Aged & Community
Services • Australia

# DISABILITY CARE AND SUPPORT PRODUCTIVITY COMMISISON DRAFT REPORT (February 2011)

## ACSA's Response

MAY 2011

# Introduction

Aged and Community Services Australia (ACSA) is the national peak body for aged and community care providers representing faith based, charitable and community-based organisations providing residential and community care services, housing and supported accommodation to more than 700,000 older people, younger people with a disability and their carers.

ACSA's interest in this discussion results from our members providing HACC services to people with disabilities; younger people with disabilities living in aged residential care facilities; and the fact that more people with disabilities are ageing and accessing aged care services. ACSA has been proactive in this area and works cooperatively with NDS on disability issues.

ACSA agrees in principle with the development of a National Disability Insurance Scheme (NDIS), but also recognises the imperative for both the aged care and disability systems to interact to provide seamless care and support for people as they age.

We are not in a position to comment on all the questions raised in the report, however, we offer the following comments on a number of the recommendations.

# Recommendations

***DRAFT RECOMMENDATION 3.5***

***Whatever the actual funding divisions between the NDIS and aged care that are put in place, people should have the option of migrating to the support system that best meets their needs, carrying with them their funding entitlement.***

***Upon reaching the pension age (and at any time thereafter), the person with the disability should be given the option of continuing to use NDIS-provided and managed supports or moving to the aged care system. If a person chose to:***

- ***move to the aged care system, then they should be governed by all of the support arrangements of that system, including its processes (such as assessment and case management approaches)***
- ***stay with NDIS care arrangements, their support arrangements should continue as before, including any arrangements with disability support organisations, their group accommodation, their case manager or their use of self-directed funding.***

***Either way, after the pension age, the person with a disability should be subject to the co-contribution arrangements set out by the Commission in its parallel inquiry into aged care.***

***If a person over the pension age required long-term aged residential care then they should move into the aged care system to receive that support.***

***In implementing this recommendation, a younger age threshold than the pension age should apply to Indigenous people given their lower life expectancy, as is recognised under existing aged care arrangements.***

ACSA supports the principle that a disabled person gets the support they need regardless of where the funding comes from, but does have some concerns for the above recommendation. It is a very simplistic approach to assume that people reaching the age of 65 can easily choose to either continue to receive support through the disability care system or transfer to the aged care system and be subject to all the financial and assessment arrangements which are proposed to exist in that system.

The funding available per individual is generally significantly less for older people than for a person with a disability. The highest subsidy for a person in residential aged care is $43,689 per annum compared with $63,000 for disability services[1]. (The figure of $63,000 for high end disability support is considered conservative. In Queensland the Young People in Residential Aged Care initiative is funding up to $120,000 per individual as an alternative to residential aged care.) Using this scenario, a person with a disability over the age of 65 would be unlikely to voluntarily elect to transfer to the aged care system. If they do transfer over, how can we guarantee they will continue to receive the same level of care?

The PC 's perceived preference for this option admits that by opting to remain in the NDIS it "would ensure that people who acquired a disability before the pension age would have the assurance that they would not get a different level of care and support" which highlights our concerns above. (Appendix C Page 12) ACSA does not recommend this option.

The funding formulae and administrative arrangements that govern the disability and aged care service systems seem to assume that a person is either disabled or aged, but cannot be both. People who have had a disability throughout their life, such as an intellectual disability or quadriplegia, will still have that disability but may have other needs as a result of ageing such as dementia. In these circumstances both disability and aged care funding would be required to effectively support that person. The same would be true if a person acquired a disability, such as quadriplegia, after the age of 65.

Whilst disability service providers are generally not equipped to manage the ageing process, conversely, aged care service providers are generally not able to meet specific disability support needs. This will require the sharing of resources and expertise across the two sectors, along with cross training activities. Many providers will need assistance adapting their service capacity and skill base to cater for a clients suffering from a combination of disability and ageing issues. Both systems need to interact to provide seamless care and support for people as they age with minimal bureaucratic and accounting requirements attached.

Therefore, the Apportionment method (discussed in Appendix C Page 11) is a more attractive scheme. The disability system would fund the support needs of the person after the pension age as if their limitations/capacity had not changed, although the real contribution would rise over time to reflect the rising real costs of care.

This option assumes that the aged care system will pick up the costs of any worsening of the disability along with the incremental support costs of natural ageing and will put the aged care system under increasing pressure. ACSA believes aged care shouldn't be picking up costs not related to aged care.

[1] ACSA submission to the PC Caring for Older Australians March 2011 P.14

ACSA recommends a blended approach to funding to ensure access to the most appropriate, expert care, whether disability or aged care or both, in the most suitable setting. This is a modified version of the apportionment option and will include the ability to "age in place" regardless of where they choose to reside - be that their own home, a residential care facility or a group home.

We shouldn't be forgetting those older people who develop a non aged related disability such as permanent injuries resulting from an accident or a person over 65 developing diseases such as Muscular Dystrophy which they may have had for many years, but doesn't present or become a problem until they are older. These people should be able to access the same specialist services as someone under 65 with the same disability. One could also argue that in the case of a person with a disability, 65 is an arbitrary cut off age as some disabilities result in an earlier ageing process e.g. Downs Syndrome.

ACSA agrees with the Commission in the interests of equity, that after reaching the aged pension age, the person with a disability should be subject to the same co-contribution arrangements set out by the Commission in its parallel inquiry into aged care.

The focus in policy and funding should be to create a positive third age with service models mirroring what typically happens to people in their 50s, 60s and 70s with recognition that people with disabilities require access to extra services. So in addition to the usual range of physical and domiciliary supports, would be added social activities, hobbies or even holidays. Enabling people to stay in their own or community group homes assists in maintaining community and family networks close to established support networks and familiar surroundings. This will require genuine consultation with the person with the disability about what they want and how their needs will best be met, rather than what is convenient for carers or the system.

**ACSA Recommendation**

ACSA recommends a modified model of the apportionment method, whereby increasing existing disabilities are not paid for by aged care, but continue to be funded by the disability sector.

The Principle of equity should also apply across both sectors so that anyone over the age of 65, who has the capacity to pay, should contribute to their care through a system of co-contributions.

***HACC FUNDING***

***While current users of NDA services will overwhelmingly receive funded supports under the NDIS, the same may not be true of all HACC users. HACC services currently cover a wider range of individuals than are the target of funded supports under the NDIS. While 'high-level' HACC users (those who receive more than one hour of support per day) would be covered by the scheme, there will be some instances where some 'low-level' HACC users would not get the same level of services using the NDIS assessment criteria. It is impossible to determine the numbers involved since so little is known about the characteristics of current HACC users, including the nature and severity of their disabilities. Consideration will need to be given, at the time, to what arrangements would be appropriate in these***

***instances. Agreed arrangements should be reflected in the MOU with the health sector. (Volume 1 Page 3.32)***

This brief statement regarding the impact on lower level clients currently accessing HACC services requires further exploration in the final PC report. While ACSA supports the notion of establishing a more flexible, universal government funded system through the NDIS that would inevitably remove the existing program structures, including the HACC program, the basic maintenance and support services currently available to younger people requiring low level support must be retained.

It is clear from the costings in Section 14 that the existing HACC funding proportioned to people under 65 years will be rolled into the new scheme, but there is a real risk that people at the low level of support end might be worse off or not considered eligible at all for assistance through the new more comprehensive assessment regime associated with NDIS. It is simplistic to suggest that this can be resolved at the time of implementation by an MOU with the health sector as this would inevitably result in different approaches across jurisdictions and in some cases a reluctance to fund the diversity of services currently available through HACC.

Community transport, home maintenance, centre based respite, and delivered meals are all examples of HACC services currently providing minimal support per week or month to younger people but enabling them and their families to function relatively independently without requiring more intensive supports. Younger people with chronic conditions, early onset dementia, and other neurological conditions that are currently not classified as a permanent disability through existing specialist disability systems are the groups most at risk of falling through the gaps in the proposed NDIS. ACSA notes that within the PC's Draft Report Caring for Older Australians, individuals' basic support needs such as house cleaning, transport and meal preparation would be determined through a minimal telephone assessment.

***DRAFT RECOMMENDATION 13.1***

***The Australian Government should attract further support workers into the disability sector:***

- ***By marketing the role and value of disability workers as part of the media campaign launching the creation of the NDIS.***
- ***By providing subsidies to training of disability workers.***
- ***Through immigration of support workers, but only in the event that acute and persistent shortages occur, and drawing on the lessons from the Canadian Live-In Caregiver program and other similar programs.***

ACSA agrees with this recommendation. There is general agreement and evidence that Australia has an ageing workforce and a national shortage of registered nurses, allied health workers and carers and that this is more acute within the disability and aged care sectors. Compounding the problem is the fact that both sectors are generally competing in the market place for workers from the same pool. Therefore what applies to the disability sector more often than not equally applies to aged care.

Without urgent action, these current labour shortages will become highly critical. The agreement in July 2007 to develop a National Disability Workforce Strategy should be linked in with a similar strategy for the aged care workforce. (Health Workforce Australia is about to develop a Workforce strategy for doctors and nurses which will include aged care, but exclude 70% of the aged care workforce i.e. personal carers.)

Unfortunately the community image of the two sectors tends to be negative. In 2008 ACSA commissioned research to report on perceptions and attitudes specifically towards aged care services[2]. The industry saw aged care as attracting largely negative media attention which was feeding myths and fear. This type of coverage causes unnecessary anxiety for older people in general, family members who have relatives in aged care services or are considering this option, and staff working in the industry. The same could be said of the disability sector.

The impact of such negative stories is seen to link to other broader problems that impact on the future of the industry:

- Workforce pressures, including shortages of qualified people being attracted to the industry;
- Morale of existing staff; and
- Undermining industry attempts to secure appropriate support from government, corporate sector and the broader community.

Of course, without improving the wages and conditions able to be offered in disability and aged care, it will be extremely difficult to attract and retain staff no matter how much marketing and media campaigning the Government funds. High turnover also increases provider costs and workloads for existing care staff compounding the problems.

Another significant feature of Australia's post-war demographics has been the influx of migrants from many different parts of the world – not all of whom speak English, or understand how to access the disability system. Providing services to disabled people of Aboriginal and Torres Strait Islander descent also presents its own distinct issues and challenges. Specific strategies to enable support of these populations need to be developed and resourced. Any training programs and subsidies should be targeted to these special groups.

ACSA firmly believes that all local avenues should be exhausted before looking overseas for staff, however, the reality is that future workforce shortfalls are unlikely to be completely filled with local labour. Therefore, it is imperative to look at alternative solutions. This includes utilising an international workforce made available through the temporary and/or permanent migration program. While sourcing overseas workers may be seen by many as a short term solution, in some states or regions this may need to be a more permanent strategy to provide an additional pool of care workers.

Before this is possible, the Australian Government will need to review the current immigration regulations. Currently the most common immigration route used by Australian businesses unable to meet their skill needs from the Australian labour market is to sponsor

[2] ACSA Key Findings and Recommendations, McGregor Tan Research May 2008

skilled overseas employees under the subclass 457 visa program. Overseas nurses and other allied health professionals are regularly recruited on a 457 visa. It is impossible under the current rules applying to the program to recruit personal carers. They are not considered to be in a skilled occupation and the temporary skilled migration income threshold of $47,480 per annum is higher than a personal carer's income.

Formal labour agreements between the Australian Government and employers are another mechanism for the recruitment of overseas workers. These arrangements are negotiated to meet special labour market circumstances that are not covered by standard business sponsorship arrangements. They have been limited in their application and tend to be valid for only two to three years. They are designed to ensure that overseas recruitment supports the longer term improvement of employment and training opportunities for Australians. Accordingly, as part of the agreement, employers or industry associations are required to make commitments to the employment, education, training and career opportunities of Australians. While ACSA has no issue with this, if there are no Australian workers to train, meeting these conditions will be impossible.

**ACSA Recommendation**

Irrespective of the introduction of a NDIS, everything possible must be done to attract further support workers into the disability and aged care sector. This includes:

- Addressing the inadequate funding that results in a low paid workforce in the disability and aged care sectors.
- Developing strategies for the attraction and retention of staff.
- Identifying opportunities and marketing strategies for influencing and improving the image of the industry, and moving the current perceptions to the preferred future state. This could be done using television, newspapers, radio, the Internet, the sectors' own networks, direct mail or the new social media.
- Recognising and providing for the need for ongoing training and career paths. (This should not include fast tracked qualifications, which have flourished recently and resulted in an influx of poorly trained workers.)
- Encouraging the employment of Indigenous and culturally diverse people within the disability and aged services sectors.
- Reviewing the temporary and permanent migration program and extending the scope to include suitable skilled and "non skilled" workers, who can provide care services in areas of critical labour under supply such as disability and aged care.
- Changing the labour agreement program to recognise the shrinking pool of workers from which to draw labour.

***DRAFT RECOMMENDATION 13.3***

***In order to promote training and counselling for carers, the NDIS should:***

- ***Assess carer needs as well as those of people with disabilities and, where needed, use the assessment results to:***

  ***- Refer people to the 'Carer Support Centres' recommended in the Commission's parallel inquiry into aged care and to the National Carers Counselling Program***

***- Include the capacity for accessing counselling and support services for carers as part of the individual support packages provided to people with a disability***

- ***Assess the best training and counselling options for carers of people with disabilities as part of the NDIS research and data collection function.***

ACSA agrees with this recommendation. ACSA's members, particularly those providing community care, appreciate the role of unpaid carers and work in partnership with them to ensure that appropriate and effective care is provided.

We believe that action to improve carer's lives is important and the recommendations in this report, along with the recently passed Carer Recognition Bill, are attempting to achieve this goal.

Better access to information and support services will undoubtedly assist carers in their roles and there are many sources of information. The problem is carers are often not aware of them or how to access them. The existing Commonwealth Carer Respite and Carelink Centres do a reasonable job of informing carers and families about available services and often provide a link to screening and assessment. Carer Support Centres and the National Carers Counselling Program will provide additional useful support for carers.

The provision of formal case management to all who need it will help carers to navigate the system and remove some of their anxiety and frustration. This is especially important for older carers concerned about the care of an adult child with a disability, when they die. Having a plan in place would have a positive impact on the carer's own health and wellbeing.

ACSA would also like to see a more proactive approach to carer health, including an assessment of their needs. It is essential for carers to be healthy and well if they are to provide the best care to the person they are looking after. More broadly, health professionals including GPs, must recognise the importance of carers' needs. This should also be part of the role of the new Medicare Locals in identifying the health needs of local communities.

Some culturally and linguistically diverse (CALD) and Indigenous carers have problems magnified beyond the norm. Often they have been isolated and unaware of the availability of special services. It is only when they become ill or a crisis occurs that they and their disabled family member accidently fall into the system.

Carers living in rural and remote areas suffer even greater hardship due to the lack of services and poor access because of the long distances they have to travel and limited public transport. Receiving information over the phone and via the internet can also be more difficult for these groups.

The provision of respite care is integral to supporting carers. There needs to be much more flexibility in the delivery of respite care, including removal of the barriers and challenges that often make it difficult for carers to access. This includes sufficient support for working carers, who may have different respite needs to a non-working carer.

As respite services are unable to meet the current demand for emergency or regular planned respite care, access is often prioritised on the degree of urgency or severity of the caring and family situation. This limits the systems ability to ensure that carers receive the level of support required to avoid crisis situations, which usually result in care arrangements breaking down and higher use and cost of formal care services.

Carers should have access to education and training to assist them in managing the condition of the person they care for. Proper investment in education and training can improve the resilience of carers and in some cases reduce the need for ongoing outside services. Certain aspects of training and education could be delivered by community service providers.

**ACSA Recommendation**

To ensure adequate access to planning options and services to people with disabilities:

- A wider range of options must be developed to support ageing carers, including access to community based respite in small home-like environments, in-home respite and more emergency overnight and weekend respite.
- The availability of respite and other support services must be increased to allow for regular, planned care and not just crisis or emergency breaks.
- Older carers must be given assurances that their child will be looked after when they can no longer do it. This will need to involve transition arrangements so that parents can witness and adjust to the changing situation.
- Elderly Carers should have ready access to HACC support (or its future equivalent).
- Easy access to information and case managers and stream lining and simplifying access to services will alleviate some of the anxiety suffered by carers.
- Provision of rural and remote services should take into account the extra distances, timeliness and other difficulties associated with gaining access to carer services.
- Fund community care providers to provide education and training when they are in the home providing services to the person requiring care. This could be training around manual handling or dealing with difficult behaviours to name a couple of issues regularly faced by carers.

***DRAFT RECOMMENDATION 13.4***

***The Australian Government should amend s. 65(1) of the Fair Work Act 2009 to permit parents to request flexible leave from their employer if their child is over 18 years old, but subject to an NDIS assessment indicating that parents are providing a sufficiently high level of care.***

***After monitoring the impacts of this legislative change, the Australian Government should assess whether it should make further changes to the Act to include employees caring for people other than children.***

ACSA agrees with this recommendation. Workplace and anti-discrimination legislation should be scrutinised to ensure the removal of unnecessary barriers to working carers. The Fair Work Australia Act which provides flexible work conditions to carers of people with a disability up to 18 years of age should be extended to people of all ages – especially in an ageing society.

## Conclusion

How the disability and aged care sectors will be funded is a key concern and the two Productivity Commission enquiries must jointly consider the ramifications for individuals and both sectors if a seamless system is to be achieved. ACSA believes the only way this can happen is through a blended funding approach to ensure people with disabilities, older people or those who are ageing with a disability can access expert services and support when and where they need them is crucial.

Workforce issues have and will continue to plague the disability and aged care sector. The fact is, as long as we continue to pay low wages, any recommended initiatives will always be facing an up hill battle to be fully effective.

The essential role of unpaid carers and our overwhelming dependence on their unfailing services makes it imperative that we rethink the way we support and "care" for them. There is no doubt that if the lives of carers are improved, so too are the lives of the people for whom they care.

In essence, the fundamental issues of adequate funding, sensible regulation and addressing workforce challenges must be addressed for any real progress to be made on the service delivery aspects of supporting carers.

This inquiry and the Caring for Older Australians Inquiry offer an ideal opportunity to get the interface right and improve the lives of many people. It is an opportunity we must take!