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Submission following the publication of the

CONSULTATION DRAFT

Aged Care Rules 2024

Service List

for the Support at Home program

New Aged Care Act Rules consultation – Release 1 – Service list | Australian Government Department of Health and Aged Care

Contents

1. Submission made on behalf of 2
2. Accounting or caring? 2
3. Questions: 3
   a) Questions about the Transition Care Program (TCP) 3
   b) Question about transport 3
   c) Question about the cost of webster-packs 3
   d) Question about the cost of incontinence supplies 3
4. Comments on this proposed service list 4
   a) Service categories 4
   b) A bizarre allocation of services between categories 5
   c) Caps on services: false economy vs safety. 7
5. In summary 7
6. References 8

1. Submission made on behalf of

[redacted]

2. Accounting or caring?

This service list is a consequence from the statement made by the Aged Task Force whose members believe that:

- Older Australians must **"*contribute towards services they have paid for their all life: food, cleaning, gardening [ ] things that whether you are 40 or 75 you pay for yourself*"**,

and the recommendations no 1 & 8 in their *final report:*

> **Recommendation 1 :**
> Underpin the Support at Home Program with inclusion and exclusion principles and clearly defined service lists.

> **Recommendation 8:**
> Introduce Support at Home participant co-contributions that vary based on the type of service accessed.

On page 24 of the same report, we read*: "This approach would allow:*
[ ] • a price signal for other services to encourage participants to prioritise their health care needs and better reflect what people would pay for throughout their lives to live in their own homes regardless of age [ ]

Comments about this approach:

1. Most Australians in their 40s do their own cooking, cleaning, gardening and light maintenance.

Then, in their 70s, when they can no longer do those tasks themselves due to age decline, they need help: this used to be called aged CARE.

2. "*sending a price signal*": does this mean influencing the choices people make about their care according to what they can afford rather than what they need?

Is this putting the individual at the centre of the CARE?

3. Questions:

a) Questions about the Transition Care Program (TCP)

1. What is a Transition Care Program?
2. What is its duration?
3. Which services in column 2 of the TCP (33) will no longer be listed under “clinical” when the TCP has run its course?

b) Question about transport

For service type 33 “assistance with transition care”, on page 10 of the Rules, we read, no 6: *assistance to access medical practitioner: Transport for the individual to visit a medical practitioner, or assistance in arranging a home visit by a medical practitioner.*
This service is under the category “clinical”

Then, the service type no 47 “transport” is under category “independence”.

Does this mean that if someone is not under the Transition Care Program (TCP), they will have to co-contribute to the cost of their trip to visit their GP?
This could be costly if they live in the country.

c) Question about the cost of webster-packs

Is the preparation of Webster pack a service under the category “independence”?
If so, one would have thought that dispensing medications would be a “clinical” act and should be classified as such.
The carers with basic training can currently only provide a reminder to take medications; they cannot give them to their clients.
So, what is cheaper: having a nurse coming to the house to give the medications or covering the cost of the webster packs?

d) Question about the cost of incontinence supplies

For service type 33 “assistance with transition care”, on page 10 of the Rules, we read, no 9: Continence management: [ ] provision of the following:

(i) unlimited aids and appliances designed to assist continence management to meet the individual’s needs.

Then, we see incontinence supplies mentioned on page 15, under nursing consumables.
Then, on page 16, under the category personal care, we read “continence management (non-clinical [ ] assistance changing aids.
Are incontinence supplies and management under clinical or personal care?

4. Comments on this proposed service list

a) Service categories

It might be understandable to keep the clinical expenses separate but why the split between independence and everyday living, other than for an accounting exercise?
When the external carers come to the house, they provide combined services, personal and domestic.
One has a shower, gets their linen changed, their bathroom cleaned, their floor vacuumed, etc…
Each person requires a unique blend of any of those non-clinical services.
This mix varies over time.
Why should the person who needs more domestic help should have to co-contribute at a higher rate than a person who needs less domestic help and can afford to spend their budget on social support?
Services should not be ranked by a variable amount of co-contribution but rather by their true care value.
Forcing people to make a choice between spending money on cleaning or on showering is not only disrespectful, but it also shows an abysmal ignorance of what caring for an older person really is.
Just let people be!
They receive a budget, and they spend it as they see fit not as you want them to.
One should not be forced to choose between having x showers a week or y hours of domestic help.
They should simply be allowed to say, “I need this number of hours of help at home this week”.

Therefore, independence and everyday living services should be one category “non-clinical” as they complement each other and ensure the physical and mental wellbeing of the individual

Instead of having 3 categories, just 2 will suffice:

-clinical: services no 32,33,34,41, 42, 44 + (54 & 51)

-essential: the rest.

b) A bizarre allocation of services between categories

Looking at the 3 proposed categories, as per the table below, one wonders why:

1. **Personal care** (keeping clean) is not under clinical? isn't prevention better than cure?
2. The **preparation of Webster packs** is not under clinical? isn't dispensing medicine a medical act?
3. **Transport** is under independence:

   Transport is not just "independence" it is a necessity when one must attend medical appointments.

   Let's take the case of a person living in the country and having to be driven to see their doctors often :5 to 50% contributions could be a lot for someone on an age pension based on the current fees charged by providers.
4. **Assistive technology equipment and products** (51) & **Home adjustments** (54) attract a co-contribution under independence.

   People are encouraged to stay at home because there aren't enough beds in residential aged care.

   Their house is an infrastructure for which the Commonwealth doesn't have to pay.

   However, to be fit for purpose this accommodation must be adapted to their needs.

   Why should they pay for a fall alarm, a stroller, a ramp, a rail, a toilet seat, etc…

   Some people simply won't or can't pay.

   The consequences will be an increased risk of accidents and admissions to hospital.

   Again, prevention is better than cure.
5. **Domestic assistance, home maintenance** & **meals preparation** under everyday living

   Not every older person needs clinical services; many are simply physically unable to perform the tasks they were once able to do for themselves.

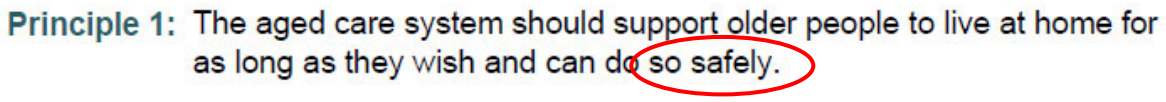
   Having a clean house and a tidy garden is not only good for mental health but also provide a safe environment.

   A clean house and a tidy garden limit the risk of hazards and accidents.

   This is a basic principle of Occupational Health & Safety.

   Yes, putting a higher level of co-contributions on these might limit spending but will very likely increase the risk of falls, accidents, infections, etc…

   Is this what principle 1 of the Aged Care Task force report is all about?



Services per category as per Rules		
Clinicals	Independence Fee for service: 5% to 50%	Everyday living Fee for service: 17.5% to 80%
Allied Health and Therapy (32) *Except: cost of dispensing medication (Webster packs)*	*Home and community general respite (39) and (35)*	*Domestic assistance (36)* Cleaning. (52 hr./year cap) Laundry Shopping
Care management (34)	*Personal care (43) +* *cost of dispensing medication (Webster packs) + continence management needs.*	*Home and maintenance repairs. (38) inc gardening (18hr /year cap).*
Nursing care (41)	*Social support and community engagement (45)*	*Meals' preparation. (40)*
(prescribed) Nutrition (42)	*Transport (47)*	*Therapeutic services for independent living (46)*
Restorative care management (44)	*Assistive technology equipment and products (51)* *Managing body functions* *Seff-care products* *Mobility products* *Domestic life products* *Communication and information management products* *Assistive technology prescription and clinical support*	
Assistance with transition care? (33)	*Assistive technology* *Home adjustments (54)*	

c) Caps on services: false economy vs safety.

Anyone who believes that

- 1 hour of cleaning per week and
- 20 min of gardening a week,

are sufficient to provide a clean and safe environment for an older person has obviously never had to do those tasks themselves.
The most ridiculous in these arbitrary caps if that they would be applicable irrespective of the level of classification, 1 or 8.
A person with limited mobility on a Zimmer frame, maybe in classification 6, won't be able to do their own housework (dishes, vacuuming, taking the rubbish out, etc...) and 1 hour a week of external support is not going to cut it. There are 7 days in a week.

Again, how safe would this older person be in a dirty house and untidy garden?

There should be no limit as to the number of hours for any services available, per right.

Controlling the quality of care in this dogmatic manner contradicts the right to independence, autonomy, empowerment and freedom of choice stated in the bill.

This is supposed to be a Support at Home program, not a supervised home detention.

5. In summary

Categorizing services to vary the co-contribution rate and force participants in the Support at Home program to spend their budget on clinical services rather than on what has been labelled independence and everyday living services, won't provide quality care.

Even if there is no co-contribution on clinical expenses, some participants might not need them, or these services are simply not available.

Coercing people to cut back on expenses such as cleaning, gardening, meals preparation and light home maintenance, is not only unsafe but also uneconomical: people will become unwell quicker and then will end up in hospital costing more to the community.

They might also need to enter residential aged care sooner than anticipated, which, ironically, is what the program is trying to prevent.

There is a need to finance aged care at home in the long term and the fee for service model, based on the financial means of the participants, could be a solution, but not on the terms currently proposed.

If the current system of support was already difficult to navigate, overpriced and inefficient, the proposed model is even more complicated, dogmatic and totally inadequate.
It lacks flexibility, adaptability, simplicity and fairness.

There should only be 2 services categories (3 at the most):

Services per category- suggestion		
Clinicals	Compulsory essential **Fee for service: Nil**	Optional essentials **Fee for service: reasonable**
Service types no 32, 34,41,42,44,33 *inc cost of dispensing medication (Webster packs) + 54,51*	*Service types no 36,38,40,43,47,*	*Service types no 39, 35, 45 & 46.*

And should a co-contribution be collected towards some of the non-clinical services, it should be one flat rate (not a sliding scale as proposed), based on income and clearly presented as per the table below.

Assessable income brackets	Co-contribution rates on some non-clinical services
From….to … $$	X % or amount $/hr
From….to … $$	Y % or amount $/hr
From….to … $$	Z% or amount $/hr

A percentage of the cost of the service, obtained from data collected by the IHACPA from the providers is a scary thought.
Why wasn't a flat contribution amount suggested?

6. References

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Support at Home

Final report of the Aged Care Taskforce | Australian Government Department of Health and Aged Care

Presentation by Taskforce members on the final Aged Care Taskforce Report - YouTube