



CARERS AUSTRALIA SUBMISSION:

**Department of Social Services
Discussion Paper on Integrated
Carer Support Service: Regional
Delivery Partners: A draft regional
delivery model**

MAY 2018

AN AUSTRALIA THAT VALUES AND SUPPORTS ALL CARERS

ABOUT CARERS AUSTRALIA

Carers Australia is the national peak body representing the diversity of Australians who provide unpaid care and support to family members and friends with a:

- disability
- chronic condition
- mental illness or disorder
- drug or alcohol problem
- terminal illness
- or who are frail aged

Carers Australia believes all carers, regardless of their cultural and linguistic differences, age, disability, religion, socioeconomic status, gender identification and geographical location should have the same rights, choices and opportunities as other Australians.

They should be able to enjoy optimum health, social and economic wellbeing and participate in family, social and community life, employment and education.

FOR INFORMATION CONTACT:

Ms Ara Cresswell

Chief Executive Officer

Carers Australia

Unit 1, 16 Napier Close

DEAKIN ACT 2600

Telephone: 02 6122 9900

Facsimile: 02 6122 9999

Email: acresswell@carersaustralia.com.au

Website: www.carersaustralia.com.au

INTRODUCTION

Carers Australia and the state and territory Carers Associations have been involved with the broad design of the new service model through the Subject Matter Expert Group (SME) established in 2016, public consultations on the Design of an Integrated Carer Support Service (Draft Service Concept) and the Delivery of an Integrated Carer Support Service (ICSS), and individual contacts with the Department of Social Services' Integrated Carer Support Services team. We appreciate the extensive consultation with carers and carer associations around the ICSS development.

In general terms we endorse the three level model of service delivery (national, regional and local) and the services identified for delivery at each level.

This Discussion Paper encapsulates a new level of granularity on the way in which the service structure identified in earlier Discussion papers will be structured and delivered.

Importantly it identifies for the first time the potential configuration of service provider delivery at the regional level, which has been a vital missing piece of information in evaluating the effectiveness of the service concept.

What it does not do with any real clarity is to identify funding arrangements around the way in which the Regional Delivery Partner (RDP) model as a whole and its different service components will operate. Without this information it is difficult to evaluate the effectiveness of different models proposed for numbers and locations or the reach of some of the programs to be delivered.

Indeed, there are so many uncertainties at this point in relation to demand for different services, coverage and the way in which funding is to be allocated that we would recommend the following.

Recommendation 1

DSS engage in further stakeholder consultation in relation to further developments of the model. This would include the needs assessment tool/tools to be adopted nationally, the evaluation framework/s to be adopted and the funding issues identified in this paper.

Recommendation 2

A process be built in so that the ICSS be reviewed after two years of operation to assess the effectiveness of its design, whether it is meeting demand, whether RDPs have been able to meet service requirements and any gaps in the model.

Our chief comments, concerns and questions with respect to the Discussion Paper are identified below. We note that, as a national consumer peak, our capacity to respond to the specific discussion points raised on page 13 on the role of consortia in RDPs and linkage to local services is limited and best answered by service providers.

THE NUMBER, DESIGN AND REGIONAL BOUNDARIES OF THE RDPS

Carers Australia acknowledges that service providers in states and territories are best placed to judge the best configuration of services within their own jurisdictions and that, while one of the options presented may best reflect the optimum outcome in one state or territory, another option will work best for others. Against this background, we have asked state and territory Carers Associations to respond separately in relation to their own area of operation and expertise.

We do note the following concerns which have been raised with us

Demographic data used to determine regions

- Some have suggested that the 2016 Census of Population and Housing is a better determinant of carer populations than the Survey of Disability, Ageing and Carers (SDAC) since SDAC uses sampling in which information is obtained only from a subset of a population, whereas the Census is intended to include everyone in the relevant population. However, because the Census is a snapshot over a two week period it will not reflect data on carers who were not providing care in that particular timeframe – which is likely to be the case for carers of people with an episodic illness. SDAC interviews take place over a six month period.
- Others have suggested a reasonable and equitable approach to defining regions would be based on the proportion of the total population, possibly weighted for regions which cover large expansive regional and remote areas where additional costs are necessary to service these areas.
- A number of state and territory Carer Associations see merit in using Primary Health Network (PHN) boundaries to determine ICSS regions. It is argued that RDPs should reflect other defined national government regions and leverage existing data sources and shared activities such as service mapping and service gap identification. In this context it is noted

that there is a close alliance between carer supports and health supports.

The dissection of metropolitan areas

There are concerns about RDP boundaries carving up metropolitan areas, producing circumstances where suburbs in very close proximity which share common mainstream services and local carer support providers are allocated to different RDPs. We understand that the logic for combining metropolitan, regional and remote areas within each RDP is to prevent provider cherry-picking of higher volume, lower cost areas. However the formula seems to ignore important practical considerations relating to arbitrary and artificial barriers to establishing a natural consumer market in geographic terms and is likely to produce consumer confusion and frustration if they find that they cannot access a suitable nearby support service simply on the basis of their address.

The problem with the ACT

RDP boundaries are contained within state and territory borders with the exception of the ACT.

It certainly isn't the case that there are an insufficient number of carers in ACT to warrant a separate RDP. Note, for example, that the SDAC identified 44,800 in the ACT compared to 11,500 in the Northern Territory.

This leaves the only reason for making the ACT an exception to the rule that RDPs should reflect federal jurisdictions is that it does not have regional or remote coverage. However, making an exception because the ACT does not meet one aspect of the overarching formula adopted in determining the RDP break-up creates some significant practical problems with efficient and effective service delivery within the territory.

There are good reasons for confining RDPs within federal jurisdictional boundaries. In particular, there are problems for entities working across different jurisdictions. They are covered by different legislative, regulatory and administrative requirements in terms of their own operations and with respect to those they work with, including organisations in a position to support carers and with respect to the advice offered to carers themselves. Examples include advice offered to carers in relation to jurisdictional specific matters (for example, legal matters and access to housing) as well as referrals they need to offer to carers in terms of accessing mainstream services that differ across jurisdictions. Given that state and territory funding will remain important to service delivery, split jurisdictions may also complicate and

act as a disincentive to funding carer services outside the very real constraints of dedicated ICSS funding. The whole situation becomes unnecessarily complicated, administratively and practically burdensome, and wasteful.

THE AIMS OF THE ICSS

Carers Australia supports the vision enunciated for the ICSS which is to:

Improve carer wellbeing, increase their capacity and support their participation, socially and economically.

Given these aims, it is somewhat disturbing to find a repeated emphasis throughout the Paper which suggests that the main rationale for providing carer supports is to sustain caring, which has overtones of justifying carer supports in terms of sustaining an unpaid labour force and reducing costs to the Budget associated with the provision of unpaid care. While it is undoubtedly the case that unpaid family and friend carers do perform this function, it should not be presented as the *raison d'être* for providing them with services.

Carers deserve support in their own right, regardless of their value to the economy. Moreover, carer support services are just as legitimate if the result is that carers conclude that they no longer can, or no longer want to provide the same level of care. Reaching this conclusion and helping them to move on may well be an outcome of counselling and peer support services and even of respite, if it provides an opportunity for carers to reflect on their future caring role. Against this background it would be particularly concerning if the success of carer support interventions were measured primarily against the criteria of prolonging the caring role (as has been the case in some studies of the usefulness of respite for carers of the aged measured against whether the person receiving care moves into residential care within a short period following the respite episode).

Another consequence of putting all the emphasis on the sustainability of care is that there is a need to provide support for some time to former carers suffering from the loss or removal of the person they have cared for, often for many years, and the accompanying loss of self-identity and, in many cases, the experience of financial hardship with the loss of the Carer Payment and the pension of the person being cared for. These former carers will also need counselling, peer support and advice.

THE EMPHASIS ON LOW COST SERVICES

Many of the services which carers require are not necessarily low cost. Respite is an important case in point.

The need for a rest will not necessarily be mitigated by counselling, coaching, education and peer support. All these services can certainly reduce carer stress. However they will not necessarily deliver a panacea to the emotional, psychological and physical strain of providing care to the point where a period of rest and recuperation is no longer needed or needed less.

There is a strong suggestion throughout the paper that respite is a service of last resort. In this context the reference in the ICSS Service Blueprint on page 36 of Appendix A to emergency respite being “replacement care for the care recipient when all other options have been exhausted” is both worrying and puzzling. Does this mean that one or more of the more low cost services must be accessed before an entitlement to emergency respite is recognised? An emergency is an emergency, regardless of what other services the carer has accessed. As noted elsewhere in the paper on page 36:

The Emergency Respite Care service is designed to offer support to carers who are: experiencing an urgent, unplanned and imminent event that temporarily restricts their ability to continue caring when no other services are available, for example: .

- *an unplanned situation that prevents the carer from providing care required by the care recipient; .*
- *an unplanned event that threatens the health and safety of the care recipient; or, .*
- *an unplanned event that threatens the health and safety of the carer (including extremely high levels of strain and anxiety).*

FUNDING

There is next to no detail in this paper about how calculations of funding have been made against the expected demand for services and the services to be delivered.

With respect to the adequacy of funding, we note that the RDPs are required to deliver a larger range of activities and services over much larger and more diverse areas than has traditionally been the case with CRCCs for example.

However, even with the addition of \$113 million over five years to the existing budget for carer services delivered by DSS, the total amount (to the extent we are able to calculate it) is considerably less than that currently available. Funding for DSS carer support services in 2017-18 is around \$162 million, noting this will decrease over time as funding from some programs moves over into the NDIS.

We acknowledge that the new model is intended to introduce administrative efficiencies and savings through greater access to online as opposed to face-to-face services. However it is hard to uncritically endorse the detailed implementation of service models presented in the Discussion Paper – which we have endorsed at a concept level – without knowing more about how the funding has been calculated and how it will be allocated across regions. For example, what account will be taken of the dispersal of populations, as well as their numbers?

The Discussion Paper does identify that when the new ICSS is fully implemented there will be approximately \$120 million per year for carer specific supports. Our understanding is that this amount is to cover both the implementation of new national online services (counselling, peer support, coaching resources and educational resources) and the funding for the new RDPs. However we have no idea how the funding is to split between the national and regional level.

Nor do we know how the RDPs are to be funded. Will it be a block funding model, a fixed unit price (fee-for-service) model or a combination of both?

Is the proposal that RDPs will allocate budgets against specific services to be delivered or will they will be expected to make their own arrangements for administrative costs and service delivery within an overarching funding envelope? If the latter, then we are unsure how the model will ensure equity of access to services across the nation – which we understand was one of the goals of this reform.

What will be the KPIs against which performance and fund management be evaluated?

Clarification on these issue is significant to choosing which options for the number and distribution of RDPs can best be accommodated within the available funding and, indeed, the extent to which providers enter into consortium arrangements and whether they think it is worth tendering at all.