Submission in response to the Aged Care Royal Commission Home Care Hearings

Propositions HC1-HC10

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Dr West has research experience in examining disability and older person support service frameworks, ableism, social inclusion and human rights. Dr West has a PhD from the University of Melbourne In the sociology of disability and impacts of funding frameworks, and has worked at RMIT University as an early career researcher for the last 7 years examining disability and aged care service frameworks including workforce issues. She has published papers relating to human rights and health, NDIS frameworks, individualised funding and emerging online uber-style service markets.

Dr West, having viewed webcast of the three days of homecare discussion from the Aged Care Royal Commission, would like to be given opportunity to comment on the home care propositions that were presented by Senior Counsel Peter Gray during the hearings.

Proposition HC1. More care at home to meet the preferences of older people wanting to age in place (transition proposition)

Dr West does not support the full integration of the Commonwealth Home Support Programme (CHSP) and the Home Care Packages Program. Dr West is of the view that, rather than full integration, the CHSP should be maintained as a time limited programme - for example an older person can use for the first 6 months or 12 months only.

This would allow immediate entry of older persons into the aged care system so that they can obtain services immediately after assessment to avoid time delays/waiting lists from when the home care package program is obtained/onboarding with providers in-provider assessments etc. It could be maintained as an immediate response mechanism for support required. In addition it could play the role of provider of last resort where, for whatever reason, the home care packages system failed for an individual, for example if there was a requirement that they immediately leave the service provider they are with because of quality issues or safety issues - it would act as a buffer until a new provider and assessments could be fond and undertaken. It could also be provider of last resort in thin markets, again as time limited segments but to at least ensure that support on-the-ground at one level was provided. A level 1 package would be then acquire the services being used in the CHSP (including services such as meals-on-wheels and nursing) and these would transition into level 1 package in a month or two once after initial assessment and once providers had been chosen and onboarded and providers have done their assessment, developed service plans and recruited and rostered workers

Dr West supports the recommendation that the time frame for older persons receiving their home care package following assessment should be no greater than one month, and that older persons are receiving on-the-ground services from providers at no later than two months. Following the ACAT assessment, there should be scope for the ACAT team to revisit an individual two months after initial assessment to ensure adequate support has been put in place. This element should be built into the mechanism of the assessment in seeking to ensure that onboarding oversight occurs and that the onboarding time to start of service prevision is done in a reasonable and adequate time following initial assessment.

Dr West support's all policy reforms that will serve to underpin 'ageing in place'. A significant increase in funding is required to support the expansion of individualised funding in home care packages within community. The use of home care packages should be seen as something in equivalent size and scale priority and ministerial importance as that of the NDIS, with a maturing field of governance, professionalisation of the workforce and service provider capacity, funding to support these structures and recognition of the field in its own right – not just as something tacked onto the aged care residential system.

Dr West supports the recommendation that funding be provided to immediately allocate a home care package at the assessed level to all people on the National Prioritisation Queue (waiting list) that do not have a package or do not have a package at the assessed need. It should be acknowledged that the National Prioritisation Queue did not exist four to five years ago when local governments were administering home care aged care, and a waiting list only materialised since the federal government centralised the funding of the aged care system and implemented the CDC package system. Significant amounts of literature outline the danger of a system transition from block funding to an individualised funding model as simply a means for government to cut costs - Australia can do better than this. Individualised funding models can work to provide consumer choice and can operate in a quasi-market environment, but they have to be funded and funded adequately to ensure all older persons in Australia receive the support they need when they need it, not just 'some of the support' or limits of support around when the budget can afford it in the next estimates.

The NDIS have obtained a dedicated revenue stream to support the individualised funding model that was achieved through a .5% increase in the Australians Medicare levy. At the time of this development there was little opposition from the general community who viewed the levy increase as worthwhile in providing a insurance based model for every person in Australia who may be born with or acquire a disability over their lifetime - the general consensus was it was a worthwhile levy increase for a valued social need. Australians are less resistant to small increases in taxation when they understand it is for a valuable and worthy cause, and despite arguments that revenue should be found within the general budget, a dedicated stream of funding will provide a surety to the functioning of the homecare aged care system in the turbulent times which are predicted post covid.

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

Dr West from her knowledge on existing service framework transitions, cautions against an entire redevelopment of the home care home package funding system. It has taken a considerable amount of time for the industry to learn the four levels of funding an on board everybody within that framework. For industry and the older persons already on the scheme, having to take on board an learn and entire new funding system after only 5 or so years of operation and in an already turbulent and stressful financial time could be detrimental to industry and stressful to these individuals. Dr West views that there is less issue with the overall framework of individualised funding and categories provided through the four level structure, but more issue with the shortage of packages provided, the difficulties individuals have finding and exiting providers once the funding has been obtained and the

exorbitant package administration fees within the CDC framework. Underfunding resulting in waiting lists has meant we have not actually seen the existing framework work to full capacity and load and effectively because it hasn't been fully funded at any stage since its inception. Also the administration function of a homecare package should separated out from service providers providing the service to avoid conflict of interest by service providers and to allow easier movement by individuals between services.

That said, there could be scope for reform to develop the allocation of the budget of each homecare package, again inline within the NDIS, where a structure of capital, core and capacity building and core budget items are utilised rather than set levels. Older person would receive a budgeted allowances from these categories based on their individual assessment and need, not just a prescribed level. There has been success with the NDIS system in working within these categories, There has however been some frustration by users around where funding has not been transferable across categories when urgent funds are needed in another category and there is budgeted money sitting there. During covid the categories were opened to allow people to purchase PPE funding from any category so policy flexibility was demonstrated. NDIS categories vid link: https://www.ndis.gov.au/participants/using-your-plan/managing-your-plan/support-budgets-your-plan

Proposition HC3. Changes to consumer directed care

There needs to be caution here about bias by service providers. Service providers will be very knowledgeable of the frameworks and it will take some time for older persons as they enter the system to be guided and to learn how to navigate the system - however if it is a shared management system, there is concern of the bias that service providers will take in establishing a package with the client to suit their needs rather than the empowerment and choice of the client. Some providers often demonstrate an unwillingness to be flexible with client choice, and this has been the reason why on many occasions, consumers have moved towards online platforms because they have been unhappy with the control and manipulation that the service providers undertake in providing services that suits them only.

Dr West supports an option system of administration functions in homecare package management, where an older person will have the option as to if they wish to self- manage fully their own package, as occurs in the NDIS with self-management (see discussion in attached paper David and West 2017). This does not mean any form of direct employment nor use of online subcontracting platforms such as Mabel, but the option to at no cost to self-administer the package (i.e. the individual can if capacity or with guardian choose a service providers, pay invoices from budgeted allocation, laise with service provides in relation to staff rostering). The self-management options run very well and allows for consumer choice and purchasing flexibility under the NDIS. There may also only be time-limited support needed in setting up the administration of the package and learning how to navigate it (the support coordination function in NDIS). The individual would then would be free to administer the package on their own or with a guardian for it length of time. Where function decreases overtime and/or where no guardian can support administration functions, then there should be administration brokerage/care management options available for a fee.

A shared management approach although guiding the client to some extent, assumes a low capacity of the older person from the onset. This is probably not the case for many people just entering the aged care system who only require a small amount of guidance at the start to get things set up and to begin learning how to navigate the system for their few hours a week of support just to get them through some main tasks. Obviously as function changes overtime the option to change the form of home care package administration should be provided.

Dr West supports Dr Laragey's proposition that any review of home care package scheme should allow for purchasing of items that work towards a client meeting their goals and social needs, maintaining independence and quality of life, not only the clinical requirements of ageing. Again this is built into the NDIS system, it is quite transparent and funds are very accountable and there's been no significant exploitation of the system in allowing people to choose the specific elements of funding that they require to meet their life goals. Sometimes it's just a small item or a small activity that can rapidly increase somebody's quality of life and keep them out of our very expensive age cave residential facility or hospitalised due to ill health. The home care packages should be working towards increasing their capacity independence and empowerment of every older person in providing their support they need and resources to live an independent life. Choice and parameters on items able to be purchased through a package can be addressed in the assessment process very easily and can have set parameters based on goals.

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

The existence of administration fees for a home care package of up to 35% - 40% - 50% have been a significant concern and issue for the existing system. There appears to be some blatant exploitation of older persons in this mechanism and this appears exorbitant given it is not even going to the provision of care by the service provider but just in running the package. Any reform in this area should clearly delineate between these two areas. The running costs of an organisation should be within the unit cost per hour charged - not cross subsidised from the administration fee for simply managing the package - a clear distinction should be made between administering a homecare package and providing a service, and service providers should be included in their unit price the full cost of just providing the service i.e. all on costs/backend costs, professional development/superannuation /insurance costs/supervision and ongoing training/travel for the workers

Administration fees for running a package should be capped for each of the functions listed here. Once an individual has chosen their service provider/purchased needed equipment/tendered out building modifications, the administration functions are really just paying of invoices/providing unless an individual chooses to change service providers -they shouldn't be exorbitant cost attached to these simple function of budgeting and invoicing. They should also be scaled administration fees that a significantly lower for people only using a couple of hours of support a week and do not require complex administration of their package to keep costs down and to ensure funding is utilised effectively.

Wherein older person is self-administering the funds of their home care package, there should not be a requirement to pay a home care package administration fee ie 0%. This would then extend how far the funding for a home care package could go and produce better outcomes for many older persons [please see, Carmel Laragy's research on with COTA on self-management). In relation to this there is certainly scope for a portal in the my aged care platform to be developed whereby users with capacity can simply organise administration and paying invoices from their budget allocation through a portal/payment platform as occurs with the NDIS.

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

There is a potential issue of repetition here with assessment and case management. Older persons may get frustrated if upon entry to the system, they have to do an assessment outlining personal details of their life, finances, capacity, living arrangements and health conditions (the ACAT assessment is extensive), and then they have to repeat this again with the case manager shortly afterwards. Possibly if an older person is not utilising administration and chooses to self-administer

their package, a care manager assessment would not be required, and a care manager assessment should only be utilised if the older person is moving onto the supported/case management administration option for their package. Again, as function changes with an individual overtime possibly the care manager role could step in as complexities increase over the course of their support journey.

Once a client has been onboarded onto the home care package system, there should be scope for a one yearly review as occurs under the NDIS of funding required. In many instances where function does not change, the package simply rolls over, a reassessment every year does not have to be a complex process of reassessment. However this does allow for reassessment if there is a change in care requirements over the year where function changes overtime, or in the case of emergency and a dramatic change in function such as after a fall, an immediate reassessment during the year as required. It also builds into the system and mechanism where the system is outreaching to the individual rather than individual being passive to the system.

For clients that are self-admnistering, the once yearly review may be the only time they contact the assessment team over the year if their needs are being met and they have capacity to run the administration well. This would keep costs down as well as meaning the system was not too intrusive into the daily lives of an individual after it had been set up unless it needed to be with changing circumstances. The once yearly review/assessment could be a single, costed item of the homecare package

Proposition HC6. Transition to the new program:

Proposition HC6(a) A suitably trained and skilled workforce

Dr West very much supports mechanisms that ensure that the home care workforce should not only be valued and supported for the high-quality support they provide, but socially acknowledged and professionalised into a strong, in-demand and expanding essential workforce

Dr West supports the view that homecare workers working in isolated and unsupervised homes of older persons should have a minimum Cert 3 qualification with pathways to further qualifications and professional development readily available, with qualification levels monitored by a worker registration scheme. Dr West supports the view that service providers should take full responsibility for their employees within the standard work relationship and should be fully responsible for the quality of support provided, supervision training and professional development of all of their workers and quality of support provided.it is not enough to really say we just match a client and then it is just the wild west after that. Service providers should be fully accountable for the service they provide and the skill levels and attributes their employees bring to the work.

A managed approach to workforce development is required. Dr West supports all of the recommendations related to homecare in the June 2018 Aged Care Matters – Aged Care Workforce Strategy Taskforce report https://www.health.gov.au/resources/publications/a-matter-of-care-australias-aged-care-workforce-strategy .

In numerous reports, clients and families communicated that they were wanting a valued, sustainable and more highly skilled workforce/workers in homecare. They group spoke of wanting a reliable, consistent and professional workforce that can deliver quality, specialist services.

Overwhelmingly, planning should include a review and development of minimum industry standards for entry into the sector, such as Cert III or a Cert IV qualification, or the acknowledgment of extended work experience in the field. This plan should also include ongoing training and professional

development for workers to develop new and emerging skills, and be up-to-date with changing perspectives of service delivery such as use-misuse of restrictive practices, zero-tolerance abuse strategies, dignity of risk or COVID19 safe practice. A robust review of curriculum for certificates courses was flagged so that knowledge and skill development is directly matched to job function, and assessed by observation and examination.

The professionalisation strategy should address retention and attraction to the industry issues. It has constantly been highlighted that there is a significant problem of worker turnover and sustainability in the industry and lack of opportunity for careers and/or vertical career progression for workers, driven by sometimes poor conditions, low wages, lack of recognition and lack of community acknowledgement of the importance of this essential work. There is strong need for marketing campaigns to build a sustainable workforce, skilled migration-focused efforts, increased focus on the tertiary education sector and need for an increase in remuneration across the sector 'to make it more equitable with other similar sectors (Charlesworth 2017). In the past there has been concern that any introduction of a mandatory minimum level of qualification would reduce the capacity of numbers of people entering the workforce in our already supply short field where demand is high. At some stage, this is going to have to be addressed, even if it is a five year window for people to obtain a base level qualification for retaining a workplace in the field, otherwise the workforce will never professionalise.

In relation to the introduction of minimum standards, there may be were difficulties for some workers that have been in the field for an extensive amount of time, sometimes two or three decades working on the ground in home care, that have low levels of literacy being unable to complete the qualifications to a standard. This could also be an issue for migrant workers with English as a second language trying to obtain qualifications to work in the field. There could be issue for these workers if obtaining a qualification is required as a registration requirement and these workers are pushed out of the employment field because they were not meeting the qualification standard linked to registration requirements.

Significant amounts of aged care research have demonstrated the need to increase workforce/worker skills. This was in relation to wanting workers to have skills specific to a medical condition, say for clients with dementia onset or say diabetes requiring support in the home. This also included workers obtaining skills to be able to interact with medical/allied health professionals, OHS knowledge, knowledge and expectations of obligations provider codes of conduct, aged care legal frameworks of human rights and rights and responsibilities of social inclusion, observation and reporting skills, food handling skills, administration of medication skills and communication skills as a baseline. Of issue is often what type of skills and workers can be taught within the tight curriculum frameworks of qualifications? The types of skills and workers required is highly contested. What are those which are likely to have the biggest positive impact towards supporting a good and valued life of an older person. Although an individual may seek to work in the field with the best intentions and with the best attributes, these forms of knowledge, which should be viewed as broad essential knowledge of the field, are really only obtained through formal training, professional development and supervision.

Significant amounts of aged care workforce research, such as that conducted by Prof Charlesworth, has identified a broad level of skills are required by a support worker in the home care field. They demonstrate the highly diverse and complex skills required by workers in the home that should be supported through training and minimum qualifications. These are not skills that are simply obtained by having the right attitude, although that is helpful, they require training, supervision and professional development and a period of time to develop these skills. In particular, in reference to discussions at the home care hearings an online platforms, one feels it would be particularly typical

for a worker to walk in cold to a client without any support structures around and undertake these skills to a higher quality level without any existing qualification, training or supervisions.

Skills and responsibilities required by a homecare worker on a general shift are extensive and should not be left to an untrained or unsupervised workforce. Requirements include:

- time management
- completion of personal care tasks (such as assistance with showering, toileting, dressing, grooming)
- getting to and managing property access issues (e.g. travel, physical access to house-gates/security etc)
- learning how equipment at house works (vac/new tv/dishwasher/washing machine)
- negotiations and interactions with clients
- administer of meds
- transfers (sometimes use of lifting equipment/slings)
- OHS
- responsibility/transparency with money
- home-cleaning (including taking-out garbage to bins/putting bins onto street)
- monitor client wellbeing
- anticipating client need
- negotiating/communications with client family and other family members at house
- completing provider progress notes
- reducing social isolation of client (support in maintaining existing social connections),
- prompting/helping with physio/exercises
- shopping for food/basic items
- community access
- preparation and cooking of meals
- encouraging client to eat/drink
- encouraging client choice/decision-making (and conversely assessing risk)
- getting clients to set appointments (organising transport)
- balancing support given with wanting to maintain client independence
- travelling to hospital with client/visiting client in hospital
- maintaining personal boundaries
- knowledge of human rights frameworks and industry duty of care obligations
- use of provider tech/apps

It is well noted that professionalisation of the industry workforce must be matched with increased wage renumeration. Dr West supports Professor Charlesworth's RC submissions on the need for increased renumeration, review of award frameworks and implementation of more detailed level classifications to match tasks undertaken by support workers. This should include skill levels in relation to not just qualifications, but also experience, capacity of the worker and length of time in the workforce [i.e. provided incentive for retention in the field).

Further, if workers are to be required to obtain a qualification to enter the home care field, then increases in wage levels should acknowledge these increased qualifications standards. The field has been characterised with a low wage history, predominantly because of the gendered undervalue of female and part-time labour in the past. The problems of workforce retention and lack of career prospect are compounded by these low wage rates and lack of acknowledgement of the social

contribution of these workers. For the worker, a significantly larger commitment must be made to enter and obtain work in the professionalised field. The burden of cost to obtain a qualification, to become registered and meet mandatory ongoing first aid, CPR and OHS training and entry training are all put onto the worker.

The new professional workers in the individualised support world is also associated with high levels of risk management of service culture and developing skills, completing training and being accredited to a standard defined by the industry. This push for professionalisation amidst an increasingly complex field of the differing forms of service delivery highlights increasing risk across the industry. Dr West supports Dr Fiona McDonalds hearing comments examining risk under the current system, high levels of risk are being pushed down onto the worker with use of online platforms where service providers are absolving themselves of responsibility in manipulating the individualised funding system.

A significant element missing for the home care workforce at the moment, as was flagged in the home care discussions in recent days at the Royal Commission hearings around home care, is a lack of supervision given to homecare workers working in an isolated home/work environment.

Supervision of work is a fundamental component in most fields of work. In the provision of funded aged care services, supervision is used as a mechanism to overview work tasks to ensure that workers are completing tasks to a designated standard in a timely manner, that workers have opportunity to debrief, seek clarification about a client or raise an issue, obtain information about any elements of the work, receive feedback and have reciprocal opportunity to discuss their work practice. Supervision is also understood as indirect oversight, with line managers providing unstructured time but still opportunity for workers to discuss their work.

The outcome of supervision seeks to build worker capacity and psychological capital – to provide a worker with the resources, tools, skills, coping mechanisms and knowledge they need to not only provide a high level of quality support with empathy and understanding, but to choose to remain employed in the aged care field and carry out their crucial work role because they feel equipped, acknowledged and resourced to do so. Supervision also provides line managers with information on where worker training and development is required and broadly, how their workforce is tracking in terms of skills and capacity. Technology is playing an increasing role in homecare supervision with online apps providing line managers with information on worker promptness in attending and completing home care shifts, completion of required tasks and obtaining real time progress notes and feedback from workers onsite.

In recent years, levels of supervision and oversight of homecare workers in the aged care under policy reforms of individualised funding have become minimal and piecemeal. There is an extensive need for reform in supervision frameworks and increased levels of supervision across the sectors to not only improve worker conditions, capacity and coping mechanisms for the workforce and retain a quality workforce, but to improve the quality of support provided to our older person demographic entitled to receive quality support. Reform and a solid policy commitment to supervision accompanied by a separate dedicated funding stream to providers is required across the aged care sectors under individualised funding models to ensure a high standard of homecare service delivery is obtained and to retain a skilled and knowledgeable workforce.

Worker Registration Scheme

Dr West supports the implementation of a worker registration scheme for homecare workers- this could be modelled on the new Victorian disability support worker registration or Scottish Worker Registration schemes. The development of the new Victorian worker registration have just dealt with

exactly the same issues the aged care sector is considering relating to parameters of a worker registration scheme, costs to workers, inclusion/exclusion criteria, mapping of skills/qualifications, frequency of review, how info is obtained and stored and who has access to information etc https://www.vdwc.vic.gov.au/

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

The issue of unpaid travel time for homecare workers is a significant element of fair working conditions. Dr West supports a recommendation for paid travel time for home care aged care workers.

Current variations of in travel and travel time for Homecare workers between clients include:

- Travel included in worker hourly unit price
- worker gets paid the hourly rate for travel and kms (paid by provider from margins – within hour)
- worker gets paid just kms for travel (paid by provider from margins – within hour)
- workers simply do not get paid travel and kms
- workers claim travel on tax (keep logbook)
- Kms are paid by client from funding package if support worker is using own car to take client out e.g.TAC Approved Travel Costs (per km) $0.76
- A further subsidy for wear and tear on the car of the support workout for things such as tyres and extra maintenance