



## Aged Care Update

2 October 2014

### **The Commonwealth Home Support Program – a bold step towards an integrated aged care system**

When the Australian Government offered in 2012 to take full responsibility for the Home and Community Care (HACC) program for over 65's to create a nationally integrated aged care system, it was on the basis that there would be no substantive changes to HACC prior to 2015.

With the release of the Department of Social Services' discussion paper Key Directions for the Commonwealth Home Support Program (CHSP), we are starting to see the future shape of the renamed HACC program and its relationship with the rest of the Commonwealth's aged care programs.

The Commonwealth's vision for the CHSP includes:

- consolidating the HACC program and the Commonwealth's other basic support programs (the National Respite for Carers Program, Day Therapy Centres and, potentially, the Assistance with Care and Housing for the Aged Program) into a single basic support program for older people living at home;
- streamlining the number of service types from 30 to 15 in order to increase flexibility, improve access and reduce administration;
- a national fees policy to increase fairness and consistency in aged care contributions and to improve affordability for taxpayers;
- consumer access and initial screening for aged care services through myagedcare for all aged care services, including a network of regional assessment organisations (independent from service delivery) that would use standardised national assessment processes; and
- a focus on reablement and self-care by introducing individually tailored, time limited, goal driven support programs delivered by a network of restorative care services built on the existing Day Therapy Centres and allied health services.

#### **Consumer choice and control**

Ideally, the CHSP should aspire to the same objectives that underpin the reforms in home care and residential care. That is, using the combination of greater consumer choice and control and fairer and more equitable consumer contributions to create more contestable, flexible, responsive, innovative and sustainable aged care services.

In home care, greater consumer choice and control is being enabled through individual budgets for

each package recipient to purchase services from an approved provider. The logical next step – allowing package recipients to direct their individual budgets to the service provider of choice – is awaited.

Unlike home care, the CHSP will not include individual budgets, at least not initially. Instead CHSP providers will continue to be block funded. Consumers will continue to identify or be referred to providers with uncommitted funding for the types of services they are seeking.

Instead of individual budgets, the paper proposes that CHSP providers will be encouraged to develop a consumer directed care culture by:

- ensuring assessments include two-way communication to identify client and carer needs;
- using CHSP Development Officers to promulgate consumer directed care concepts; and
- through research and demonstration projects.

On their own, these measures are a poor second best, and are not a substitute for the power of consumer choice and control. A network of CHSP Development Officers may be an interim measure, but as a longer term arrangement it would direct scarce resources away from service delivery.

### **Block funding**

As well as diluting consumer choice and control, block funding providers has implications for how the CHSP will be administered ie the program will remain heavily dependent on regulation rather than consumer choice to drive quality, responsiveness and value for money.

Reducing the number of service types from 30 to 15 will reduce fragmentation and enable organisations more flexibility in service delivery. However, it will still require regulations and centralised service planning and allocation processes to fund outputs for the 15 service types. This situation contrasts with home care where restrictions on the services that may be purchased by the consumer from within their individual budget have been substantially loosened.

Encouragingly, the discussion paper has not entirely discounted individual budgets. To quote:

*“... in view of the pace and scale of change being experienced by the community sector, particularly those providers who are also involved in the establishment of the NDIS, it is not proposed to move away from traditional block funding arrangements in the short term.”*

Perhaps more instructive, however, is the additional comment that individual budgets will have to await the development of assessment processes that identify the amount of service each client would receive and then translate this into a funding amount. In this regard, it is relevant that there are about 750,000 HACC consumers currently, a figure that is set to grow rapidly, and each on average receives a small amount of services.

### **Contestability**

The discussion paper notes the Government’s support for the use of contestable processes to maximise consumer outcomes and achieve value for money. Whatever form competitive tendering takes, the cost for both Government and providers of administering tendering (and retendering) processes involving 15 different outputs and large numbers of prospective tenderers will be a significant ongoing overhead.

In addition, ways around the time limited nature of tenders would need to be found because, unless carefully managed, the ‘end of period’ factor for contracts could pose a significant threat to continuity of care.

Short of individual budgets, a more cost effective way to maximize client outcomes by using greater consumer choice and service competition might be to allow consumers to choose their preferred provider(s) who would be funded a per capita amount to provide care and support for people choosing their service.

Consumer choice and flexibility could be improved, and administrative costs reduced, by not prescribing service types or outputs for each service provider. Instead, services would be negotiated between the provider and the consumer. Some monitoring of outputs or outcomes at the aggregate may still be required.

As with an individualised funding model, there may be certain services that could continue to be funded under separate arrangements, such as carer respite services and specialist information and counselling services targeting groups such as people with dementia.

Whatever form increased contestability and consumer choice takes, it will have to be carefully stepped out given the complexity of the current arrangements and the vulnerability of the client group.

### **Assessment**

The discussion paper proposes that from 1 July 2015 all new CHSP clients would access aged care services through myagedcare and associated regional assessment organisations.

The objective is that within a few years, all age care recipients would access services through myagedcare, supported by a standardised national assessment tool and a central electronic client record. Over time, the Aged Care Assessment Teams would be integrated into these arrangements to create a single assessment service for all aged care.

A gradual build-up of the myagedcare gateway is sensible, but its role in reassessment of people receiving basic services as their needs change is unclear. Efficiency and timely responsiveness to changing circumstances would suggest a role in reassessment for the service provider.

### **Restorative care**

Assessing people to determine whether they would benefit from a time-limited episode of restorative care would be a welcome extension of a practice already being successfully introduced under the Western Australian and Victorian HACC programs.

It is proposed that myagedcare regional assessors would match and refer clients to services that support the client to achieve the goals specified in a care plan, after which the assessor would review the client's ongoing needs. To be effective, however, the regional assessors would need to be funded appropriately so that they can purchase readily accessible episodes of care as soon as a care plan has been developed. Any waiting list for restorative care would be a good measure of unmet need.

There is also a case for making the regional assessment organisations the budget holders for home modifications. This would enable consumers to be assessed for both restorative care and home modification needs at the same time, and for the regional assessment organisation to purchase the appropriate home modifications before handing over to the service provider to provide ongoing care and support.

### **National fees policy**

The Commonwealth Budget's forward estimates already provide for an incremental increase in consumer contributions under the CHSP from about 5% currently to 15% of costs by 2017-18. It is important not only that fees are consistent within CHSP, but also that they are aligned with

consumer contributions in home care and residential care. Because of the diversity of services that will be available, the fee arrangements have the potential to be quite complex. Also, given the number of people who will be receiving services under the CHSP, it will be important that means testing arrangements are kept as simple as possible, including making use of the current age pension means testing arrangements wherever possible.

An important issue will be how the fees policy is applied to time-limited restorative care episodes. There is a case for modifying the fees policy for certain elements of the restorative care episode as an incentive for participation

### **Budgeting within the funding envelope**

Overall, a question mark hangs over the affordability of the new arrangements within the existing and forecast funding envelope.

The vision for the CHSP involves a significant re-direction of existing funding which will need to be carefully managed and transitioned. For example, additional funding for restorative care services will be required if referrals are to be serviced in a timely way and regional assessment organisations will have to be adequately funded in order to avoid backlogs. The new arrangements also envisage a significant re-allocation of funding for case management and care coordination. The next stages of the development of the CHSP will therefore need to be transparent about how the re-packaging of funding within the existing funding envelope is to be achieved.

*Disclosure Statement: The author of Aged Care Update, Nick Mersiades, is a member of the Aged Care Financing Authority. The opinions in this Update should not be read as being an expression of the views of the Aged Care Financing Authority.*

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PO Box 330  
Deakin West ACT 2600