to manage other aspects of their life and also, importantly, helping them to continue in their caring role.

Respite care programs that are funded by the Commonwealth include respite delivered through the Commonwealth Home Support Programme (CHSP), respite supported by home care packages and residential respite.

The CHSP provides respite care for around 40,000 people a year and around 60,000 people a year use residential respite. Government funding for respite services includes \$248 million paid in 2016-17 as grants to providers under the CHSP program, and \$312 million paid in 2016-17 in subsidies and supplements to residential care providers to support residential respite. Data is not available on the number of people using a home care package to purchase respite services. Access to CHSP respite services is available following assessment by a Regional Assessment Service team and by an Aged Care Assessment Team for respite services through a home care package or in residential care.

In addition to different Commonwealth funding arrangements applying to these programs, there are also different arrangements for consumer fees across programs. Fees in CHSP are not compulsory (though there is a recommended framework for charging fees) whereas the fees in home care and residential care, are prescribed by legislation.

CHSP respite services generally take the form of flexible respite (for example, in a person's home for a short time during the day or overnight), centre-based day respite and overnight 'cottage' respite delivered in a cottage style respite facility. Commonwealth Respite and Carelink Centres (CRCCs) support access to respite, including for emergency purposes.

There is no specific provision for respite services under a home care package, but home care consumers may purchase respite care using their individual budget if there are sufficient funds in their budget.

Residential care respite is provided in a residential care facility – it can be on a planned or emergency basis to help the carer have a break from caring responsibilities. Residential respite is most commonly accessed in weekly units, with a fortnight the most common length of stay.

## **Issues identified from consultations**

ACFA identified a noticeable uptake in the use of residential respite care in recent years, reflecting in part a market demand for the use of residential respite for purposes other than supporting older people to remain living at home for as long as possible and their carers. This includes the use of respite as a 'try before you buy' model before a person enters permanent residential care.

ACFA also identified concerns with the process for allocating and administering residential respite places.

There are a number of reforms currently under way which may support the provision of and access to respite care and the needs of carers. These include the new Carer Gateway being developed by the Department of Social Services (DSS) to support carers.

ACFA released a consultation paper seeking views on issues relating to the provision of respite care, with 71 submissions received. Key issues raised in submissions included:

- Issues in relation to access including difficulties with the assessment process (difficulties in finding services and navigating My Aged Care); the importance of giving consideration to carer needs as well as care recipient needs; and the problems faced by people with special needs (including CALD communities and dementia and bariatric care).
- Funding – concerns that funding, particularly of residential respite care, does not meet the cost of care and accommodation; proportionally high administration costs associated with short-term respite care compared with permanent residents; and the nature and administrative processes for respite care which can expose providers to greater financial risk than for permanent residential care.
- Fees – concerns that fees for residential respite care are a barrier to access, and that there is a disparity in fees for different types of respite care in CHSP, home care and residential care.
- Administrative processes – concerns over the administrative process for managing residential respite, including the rules for minimum and maximum place allocations, the 70 per cent respite incentive supplement and the 63 day limit per year on an individual's respite care use.
- Availability – general concerns over the availability of respite care in CHSP (including concerns over the availability and funding of 'cottage respite') and residential care, with issues over different business models and approaches to offering respite by different providers affecting availability of residential respite care and the use of respite as a 'try before you buy' approach before permanent admission into residential care

## **Conclusions and Recommendations**

ACFA has identified a range of issues and areas for potential improvement of respite care services. Many of these issues would be best addressed as part of broader consideration of reforms in other parts of the aged care system. This appropriately reflects that respite care is an important and integral part of the aged care system and should move in line and be consistent with the direction of broader reform.

Consequently, ACFA's recommendations include a mix of issues to be considered with other related broader reforms (with some guiding principles offered to help shape future respite reform) as well as more specific recommendations where adjustments to the respite system could proceed separately to other reforms. The recommendations are summarised below and are outlined in full in Chapter 3. They include:

- 1) Recognising respite care as a vital component of aged care services and, that the Government should implement policies to facilitate a sufficient supply of the different types of respite services to meet care recipient and carer needs and preferences.
- 2) Ensuring the needs of carers, as well as care recipients, are recognised when assessing access to respite care.
- 3) Establishing funding arrangements that are neutral between respite residents and permanent residents, and not act as a disincentive to respite care.
- 4) Ensuring access to, and suitability of, care for special needs groups, including people with dementia, needing bariatric care, and from CALD communities.
- 5) Recognising that consumers should make an appropriate contribution towards the cost of their respite care and accommodation where they can afford to do so, with appropriate support from the Government where consumers are not able to contribute.
- 6) Ensuring consistency with other potential reforms, including that consumer fees for respite care be considered in conjunction with wider changes to consumer care fees, such as better integration of fees more broadly in the residential, home care and CHSP sectors as recommended by the Legislated Review.
- 7) Facilitating care recipients' and carers' easy access to information on respite care options (through CHSP, home care, residential and other DSS services) and in doing so help care recipients and carers readily obtain care when and where they need it.
- 8) Ensuring Government agencies adopt a co-ordinated approach to the delivery of, and information dissemination around, respite care, including working with providers to establish real time information on the availability of respite care.
- 9) Recognising that the use of respite care for purposes other than supporting people to live at home for as long as possible and their carers can be responding to a market demand for other uses of respite, but that this should not be crowding out consumers with genuine respite care needs.
- 10) Examining the need for specific arrangements that facilitate the transition of a resident into permanent care, particularly in the context of the current review of residential aged care funding models following the RUCS exercise.
- 11) Allowing the market to respond to consumer demand and in turn the numbers of respite places that providers offer based on funding arrangements that do not act as a disincentive or incentive to the provision of respite care. Given that respite care is central to the aged care system, there should be an expectation that all providers be prepared to offer respite care.
- 12) If neutrality in the funding of respite and permanent residential care is achieved, the Government should remove the minimum and maximum allocation rules for respite care and allow providers respond to consumer demand for respite, subject to appropriate transitional arrangements and monitoring of the impacts of such as change on respite availability.

- 13) Renaming the current respite care supplement as the respite care accommodation supplement to reduce confusion as to its purpose and paying the supplement irrespective of whether a person has been assessed as low or high level care, with rates aligned with those that apply for permanent residents .
- 14) Reviewing the respite incentive supplement in the context of the outcomes of the University of Wollongong work on broader residential care funding reform. If the relative rates of funding between respite residents and permanent residents are set appropriately, there may not be a need for a separate incentive supplement with all the associated administrative red tape that it brings.
- 15) Recognising that if the incentive supplement is to continue, the administrative processes that support the incentive supplement are inefficient and should be changed. The current process whereby some providers have a minimum respite allocation and others a maximum allocation is highly confusing and likely contributes to some providers missing out on respite subsidy they should receive.
- 16) Reconsidering the limitation of 63 days per year per respite client in residential care because it imposes administration burdens on providers, consumers and the Government, and is not readily tracked. ACFA recommends keeping a cap on respite care, but suggests that consideration be given to whether it be less than 63 days and to introducing some form of means testing after a specified period of respite use. The latter would address concerns that other uses of respite care may crowd out respite for supporting people wishing to live at home for as long as possible (and their carers).
- 17) ACFA does not see the need for any changes to how home care packages can be used to access respite care. While there are issues around different fee structures which should be considered, the purchasing of respite care should remain an appropriate use of home care packages.
- 18) Similarly, noting that other than in relation to fee contributions, ACFA does not consider there is a need for any major changes to how CHSP respite services are offered.
- 19) Recognising that cottage respite is in effect another type of short-term residential respite care, when considering neutrality of funding settings following the RUCS study, consideration be given to whether the current funding model for cottage respite is appropriate.

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# Chapter 1 – Introduction

## 1.1 The ACFA Respite Care Project

### 1.1.1 ACFA

The Aged Care Financing Authority (ACFA) is an independent statutory committee whose role is to provide independent, transparent advice to the Australian Government on financing and funding issues in the aged care industry.

### 1.1.2 Terms of reference for the project

On 31 July 2017, Mr David Tune AO PSM, as the independent reviewer appointed under the *Aged Care (Living Longer Living Better) Act 2013*, provided his report, known as the Legislated Review of Aged Care 2017 (the Legislated Review), to the Minister for Aged Care, the Hon Ken Wyatt AM, MP.

The Minister tabled the report in Parliament on 14 September 2017.

Recommendation 8 of the Legislated Review 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.

Additionally, in its 2017 annual report (published in August 2017), ACFA noted the increasing use of residential respite care and recommended that further analysis be done.

In October 2017, Minister Wyatt requested ACFA “undertake a study and report on the increasing use of residential respite care and the appropriateness of the current arrangements, including funding structures, for providers and consumers.”

Noting that the respite care model had not been reviewed for some time, Minister Wyatt instructed ACFA to consider Recommendation 8 of the Legislated Review in its report.

In February 2018 the scope of the review was broadened to include other types of respite care being provided to aged care recipients, in recognition that residential respite is not a stand-alone service.

The reporting date for the project is 31 October 2018.

## 1.2 The intention of respite care in aged care

Respite care is defined in the *Aged Care Act 1997* as “residential care or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short-term break from their usual care arrangement.” The intention is to support the carer in their caring arrangement, to enable the care recipient to remain living in the community longer.

Many older people in Australia receive care from their partner, family members or friends. Caring is a challenging and demanding yet rewarding role. It is recognised that carers also need care and they need to take a break from their caring role. Respite care can provide that break. It can help carers to manage other aspects of their life as well, enabling them to continue in their caring role and to look after their own health and wellbeing.

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.

Care recipients and carers access respite care for a range of reasons including:

- to give a carer or care recipient a break from their usual care arrangements
- periods when a care recipient's usual carer is not available, for example if they go on a planned holiday
- in an emergency, such as when the care recipient's carer is unexpectedly unavailable
- to allow a carer time to attend to responsibilities outside of their caring role.

Respite care is an important support service for frail, older people and their carers, and it is provided in a number of settings to allow flexibility for carers and consumers.

Respite care is funded by the Australian Government through the following programs:

- the Commonwealth Home Support Programme (CHSP)
- the Home Care Packages Programme
- residential aged 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.

### 1.3 Government funded respite care programs in aged care

This section summarises how carers and care recipients are assessed for and access respite care. It also includes an outline of the three main types of Australian Government funded respite care - CHSP, home care and residential respite care. Table 1.1 provides a snapshot of each type of program in 2016-17.

#### 1.3.1 Accessing Respite Care

The national, online and phone contact points listed below provide information on, or access to government funded aged care, including respite care. Callers can contact these numbers for help and information for themselves, a family member, friend or someone they're caring for.

- [My Aged Care](#) (phone 1800 200 422) provides information and access to services
- [Carer Gateway](#) (phone 1800 422 737) provides practical information and resources for carers
- [Commonwealth Respite and Carelink Centres](#) (phone 1800 052 222 business hours or 1800 059 059 out of hours for emergency respite) is a national network that provides information and links to local support services to assist callers in accessing short-term and emergency respite.

**My Aged Care** is the first point for access to any government funded aged care services, including respite care. A person needs to register as a client with My Aged Care before scheduling an assessment that will determine their eligibility for aged care services.

#### **Commonwealth Respite and Carelink Services**

Commonwealth Respite and Carelink Services (CRCCs), funded under the CHSP, broker respite care in emergency situations, and have funds to assist when the client cannot afford to pay.



Some CRCCs provide a booking coordination service, although this requires the cooperation of service providers who choose to participate. Some providers opt out of this and manage their own respite bookings.

Some CRCCs also case-manage respite bookings, seeking suitable services on behalf of the carer/care recipient.

### **1.3.2 Assessment**

Consumers currently require different assessments to access different types of Government funded respite care.

To access respite services through the CHSP, a person is normally assessed and approved by a Regional Assessment Service (RAS), though an Aged Care Assessment Team (ACAT) can also approve access to respite through the CHSP. However, to be eligible for residential respite care, a care recipient requires an assessment by an ACAT.

While no specific assessment is required for a home care package consumer to purchase respite care through their home care package, ACAT approval for a home care package is required in the first place.

People seeking respite services must register and book an assessment (RAS or ACAT) through My Aged Care to be eligible for Government funded respite care. However, when respite care is needed in emergency situations, consumers can call their local Commonwealth Respite and Carelink Centre and, if necessary, the appropriate assessment can be conducted after the commencement of the respite care.

RAS and ACAT assessments are provided at no cost to the consumer.

#### **The My Aged Care assessment process**

The My Aged Care contact centre registers the client when they first make contact, conducts a screening process over the phone and will then do one of the following:

- refer the client for a face-to-face home support assessment to be conducted by a RAS, if the client can be supported by the CHSP
- refer the client for a face-to-face comprehensive assessment to be conducted by an ACAT, if the client's needs indicate a higher level of care could be required under the *Aged Care Act 1997*
- refer the client directly to a CHSP service, in exceptional circumstances only, for example if they have an immediate health or safety issue that cannot be supported by other means, as well as arranging a face-to-face home support assessment to be conducted by a RAS or ACAT
- provide information about non-Commonwealth funded services, such as local community services or privately funded services.

Where it is not possible to conduct registration and/or screening over the phone (for example if a person has difficulty communicating over the phone), or the person expresses a desire not to continue over the phone, the person will be referred directly to face-to-face assessment.

ACFA notes that the Legislated Review recommended simplified assessment processes for simple, short term services (Recommendation 26).

Additionally, the Legislated Review recommended a single assessment workforce, thus reducing duplication of the assessment process (Recommendation 27). If implemented, this would combine the RAS and the ACAT assessment process.

**Table 1.1: Government funded respite care, 2016-17**

	TYPE OF RESPITE CARE		
	Residential	Home Care	CHSP
Number of individuals accessing respite care in a year	59,411	(available data does not identify whether home care packages are used to purchase respite)	40,720
Number of services providing respite care	2,455	not available	579
Setting where the respite care is delivered	Residential aged care services	Care recipient's home	<ul style="list-style-type: none"> <li>• Centre based day respite</li> <li>• Cottage respite</li> <li>• Flexible respite</li> </ul>
Government funding method	Subsidy and supplements to provider	Individual Package Budget	Block funding
Eligibility assessment	Aged Care Assessment Team	Aged Care Assessment Team	Regional Assessment Service
Government funding amount paid to providers for respite care per annum	\$312.7 million	(available data does not identify how much of the package budget is used to purchase respite)	\$247.9 million

### 1.3.3 Commonwealth Home Support Programme

The CHSP provides funding for a broad range of entry-level support services to assist frail older people aged 65 years and over (50 years and over for Aboriginal and Torres Strait Islander people) and who have functional limitations (including cognitive), to remain living independently at home and in their community.

The main objective of respite care services through the CHSP is to support and maintain care relationships between carers and clients, through providing quality respite care for frail, older people so that regular carers can take a break.

Respite care benefits the carer through providing supervision and assistance to the frail older client. The carer may or may not be present during the delivery of the service. The types of services funded in order to meet this objective are flexible respite, centre-based respite, community access-group respite and cottage respite. As noted earlier, eligibility for respite care in the CHSP is determined by a RAS.

**Flexible respite care** includes:

- In-home day respite – provides a daytime support service for carers of clients needing assisted support in the carer’s or the client’s home
- In-home overnight respite – provides overnight support service for carers of clients needing assisted support in the carer’s or client’s home
- Community access(individual) – provides one-on-one structured activities to give clients a social experience to develop, maintain or support independent living and social interaction and offer respite to their carer
- Host family day respite – day care received by a client in another person’s home
- Host family overnight respite – overnight care received by a client while in the care of a host family
- Mobile respite – provides respite care from a mobile setting
- Other – innovative types of service delivery to clients.

**Centre-based respite care** includes:

- centre based day respite – provides structured group activities to clients to develop, maintain or support independent living and social interaction conducted in a community setting
- residential day respite – provides day respite in a residential facility to the client
- community access group – provides small group day outings to give clients a social experience and offer respite to their carer

**Cottage respite** (overnight community respite) provides overnight care delivered in a cottage-style respite facility or community setting other than in the carer, care recipient or host family’s home.

In general CHSP services should not be provided to people who are already receiving other government-subsidised services that are similar to service types funded through the CHSP.

CHSP providers receive grant funding to provide specific services in their identified coverage area. In some areas there may only be certain types of respite available through the CHSP, while in other areas there may not be an approved CHSP provider of respite. The amount of grant funding a CHSP provider receives determines the amount of service they are able to provide in each service type.

### **Supply of CHSP respite services**

During 2016-17, the number of CHSP providers that offered respite care were:

- Flexible respite – 517 providers
- Centre-based respite – 238 providers
- Cottage respite – 98 providers

During 2016-17, grant funding for these respite care service types totalled:

- Flexible respite – \$143.2 million
- Centre-based respite – \$70.4 million
- Cottage respite – \$34.3 million

During 2016-17, the number of people who received respite care through CHSP were:

- Flexible respite – 27,962
- Centre-based respite – 14,773
- Cottage respite – 3,559

The CHSP is complemented by access to emergency respite services provided through the Commonwealth Respite and Carelink Centres and services provided through:

- the National Carer Counselling Program and Carer Information Support Service
- the Dementia, Education and Training Program
- the Counselling, Support, Information and Advocacy – carer support program.

### **CHSP consumer contributions**

Consumer contributions towards services delivered under the CHSP (including respite services) are not mandatory but providers charging fees are encouraged to follow a voluntary principles-based Client Contribution Framework (the Framework) which was released by the Department of Health in October 2015.

The Framework and a supporting National Guide to the CHSP Client Contribution Framework have been developed by the Department to assist service providers with establishing client contribution practices for the CHSP services they deliver. The Framework outlines the principles service providers can adopt in setting and implementing their own client contribution policy with a view to ensuring that those who can afford to contribute to the cost of their care do so, whilst protecting those most vulnerable.

The Framework does not include a mandatory fees schedule or require formal means testing, but does stipulate that consumer contributions should not exceed the actual cost of service provision.

#### **1.3.4 Home care**

To receive a government subsidised home care package, a care recipient must have been approved for home care by an ACAT. There are four different levels of home care packages that an ACAT may approve an eligible care recipient to receive.

There is no specific type of respite care available under a home care package. Instead, respite may be incorporated into an individual care plan negotiated with the provider and purchased using funds in the package budget. A consumer can access respite at full cost recovery to the home care budget – that is, it is charged at an hourly rate by the home care provider, or billed to the package if provided by another service provider.

There are practical limits on how much respite care can be accessed, depending on the person's care needs and the funds available. In addition, as the package funding is assigned to the home care recipient, they need to agree to the services being purchased.

Information about the amount of respite care purchased by home care package consumers is not available. Under consumer directed care, each care plan and individual budget is designed to meet the care needs of the consumer. Data about the types of services purchased through a home care package are not collected.

At 30 June 2018, there were 91,847 home care package consumers. Of these, 27 per cent were Level 3 and 4 packages. The Government has announced changes that will see the overall number of packages increase to 155,000 by 2021-22 and of these, around 50 per cent will be Level 3 and 4.

People approved for a home care package can access CHSP services while they are waiting to be assigned a package. Where a new client has been assessed and approved as eligible for a home care package, but is waiting to receive that package, the client may be eligible to receive some services under the CHSP as an interim arrangement. However, these services are only to an entry-level of

support consistent with the CHSP, not at the level of support of the home care package for which they have been assessed.

### **Home care interface with CHSP**

Home care package consumers have limited access to CHSP services under specific circumstances:

- For clients on a Level 1 or 2 home care package: where the client's home care package budget is already fully allocated, the client can access additional, short-term or episodic allied health and therapy services or nursing services from the CHSP, where these specific services may assist the client to get back on their feet after a setback (such as a fall).
- For clients on a Level 1 to 4 home care package: where the client's home care package budget is already fully allocated and a carer requires it, a home care package client can access additional planned respite services under the CHSP (on a short-term basis).
- For clients on a Level 1 to 4 home care package: in an emergency (such as when a carer is not able to maintain their caring role), where the client's home care package budget is already fully allocated, additional services under the broader CHSP can be obtained on an emergency or short-term basis. These instances must be time limited, monitored and reviewed. (CHSP Manual, July 2018).

The July 2018 CHSP program manual stipulates that CHSP service providers "should only supply additional CHSP services to home care package clients where they have capacity to do so without disadvantaging other current or potential CHSP clients - that is, CHSP services should prioritise people who need CHSP support but do not have access to other support services over people who are already in receipt of a home care package."

### **Home care consumer fees**

Home care package funds cannot be used for the payment of consumer fees in other government-subsidised programs. These must be met by the home care consumer using private funds.

A home care consumer can purchase community respite services under full cost recovery through their package, which means the cost of the respite care (day centre, cottage care etc) will be billed to the home care package budget, except for any consumer fees, which the consumer must pay.

In addition to respite purchased directly through their package, home care consumers can access respite directly through the CHSP and residential respite care. When accessing CHSP respite, a home care consumer must pay any client contributions set by the provider. These contributions cannot be paid from the package funds. The home care consumer is still required to pay the basic daily fee and income tested care fee (if eligible) for their home care package while accessing CHSP respite services. Home care package services are not suspended during periods of CHSP respite.

A home care consumer must have ACAT approval to access residential respite care. Home care package services are suspended while a home care package holder is in residential respite care. Payment of the basic daily fee for the home care package is suspended while a home care consumer is in residential respite care, although the home care provider continues to receive the full home care subsidy for up to 28 days of respite care leave. Instead, consumers are required to pay the residential respite basic daily fee, which is 85 per cent of the single age pension. Note that a home care consumer's income tested care fee is not suspended during periods of residential respite care.

At 20 September 2018, the basic daily fee in home care was \$10.43 per day which is 17.5 per cent of the single age pension. Any home care income tested fee cannot exceed the cost of the care

recipient's package. Home care income tested fees have daily caps of \$14.81 where the consumer's income does not exceed the first threshold of \$26,985.40 (single person) and \$29.92 where the consumer's income exceeds the income threshold of \$52,036.40 (single person). In addition, an annual cap of \$10,892.89 applies to income tested fees in home care.

A hardship supplement is available for home care recipients who cannot afford to pay their aged care costs.

### **1.3.5 Residential respite care**

The primary intention of residential respite is to give a carer or care recipient a break from their usual care arrangements. Residential respite care may be used on a planned or emergency basis to help with carer stress, illness, holidays or the unavailability of the carer for any reason.

To receive government subsidised residential respite care, a person must have been approved for respite care by an ACAT. Service providers are paid either a high or a low level residential respite care subsidy as determined by the ACAT assessment. Respite users are entitled to 63 days of subsidised respite care in a financial year; however this approval can be extended by an ACAT for up to 21 days at a time. Once a person has exceeded their approved respite days, no further respite care subsidy is payable to the provider, unless an extension for residential respite care is given by an ACAT.

Residential respite care extensions cannot be backdated.

#### **Respite subsidies and supplements**

Unlike permanent residents entering an aged care facility, respite residents do not have an Aged Care Funding Instrument (ACFI) assessment. Instead, the rate of respite basic subsidy that is paid is based on the level of care (high or low) approved by an ACAT. This approval does not limit the care to be provided, but can have implications on when fees are payable for certain specified care and services, and the aged care supplements the Australian Government pays.

The means tested accommodation supplement that is paid to providers on behalf of eligible permanent residents is not paid on behalf of respite residents. Instead, a non-means tested respite supplement is paid at particular rates for respite care users, depending on their assessed needs.

Following the 2005 Budget, a respite incentive payment was introduced to encourage providers to use their respite care allocations, and also to encourage provision of respite care to those with a high level respite ACAT assessment. The incentive is paid per day for each high care respite resident once a provider's respite occupancy rate reaches 70 per cent of their total respite allocation over the 12 months up to and including the current claim month.

Residential respite care consumers are covered by the Schedule of Specified Care and Services that applies for permanent residents, and are eligible for higher or lower levels of care based on their ACAT approval. As a result, respite residents with a low level respite approval may be required to pay additional fees for some goods and services, such as clinical nursing services. This is the same as for permanent residents with lower ACFI levels.

In 2016-17, the Australian government paid respite subsidies and supplements totalling \$312.7 million to residential care providers.

Respite subsidies are paid at two rates; low or high. Respite supplements are paid at three rates; low, high and incentive (see Table 1.2 for the amounts).

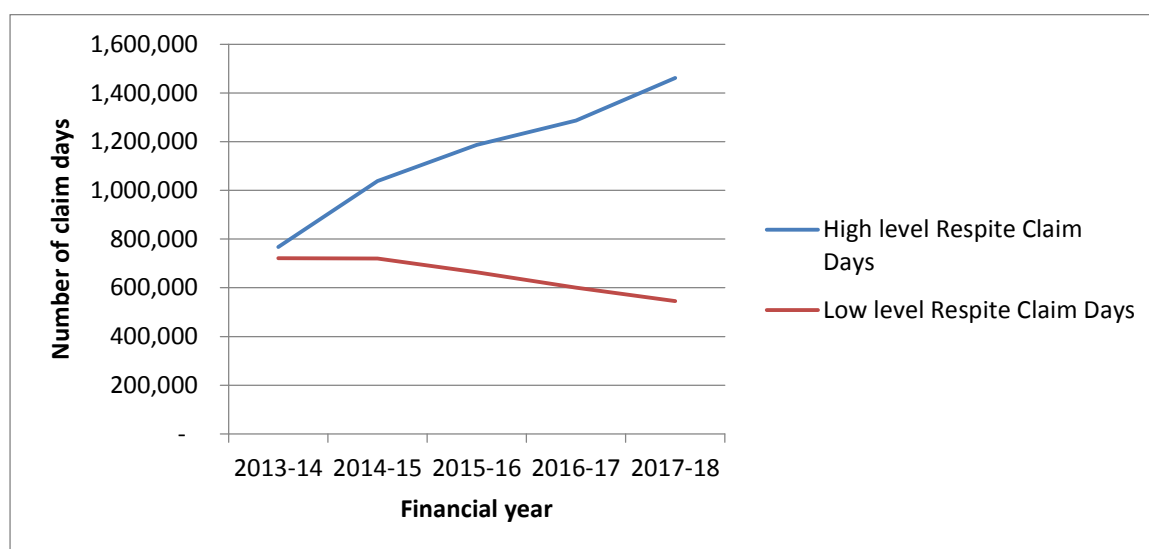
**Table 1.2 – Residential respite care subsidies and supplements at 1 July 2018.**

	Daily Respite Care Basic Subsidy	Daily Respite Care Supplement	Total paid per day (subsidy + supplement)
Low level respite care	\$46.74	\$38.46	\$85.20
High level respite care	\$131.05	\$53.91	\$184.96
High level respite care when provider has 70% occupancy or higher of allocated respite places	\$131.05	\$91.73	\$222.78

**Trends in usage**

Since the introduction of the 70 per cent occupancy incentive, there has been a steady increase in the provision of high level respite care respite. However, recent data shows there has also been a pronounced increase in the use of high level respite care since the 1 July 2014 reforms (see Chart 1.1).

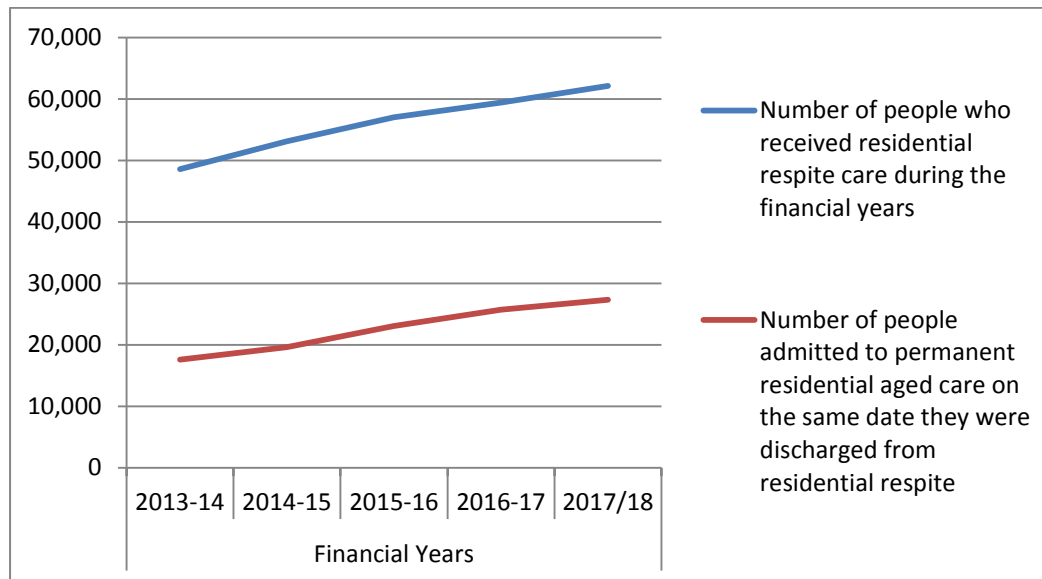
**Chart 1.1 Provision of respite care days by high and low levels**



On 1 July 2014, new means testing arrangements for permanent residential care recipients were introduced. However, respite care recipients were not included in the care recipients affected by the new means testing arrangements and are therefore not required to pay a means tested fee. The introduction of the new means testing arrangements for permanent residential care recipients coincided with a marked increase in the number of care recipients accessing high level residential respite care, and also an increase in the number of respite care recipients converting to permanent care recipients.

## Increase in people moving to permanent care from respite

Chart 1.2 – Changes in permanent care admissions from residential respite care



As shown in Chart 1.2, 62,087 people received residential respite care at some time during 2017-18. This is an increase of 28 per cent on the number of people (48,556) who received residential respite care at some time during 2013-14. The chart also shows that during 2017-18, 27,344 people were admitted to permanent residential aged care on the same date they were discharged from residential respite care. This is an increase of 55 per cent on the number of people who were admitted to permanent residential aged care on the same date they were discharged from residential respite care during 2013-14 (17,590).

During this period, the number of people admitted to permanent care each year has remained relatively steady at between 68,000 and 70,300 (except for 2013-14 when only 63,733 people were admitted to permanent care).

ACFA discussed the increasing and changing use of residential respite care in its 2017 and 2018 annual ACFA reports. There has been a significant increase in the number of respite care consumers proportionate to permanent residents, closely mirrored by an increasing proportion of respite care consumers who transfer directly into permanent care following a respite stay. These are outlined in Table 1.3.



**Table 1.3: Admissions to residential care, permanent and respite, 2013-14 to 2017-18**

	Financial Year				
	2013-14	2014-15	2015-16	2016-17	2017-18
Number of people admitted to permanent residential aged care	70,295	63,733	68,690	69,788	68,839
Number of people admitted to residential respite care	48,556	53,106	57,020	59,411	62,087
Number of people admitted to permanent residential aged care on the day they were discharged from residential respite care	17,590	19,597	23,072	25,727	27,344
Percentage of respite care recipients admitted to permanent care on the same day they were discharged from residential respite care as a proportion of all permanent care admissions.	25.0%	30.7%	33.6%	36.9%	44.0%

There has been a steady increase in the proportion of people who enter permanent residential care immediately after a period of residential respite care. In 2013-14, around 25 per cent of the people admitted to permanent residential aged care had just ended a period of respite care. This increased to 44 per cent in 2017-18.

ACFA acknowledges that there was a significant occurrence of respite-to-permanent admissions occurring prior to the 1 July 2014 reforms. It is to be expected that there will be a percentage of respite care consumers who, for a range of reasons, are unable to return to their home. For example, there may have been a deterioration in the person's condition or there may have been some element of respite being used to try out an aged care home before committing to permanent care.

However, the increase in the percentage of people entering permanent residential aged care immediately after a period of residential respite care since 2013-14 could also indicate that other factors are influencing this behaviour. ACFA notes that during 2015-16, 2016-17 and 2017-18, more than a third of all residential respite care recipients converted to permanent residential aged care at the end of their respite care stay.

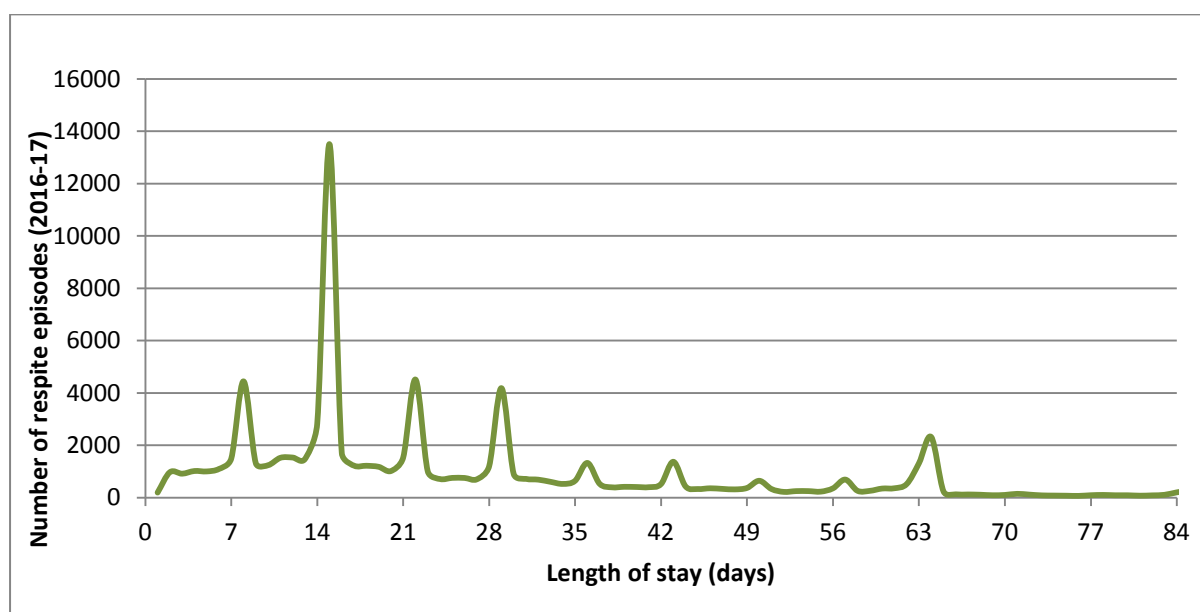
This trend may indicate that the increasing use of residential respite care is not primarily for the intended purpose of providing a period of respite, but may be people wanting to try out a facility, or who are waiting for advice of their means test prior to completing their permanent admission. Comments in the submissions suggest that respite is increasingly being used by providers and consumers as a "pre-entry" to permanent care.

### Length of stay in respite care

In 2016-17, 59,228 people received residential respite care. Around 75 per cent of residential respite users have only one episode of respite care per annum. This trend has remained relatively stable over the past few years.

There is a clear pattern in the length of stay in respite care (Chart 1.3). 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, followed by nine weeks (63 days), which is the maximum annual amount of respite approved for each person without requesting an extension. This pattern has been stable over a number of years.

**Chart 1.3: Frequency of length of residential respite care stays, 2016-17**



### Residential respite care consumer contributions

The basic daily fee for residential respite care is 85 per cent of the maximum rate of the single basic age pension. At 1 July 2018, the fee was \$50.16 per day. Residential respite consumers may also be required to pay for any agreed extra or additional services.

The basic daily fee does not cover items such as social outings. In addition, if a person is receiving low level respite care, they may be required to pay for some services that are not covered by the Specified Care and Services for people with lower care needs.

Respite residents are not required to pay means tested care fees or accommodation payments to residential respite care providers.

#### 1.3.6 Hardship supplement in residential respite care

Financial hardship assistance is available to people in residential respite care that do not have sufficient income to pay their basic daily fee.

When a person is granted financial hardship, the Australian Government will pay some or their entire basic daily fee on their behalf. The amount payable by the person will be reduced by the amount paid by the Australian Government, which may be to the full value of the basic daily fee.

Each case is assessed on an individual basis, taking into consideration a range of issues that may be unique to the resident.

Applicants need to demonstrate how much income they have access to after they have paid all of their essential expenses. If they have access to more than 15 per cent of the basic age pension amount (or \$123.93 per fortnight as at 1 July 2018), they may not be eligible for financial hardship assistance.

### **1.3.7 Allocation of residential respite places**

Providers who are successful through the Aged Care Approvals Round (ACAR) process, and who indicated in their application that they would provide respite care in their allocation, receive a condition of allocation for the number of respite days they may provide. ACAR applicants from all regions are specifically requested to address services for Special Needs Groups, defined in the *Aged Care Act 1997*, particularly dementia care and residential respite care.

Depending on the conditions of allocation, an approved provider may be allocated a maximum or minimum number of residential respite days per financial year. A residential service must have an allocation of respite care days recorded in the payment system in order to receive respite care subsidies and supplements.

Historically, the allocation was for a maximum number of respite days in a year and providers would have to apply for a variation to the allocation to either increase or decrease the number of respite care days they could offer.

However, since July 2013 allocations have been for a minimum number of respite care days per year. This change reduced red tape as it enables providers to more easily increase their allocation through a request to the Department's office in the state or territory where the service is located without undergoing a variation of allocation process. The conditions of allocation do not specify whether the respite care is to be provided at a high or a low level.

## **1.4 Changes underway relevant to respite services**

The Australian Government is currently implementing a number of measures that, while not directly targeted at respite care, are relevant to some of the issues that have been raised in this report concerning access to and the provision of respite care.

The 2018-19 Budget provided funding to make it easier for senior Australians to use My Aged Care by enhancing self-service options and improving website and aged care service finder functionality. Work is also underway to simplify the forms required to apply for aged care services. Navigator services to assist consumers wishing to access aged care are also being developed and trialed, including outreach services to help older Australians make informed choices about their aged care needs.

The Government has announced the delivery of an additional 20,000 home care packages over the next four years for people with high level needs, with more than 14,000 home care packages funded in Budget 2018-19 (on top of the 6,000 packages released in the Mid-Year Economic and Fiscal Outlook).

The Department of Social Security (DSS) has announced new services will be introduced from October 2018 that will focus on providing carers with access to early-intervention, preventative and skill building supports, to improve carers' well-being and better long-term outcomes. These new services form part of the Integrated Carer Support Service (ICSS) and will be implemented in two phases.

As part of the first phase, from October 2018, new digital services for carers will be rolled out through the Carer Gateway website. The Carer Gateway will help carers navigate the system of support and services available. It is an information service and does not provide services directly to carers.

The new services include:

- digital counselling services to help carers manage daily challenges, reduce stress and strain, and plan for the future
- online peer support, connecting carers with other carers for knowledge and experience sharing, emotional support and mentoring
- online coaching resources with simple techniques and strategies for goal-setting and future planning
- educational resources to increase skills and knowledge of carers relating to specific caring situations, to build confidence and improve wellbeing.

The second phase from September 2019 will see the Government establish a new network of Regional Delivery Partners across Australia to deliver and/or coordinate local and targeted services including:

- needs assessment and planning
- targeted financial support packages with a focus on employment, education, respite and transport
- in-person and phone-based coaching, training and peer support
- information and advice
- access to emergency crisis support
- assistance with navigating relevant, local services available to carers through federal, state and local government and non-government providers including the National Disability Insurance Scheme (NDIS), My Aged Care and palliative care.

The Regional Delivery Partners will conduct outreach activities, and link to social, health, education, community and cultural groups, to better understand regional needs.

## Chapter 2 – Issues raised in consultations

This chapter discusses the issues raised in submissions to the ACFA Respite Project consultation paper.

### 2.1 Public consultation

On 9 March 2018, ACFA released a consultation paper seeking public comments on current respite care practices and issues.

Respondents were invited to comment on:

1. the process for applying for and seeking access to respite care
2. bottlenecks or delays in accessing either residential or non-residential respite care
3. whether current provider funding structures for the provision of residential respite care are appropriate
4. whether the current system for allocating respite bed days to residential care providers impacts the availability and provision of respite care
5. costs to consumers and/or carers seeking to access respite care
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
7. any unintended impacts or consequences of the current arrangements supporting access to residential respite care
8. use of CHSP respite care services and the interaction with other programs that deliver respite services, including residential respite care
9. any other matters relevant to respite care.

The consultation closed on 13 April 2018.

A total of 71 submissions were received in response to the consultation paper, from:

- 27 aged care providers
- 17 health providers
- 12 peak bodies
- 2 carer/care recipients
- 2 state government departments
- 11 others

### 2.2 Access

#### 2.2.1 Issues raised in relation to access

A number of issues were raised in the submissions regarding access to respite care, including:

- the assessment process
- carer needs
- access by people with special needs
- people moving directly from residential respite to permanent care ('try before you buy').

### 2.2.2 Assessment Process

One of the key issues raised in the responses to the ACFA consultation paper was the difficulty experienced by older people using the My Aged Care website and national call centre. Of the 71 submissions received, 24 cited access to a computer, computer literacy or difficulty navigating the website as an issue in accessing respite care.

Several submissions also noted that older people, particularly those from special needs groups or located in regional and remote areas, are less likely to use a national phone line for the following reasons:

- lack of access to interpreters
- call centre staff do not have local knowledge
- callers do not want to talk to a stranger.

In addition, CALD groups experience significant barriers to entering the aged care system. Submissions cite issues with My Aged Care and the registration and assessment processes, including phone calls and letters in English and with privacy settings in the My Aged Care system.

A further issue was the lack of an effective, real-time respite service finder that includes accurate information about the type of care being offered. Several referred to the need for a “live” online booking service, with many of these stating such a service needs to have accurate and up-to-date information about what services are available to consumers locally. Some submissions referred to inaccurate and out-of-date information on My Aged Care, which led to carers needing to contact facilities individually to find out (a) if the service had respite care available at the required time, and (b) if the service was suitable to meet the care recipient’s needs. This resulted in a lengthy process to obtain suitable care, and often increased carer stress.

In some areas, the CRCC provides a local booking management service, however this is not consistent across all areas, and providers can choose not to use the service. Feedback in the submissions about CRCCs and the services they provide was generally positive.

### 2.2.3 Carer needs

Responses to ACFA’s consultation raised concerns about the separation of the carer and care recipient in policy and assessment processes, and the resulting confusion for carers who want to access respite. A number of submissions argue that this is an artificial separation and that the needs of carers and care recipients are interdependent and should be assessed accordingly.

As noted in several submissions, the assessment is generally focused on the care recipient, so carer needs may not be properly considered unless the carer has care needs in their own right – in which case they can be assessed for aged care services. Approval for respite care is given to the care recipient, not the carer. The care recipient has the right to refuse respite care. Several submissions commented that the carer is sometimes removed from the assessment process which impacts on the opportunity to have their needs as a carer taken into consideration. This is distinct from any needs they may have as a recipient of aged care services in their own right.

ACFA notes that DSS has developed the Carer Gateway, and is expanding services for carers. However, it is not clear how this will integrate with the aged care system to provide support for carers accessing respite.

## 2.2.4 People with special needs

Some submissions raised concerns about the difficulty people with special needs (eg bariatric, CALD, behavioural symptoms of dementia) have accessing respite care. Many submissions expressed there was a preference for smaller, homelike or cottage style care for people with special needs.

Lack of availability of respite care for people with dementia was identified as an issue in a large number of submissions. Often, people living in the community who have dementia are only mildly or moderately affected, and are still mobile and active. Some submissions noted that CHSP respite is generally for low-level care needs and therefore not suitable for people with dementia. It was argued that settings such as day therapy centres do not have sufficient trained staff and suitable facilities to care for people with dementia who may wander or have behavioural and psychological symptoms.

Many submissions claim there is not enough access to secure residential respite beds available for people with dementia. On the other hand, some submissions argue that high care dementia units are not suitable for people with only mild or moderate stages of dementia, and that secure dementia care units can lead to an escalation of behavioural and psychological symptoms.

Submissions from organisations that work with or represent people from CALD communities consistently expressed their clients' preference for home or community based respite care. Key issues raised for this client group included language barriers and a lack of suitable respite care options in the local area.

People from CALD communities can experience isolation when they are placed in an aged care home or service where their language is not spoken. This is a particular problem if the care is some distance from their normal place of residence as they do not have access to their regular community to receive support and social contact.

Isolation is also an issue for care recipients in rural and remote areas, where the only respite care place may be a significant distance from their home and community. There are fewer options available in these areas, particularly for people with dementia. A number of submissions raised concerns about care recipients being placed in respite care at long distances from their community, with some being more than 100km from home. Submissions note that maintaining connection with their regular community in such cases is difficult and raise concerns about the psychological effects of isolation in such cases. Often respite care in the home, through CHSP or their home care package, is not available in regional, rural and remote areas. The lack of available services can lead to carers going without a break.

Provision of bariatric care in respite was also seen as very limited. Obese care recipients may require specialised equipment and additional staff to assist with activities such as transfers. A few submissions noted that, although obesity is increasing in the general population, very few aged care services are equipped to provide care for obese care recipients.

## 2.2.5 More people moving directly from residential respite to permanent care - "Try before you buy"

As discussed in Chapter 1 of this report, there has been a steady increase in the number of residential respite users who enter permanent care immediately after discharge from respite during the period from 2013-14 to 2017-18.

A number of admissions in response to ACFA's consultation paper cited the use of residential respite care as a trial period when considering permanent residential care. Many (23 out of 71 responses)

indicated that providers gave preference to permanent admissions, and to respite care admissions where it was indicated that the person was considering entering permanent care, over respite care. Some of the reasons cited were:

- To enable providers to minimise or recoup the cost of the admission and assessment processes, which are similar for permanent and respite care admissions
- To allow time for the care recipient and/or family to finalise the means test assessment
- To see if the aged care home is a 'good fit' for the resident
- To delay the commencement of paying means tested fees.

It was also noted that, for people who are fully or partially self-funded retirees, the fees for residential respite are generally lower than the means tested fees for permanent residential care.

Many submissions noted the increasing practice of using residential respite care as a pre-entry period prior to permanent residency. The primary concern raised in submissions from consumer and community representatives is that this practice is preventing residential respite care being available for care recipients and carers genuinely in need of respite care. Several submissions mentioned many residential care providers are reducing or ceasing to provide respite care.

The practice of using residential respite care as a pre-admission period, rather than for providing genuine respite care (that is, where the person intends to return to their home), can be a valuable means of entry to ensure all parties are satisfied before making a more permanent arrangement. It also gives the consumer and their family an opportunity to finalise any financial arrangements prior to entry. This arrangement may enhance consumer choice when seeking an appropriate aged care home for permanent care, while also reducing financial risk for the provider.

Nevertheless, it is not respite care as defined in the *Aged Care Act 1997* - "*residential care or flexible care (as the case requires) provided as an alternative care arrangement with the primary purpose of giving a carer or care recipient a short-term break from their usual care arrangement*" and so may be crowding out people living at home who are seeking short-term respite.

## **2.3 Residential respite care**

### **2.3.1 Issues raised in relation to residential respite care**

Several issues regarding residential respite care were identified in the submissions. The most common issues were:

- Residential respite funds do not meet the cost of providing care and services
- Additional costs in providing care for people with special needs, such as dementia and bariatric care and for CALD communities
- The proportionally high cost of admission processes for short-term respite
- Respite care funding does not address accommodation costs
- Consumer fees for residential respite care are a barrier to access.

These issues are discussed below.

#### **1. Residential respite funds do not meet the cost of providing care and services**

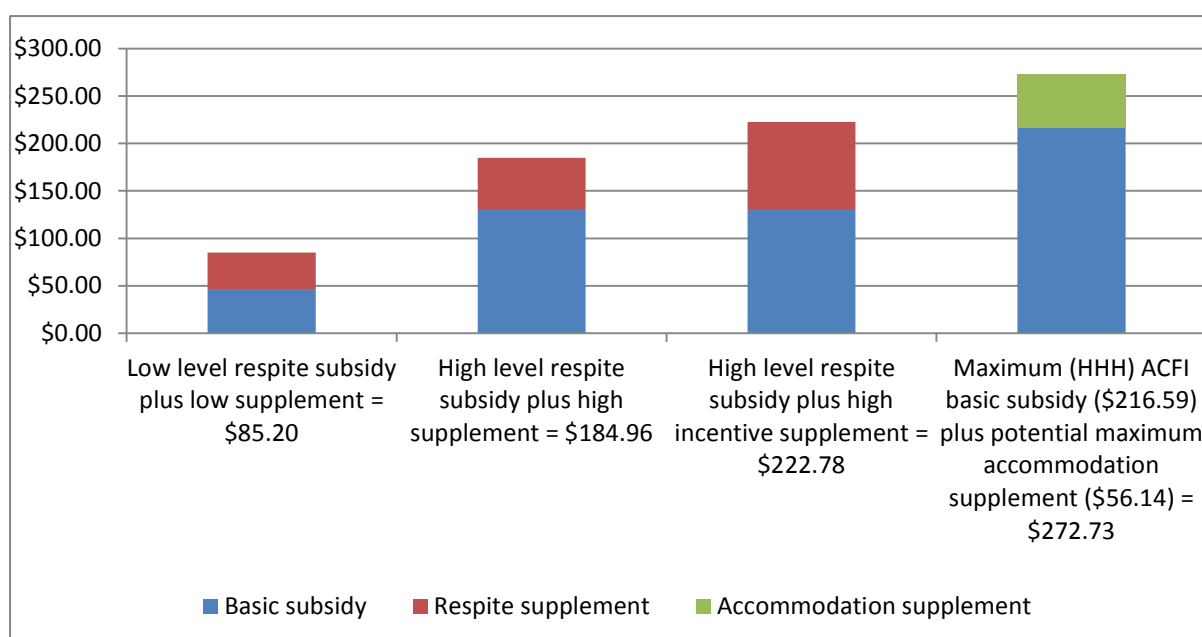
The residential respite subsidy and supplement rates are set out at Table 1.2 on page 12, which is repeated below for ease of reference.



	Daily Respite Care Basic Subsidy	Daily Respite Care Supplement	Total paid per day (subsidy + supplement)
Low level respite care	\$46.74	\$38.46	\$85.20
High level respite care	\$131.05	\$53.91	\$184.96
High level respite care when provider has 70% occupancy or higher	\$131.05	\$91.73	\$222.78

In comparison, the maximum ACFI rate for permanent care was \$216.59 per day at 1 July 2018. Providers may also receive an accommodation supplement on behalf of eligible permanent care recipients. The maximum rate of accommodation supplement was \$56.14 at 1 July 2018. This rate of accommodation supplement only applies to new or recently refurbished residential aged care homes with more than 40 per cent supported residents. Lower rates apply to other facilities.

**Chart 2.1: Amount of respite care basic subsidy plus respite care supplement compared to the maximum permanent care ACFI basic subsidy and potential accommodation supplement at 1 July 2018**



Permanent aged care residents with higher means may also be required to pay a Refundable Accommodation Deposit (RAD) or Daily Accommodation Payment (DAP) at a higher rate than the equivalent maximum accommodation supplement rate.

Several submissions from providers raised concerns that the level of funding was insufficient to support the provision of quality care to residential respite care recipients.

Providers noted that they are required to develop a care plan for a residential respite care recipient, just as they would for a permanent residential care recipient. Several submissions refer to the staff time required for effective care planning, which is the same regardless of whether the person is entering the service for permanent or respite care. However, in the case of residential respite care where a higher number of care recipients enter the service throughout the year, the need for care planning occurs more frequently, and therefore a respite bed can be a higher cost to the provider.

Another issue raised in a number of submissions is the difficulty having a low care respite approval updated when the care recipient's care needs have increased. This issue is more prevalent since 2009, as ACAT assessments for low level respite care no longer expire. Significant wait times for ACAT assessments in some areas exacerbate this issue, with people not being reassessed in a timely manner.

## **2. Additional costs in providing respite care for people with special needs, such as dementia and bariatric care, and for CALD communities**

A significant number of submissions raised the difficulty of finding suitable respite care for special needs groups. This issue was identified in submissions from both provider and consumer groups as an area of unmet demand. Providers in particular discussed the higher costs involved in meeting the care needs of particular special needs groups.

The majority of references to costs associated with special needs groups referred to the additional cost of meeting the needs of people with dementia who are still mobile, who have significantly different care needs from those with moderate to advanced levels of dementia.

## **3. The proportionally high cost of admission processes for short-term respite**

New residents need time to adjust to their new surroundings, including the size of the facility and the regulation of daily activities conducted on a schedule. This adjustment period can require a high level of staff assistance. Respite residents go through the same adjustment stresses as permanent residents; however, there is higher turnover as respite care is short term. Therefore respite residents will often require a higher level of staff assistance for the entire duration of their stay, and can require similar assistance on subsequent stays as they go through readjustment again.

Several submissions argued that the cost of providing residential respite care can exceed the funding the provider receives. Some providers mentioned having to choose between accepting a person for respite care and absorbing the additional care costs, or refusing to admit the person. Some providers state this is more likely to be an issue if the person has an ACAT approval for low level respite care.

As noted previously, many providers cited the high cost of the admission process as a significant barrier to offering residential respite care. The admission process for residential respite care is similar to the admission process for permanent residential care. Providers are required to conduct an assessment and develop an appropriate care plan regardless of whether a person is entering permanent or residential respite care. However, for a permanent resident, there is an opportunity to recoup the cost of the admission process over the duration of the resident's stay. There is significantly reduced opportunity to do this over the course of a short-term residential respite care stay, especially if the person is approved for low level respite care.

Providers generally reported that the practice of offering residential respite care in weekly blocks, with two weeks being the most common length of stay, results from the high cost of the admission process to the facility, which makes shorter stays financially less viable. Several submissions included a recommendation that the cost of the admission process should be addressed in any funding reform of residential respite care.

An additional advantage to the practice of providing residential respite care in weekly or fortnightly blocks is that it enables providers to plan admissions to avoid having empty beds, for which they receive no subsidy.

This practice was raised as an access issue in many of the submissions, particularly those representing the consumer perspective. Many submissions suggested that carers have a preference for short stays, such as overnight or weekend stays, but stated that such periods are generally not available in residential respite care.

#### **4. Respite funding does not address accommodation costs**

Respite residents are not required to make an accommodation payment and providers do not receive the accommodation supplement that is payable for eligible permanent residents.

Instead, as well as the respite basic subsidy (either high or low) to meet care costs, providers receive a respite supplement (either high or low) to cover accommodation costs. Respite supplements are indexed on the same basis as accommodation supplements for eligible permanent residents.

Providers claim, however, that the entire respite basic subsidy, respite supplement and any incentive payment that is payable is used to meet the cost of admission and provision of care, leaving no revenue to cover the cost of accommodation.

Submissions from some providers noted that the absence of means tested care and accommodation fees means that people who can afford to contribute to the cost of their care are not paying proportionally the same amount for respite care as they would for permanent care. This may be contributing to the increase in use of residential respite care prior to admission to permanent care, as a strategy to delay the commencement of paying means tested fees.

ACFA notes that providers are also unlikely to offer low level respite care as revenue is insufficient to cover costs.

#### **5. Consumer fees for residential respite care are a barrier to access**

Almost half of the submissions in response to the consultation paper cited payment of the basic daily fee for residential respite care as a barrier to access.

The main concern was the need for respite residents to maintain their ongoing costs of living at home, such as rent (for non-home owners), utilities costs and other household expenses, while they are in residential respite care. Another issue is the requirement of some providers that the basic daily fee be paid in advance, which relies on people having sufficient savings. In some cases, carers choose not to take a break because the fees would cause financial hardship.

This issue was raised specifically in relation to residential respite care where the person returned home. When residential respite is being used as a pre-admission period, there may be a financial advantage to consumers, particularly if they are partially or fully self-funded retirees, as the fees for residential respite care can be lower than those for permanent residential care.

The home care basic daily fee is not payable while the home care package consumer is using residential respite care. However, package holders who pay an income-tested care fee are required to continue paying an income tested fee to their home care provider during periods of residential respite care.

### **2.3.2 Hardship supplement in residential respite care**

A hardship supplement is available for residential respite care users who cannot afford to pay their aged care costs. The person receiving respite care, or their nominated representative, is responsible for applying for the hardship supplement.

As noted in some submissions, internet access and a scanner are required to submit an online application for the hardship supplement, or a person can attend a Centrelink office to lodge the forms manually. Several submissions from consumer representatives noted that this process causes stress for carers, particularly older carers or those in regional and remote areas with limited or no access to technical equipment, and carers from CALD backgrounds. One submission pointed out that some carers may not have the ability to leave the person they care for in order to attend a Centrelink office.

Several submissions raised the concern that the application process for the hardship supplement is too difficult and time consuming. Some mentioned that care recipients and/or their carers are put off by the process so do not apply for the supplement. Instead, they choose to go without respite care.

Of the more than 59,000 people who received residential respite care in 2016-17, approximately 140 applications for hardship supplement were lodged, and 72 care recipients were approved.

It should be noted that a significant number of submissions from both providers and consumers demonstrated a lack of awareness of the financial hardship provisions for residential respite.

### **2.3.3 Financial risk for providers of residential respite care**

Subsidies and supplements are only paid for approved respite residents for approved occupied bed days. Providers face a financial risk if they provide respite care that is not approved or if the respite place is not occupied. Subsidies and supplements are not paid to the provider if the following occur:

- The provider exceeds their maximum allocation of respite days – an administrative issue that could be missed by the provider.
- A person exceeds their approved respite days – an administrative issue that is difficult to track due to the system being updated only when monthly claims are submitted by providers.
- An application for emergency ACAT approval is denied, or is not backdated to commencement of respite care episode - some submissions note this is one reason providers refuse emergency admission to residential respite care.
- A person who has booked respite cancels at short notice and their intended bed/place is not able to be filled.
- A person leaves respite care during a residential respite stay – unlike for permanent residents, the provider receives no subsidy for temporary leave if a respite resident leaves a service for any reason during their residential respite stay. For example, discharge to hospital was noted in several submissions as a relatively common reason for a person leaving residential respite care during their stay.

**Table 2.1: Number of unpaid residential respite care days**

<b>Financial year</b>	<b>Unpaid respite days</b>	<b>Number of unpaid respite days as a percentage of paid respite days</b>
2013-14	25,739	1.7%
2014-15	20,427	1.1%
2015-16	25,905	1.4%
2016-17	31,231	1.6%

Data on the number of unpaid respite days attributable to each of the risks mentioned above is not available. However, Table 2.1 suggests that failure to meet any one of a number of administrative and eligibility requirements can result in providers missing out on funding for the provision of respite care. These requirements are discussed further below.

### **2.3.4 Administration of residential respite care**

#### **Allocation of respite care**

In several submissions, it was noted that providers need to actively manage their allocations of respite care days to maintain the 70 per cent incentive payment threshold and/or to avoid exceeding their allocation. For some providers, in particular smaller or rural and remote providers, this can take a disproportionate amount of staff time.

Some submissions stated that the system for changing an allocation was onerous, while others referred to it as straightforward. A provider with facilities across a number of states noted inconsistency in how the process was applied in different states.

Several submissions from providers questioned the need for an allocation process at all.

Recommendation 3 of the Legislated Review is:

*That, as soon as possible, the Government discontinue the Aged Care Approvals Round for residential care places, instead assigning places directly to the consumers within the residential care cap, with changes to take effect two years after announcement by Government.*

As respite places are currently allocated to providers through the ACAR process, removal of the ACAR will require consideration of the potential implications for the availability of residential respite care. The Department of Health has commissioned a review of the broader impacts of removing the ACAR, including the implications for respite care.

#### **Approval of respite care**

One of the most common issues raised by both aged care providers and consumer groups in responses to the consultation was the difficulty in getting an ACAT approval for an emergency admission to residential respite care.

There is provision for providers to request an emergency ACAT assessment for residential respite care within five days of an emergency admission, however approval for care is not guaranteed, resulting in a financial risk to providers. As a result, some providers refuse to admit people for respite care in an emergency if they do not already have ACAT approval for respite care.

From information in the submissions, it appears that some providers are not accepting people without ACAT approval as they are not aware of the ability to request an emergency ACAT assessment within five days of admission to respite care. Others are not willing to take the financial risk that the person may not be approved as an emergency admission for respite care after the event.

Several submissions argued the problem is partly a result of ACATs refusing to give approval for respite care unless there is an intention for the carer/care recipient to use residential respite care in the next six months. However, there is no requirement for this in the ACAT assessment manual. Rather, the manual states that ACATs should:

Ensure recommendations are for services and supports for current needs and not recommending services that are not supported by the assessment or are anticipated future needs. (*ACAT Assessment Manual*, section 10.9)

Limiting approval of care recipients to 63 days of residential respite care per financial year causes administrative difficulty and can result in an inadvertent loss of subsidy for providers.

Each individual's use of respite care is not tracked in real time, but is updated when the provider submits their monthly payment claim to DHS. Often, respite residents and their carers do not keep records of how much respite care they have used in a financial year, and respite users may use different providers for separate episodes of respite care. A number of submissions mention the difficulty of finding out the balance of respite care a person has remaining prior to admission. Further, significant amounts of staff time can be used to get this information.

### **Payment system and allocations of respite care days**

The aged care subsidy and supplement payment system records a maximum allocation of respite days for residential aged care services. This enables the system to calculate the proportion of respite care the service has provided and whether or not it has equalled or exceeded 70 per cent of the specified proportion for payment of the high level respite care supplement incentive. Services that exceed the maximum number of respite days recorded in the payment system receive no respite care subsidies or supplements for the days they provide respite care above that maximum.

The limitations applied in the current payment system mean that providers must actively monitor respite care usage to avoid non-payment of respite care subsidies and supplements.

### **2.3.5 Availability of residential respite places**

Residential respite care can be used for emergency and planned respite. However, the availability of a respite place depends on each provider's business model.

Several submissions from providers stated that residential respite care is usually only offered to fill an empty bed between the discharge of a permanent resident and the admission of another permanent resident. This practice limits planned access to respite care, as providers cannot predict when they will be able to offer a place.

Often in this situation, the respite resident will be occupying a room/bed that has just become vacant on the discharge of a permanent resident. Vacancies often occur in permanent residential

aged care due to the death of a resident, which could be a distressing period for the permanent residents who may be grieving. In addition, permanent residents can sometimes find short-term respite residents disruptive to their settled routines.

Other providers stated they only offer planned residential respite care. Booking planned respite periods guarantees income for the provider and enables planning of occupancy. However, many submissions raised the issue of a general lack of availability of respite care as places can often be booked out months in advance. A number of submissions mentioned the practice used by some providers of rebooking people for future respite care when they are discharged from a respite care episode, which ensures a measure of continuity of care for some, but can limit access for others seeking respite care.

Another common theme raised in submissions was the number of providers who have reduced or ceased providing respite care in the last few years. However, evidence from provider claims, as shown in the table below, indicates that the number of residential care services being paid respite subsidy is fairly steady.

**Table 2.1 – number of services receiving residential respite subsidy per financial year**

	Financial Year			
	2013-14	2014-15	2015-16	2016-17
Number of services that received residential respite subsidy during period	2,738	2,714	2,712	2,708

Several submissions mention a reduction in the availability of residential beds in their area for short-term respite, including several providers who have ceased to provide short-term residential respite care. On the other hand, the increase in the number of providers receiving residential respite subsidy coincides with the increase in respite residents converting to permanent care on the day of discharge. Taken together, these trends indicate that the availability of residential respite care to support those seeking to live at home for as long as possible and their carers is not increasing, and that residential respite subsidy is increasingly being paid to providers for care that is not short-term respite care.

## 2.4 Respite care in the community

It is the preference of many older people to remain living at home. However, an increase in the number of people remaining at home impacts the aged care system in several ways. The ability to remain living in the community for longer while receiving aged care services leads to an increase in age and acuity of people entering permanent residential care. In addition, an increase in the number of people with aged care needs accessing care in the community will have a flow-on effect on demand for respite care.

### 2.4.1 Issues raised in relation to community-based respite care

Several issues were identified in submissions regarding access to community-based respite care under the CHSP and the home care packages program. The most common issues were:

- Insufficient supply of community-based respite care
- Disparity in costs and access between CHSP and home care packages
- Difficulty accessing community-based respite for home care package consumers
- Lack of suitable care for people with dementia and other special needs groups.

#### 2.4.2 Respite in CHSP

When a person registers with My Aged Care, they are referred for either a RAS or an ACAT assessment, depending on their level of care needs. Both a RAS and an ACAT can approve a person to receive care through the CHSP. However, a RAS cannot approve people for higher care needs, such as home care or residential aged care.

The Legislated Review recommended changes to the assessment processes for aged care in general, including having a single assessment for all types of aged care.

Many of the submissions noted a general preference for community-based respite care over residential respite care. In particular, many carers and care recipients called for an increase in access to overnight cottage respite and flexible respite. As noted in Chapter 1, CHSP is a block-funded program, which limits the amount of respite care able to be provided under the program. There is currently no measure of unmet demand for CHSP respite services.

Many submissions raised the issue of suitability of community-based respite facilities to meet the needs of people with dementia or other conditions. Day respite is generally not secure for people with dementia, and many of these facilities do not have staff suitably qualified to care for people with particular care needs, such as incontinence, or who may require administration of medications.

On the other hand, a number of submissions noted the preference of carers and care recipients for small cottage facilities for overnight respite, particularly for people with dementia. This type of care offers a more homelike environment and is likely to be less stressful than staying in a large, institution-like aged care facility.

There also appears to be difficulty accessing overnight and weekend respite care through the CHSP. Accessibility issues for this type of care often relate to the cost of care, particularly for home care package consumers as the costs are recovered from their home care package budget. However, a significant number of submissions also refer to a shortage of places, in particular for cottage type respite care. A number of submissions mention that cottage respite facilities have been closing since CHSP was introduced.

However, as also raised in submissions, the cost of setting up accommodation suitable for cottage respite is high, requiring substantial capital investment. CHSP providers do not receive capital funds to build new cottage respite facilities, and the requirements for this type of accommodation are not easy to meet through conversion of an existing dwelling.

A number of submissions argued that the availability of community-based respite care was inadequate and did not meet carers' needs. Submissions cited caps on the provision of CHSP respite care, sometimes as low as two hours per week. People who require "excessive" amounts of respite care are referred to assessment for a home care package. Some suggested that this practice may be contributing to the increase in waiting lists for home care packages. Several submissions called for carers' needs for respite care to be considered separately from the care recipient's use of other services, to avoid escalation to a higher level of care that may not be necessary at that time.

A particular concern in some submissions was the lack of consideration of the needs of working carers in any of the currently available respite programs. It was suggested that the hours offered



through community-based respite are not sufficient to meet the needs of carers who work, which can lead to the care recipient prematurely entering residential care or the carer leaving the workforce.

### **2.4.3 Home care packages**

Many submissions from consumer groups noted the difficulties for carers in accessing respite through home care packages. In particular, the cost of community-based and in-home respite care through CHSP is recovered from each person's package budget, which can limit carers' access to this type of respite care. This is compounded for carers who are caring for a person on an interim home care package - that is, a home care package at a lower level than the level approved through the ACAT assessment – as the individual budget is more likely to be entirely expended on meeting the care recipient's basic care needs.

These submissions point out the need for increased access to respite for carers to accompany increased access to care in the home, as discussed further below.

#### **Unmet need**

The length of the national prioritisation queue and the number of people with interim packages indicates there may be a high level of unmet need for care at home. At 30 June 2018, 29.5 per cent of all people approved for a Level 4 home care package had not been assigned an interim package. At the same time, there were 121,418 consumers on the national prioritisation queue, with 53.3 per cent either in, or assigned, an interim package. Many in the queue not linked to an interim package are, however, receiving a basic level of care through the Commonwealth Home Support Program.

Many submissions argued that increasing access to care at home by increasing the number of home care packages should logically include increasing the provision of respite care for carers to continue to maintain their caring role and to support people preferring to live at home for as long as possible.

One of the impacts of people being assigned interim packages is that it is highly likely that their individual budget is entirely expended on basic care needs. In this event, it is unlikely that there are sufficient funds in the budget to purchase any respite care to assist with maintaining the carer in their role. An added barrier to accessing respite for a carer is that the package funds are assigned to the care recipient, who must agree to any care and services purchased through their home care package.

#### **Consumer fees and costs for home care package recipients**

A significant number of submissions referred to an inequity in the fee structures across the different programs that provide respite care. Of particular concern to consumer groups was the requirement for home care package consumers to pay fees in multiple circumstances to access respite care. For example, a home care package consumer pays consumer fees applicable for their home care package, but is also required to pay the consumer fee for any CHSP services they access. The basic daily fee in home care is a flat rate regardless of the package level.

If a person assigned an interim home care package requires top-up CHSP services to meet their care needs, they may be required to pay additional consumer fees for those services. The payment of consumer fees in two aged care programs at the same time was noted in several submissions as a financial penalty for consumers with interim packages whose care needs are not able to be met through their interim package. Consumer fees for CHSP services can be waived for people in financial hardship, however this is at the service provider's discretion.

An alternative for people with an interim home care package is to purchase additional care using their own funds. Once again, this was identified as a financial penalty for people who have been approved for a high level of care but are not able to access that care.

In addition, home care consumers are income-tested and may be required to pay a fee to offset a portion of their package funds paid to their home care provider by the government. The income-tested fee is not suspended when a home care recipient accesses other services, such as CHSP services or residential respite care.

These issues demonstrate that home care consumers can be required to pay additional fees to access services such as respite care. In addition, those with interim packages pay additional fees for care that they might not need to pay for if they were in receipt of their assessed higher package level.

An unintended outcome of the current system raised in some submissions is the high prices charged to home care consumers' individual budgets to access CHSP respite services. Some submissions noted that home care consumers could expect to have their package charged at the full rate for provision of respite care, with one submission stating the local cottage respite provider charges up to \$500 per night. As already discussed, the home care consumer may also be required to pay a fee to the CHSP provider, while also continuing to pay their basic daily care fee and any income tested fees for their home care package. The high cost of CHSP respite services charged to home care packages, particularly for consumers on interim packages, limits access to services such as overnight or long day respite.

## 2.5 Wellbeing of carers

Several submissions raised concerns for the wellbeing of carers, arguing that informal carers are filling the gap of the unmet need for formal, Government subsidised care, and that many of those carers are frail aged themselves.

One submission stated that the local respite provider in their area does not recognise carer emotional stress as an emergency, and will only provide access to emergency respite in cases of physical emergency (e.g. hospital admission of the carer). Other submissions noted the high levels of stress experienced by carers is exacerbated by the complicated process of finding and accessing respite care, whether in an emergency or for a planned break.

Many submissions point to the problems arising from the separation of carer and care recipient in the current policy environment. The focus is primarily on the care recipient when assessing care needs, which can lead to carer needs not being taken into consideration. They point out the impacts on carers of not being able to access respite care when it is needed. Situations raised in submissions include:

- Carers being unable to undergo planned medical procedures because they are unable to arrange respite care
- Carers unable to plan and book holidays because of a lack of availability of planned respite care
- Carers seeking planned respite being advised to request respite at the last minute as facilities do not book respite care in advance
- Carers being advised that they cannot access respite care in an emergency as facilities are fully booked months in advance
- Care recipients being admitted to the acute care system along with their carer because of the inability to access emergency respite care
- Premature admission of the care recipient into permanent residential aged care.

It was asserted in some submissions that a lack of access to suitable, affordable and timely respite care is leading to pressure and high costs on other areas of the health and aged care systems. Further, a lack of timely access to appropriate respite care may lead to carers using unregulated care or inappropriately accessing the acute care system.

## **2.6 Consumer choice**

As noted in the Legislated Review, residential respite care has not been reviewed for some time. Current practices do not reflect the move to consumer choice in other areas of government-funded aged care.

Many submissions referred to the difficulty carers and care recipients experienced in finding suitable respite care in any setting. The submissions noted that the dual assessment process whereby the RAS can only approve a person for CHSP respite care, and ACAT approval is required for other types of respite care, works against consumer choice by creating a barrier to particular types of care and/or care settings. The recommendation in the Legislated Review to have a single assessment team able to approve for all types of care may go some way to addressing this issue. ACFA notes that consumer choice would be facilitated by having a single, automatic respite approval that enables people to access their preferred type of respite care depending on care needs.

Submissions also noted that the other main barrier to consumer choice in respite care is the general lack of availability of respite care in any setting.

It was suggested that changes to assessment processes and funding models would go some way to addressing access and availability issues, and enhance consumer options.

# Chapter 3 – ACFA’s conclusions and recommendations

## 3.1 Responding to concerns over respite care

Carers are a critical component of the aged care system and respite care is a vital aspect in assisting carers and consumers, including supporting the choice of many older people to remain living at home for as long as possible. As noted in the Legislated Review, it is essential that the objectives of respite care are met and that there is adequate supply and equitable access to respite care.

The submissions to ACFA’s consultation paper have highlighted, however, a number of concerns over the existing arrangements for the operation of respite care.

For consumers, the concerns raised include:

- Difficulties in using the My Aged Care website and national call centre and obtaining accurate information on the availability of respite services
- Inadequate attention given to the needs of carers with the focus being on the care recipient
- The reduced availability of respite care given the trend to use respite as a path for entry into permanent residential care
- The difficulties faced by people with special needs - particularly CALD and those with dementia – in accessing respite care
- The cost of respite care for some consumers.

For providers, the concerns raised include: the cost of respite care not being adequately funded, particularly given the high administrative costs of respite; inadequate coverage of accommodation costs; and the risk of unpaid respite if a range of administrative requirements are not met. The result is that there is an incentive for providers to favour permanent residents over respite care.

A response to many of these issues should not be considered in isolation but as part of other reforms which are being implemented or considered in the broader context of the aged care industry. This appropriately reflects that respite care is an integral part of the system and needs to move in line and be consistent with the direction of broader reform.

For example, a major concern raised in the submissions was the difficulty older people and their carers have in using the My Aged Care website and accessing timely information on the availability of respite services. However such concerns are not limited to those seeking information on respite care. The Legislated Review highlighted significant widespread concern over the usability and functionality of My Aged Care and related IT platforms. As a result, the Government allocated additional funding in the 2018-19 Budget to make it easier for senior Australians to use My Aged Care by enhancing self-service options and improving website and aged care service finder functionality.

The implementation of this initiative, and the Government’s decision to simplify the forms required to apply for aged care services and to trial a comprehensive navigator for the aged care system, should specifically take into account the particular issues raised in the submissions regarding accessing respite services.

In a similar fashion, the issues raised by providers that the cost of respite care, especially residential respite, is not adequately funded under current arrangements, should not be addressed in isolation but in the context of the overall arrangements for funding residential care. The objective should be to ensure that all forms of residential care are appropriately funded and there is not an incentive to provide one form of care (such as permanent) over another (such as respite care).

ACFA considers it would be optimal to consider the relative funding of respite care at the same time as consideration of the outcomes of the review of the funding model for residential care being undertaken in conjunction with the University of Wollongong's Resource Utilisation and Classification Study (RUCS). This would ensure that any changes to the respite funding arrangements will work together with any changes to the funding arrangements for permanent residents, thereby avoid incentivising one form of care over the other. This would be difficult to achieve in advance of the RUCS results and broader ACFI reform.

Taking these considerations into account, ACFA's recommendations on respite care consist of:

- Recommendations related to broader aged care reforms that are being implemented or are under consideration which need to take into account the concerns raised over access to and the availability of quality respite care. Some principles are offered to guide how respite care issues should be considered in the context of the broader reforms.
- Recommendations that respond to specific concerns with respite services which could be dealt with in the short-term and prior to the implementation of broader reforms.

### **3.2 ACFA's recommendations**

#### **Recognise respite as a vital component of aged care services**

- 1) The critical role of respite care in supporting carers and enabling older Australians to exercise their choice to stay at home needs to be clearly recognised by all stakeholders, especially the Government and aged care providers. In particular, residential respite care should not be considered only as an option if there are residential vacancies. The Government should implement policies which aim to facilitate a sufficient supply of the different types of respite services to meet care recipient and carer needs.

#### **Give recognition to the needs of carers as well as care recipients when assessing access to respite care.**

- 2) The assessment and eligibility processes for respite care need to include both the needs of the carer and care recipient. This should be appropriately incorporated in RAS and ACAT assessment processes for respite care, as well as being recognised in the My Aged Care platform and other sources of information on aged care services and support for carers, such as the Carer Gateway.

#### **Funding arrangements should be neutral and not act as a disincentive for respite care**

- 3) All forms of residential care should be appropriately funded such that residential care providers are neutral towards accepting respite or permanent residents. The appropriate funding of residential respite care should be considered in the context of the outcome of the University of Wollongong's RUCS exercise. This should include consideration of whether the funding of respite care at two levels (low and high) should continue, or whether a new funding structure would be more appropriate. It should also involve consideration of whether allowance should be made for proportionately higher administrative costs for respite care residents. It is also necessary to ensure that the accommodation costs for residential respite care are appropriately covered.

#### **Ensure access to, and suitability of care for special needs groups, including people with dementia, people needing bariatric care, and people from CALD communities**

- 4) The care needs of special needs groups should be considered in any respite funding reform to ensure they have access to quality respite care that meets their specific care needs. This should align with the consideration of special needs groups under broader funding reforms.

### **Consumer contributions across all types of respite care**

- 5) Consumers should make an appropriate contribution towards the cost of their respite care and accommodation where they can afford to do so, with appropriate support from Government where they are not able to contribute. This is consistent with the principle of achieving neutrality in terms of funding and consumer contributions between respite and permanent residential care. ACFA recommends the process for accessing the hardship provisions be reviewed to ensure they are as streamlined and simple as possible. This should be included in the initiative to make the My Aged Care platform easier to use and to simplify the forms required for aged care services.
- 6) To ensure consistency with other potential reforms, consumer fees for respite care should be considered in conjunction with consideration of wider changes to consumer care fees, including better integration of fees more broadly in the residential, home care and CHSP sector, including as recommended by the Legislated Review.

### **Access to Information**

- 7) Care recipients and carers should be able to readily obtain information on respite care options (be that through CHSP, home care, residential care and other DSS services) and readily obtain care where they need it. ACFA recommends that the work being undertaken to improve the My Aged Care platform and to develop a system navigator for the broader aged care system should take into account the concerns raised in submissions about difficulties for special needs groups in particular, including those from CALD backgrounds and in rural and remote areas, in accessing respite care.
- 8) Government agencies, particularly the Department of Health and Department of Social Services, should ensure a coordinated approach to the delivery of and information dissemination around respite care. In particular, Government agencies need to coordinate with providers with the aim of establishing real time information on the availability of respite care and that this information is readily accessible by consumers and carers. Participating in arrangements to provide information on the availability of respite care should be a condition of being an approved care provider.

### **Respite care being used for non respite purposes**

- 9) The use of respite care for purposes other than to support people living at home and their carers is common practice in the market. ACFA considers this is an appropriate market response to other service demands, such as 'try before you buy' in residential care or as a transition for consumers who are about to enter mainstream residential care. However, this needs to be balanced against ensuring that the availability of short-term respite to support those wishing to remain living at home for as long as possible and their carers is not compromised.
- 10) To the extent that neutrality is achieved in the funding of, and consumer contributions to, respite and permanent residential care, there would be less incentive for providers to favour 'try before you buy' options over short-term respite. Nevertheless, there may be a need for specific arrangements that facilitate the transition of a respite resident into permanent care. This should be considered in the context of the review of residential aged care funding model following the RUCS exercise. While appropriate fees should be charged for consumers transitioning into permanent care, it may be practically difficult to introduce means testing arrangements for short periods of stay. However, it is important to ensure as far as possible comparability in consumer contributions across all forms of residential care.

### **Administrative rules and processes**

- 11) Government should not overregulate respite care with administrative red tape. Instead, the market should be primarily left to respond to consumer demand and determine the number of respite places particular providers offer based on appropriate funding arrangements that do not act as a disincentive or incentive to the provision of respite care. Respite care should be a viable business model for all providers. There should also be an expectation that all providers be prepared to offer short-term respite care.
- 12) If neutrality in the funding of respite and permanent residential care is achieved, the Government should remove the minimum and maximum allocation rules for respite care and allow providers respond to consumer demand for respite, subject to appropriate transitional arrangements and monitoring of the impacts of such as change on respite availability.

### **Respite care supplement**

- 13) Pending any substantive reforms to the funding of respite care, the current respite care supplement should be renamed the respite care accommodation supplement to reduce confusion as to its purpose. Recognising that this supplement is not intended for care, but for accommodation, the same amount of supplement should be paid irrespective of whether a person has been assessed as low or high level respite care, and rates should be aligned with accommodation supplements for permanent residents.

### **Respite incentive supplement**

- 14) The respite incentive supplement should be reviewed in the context of the outcomes of the University of Wollongong's RUCS work. If the relative rates of funding between respite residents and permanent residents are set appropriately, there may not be a need for a separate incentive supplement with all the associated administrative red tape that it brings.
- 15) If the incentive is to continue, ACFA considers the administrative processes that support the incentive supplement are poorly designed, inefficient, confusing and should be changed. The current process whereby some providers have a minimum respite allocation and others a maximum allocation is confusing and likely contributes to some providers missing out on respite subsidy they should receive. It is also likely that this encourages some providers to juggle their minimum or maximum allocation to maximise qualification for the incentive supplement. This is unnecessarily diverting resources to administration and is inefficient.

### **Limitation on respite care use**

- 16) The limitation of 63 days per year per respite client in residential care should be reconsidered. It imposes administration burdens on providers, consumers and government, and is not readily tracked. It is not clear that the cap on respite use provides any significant protection to Government expenditure and it is unlikely that an individual and/or their carer will seek more respite days than they actually need. Moreover, if there is broad neutrality in the funding of respite residents and permanent residents, along with neutrality in terms of consumer contributions, there is less need for a cap on an individual's use of respite care.

ACFA notes, however, that in the absence of achieving funding and user contribution neutrality between respite residents and permanent residents, there would be a risk that removing the 63 day rule may encourage more use of respite as a 'try before you buy' arrangement at the expense of genuine respite care. An option may be to strengthen and reinforce the ACAT assessment process so that respite care is only approved where it is clearly to support people who wish to continue living at home and their carers. On balance, ACFA recommends keeping a cap on respite care but suggests that consideration should be given as to whether it should be less than 63 days. In addition, to ensure equity of access and

fees for short-term respite users and 'try before you buy' uses, consideration could be given to introducing some form of means testing after a specified period of respite use.

### **Home Care Packages**

- 17) ACFA does not see the need for any changes to how home care packages can be used to access respite care. While there are issues around the fairness of different fee structures raised in submissions which should be addressed, ACFA considers the purchasing of respite care should remain an appropriate use of home care packages.

### **CHSP**

- 18) Similarly, ACFA does not consider there is a need for any major changes to how CHSP respite services are offered, noting they continue to provide a useful mixture of support services (such as the Commonwealth Respite and Carelink Centres) and direct respite assistance. Fee issues should be considered as part of broader consideration of how fees should operate, including integrating fees between CHSP and home care.
- 19) The cost of providing overnight cottage respite was raised as an issue by both consumers and providers. Consumers and carers have expressed a preference for cottage-style care over residential respite care in a large facility, but note there is a shortage of this type of accommodation. They also raise the issue of the high cost of accessing cottage respite, particularly for home care consumers. On the other hand, there is a high capital cost for providers of cottage care. Cottage respite is in effect another type of short-term residential respite care, and in considering neutrality of funding settings following the RUCS work, consideration could be given to whether the current funding model for cottage respite is appropriate.