australian homecare | Leading Provider of Care in the Community

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The Commissioners
Productivity Commission Report
Caring for Older Australians
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Australian Home Care Services (AHC) which is wholly owned by Multiple Sclerosis Limited (MSL) is one of the largest third-party providers of Community Aged Care in Australia. Nearly 300 Approved Aged Care providers broker their services to care recipients (HACC, Cacps, Each and EACH-D) per AHC.

AHC has built on its traditional neurological service base and its strengths and capabilities in working with clients with complex care needs and provides in excess of 1.5 million hours of direct care and support to more than 2500 clients per year. AHC also wholly owns Nationwide Health & Aged Services, which provides cleaning, laundry and other services to more than 300 residential care facilities. AHC currently operates across three states, Victoria, NSW and South East Queensland and the ACT.

Our primary assertion for the consideration of the Commission, is for the deconstruction of funding silos and for the adoption of more integrated care and support models for Clients and carers who are either (or both) Aged and Disabled.

AHC is a quality certified organisation and is both an approved attendant care provider and an approved aged care Provider. AHC provides the following services:

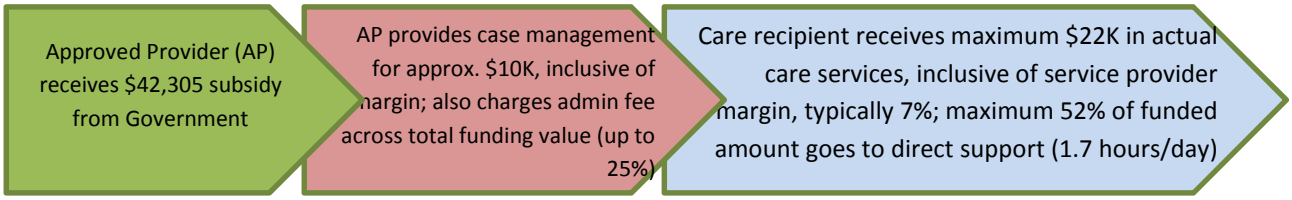
- Accommodation (residential and in-home)
- Health Services (nursing and allied health, including case management and assessment))
- Care and support (including care management, planning and co-ordination)

AHC supports the fundamental reform tenets of the PC draft report, and makes the following observations/comments in support of its work.

Service Delivery Community Care

There is an Inherent assumption in the report that Approved Providers are direct providers of care to Care recipients. Many agencies broker direct care services to care recipients through the use of third-party providers, retaining a case management component and charging an administrative levy. This is observably inefficient, usually such agencies then have less than fifty cents in the packaged care dollar left for service purchase (e.g. Cacps) for care recipients.

There are no evident constraints on profits (or retained funds) derived from packaged care delivery. Little wonder submissions for these funds are oversubscribed. (P129). The following demonstrates the inequity and limited allocation on the very services that the care recipient, and the primary carer, need greatest.



A real question emerges here around price and fees manipulation (including means testing) by such brokerage companies/organisations.

- The Approved Provider is effectively both a price setter and a margin setter in a direct care service market which is characterised by increasing expectations of responsiveness, quality and training, OH&S as well as salary expectations from care workers and the consequence is in low and mostly unrealistic operational margins for providers.
- They set fees and charges in what appears to be an arbitrary manner, and in an environment where demand exceeds available packages, the consumer (care recipient) is at a distinct disadvantage.
- The effect of the above creates considerable and inequitable market distortions.

Case Management

Recommendation 8.1 envisages case management would be provided in the community or in residential care facilities by an individual's provider of choice. AHC supports this recommendation and strongly urges the PC to consider discrete unit costing for this services within the context of proposed Gateway care planning.

Independent care co-ordination

AHC supports the independent provision of Referral, Assessment services and Care Planning and Co-ordination (recommendation 8.1).

Consumer directed care

AHC is experienced in Care recipients managing their own budgets and care, though it is noticeable that they self-manage conservatively and often tend to underspend their budgets. They would observably benefit from active and collaborative Care Planning and co-ordination.

Community Care Re-structuring

It is not enough for the PC to focus solely on future resource allocative mechanisms. Industry and markets are observably deficient in the provision for exchange and pricing mechanisms that would provide for and indeed incentivate voluntary movements, transitions and exits. There has long being a market for bed licences but not for packaged care. Perhaps an independent mechanism or clearing house for the exchange and pricing of care packages would facilitate reform of the base.

Tax Treatments

As a not for profit AHC does not support removing any taxation concessions from the industry. The aged care industry is not an equal playing field and the removal of such concessions is philosophically naiveté at best.

Pricing

AHC supports the unbundling of care funding although it regrets the potential loss of cross subsidisation across care types or different users. The later has been a potent tool in the management of diverse presentations and client groups. For instance when clients are episodically ill or experiencing a family trauma (carer arrangements breakdown) the need for flexible responses will be diminished, and particularly for agencies like ours that deal with Clients with a Disability as well as Aged, cross subsidisation has served a useful mechanism to address resource deficiencies in other streams.

Funding

AHC also supports a user's pay system for Aged Care as well as a collective risk/cost pooling or sharing mechanism (safety net). AHC additionally supports the introduction of "Compulsory Social Care Insurance", as a mechanism for the long term care provision for both Aged & Disabled clients. The PC's reluctance to commit to such insurance is inhibited by its narrow focus on Aged care only rather than a broader social care mechanism involving Clients with a Disability.

AHC supports the recommendation (6.3) to remove regulatory restrictions on the number of community care packages.

Care & Support: Choice & Power

AHC support s the PC recommendation 8.2. The Australian Government should replace the current system of discrete care packages with a single integrated, and flexible, system of care provision. AHC also supports funding to individuals, who choose their approved provider.

AHC does not support the PC's differentiation (p266) between Aged Care and Disability Services. Both require client specific servicing.

Housing

AHC supports the PC recommendation 10.2 and would strongly urge the PC to support the development of innovative, independent, non-institutional, congregational living options. Such options will and are emerging as alternatives to retirement communities, Independent living communities and serviced apartments.

Many clients would prefer to live in more appropriately designed and non stigmatised environments with others of similar culture, interests and backgrounds. It is cost efficient and more effective to provide care and support to clusters of clients in such environments. These environments are also more mutually supportive and can provide significant enhancements to well being and lifestyle, for instance shared resources, carers, equipment etc.

Workforce

AHC has an extensive workforce and invests significant resources, time and effort to maintain and develop workers training, potential, experience and personal development. Recent initiatives have reduced some of the onerous burdens associated with workforce management and development, however the coherence and comprehension of such options is as complex a journey for care support workers as it is for care recipients. It is often a journey undertaken by the individual at their own cost, with significant effort.

Again AHC supports the thrust and directions of PC recommendations 11 (et al), but strongly urges the PC to consider a more unified approach to community care training and recognition standards for all (Aged & Disability support) workers.

Regulation

Common standards and compliance are significant regulatory burdens for organisations such as AHC which work in multiple legislative and programmatic jurisdictions (federal and state). We support the PC recommendations in this area (12.1 and 12.2) and again urge the PC to consider the alignment of compliance regimes across the aged and disability sectors.

Michael Boyce
Chief Executive Officer