LASA
LEADING AGE SERVICES AUSTRALIA
*The voice of aged care*

# AGED CARE ROYAL COMMISSION DRAFT HOME CARE PROPOSITIONS

LASA Response

18 September 2020

***A strong voice and a helping hand for all providers of age services***

## Leading Age Services Australia

Leading Age Services Australia (LASA) is a national association for all providers of age services across residential care, home care and retirement living/seniors housing. Our purpose is to enable high performing, respected and sustainable age services that support older Australians to age well by providing care, support and accommodation with quality, safety and compassion – always.

LASA's membership base is made up of organisations providing care, support and services to older Australians. Our Members include private, not-for-profit, faith-based and government operated organisations providing age services across residential aged care, home care and retirement living. 55% of our Members are not-for-profit, 37% are for-profit providers and 8% of our Members are government providers. Our diverse membership base provides LASA with the ability to speak with credibility and authority on issues of importance to older Australians and the age services industry.

# Contents

## HC1. Uncapped integrated home care program

### Summary of proposition

***HC1. More care at home to meet the preferences of older people wanting to age in place (during transition to a single aged care program)***

This proposition recommends the transition to a single integrated system of home care over three years, with immediate uncapping of places (one month maximum wait time), and provision for people on home care packages (HCP) to access social support, centre-based respite, transport and meal services through the Commonwealth Home Support Program (CHSP).

It also says that the Government should commence work on a new planning system and appropriate safeguards to implement an uncapped system, and that the transition should be based on the actions set out in HC6 – transition to the new program.

### LASA comments

This proposition is right in general, but requires further consideration of the details.

On one hand it says immediately give places to everyone on the queue and introduce a one month wait time. However, it also says that uncapping demand should depend on a series of other reforms that will necessarily take time themselves.

In our view, giving a package to everyone on the queue overnight could cause significant disruption in the market. There needs to be some sort of staged release of additional packages. That staged released could conceivably occur over a 12 month period. It is LASA's view that package release should be steadily accelerated using the quarterly home care data reports to monitor progress until the one month threshold is reached.

The second important point is that transition to an uncapped system cannot be made contingent on government undertaking other reforms as this may result in delays. It is often said that we should not invest more money in a system that needs reform. This is not the perspective of those waiting years for care that they desperately need.

We are also unsure how the proposal to give people access to CHSP social support, meals, transport, enabling care, home modifications, assistive technologies and respite care would work in ensuring the transition from current arrangements to support equitable access to and delivery of these services relative to current demand for and supply of these services.

There needs to be market based arrangements put in place during the three-year transition (and without delay) to ensure consumers have choice over who will provide these services and to ensure home care providers are not restricted from delivering these services if they are capable of providing social support, enabling care and respite care arrangements. Noting current CHSP contract commitments extend to June 2022, LASA believes market based arrangements should be enacted immediately following.

## HC2. Plan based home care

### Summary of proposition

***Proposition HC2. More funding for care at home to meet assessed needs***

The headline description of this proposition does not appear to reflect the detail. There is nothing in this proposition that directly relates to whether the level of funding that a person receives would be higher or lower than currently available.

Rather what the proposal says is that funding should be divided into four streams:

1. social support (including social support, meals and transport)
2. enabling care (including short term enabling plans, home modifications and assistive technology)
3. respite care (including at home, in the community and in facilities)
4. care at home (including care management, living supports (domestic assistance and home maintenance) and personal, clinical and therapeutic care, and end-of-life and palliative care).

The proposition suggests that the new model should provide personalised funding for 'care at home' based on assessed needs (which seems to also imply by omission that supports in other streams should not be personalised).

LASA notes Lead Counsel has referenced in his outline of the proposed new service arrangements that:

1. Social Support and Respite care streams be grant based and administered at regional level, accounting for regional planning.

   LASA notes government may likely administer this grant-based program stream at a state level if provided the option to do so. LASA believes there are risks in state-level administration impacting on the robustness of regional visibility/planning and data/engagement with communities that would need to be addressed in system governance design to achieve a 'purposeful fit'. Primary Health Networks provide alternate regionally based primary health service infrastructure that would be well suited to administer this grant-based program.

2. The enabling care stream be commissioning based which raises the issue of independence of commissioning agents from service delivery and regional structures to administer this program. This may end up being administered through a state-based grants program by simplicity of design.

3. Assessors would set 'Care at Home' hours of care/service across major individualised care domains: care management; living supports; personal, clinical, enabling and therapeutic care; palliative and end of life care. Assessors would also identify when a person is no longer safe at home even if they receive the maximum amount of funding. However, the proposition does not say how the maximum funding should be determined.

It does say that specific funding amounts should be based on a standard schedule of fees for the relevant area. It is not clear whether 'area' in this context refers to the care domain or regional area that services are provided.

## LASA comments

This proposition suggests that the Commission's thinking on home care reform is similar to the Consultation Paper One on system redesign published in December 2019.

That paper suggested a National Disability Insurance Scheme (NDIS) style approach with individual plans that set out the number of units of reasonable and necessary supports with government setting prices for those supports.

The specific categories of support have changed somewhat and the proposition is silent on how levels of need would be determined but the basic thrust of the recommendation appears to be the same.

LASA was equivocal in responding to Consultation Paper One's proposal for a plan based approach. Specific issues are outlined below. However, the bottom line is that much more detail is needed on how this new model is intended to work, and how previously expressed concerns will be managed.

Clearly, further work would be required to develop regional social care program administration infrastructure with Primary Health Networks and the Department of Health (DoH) over the next three years to ensure greater regional-level engagement between government and communities to support co-design in planning activities to ensure supply/demand responsiveness.

LASA also notes that in the Home Care Hearing on 31 August that Lead Counsel had referenced the use of a risk-stratified care plan for input and monitoring by assessors/multiple care providers to trigger reviews and ensure care/service allocation is adjusted in a timely manner to match care recipient need. Information technology infrastructure and support for sector capability to access risk-stratified care plans would be necessary. Modelling of assessor workforce time demands to complete assessments and reviews to match the changing needs of consumers would also be necessary. Currently, both appear inadequately resourced.

### Level

Full adoption of the NDIS 'reasonable and necessary' benchmark would mean significantly more support for older people relative to their identified care needs. If government does not match the level of support provided by the NDIS it is unclear how the appropriate level of care will be determined.

### Pricing

There has been significant criticism of the NDIS approach to pricing individual units of activity to determine overall funding, including by the Productivity Commission. It is very hard for government to determine the right price for something as simple as electricity, let alone something as complicated and differentiated as human services. Government can be tempted to use price setting to pursue fiscal objectives. LASA's view is also that the price of delivering a service should be based on the case-mix adjusted cost + margin rather than theoretical modelling exercises.

Generally, LASA's view is that it is better to set prices for units of activity at a more general level such as the cost of 'personal care for a person with '*xyz impairments*' rather than an 'hourly rate for the delivery of personal care'. LASA notes the NDIS has used reference packages to support individualised funds allocation/determinations. InterRAI[1] also provides an evidence based home care classification model.

[1] A suite of seamless and comprehensive clinical assessment instruments, developed by an international collaborative to improve the quality of life of vulnerable people. https://www.interrai.org/

### Flexibility

Another problem is that funding based on units of activities incentivises the pursuit of volume over efficient and effective delivery of outcomes. If people can use the amount they are allocated flexibly, this can help ensure that people at least have the incentive to get the most out of what they have been allocated. It also facilitates data-driven insight and investigation into understanding how variations in resourcing will effect outcomes (accounting for the implementation of system indicators of health and well-being –Proposition HC6e).

### Streams

Related to the issue of flexibility is the proposed division of funding into streams. Depending on the approach that is taken to determining how much support different people receive, there may be cases for taking different approaches to assigning funds for different types of services. However, our view is that once funding is assigned it should be able to be used flexibly between different types of services unless there are specific well-articulated reasons for this not to be the case – such as risk of perverse incentives. This approach will support timely access to necessary supports in the context of funding constraints and delays in care allocation reviews – both of these being key vulnerabilities in the current and future program design.

We also have particular concern about any separation of support for basic services, personal care, and clinical care. These services intermesh and influence one another. The best mix will depend on the individual and the model of care. This may also vary from day to day, as a person's needs change.

It is not clear how the streams outlined in this proposition would work or the specific logic for dividing them in this way.

### Accuracy and timeliness

Individualised plans should provide a closer match between funding and need than the current system. However, it is not clear how much closer they would be than a case-mix approach.

The NDIS shows that lots of time and revisions are needed to get plans right, and this is problematic for aged care where care episodes are shorter and conditions are generally less stable.

The NDIS also has case management undertaken by the same organisation that drafts the plan whereas that would appear not to be the case in the model that the Commission has proposed.

## HC3. Changes to consumer directed care

### Summary of proposition

***Proposition HC3. Changes to consumer directed care***

This proposition outlines further implications of the changes proposed in HC2.

It states that people will have choice about how the hours of care allocated will be used. This presumably means the option of reallocating hours between different care types. However, it is not clear how this works given different types of care are associated with drastically different costs. People may also choose to purchase higher levels of experience or other labour saving devices rather than having further hours of care.

It states that people will no longer be able to use funding on non-aged care related needs or items. But it is unclear what this means since this is notionally already restricted – albeit with issues in enforcement and a lack of clear guidance emerging from enforcement rulings to encourage consistency of market application.

It states there will be a shift from self-management to shared management but it is not clear what this means.

### LASA Comments

Much of this proposition is unclear. The emphasis on choice and flexibility is welcome (as per comments on HC2) but since it is not clear what is precisely being proposed it is difficult to say more.

LASA notes the evidence base on consumer choice and consumer self-directed care including the risks associated with offering self-direction in a market environment.

## HC4. Pricing overheads

### Summary of proposition

***Proposition HC4. Pricing that accounts for the administration activities of home care providers***

This proposition suggests that prices for aged care services should be set by government and take into account the required overhead for providers, including education, management, workplace safety, and 'funding to support the transition to high quality care'.

### LASA comments

As per previous comments, there have been significant problems in the NDIS context with having government determine the price for units of service. The proposition does not confront any of these issues or explain how they would be resolved.

Additionally, the variation in pricing structures across the range of published HCP price schedules suggests there is in fact a high level of variability in cost structures across providers relative to their organisation size, location, workforce structure, and investment strategy in delivering quality care. Scaling this back to a price per unit approach will substantially stifle sector innovation and investment.

A further issue that needs to be considered is how private contributions would be considered in the context of prices set by Government. In the NDIS context, providers cannot charge more than the price cap. Would a similar restriction be imposed in home care, or would the current price flexibility be maintained?

In the absence of further explanation, LASA would not support this recommendation.

## HC5. Coordination of home care

### Summary of proposition

***Proposition HC5. Responsibility for co-ordination of care in the new program***

This proposition says that an older person receiving personalised home care from the 'care at home' stream must have a level of care management based on need that is assigned in their budget. It then

lists various things that care management should include, such as developing and revising a care plan biannually.

The proposition states that the care manager must meet the hours of care management set out in the personalised budget and support the older person to access re-assessment as their care needs change. They must have relevant qualifications matched to client need.

### LASA comments

The main implication of this proposition appears to be that a level of care management would be assigned to a person. The issue with this approach is that it limits people's ability to substitute more or less care management for less or more services. This is particularly problematic as it may often be unclear how much care management a person requires at the outset. Care management needs are also likely to change over time.

There is also no clarity regarding how care management will align with overall program design (such as system navigation/care finder services) noting care management needs for care recipients will vary across their aged care journey. LASA has made a prior submission on the positioning of care management relative to aged care system navigation to support program design.

The availability of a suitably qualified care management workforce relative to needs-based demand may also become an increasingly pressing issue in coming years as the number of older people receiving higher levels of care in their home increases. This may create challenges in ensuring equitable access to suitably qualified clinical oversight.

There will likely be need for a tiered approach to establishing a suitably qualified care management workforce and this should be planned for now. Such an approach has been used in hospitals, noting nursing tier levels comprising enrolled nurses, registered nurses, clinical nurse specialists and clinical nurse consultants where more qualified nurse consultants support other nursing staff in managing a base of complex care recipients. Issues relating to care management remuneration and funds allocation relative to care management need would need to be accounted for in such an approach.

## HC6. Transition to the new program

There are six transition elements for which propositions are proposed to support the redesign of home care service provision.

## HC6(a). Transition – skilled workforce

### Summary of proposition

***Proposition HC6(a) A suitably trained and skilled workforce***

This proposition makes general statements about the need for a valued and supported home care workforce, including professional development and a career path.

The main substantive point that it makes is that personal care workers (PCWs) in home care should have a minimum certificate IV qualification.

### LASA comments

LASA supports the general propositions, but further consideration of the details is required.

The universal requirement for a Certificate IV qualification for home care PCWs is questionable. LASA recognises that the PCW workforce is largely autonomous in respect to delivering care. However, many home care workers will be dealing with clients with much less complexity than in residential care.

Consideration should be given to the level of PCW qualification to be applied across the four care streams relative to the care tasks/skill sets required, noting 'care at home' care tasks may require a more sophisticated skill set than social support and respite care tasks (with the exception of dementia care).

Delineation is required between care tasks that occur at high volume and that would only require a PCW skill set equivalent to a Certificate III qualification relative to care tasks that require a PCW skill set equivalent to a Certificate IV qualification and even tertiary level training (i.e. care management)

These will be important considerations in terms of the need to grow the aged care workforce over a short period while creating an incremental career progression framework to be applied to a workforce mix of varied employee skill levels, experiences and cross-cultural challenges for individualised care provision in the home.

## This considered approach will subsequently support targeted workforce recruitment, retention and career progression. HC6(b). Transition – employment and engagement arrangements for home care workers

### Summary of proposition

***Proposition HC6(b) Suitable employment and engagement arrangements for home care workers***

It is proposed that the use of contract and sole trader aged care workers be regulated, and that all persons delivering home care must comply with the Aged Care Quality Standards.

It is also proposed that providers be required to deliver a percentage of their care hours through workers they 'employ directly'.

It is proposed that there be minimum labour standards for home care workers, including paid travel time and minimum hours per week.

### LASA comments

LASA agrees that all people delivering Commonwealth funded aged care need to do so in accordance with the Aged Care Quality Standards.

This can raise issues with current self-management models where current online care worker introduction platforms support care recipients to liaise directly with prospective staff to deliver care with the involvement of an approved provider with these independent contractors often occurring after care recipients have engaged contractor services to process payment for service. In such arrangements the approved provider has no assurances around the quality of care independent contractors provide other than simple screening checks facilitated by the care worker introduction platform.

In its current form, it is not clear that these sort of self-management arrangements could persist under the Commission's proposed model and indeed proposition HC3 explicitly signals a move away from self-management.

The proposition also emphasises that the approved provider retains responsibility when they arrange for subcontracting of service delivery to non-approved providers, but this should already be well understood.

The proposal to place limits on subcontracting seems problematic – ruling out current models of care where the approved provider acts largely/solely as a broker but does retain oversight of contracted partners.

If each contractor must comply with the Standards AND there are limits on subcontracting by approved providers then there will be a significant reduction in choice regarding service delivery.

Consideration also needs to be given to the impact of limited contracting on overall program expansion relative to population demand and the need to facilitate PCW workforce expansion. Limiting the use of contractors may potentially create a division in the home care workforce with the separation of approved and non-approved home care providers that will further constrain workforce supply in response to increasing demand.

Additional industrial relations rules for home care workers is an entirely separate issue, though it is important to note the tension between the flexibility and choice desired by consumers, price, and these proposed industrial changes. The guarantee of minimum hours per week and paid travel time must be matched with funding to ensure viability of service delivery into these markets.

## HC6(c). Transition – quality regulation

There are six specific propositions that are proposed to support quality regulation transition for home care service provision.

## HC6(c)(i). Service level certification

### Summary of proposition

***Proposition HC6(c)(i) Quality regulation: Certification prior to delivering services***

This proposition sets out a two-stage process where there would be provider approval and then service approval. The key change here is not so much the two-stage process itself but that providers could be approved to deliver some but not all services.

### LASA comments

LASA's preliminary view is that it is sensible to specifically approve providers for particular areas of a service delivery, particularly in the context of an integrated program with multiple care and funding streams. There should not be an automatic expectation that a provider must be capable of delivering complex nursing care to people with high levels of need to be allowed to provide more basic services.

LASA notes that it had previously approached DoH in 2018 regarding the need to provide new market entrants with orientation to the legislative aged care environment and in supporting their undertaking a capability analysis in supporting the provision of high quality and safe care. While DoH

noted that it had provided advice to the Australian Aged Care Quality Agency about new approved providers and referred new providers to an online 'commencing services assessment module', there was no assurance or transparency concerning the level of orientation/support provided to a large number of new market entrants in response to the issues LASA had raised.

As such, provider approval targeting fitness and propriety should be coupled with a base level capability analysis for service approval for commencing services. This coupling should seek to streamline the approvals process for new market entrants with spot checks and continuous improvement supports being encouraged to assist new market entrants where capability issues are identified. Importantly, this must be enacted immediately after approval as a preventative measure and not postponed until complaint processes signal the need for a corrective regulatory response.

There should also be alignment of this proposition to proposition HC6(a) transition - skilled workforce, noting the minimum workforce skill set required to deliver base level services such as companion care through social support and respite care services (with the exception of dementia care).

Higher level service approvals could then be set for specialist (e.g. assistive technologies/home modifications) or more complex care tasks/care management that require higher levels of qualification/skill sets in the workforce for care delivery. Consideration needs to be given to not only the care task for modes of service delivery across an integrated program but also skill sets required for specialist high volume care tasks such as dementia care and end of life care in establishing service approvals criteria.

Importantly, consideration needs to be given to the skill mix/experience of the certification workforce given the breadth of regulatory responsibilities across a two-stage certification process, the exchange of certification information through this workforce and the feeding of this information into continuing certification processes. LASA notes the separation across home care provider approvals mechanisms, quality review mechanisms and complaint response mechanisms that has resulted in a fragmented regulatory response and poor process in engagement with the home care sector since *Increasing Choice in Home Care* commenced.

## HC6(c)(ii). Continuing certification

### Summary of proposition

***Proposition HC6(c)(ii) Quality regulation: Continuing certification***

The key element of this proposition is that there would be some sort of annual certification of existing provider and service approvals although this would be proportionate to the level of risk. It also notes that the approval period should vary based on a providers risk category.

### LASA comments

It is not clear how these twin suggestions of annual assessment and variable approval periods work together.

LASA notes that with the introduction of the Aged Care Quality Standards there has been an increasing resource impost on implementing quality regulation. Similarly, the experience of implementing the regulatory framework in the Netherlands, being largely geared toward in-home care delivery, was reported during the Royal Commission's home care hearing on 31 August as

generally resulting in quality review audits occurring every 1-3 years. Their prioritisation of audits is based on the risk profile of services. While their intention has been for annual audits to be implemented, the reality is that some audits may occur every three years.

LASA queries the feasibility of setting annual audit targets against which to measure regulatory functions, particularly in the context of competing financial pressures. In response, it broadly makes sense to have a regular risk based assessment program.

Another consideration is the skill set and experience of the quality assessor/reviewer workforce of the Aged Care Quality and Safety Commission (ACQSC) for conducting audits of home care providers. Two key requirements for the quality assessor/reviewer workforce include understanding home care operations with regard to (1) the marketisation of care and commercial contracting arrangements between consumers and care services, and (2) the clinical governance/care delivery arrangements. Quality assessors often may have experience limited to either of these areas but are required to undertake a comprehensive audit from an experienced position, casting a wide net across a broad range of home care operations to be audited. This may often translate to poor review experience amongst providers and an additional administration response burden for them. It also often draws out the need for the education of the quality assessor/reviewer workforce about home care operations given some providers' questioning of the quality and veracity of current review processes.

More work is required in the development of the quality assessor/reviewer workforce skill base and quality review/regulation mechanisms in a rapidly expanding home care environment to improve and streamline the implementation of continuing certification.

## HC6(c)(iii). Direct service recipient involvement in assessment of home care certification

### Summary of proposition

***Proposition HC6(c)(iii) Quality regulation: Assessment of home care certification***

The key element of this proposition is annual contacts with at least 20% of home care service recipients and the publication of the results.

### LASA comments

Although this is described as being about certification, it appears to be more a recommendation with respect to reporting of ratings information for consumers.

We are not convinced that having the regulator contact such a large proportion of a service's clients on an annual basis is the most useful and cost effective way to measure these elements of service quality. Especially in the context of incorporating all CHSP clients into home care. We also note that under the Commission's proposed system, clients would have multiple approved providers.

As stated, this would result in the need to conduct hundreds of thousands of consumer contacts each year.

We also have specific concerns with the usefulness of the consumer experience reports as an instrument. Noting the difficulty that the Commission itself has had with interpreting the results of Consumer Experience Report (CER) data in residential care to differentiate good from bad

performance, there are other instruments that have a much stronger research backing and are likely to be more useful in shaping the delivery of care.

It is LASA's view that it would be better to have measurement of satisfaction (experience) and quality of life (outcome) incorporated into care delivery and service management processes as a function of a consumer's episode of care. This may align well with the implementation of a risk-stratified care plan (as referred to in LASA commentary for proposition HC2 – Plan based home care) that can give regard to care review in terms of consumer experiences and outcomes relative to care goals specified in the plan. It may also support the development of system indicators as per proposition HC6(e).

Some consideration needs to be given to how this might be done for clients with different levels and types of assessed need.

A further consideration is how meaningful these sort of reports will be if home care providers specialise more narrowly in a particular aspect of care rather than being holistically responsible for care as is currently the case.

## HC6(c)(iv). Publication of annual report

### Summary of proposition

***Proposition HC6(c)(iv) Quality regulation: Publication of annual report***

This would introduce a published annual reporting requirement for all home care providers. Items proposed for reporting include:

- Names of people who had been key personnel during the year
- Financial reporting including profit and loss and balance sheet information
- Information on service utilisation
- Information on the number, type and disposition of complaints
- Information on staffing, including staffing turnover.

### LASA comments

This recommendation would appear to impose a very large barrier to entry to small organisations participating in home care, with negligible benefits – particularly the requirement for report publication and audited financial reporting.

It also requires a high degree of aged care acumen for interpreting published information. Some of the report elements may not be comparable across services, noting there are large services that are volume focused and operate over large geographical regions while there are also niche services/products that have a very different market focus.

Some of the suggested information – such as staffing turnover – may be worth considering. However, it seems that direct indicators of quality outcomes are likely to be more useful.

Some elements such as service utilisation would only be relevant for providers actually managing a person's plan, and even then would be highly dependent on the availability of services locally and the price set by government for these services.

Any published report proposal would need to be user tested with both consumers and providers to draw out the scope and benefits of any included information relative to the administrative demand for implementation placed on providers. LASA notes that during the Royal Commission's home care hearing on 31 August that the experience of implementing standardised indicator reporting in the Netherlands has needed to balance additional administrative burden placed on home care providers. The value/utility of this information to the broad aged care consumer base needs to be weighed against the demand/burden for its collation on an annual basis.

## HC6(c)(iv). Serious incident reporting

### Summary of proposition

***Proposition HC6(c)(v) Quality regulation: Serious incident reporting framework***

A Serious Incident Reporting framework should apply in home care.

### LASA comments

This is worthy of further consideration, but involves significant challenges given the different nature of home care and residential care with regard to supervision and work environment.

Importantly, implementation of this measure should be aligned with the multiple other home care HC6(c) propositions to account for reducing administrative burden for home care providers, streamlining quality regulation improvements and refining the scope of their collective impact for improving in-home aged care quality regulation.

The development of a comprehensive framework to respond to serious incidents in the home will also need to give regard to issues of elder abuse and neglect from parties other than home care providers, such as primary carers, other family members or significant others. As such, responsibilities for the framework's implementation may need to extend across both Federal and State regulatory responsibilities and this will need further consideration noting the implementation of a *National Plan for responding to the abuse of older Australians* currently being overseen by the Attorney General's Department.

## HC6(c)(vi). Graduated reporting system

### Summary of proposition

***Proposition HC6(c)(vi) Quality regulation: Graduated reporting system***

This recommendation suggest star ratings for home care by July 2022 including serious incidents, staffing and consumer experience surveys.

### LASA comments

We are generally supportive of the publication of quality indicators, and it can be reasonable to report these in simplified format.

Having said that, star ratings are problematic in that they represent arbitrary decisions about how to weight different factors when those may vary by individuals. Underlying data should be available so that more nuanced solutions/service choices can be identified for older Australians with individualised decisions made on the weight given to different factors.

Some of the proposed elements of the quality ratings are also problematic. Serious incident reporting should – for a variety of well recognised reasons – not be part of any public reporting scheme. Firstly, it discourages event reporting when we want to encourage a precautionary approach to reporting. Secondly, it unfairly compares services based on their approach to reporting. Thirdly, incidents may be sufficiently rare that much of the prevalence will be chance. Finally, the presence of an incident does not indicate culpability of the provider, and where the provider is culpable, this should be reflected in regulatory assessments, eliminating the need to report the incident itself.

## HC6(d). Transition - safeguards for home care services

### Summary of proposition

***Proposition HC6(d) safeguards for older people receiving home care services***

This proposition has three components:

- That assessors (presumably needs assessors not quality assessors) identify potential vulnerabilities for clients and make this information available to the care management provider, care finder and recipient;
- Care finders have access to quality indicator outcome reporting for care recipients for whom they have case management responsibilities; and
- Advocacy organisations are funded and empowered to act on behalf of home care recipients, including funding of at least two advocacy organisations in each region – with these organisations empowered to act on behalf of recipients.

### LASA comments

Having assessors identify particular vulnerabilities has potential benefit and consideration should be given to what instrument/vulnerability flags are used. The usefulness of this may be limited if assessors only have limited access to clients. Clear procedures for response to specified vulnerability flags within an integrated care environment of assessors, care finders and care providers is required.

There may also be a role for other Federal and State funded services outside of aged care (for example in responding to financial neglect/abuse). Further consideration is required in regards to the prevalence and consequence of vulnerability flags for older people and suitable community-level responses across jurisdictions. Such an approach can indirectly support the combatting of ageism and promote ageing well.

The broad sharing of this potentially sensitive vulnerability information also needs to give account to the choice/consent of the client.

It is not clear what the Commission envisages in care finders having access to ‘quality indicator information’. There are too many questions with this to easily unpack.

LASA notes the evidence provided regarding the Netherlands’ experience presented at the 31 August hearing that highlights the tension between national data collection and provider burden to participate in this (which in turn translates to higher administrative overheads for service delivery).

Regarding the empowerment of advocacy organisations and their need to exist in regions, it is again unclear what is meant by having a 'presence in regions'. Advocacy organisations do already act on behalf of clients where they have been authorised to do so.

## HC6(e). Transition - systemic indicators of health and well-being

### Summary of proposition

***Proposition HC6(e) Systemic indicators of health and well-being***

This proposal also has a number of elements:

- system level outcome indicators
- a quality of life assessment tool
- assign responsibility for the collection of indicators to an entity within the institutional architecture including the promotion and use of these indicators
- establish benchmarking/targets and associated reports

### LASA comments

This proposal is broadly consistent with LASA's previous recommendations. Much consideration however needs to be given to the details with a considered roadmap for data development.

LASA notes the evidence provided regarding the Netherland's experience, presented at the 31 August hearing, which highlights the tension between mandated data collection and home care provider burden to participate in this relative to other regulatory responsibilities. This includes consideration of where the cost for data collection requirements will be borne relative to competing expense items focused on responding to care demand/unmet need.

## HC6(f). Transition - system management and coverage

### Summary of proposition

***Proposition HC6(f) System management and coverage***

This proposition indicates government should undertake market analysis and invest in market and capability development for providing the full range of home care services.

To support equitable access to services, commissioning arrangements for home care service provision should be implemented on a region-by-region basis.

### LASA comments

LASA has previously made a submission to the Commission on system governance that gave account for home care issues pertaining to system management and coverage.

LASA broadly supports the existing approach to service provision in home care packages where non-government service providers are accredited to deliver a service, and service recipients are given a subsidy based on their level of need and their ability to contribute to the cost of their care to access services from these accredited providers.

LASA also notes the Commission's proposition (HC2) to introduce care streams with some services being administered at a regional level, accounting for regional planning. LASA is concerned that government may administer this grant-based program stream at a state level if provided the option

to do so. LASA believes there are risks in state-level administration impacting on the robustness of regional visibility/planning and data/engagement with communities that would need to be addressed in system governance design to achieve a 'purposeful fit'. Primary Health Networks provide alternate regionally based primary health service infrastructure that would be well suited to administer this grant-based program.

LASA is broadly supportive of the use of commissioning in procuring services to meet the needs of consumers in vulnerable groups that are not adequately addressed through mainstream funding mechanisms, or to deliver minimum geographic access to services in thin markets or on a region-by-region basis.

LASA does however view these arrangements as having not been entirely successful where utilised, with DoH not managing perceived conflicts of interest. Commissioning arrangements need to include mechanisms for the rectification of issues in the early stage contracting to deal with any unintended impacts. In Australia, Primary Health Networks may offer the best structure to use commissioning and to learn about what does and does not work within jurisdictional structures.

Given the above, LASA sees a potential role for local/regional authorities in coordinating services, monitoring the availability of services, and potentially commissioning services to fill gaps where services are not adequately available.

## HC7. Duty to provide high quality and safe care

### Summary of proposition

***Proposition HC7. Duty on home care providers to provide high quality and safe care***

This proposition appears to involve the application of a general duty to home care providers on top of the existing Aged Care Quality Standards in providing high quality and safe care. Specifically, it gives regard to the views and preferences of the older person, this being the major focus of Standard 1 – Consumer dignity and choice. It also refers to the nature and scope of the services that the provider is funded to provide for the older person.

### LASA comments

The rationale for this additional duty on top of the existing Standards is unclear. However, LASA notes that among care streams (social support, respite, meals, assistive technologies and home modifications) administered as grant-funded services, these arrangements may limit consumer choice within a regional catchment if implemented as traditional 'CHSP-like' grant-funded care arrangements. LASA believes there needs to be market arrangements integrated into the delivery of these grant-funded care streams.

## HC8. Carers leave

### Summary of proposition

***Proposition HC8. Carers Leave***

This proposition involves amending the National Employment Standards to allow for up to two years of unpaid carers leave and a right to flexible carers leave for caring for an elderly person.

### LASA comments

This relates to broader employment law rather than being aged care specific. It would need to be considered in light of other carer related entitlements.

## HC9. Minimum staff contact time

### Summary of proposition

***Proposition HC9. Minimum staff contact time for home care***

The proposition recommends that home care providers be required to ensure minimum client contact time that is aligned with responding to assessed care needs in delivering high quality and safe care. It should be applied to nurses, personal care workers and allied health professionals.

### LASA comments

It is not clear what this recommendation relates to, noting that current limitations in providing care are largely driven by the existence of a capped funding supply of in-home care services relative to demand. This in turn translates to unmet care needs against which services are thinly stretched. It could, however, be a point about industrial relations. It could be a suggestion to have some sort of case mix adjusted minimum number of hours of care for people with different levels of need.

Assuming the intention is to have case-mix adjusted minimum hours, this is likely to be problematic since it will vary greatly based on the level of informal support a client has access to. It may be possible and useful to have some sort of general guidance on the number expected hours of support for people with different levels of need. LASA notes the NDIS uses reference packages during assessments to offer this guidance, against which individualised care recipient circumstances inform case-mix adjustments.

Concurrently, where there is limited workforce supply of in-home care services in some regions/thin markets, issues concerning minimum staff contact time may also emerge. In such situations, flexibility will be required to facilitate innovative, community-level, co-design solutions in response to workforce supply constraints (where funding constraints are removed). Such an approach will be more solution focused than simply legislating minimum staff contact time.

## HC10. An enablement approach to care in the home and community

### Summary of proposition

***Proposition HC10. An enablement approach to care in the home and community***

This proposition recommends that the assessment process consider what physical and mental health support is needed to facilitate and maintain reablement at the highest level possible.

### LASA comments

LASA supports a reablement approach to in-home care but the issue will be how the level of support is to be assessed relative to available evidence concerning the efficacy of community-based reablement interventions targeting the specific restorative care needs of older Australians, and this remains uncertain in regards to many reablement targets.

LASA notes that many reablement interventions for older people are best delivered through integrated health and social care interventions. The Australian Association for Gerontology has also

recently published a series of core reablement principles consistent with this. In this regard, regionally based service infrastructure and a skilled workforce supply for the delivery of integrated care will be a key consideration to recognise universal access to enablement among older Australians.