Catholic Health Australia

Community Aged Care: A Better Way Forward

Policy Paper: February 2010

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About Catholic Health Australia

21 public hospitals, 54 private hospitals, and 550 aged care services are operated by different bodies of the Catholic Church within Australia. These health and aged care services are operated in fulfilment of the mission of the Church to provide care and healing to all those who seek it. Catholic Health Australia is the peak member organisation of these health and aged care services. Further detail on Catholic Health Australia can be obtained at www.cha.org.au.

Executive summary

Australia faces significant challenges in caring for its current and future generations of older people.

The more significant challenges include the quadrupling in the number of older people; higher consumer expectations concerning choice and responsiveness of services; the expected surge in the proportion of the frailer aged with more complex high care needs due to neurodegenerative and chronic conditions; and the need to attract, train and retain a growing skilled and flexible workforce as the number of older people needing care increases and the availability of informal carers declines.

Faced with these challenges, there is a growing concern among Catholic aged care providers about the implications for their fulfilment of the Catholic Church's mission of care. In response to these concerns, Catholic Health Australia (CHA) convened a forum of its members to consider the future provision of community aged care services.

This paper draws on the outcomes of that forum and the analysis of recent reports, and presents a package of reforms to improve the responsiveness and sustainability of community aged care services. The reforms focus on:

- measures to increase consumer choice of aged care services, which extends to flexibility to exercise the widely held preference of many to continue living in their own homes with the support of community services;
- more widespread use of independence and wellness models of care; and
- an expansion of related services to support community aged care such as sub acute and restorative services, respite services and community-based palliative care.

In summary, the reform measures proposed include:

- Funding individuals eligible for assistance under the *Aged Care Act 1997* as an entitlement based on assessed needs and allow people the option to choose what mix of services they receive, who delivers the services and where they are received.
- Aligning care fees and subsidies for people receiving care in their own home with those applying in residential care for people with similar care needs in order to allow fair and equitable choice.
- Basing care subsidies and fees on independent periodic reviews of the cost of care and support provided in a less controlled supply environment against a benchmark of care.
- Funding accredited providers of home and community care services for the less frail aged on a per capita basis based upon the number of people assessed as eligible for these services who choose each provider for their services; adjusting accountability arrangements for home and community care to promote and support the adoption of independence models of care designed to achieve early intervention and prevention and thereby reduce the need for ongoing support.

- Providing incentives to increase the supply of Allied Health Assistants in order to improve the capacity to deliver services in the home focussed on restoration and maintenance of function.

- Implementation of the National Health and Hospitals Reform Commission's recommendations to increase the provision of inpatient and community-based sub acute and restorative services and to improve community-based palliative care services.

- Replace the current Aged Care Assessment Team structures and related information services such as Commonwealth Carelink Centres and Access Points Demonstration Pilots with a Commonwealth funded and administered national network of access and information centres to provide a fair, consistent and timely assessment service and common entry point for all aged care services.

- Funding arrangements for community care services to include specific provision to encourage the take up of technology, including assistive technology, to improve the effectiveness of delivering care to people living in the community.

These reforms entail a very significant change to current aged care arrangements and need to be carefully implemented. A precipitous move to increase consumer choice in how older people use aged care services would pose a risk to the continuity of existing services as there is a high probability that the current regulated balance of care ratios which determine the proportions of residential low and high care places and community care places will not align with consumer preferences.

In order to manage these risks to continuity of service for vulnerable people, it is essential that the implementation of the reforms be accompanied by transition arrangements for the phased introduction of greater choice which would allow a reasonable period for adjustment and clear timelines and milestones. These arrangements should be developed in consultation with consumers and providers.

Timely and coordinated implementation of these reforms would also be helped if they were managed by one level of government. Accordingly, it is recommended that the Commonwealth moves quickly to assume full responsibility for all of aged care. This would allow policy integration across the full spectrum of aged care services around issues such as consumer choice, assessment and eligibility, subsidy and fee policies, and accountability, reporting and quality assurance arrangements.

Introduction

Catholic Health Australia members are major not-for-profit providers of aged care services in Australia. These services are provided in fulfilment of the Catholic Church's mission to provide care and healing for those who seek it.

Catholic aged care services care for up to 19,000 older people in aged care homes across Australia each night, and help up to 14,000 older people continue living at home with care and support services provided through community care packages and the Home and Community Care program.

There is growing concern amongst Catholic Health Australia members, however, about their capacity to continue fulfilling their mission of care for older people in the community in the years ahead. In response to this concern, a Community Care Forum was convened by Catholic Health Australia in October 2009 to consider issues facing the effective provision of community care services.

This paper is a result of that Forum.

A distinguishing feature of what is generically known as 'community care' is the delivery of care and support services , including assistance with daily living and nursing care, in the care recipient's own home. Support for informal carers is also an integral component of community care.

An individual's need for care and support can arise as a result of a number of circumstances, including congenital or acquired disability, family breakdown or the frailty of older age. A number of health related services may also utilize support provided in a community setting, including drug and alcohol services, mental health services and various models of 'hospital-in-the-home'. The need can be life long, or arise at particular times in the life cycle, including at times of transition, or be episodic. At present, the bulk of community care and support is provided by unpaid family members and informal carers.

The main focus of this paper is community care and support provided for frail older people.

2. Background

Reform of community aged care cannot be considered in isolation of the wider system of aged care services in Australia. The challenges faced by Australia in caring for its older people are relevant to all modes of aged care services, and their interaction will have implications for how well we serve the needs of older people.

2.1 Community aged care in context

Aged care services in Australia are currently broadly distinguishable as:

- services for the more frail aged; and
- services for the less frail aged.

Services are further distinguishable according to whether they:

- are provided in a residential aged care home ; or
- support people living in their own home (i.e. community care services).

These distinctions largely reflect the evolution of Commonwealth/State responsibilities in aged care rather than a holistic model of care and support for older people, but these distinctions are useful to an understanding of current arrangements and possible reform directions.

2.1.1 Services for the frail aged

The overwhelming majority of aged care services for frailer older people are currently provided in residential aged care homes under the Commonwealth's *Aged Care Act 1997* (175,225 places at 30 June 2009). A smaller and capped proportion of services for this group are provided as community care to give people the option to continue living in their own home (42,694 community care packages at 30 June 2009).

Aged care places (residential places and community care packages) are made available according to a provision target of 113 places per 1000 people aged 70 and over, comprising 44 places each for residential low and high care and 25 places for community care.

Funding for care in a residential aged care home can be paid at up to sixty-four levels depending on each person's need for personal care, assistance with activities of daily living and nursing care as assessed under the Aged Care Funding Instrument (ACFI), with eligibility initially assessed by Aged Care Assessment Teams (ACATs). Eligibility for community care packages is also assessed by ACATs, however, they are funded at only three levels (CACPs, EACH and EACH Dementia).

The package of services that may be provided under a CACP includes personal care, social support, transport to appointments, home help, meal preparation and gardening. The package of services for EACH and EACH Dementia also includes registered nursing care, allied health and assistance with oxygen and /or enteral feeding.

2.1.2 Services for the less frail aged

All of the services for the less frail aged, on the other hand, are used by people living in their own homes and are mainly provided under the Home and Community Care program (HACC), a joint Commonwealth/State funded program administered by each State. Veterans' Home Care is an equivalent program for veterans which is funded and administered by the Commonwealth. HACC also supports younger people with disabilities living at home, with approximately 25% of HACC clients aged under 65.

HACC funds basic maintenance and support services for people with moderate, severe or profound disabilities (and their carers) whose capacity for independent living is at risk or who are at risk of premature or inappropriate admission into long term residential care. HACC services were provided by 3,300 agencies in 2007-08, assisting some 835,000 people. The 2007-08 HACC Annual Report estimates that this equates to 47% of the target population.

The average HACC client receives on average four hours of service a month, with domestic assistance being the most common. The most common combination of services is centre-based day care, meals delivery and transport assistance.

Services providing respite for carers and various counselling and information services are also available to support older people living in their own homes, including Carer Payments and a Carers Allowance.

Funding for community aged care programs for the less frail aged are allocated to providers on a block grant basis for which providers are accountable to deliver specific amounts of care and support services, including domestic assistance, social support, nursing care, allied health services, personal care , meals,

home maintenance, respite, assistance with transportation and care coordination and case management. Carer Payments and Carers Allowances are paid direct to the carer.

Eligibility for community care services for the less frail aged is determined by the service providers, operating within guidelines set by Commonwealth and State Governments.

2.2 The reform debate to date

The challenges faced with the provision of aged care have been well documented in recent Reports [1]. The most significant challenges include:

- A huge increase in the demand for aged care services, with the number of people aged 85 and over projected to quadruple by 2050 to 1.8million, and the number of people over 65 projected to increase by 5.1 million over the same period to 8.1million.

- The higher expectations of the current and future generations for choice, responsiveness, and flexibility in how they access and use aged care services, including a preference for independent living arrangements supported by community care.

- A surge in the number of people living with dementia and other neurodegenerative conditions and the increasing prevalence of chronic disease among the aged which are expected to increase the proportion of frail aged with more complex high care needs and the proportion of older people living with co-morbidities.

- The need to attract, train and retain a growing number of skilled carers as the number of older people needing care increases and the availability of informal carers declines.

[1] Report of the Review of Pricing Arrangements in Residential Aged Care (W P Hogan, April 2004)

The Future of Community Care (The Allen consulting Group, March 2007)

Trends in Aged Care Services: Some Implications (Productivity Commission Research Paper, September 2008)

Residential and Community Aged Care in Australia (Report of the Senate Standing Committee of Finance and Administration, April 2009)

A Healthier Future for All Australians (National Health and Hospitals Reform Commission, June 2009)

Review of Regulatory Burdens: Social and Economic Infrastructure Services (Productivity Commission, September 2009)

Leading the Way: Our Vision for Support and Care of Older Australians (National Aged Care Alliance, September 2009)

- Continued dependence of the overwhelming majority of older Australians on the age pension to support basic living standards and Government funding for their care needs, with life time savings for the majority being in the form of home ownership.

- An ongoing need for services for groups with special needs, including older homeless people and older people with psycho-geriatric conditions.

In many respects, the matters raised by these Reports mirror the issues and concerns raised by participants of the Forum (see Attachment).

The Reports also canvass a range of reforms to address these challenges. These reforms would reshape the current aged care arrangements to better meet the aged care needs of current and future generations of older Australians and their families. The reforms include specific recommendations for change by the National Health and Hospitals Reform Commission as well as calls for consideration, with varying degrees of emphasis, of a range of reforms proposed by the Productivity Commission, the Senate Standing Committee on Finance and Public Administration (Senate Committee), The Allen Consulting Group and the Review of Pricing Arrangements in Residential Aged Care (Hogan Review).

The major reform directions include:

- Ensuring greater choice and responsiveness in how people use aged care services by:
    - directly funding frail aged people according to assessed needs rather than aged care places (NHHRC);
    - developing a more flexible range of care subsidies for people receiving community care packages determined in a way which is compatible with subsidies for care provided in residential facilities (NHHRC);
    - funding services for the less frail aged on a per capita basis (The Allen Consulting Group);and
    - allowing service providers greater flexibility by lifting the current restrictions on the services they may offer (NHHRC, Productivity Commission and Allen Consulting Group).
- Expanding community aged care funding and services to meet growing demand and expected quality service provision outcomes (Senate Committee).
- Consider dispensing with the planning and allocation system for frail aged care and rely on an entitlement for aged care services established by ACATs, and free up supply constraints in the provision of aged care services (Productivity Commission, Hogan Review).
- Taking a client-centred approach to community (and residential) aged care to ensure that the system is client- focussed, and consider options to enable greater flexibility in relation to payments and services directed at providing a client-centred aged care system (Senate Committee).
- Expanding the independence model of care supported by appropriate use of care coordination, and shifting the emphasis of community care funding arrangements from inputs to client

outcomes by giving service providers greater flexibility about how they can provide services (The Allen consulting Group).

- Consider options for consumer directed care and expanding the opportunity for people supported in the community to determine how the resources allocated for their care are used (NHHRC, Productivity Commission, The Allen Consulting Group).

- Better information for older people and their families on the availability and quality of aged care services and how to access these services (NHHRC, Productivity Commission, The Allen Consulting Group, Hogan Review).

- Consolidating aged care under the Commonwealth by making aged care under the HACC program a direct Commonwealth program (NHHRC)

- Developing and introducing streamlined and consistent assessment for eligibility across all aged care by transferring ACATs to the Commonwealth, developing new assessment tools and integrating assessment for HACC with assessment for higher levels of residential and community care (NHHRC), and affirming ACATs as a single nationally consistent program which genuinely serves as a single entry point for aged care services (Senate Committee).

- Setting clear targets to increase the provision of both inpatient and community-based sub acute and restorative services to reduce the number of people accommodated inappropriately in acute hospitals and reducing the need for residential care by maintaining or increasing people's independence (Productivity Commission).

There is a coherence in the reform directions in these Reports which, together, would take the provision of aged care and support, and especially community aged care, to a new level focussed on quality, responsive, flexible and client-centred care.

3. Reform directions for community aged care

Drawing on the research and analysis available in the above Reports and the discussion at the Forum, Catholic Health Australia proposes that the Commonwealth Government pursues, in consultation with the sector and consumer peak groups, the following package of reforms designed to improve the provision of community aged care services, and aged care services overall.

3.1 Increasing consumer choice, flexibility and access

There is a need to change the current highly regulated arrangements for the provision of aged care services in response to the higher expectations of the current and future generations for choice, responsiveness and flexibility in the way they use aged care services. The change would encompass the ability for older people to exercise the widely held preference to continue living in their own homes for as long as possible with the support of community care.

Changes to current arrangements along the following lines are recommended in order to make the provision of aged care services more responsive to community preferences and more accessible.

RECOMMENDATION

For the <u>more frail aged</u>:

a) **Provide funding to individuals eligible for assistance under the *Aged Care Act 1997* as an entitlement based on assessed needs, rather than funding places according to a quota, and allow care recipients and their families choice over what mix of services they receive, who delivers the services and where they are received.**

b) **Lift the current restrictions on the services providers may offer.**

c) **Separate fees and subsidies for care and accommodation and hotel services in residential care so that choices about each are as far as possible independent of each other, thereby enabling more options and choice over both services and where services are received (as well as providing an incentive for the development of innovative housing options for older people, including community housing options for the large number of pensioner renters).**

d) **Align care fees and subsidies for people receiving care in their own home with those applying in residential care for people with similar care needs in order to help the exercise of equitable and free choice over where care and support is received, including the option to continue to receive care in the community as a person's care needs change.**

e) **Allow people in receipt of community care the option to determine how the resources allocated for their care and support are used.**

f) **Develop an appropriate suite of quality of care and quality of life indicators to enable older people and their carers /families to compare services.**

With regard to the <u>less frail aged</u>, allocating funding to each individual as an entitlement based on assessed needs would be very complex to administer centrally at this time given the large number of potential clients in this group and the variation in the nature and intensity of services needed.

However, a feature of the current funding arrangements for this group is that providers are limited to providing only those service types for which they have obtained funding by tender, which constrains their flexibility to tailor services to the needs of each care recipient and carer. Understandably, such arrangements tend to encourage a service delivery and reporting mindset focussed on inputs rather than client outcomes, and is not conducive to innovation in service delivery and workforce flexibility to optimize client outcomes. It also supports a large, expensive and remote bureaucracy in each State to plan and administer the distribution and allocation of service types amongst some 3,300 agencies across all regions of Australia.

An alternative and potentially more efficient funding arrangement which would be more amenable to a client-centred approach is to shift the emphasis from inputs to client outcomes by giving providers greater flexibility over how they provide services, giving consumers a choice as to which organisation provides their care, and making providers more accountable in terms of client outcomes.

RECOMMENDATION

For the less frail aged:

a) **Individuals assessed as in need of community care would become eligible to receive community care and support services and to enrol with an accredited community care provider of their choice to receive their care services; and**

b) **Each accredited community care provider would receive funding on a per capita basis for each client who chooses to enrol in their service. The per capita amount could be reviewed to reflect the profile of each provider's client group (including, for example, the degree of rurality and cultural diversity of the client profile and client capacity to contribute towards the cost of their care and support).**

Given the inherent vulnerability of many in old age, it is essential that careful attention is given to maintaining effective consumer protection measures.

3.2 Independence and wellness

The current focus of community service provision in aged care is to respond to client dependency needs, with the primary objective being to provide basic maintenance and support.

An emerging trend in community care service delivery is to place more emphasis on promoting and enhancing the independence of clients, commonly referred to as the 'independence model' of care. This model does not deny the continuing need for services directed at support and maintenance, but in addition includes a commitment to early intervention and prevention for certain assessed clients to promote independence and thereby reduce the need for ongoing support in the future.

More widespread use of the independence model would be helped by the adoption of the per capita funding model for the less frail aged outlined above. Under this model, service providers would have the flexibility to tailor services around the needs of individual care recipients and carers, rather than be restricted to the provision of certain specific service types. This flexibility would extend to making appropriate use of care coordination to support the tailoring of services to the individual.

The increased flexibility would also provide a better platform for negotiating partnerships and protocols with primary and post acute care services as community care providers would be better placed to respond in a timely and responsive way, and with greater certainty.

As further encouragement of a service model which seeks to reduce dependency, community care providers would be required to report on performance in reducing dependence, rather than only accounting for the outputs of each service type regardless of outcomes for the client.

In contrast to the HACC program, community care packages allow service providers greater flexibility to tailor services to the needs of each client. Outcomes for the client, however, could be improved if the range of permissible services in CACPs was extended to include allied health services such as physiotherapy, occupational therapy and speech pathology.

RECOMMENDATION

It is recommended that:

a) **The per capita funding model proposed for the less frail aged should incorporate the independence model of care; and**

b) **The range of permissible services in CACPs should include allied health services such as physiotherapy, occupational therapy and speech pathology**

3.3 Expansion of related services to support community aged care

Allowing older people and their families greater choice to receive their care in their own homes needs to be accompanied by increased investment in a range of related services, including sub acute and restorative care, palliative care and respite services.

This investment would reduce the risk of community aged care being used to compensate for a lack of appropriate clinical intervention, or failing as a result of unreasonable expectations being placed on informal carers, or from services not being equipped to manage more complex care needs.

3.3.1 Sub acute and restorative care

The importance of additional funding to increase sub acute and restorative services was explicitly recognised by the National Health and Hospitals Reform Commission (NHHRC) which recommended clear targets to increase the provision of sub acute services to cover both in patient and community based services.

This would ensure that older people receive adequate rehabilitation after a post acute episode or restorative care while living in the community to support independent living and avoid unnecessary hospitalisation or premature entry into residential care.

This paper strongly supports the NHHRC's recommendations. It is essential that every opportunity is taken to highlight to Governments the high priority that should attach to the implementation of the Commission's recommendations.

The expansion of rehabilitation services should include an expansion of the community based Day Therapy Centres so that they are easily accessible by older people living in all regions of Australia. The current distribution of Centres is very uneven across Australia, with South Australians having the best access.

RECOMMENDATION

It is recommended that:

a) **The Commonwealth Government implements the NHHRC's recommendation to increase the provision of inpatient and community-based sub acute and restorative services and to include slow stream rehabilitation; and**

b) The number of Day Therapy Centres should be increased to allow access in all regions of Australia.

3.3.2 Palliative care

An expansion of services caring for older people in their own home will need to be complemented by an expansion of the capacity and competence of primary health care services to provide generalist palliative care for people living in the community, supported by increased collaboration and networking with increased specialist palliative care services.

This need was also recognised by the National Health and Hospitals Reform Commission which recommended the expansion of the capacity of primary care to deliver palliative care services, and additional investment in specialist care services to support people living at home in the community and in residential care.

Again, this paper strongly supports the Commission's recommendations and the need to highlight to Governments the importance of these recommendations to the successful provision of community aged care services.

Approaching the end of life, whether through palliative care or longevity, brings up both existential and spiritual issues for older people and their families. To ensure that these needs are appropriately attended to, there is a case for the provision of such services to be explicitly provided for as a cost component of care subsidies.

RECOMMENDATION

It is recommended that:

a) The Commonwealth Government implements the NHHRC's recommendations to improve palliative care services in community settings; and

b) Pastoral care be recognised as a distinct funded component of the aged care subsidy.

3.3.3 Respite services

At present, a substantial proportion of the care and support for older people living in the community is provided by informal carers, especially women family carers. They perform a demanding and stressful role and are integral to the community care framework by reducing the demands on formal care.

However, it is expected that changes in family structures, participation of women in the workforce, workforce shortages and the ageing of the population will combine to reduce the availability of informal carers to support older people living at home with the assistance of community care.

Because of the dependence of community care on informal carers and the above pressures on informal carers, more effective support to help available carers maintain their caring role will need to be a key element of future aged care arrangements. Services to help carers will need to include accessible respite services to give carers a break, education and information services about effective care techniques and strategies, and income support to offset the cost of caring.

Accordingly, reform of community aged care services needs to be accompanied by a significant expansion of more flexible respite services, both centre-based and emergency respite, which can most effectively support each carer and cater for the needs of each care recipient. There is also the opportunity to make more widespread use of a wellness approach in centre based care designed to improve the capacity of older people to live more independently, with fewer demands on their carers.

RECOMMENDATION

It is recommended that the Commonwealth Government increase the availability of more flexible respite services to cater for individual circumstances, including allowing recipients of community care packages to use their care entitlement to purchase respite care.

3.4 Properly funded and sustainable community care services

There is currently no objective basis for setting prices and subsidy levels for the provision of community or residential aged care, including meeting the competitive remuneration needed to attract and retain the skilled staff that will be required to care for the increasing number of older people with more complex care needs. Nor is there a benchmark of care to guide the setting of prices and subsidies.

The current subsidies for community care and support for the frailer aged were initially set having regard to care subsidies paid in residential care, but have since only had the benefit of minimum wage adjustments (COPO). Residential care, on the other hand, has also received the Conditional Adjustment Payment which has increased care subsidies by 8.75% on top of COPO indexation (1.75% annually over five years).

The use of minimum wage adjustments assumes that wages in all sectors are offset by productivity gains and uses the flawed assumption that the community aged care sector has the same capacity as all other sectors to achieve productivity gains through labour substitution. As a consequence of this approach, industry surveys (Stewart Brown) show that average hours of care and support per person have been gradually declining.

As indicated above, one approach to setting subsidies for community care for the frail aged is to link the amount to that applying in residential care. This would mean increasing subsidies to match the increase provided for residential aged care under the Conditional Adjustment Payment, and link future subsidy levels in community care to those which apply in residential care for people with similar assessed care needs. This approach is premised on the likely Commonwealth view that it would not wish to pay more for an individual's care in the community than it would cost to care for that person in an aged care home.

Introducing more consumer choice into future arrangements as proposed earlier in this paper would not only improve the flexibility, quality and responsiveness of services, but would also provide a more evidence-based and transparent basis for assessing comparative performance and for setting care fees and subsidies in residential care, which could in turn provide a benchmark for community care services for the more frail aged.

RECOMMENDATION

It is recommended that the following arrangements be implemented to provide a more objective basis for setting care subsidies and fees for the more frail aged:

a) Develop Special Purpose Financial Reports or equivalent which would allow the collection of comprehensive and audited national comparative financial data and independent analysis of the financial performance of the aged care sector.

b) Undertake independent periodic reviews of the cost of care and support to ensure that care subsidies are adequate to meet the care needs of people in residential care having regard to a benchmark of care.

c) Align care subsidies and fees in community care to those in residential care for those assessed with similar care needs.

Commonwealth funding for care and support provided for the less frail aged under HACC has also been based on COPO, but with a 6% additional annual real increase over the last decade to meet unmet need. As HACC is not based on individualised funding, but rather block grants, the only feasible option is to seek more appropriate cost indexation, such as the Consumer Price Index, health cost index or a specific community care index, which would more closely reflect cost increases in the sector.

A similar indexation approach could be used for the per capita funding model for the less frail age.

RECOMMENDATION

It is recommended that a more appropriate cost index which more appropriately reflects cost movements in the sector should be identified or developed.

3.5 Assessment and information

There is a need for a single integrated aged care assessment service regardless of the level of care for which people are assessed which achieves timely, consistent and equitable outcomes, and simplifies access to services.

Accountability for assessments by ACATs for the more frail aged is currently spread across levels of Government, and statutory authorities in some States, which hinders consistency and fairness in eligibility assessments and effective performance management. Assessment processes can also vary across programs and creates confusion and duplicated assessments for care recipients, with assessment for eligibility for services for the less frail aged residing with each service provider.

As noted earlier, there is also the need for easily accessible and understood information and guidance about how to access services, and about their availability and quality.

RECOMMENDATION

The following reforms to the current assessment arrangements are recommended:

a) Establish a Commonwealth funded and administered national network of access and information centres to provide an integrated assessment service and common entry point to:

i. ensure that eligibility is determined fairly, consistently and quickly;

ii. simplify access to services for the community; and

iii. support consumer choice by providing comprehensive, consistent and accurate information on available services and quality and eligibility, (including information accessed from commonly used mediums such as General Practice surgeries and local government).

b) Aged Care Assessment Teams be reformed and re-badged to provide the core of a national network of access and information centres.

c) The network would incorporate other existing information services such as Commonwealth Carelink Centres and the Access Points Demonstration Pilots.

The network would continue, as is the case currently with ACATs, to seek clinical input as necessary to assist with eligibility assessment.

3.6 Workforce

The capacity to offer competitive salaries is crucial to the sector's ability to attract and retain the expanding workforce that will be needed because of the growing number of older people and the expected decline in the availability of informal carers.

As well as the measures recommended to address the viability of community aged care services, there is a need to ensure that there will be sufficient skilled staff to meet this growing demand, including to manage the anticipated increased acuity and diversity of aged care needs.

As a first step, it is recommended that Health Workforce Australia be commissioned to undertake an analysis of the projected demand for aged care staff and skill needs to inform the planning of future training place numbers.

The analysis should encompass the workforce needs of both the community and residential aged care sectors, recognising the close relationship of the two modes of service delivery.

As highlighted in the National Health Workforce Taskforce discussion paper, *Workforce innovation and reform: Caring for older people (2008)*, there is a need for workforce planning in aged care to be consumer focussed, closely aligned with service delivery plans, multidisciplinary and holistic in the approach to addressing workforce issues. This will require new approaches such as strategies to overcome barriers to increased collaboration and teamwork across disciplines and extending existing roles and scope of practices to provide greater workforce flexibility.

The greater use of assistant roles such as Allied Health Assistants, working under the direction of an allied health professional, would be a particularly effective way of increasing workforce flexibility. Applied in community care, Allied Health Assistants would be an effective means of providing a wide range of services in the home focussed on the restoration of function to improve or maintain a client's capacity to stay independent for as long as possible.

RECOMMENDATION

It is recommended that:

a) **Health Workforce Australia be commissioned to undertake an analysis of the projected demand for aged care staff and skill needs to help inform the planning for future training places and inform strategies to increase workforce flexibility;**

b) **Incentives be provided to increase the supply of Allied Health Assistants in order to improve the capacity to deliver services in the home focussed on the restoration of function to improve or maintain a client's capacity to stay as independent as possible for as long as possible.**

3.7 Technology

There is scope to make greater use of technology, including assistive technology, to improve the effectiveness and efficiency of delivering care and support for older people receiving care in the community. This includes home and personal security monitoring technology, as well as the capacity to make appropriate use of e health initiatives being promoted by Governments such as person-controlled electronic health records and electronic client records.

The potential for improved technology and communications to improve aged care services, and community aged care services in particular, was explicitly recognised by the NHHRC.

The current funding arrangements for HACC focus on the delivery of specific service types and the acquittal of expenditures against those service types. The arrangements for funding capital investments are not well developed. In particular, they are not geared to allow service providers to take advantage of the increasing availability of innovative technology to improve service delivery. A similar gap applies in relation to the funding arrangements for community care packages.

RECOMMENDATION

It is recommended that future funding arrangements for community aged care recognise the potential for making greater use of technology by making specific funding provision and incentives available to encourage the take up of technology, including managing the upskilling of staff and cultural change.

3.8 Consolidation of aged care under the Commonwealth

Timely and coordinated implementation of the reform directions for community aged care proposed in this document would be helped by early assumption by the Commonwealth of full responsibility for all aged care services, including the Home and Community Care program and assessment services (Aged Care Assessment Teams).

This would allow policy integration around consumer choice and access, assessment and eligibility, subsidy and fee policies, and accountability, reporting and quality assurance arrangements across the full spectrum of aged care services, and help reduce duplication in administration.

RECOMMENDATION

> **It is recommended that the Commonwealth moves quickly to assume full responsibility for all aged care to enable more timely and coordinated implementation of aged care reforms.**

3.9 Transition arrangements

There is a high probability that the current regulated balance of care ratios which determine the proportions of residential low and high care places and community care places will not align with consumer preferences. As a result, increasing consumer choice and responsiveness in how older people use aged care services without phasing in the reforms would pose a risk to the continuity of existing services.

In order to manage these risks to continuity of service for vulnerable people, it is essential that the implementation of the reforms be accompanied by transition arrangements for the phased introduction of greater choice which allows a reasonable period for adjustment and clear timelines and milestones. These arrangements should be developed in consultation with consumer and provider stakeholders.

The transition arrangements would, inter alia, set out timelines and arrangements for:

- the gradual conversion of existing low care residential places to community care or high care;
- removal of the current artificial low/high distinction in residential aged care;
- allowing community care recipients to choose their care provider, transition to higher care levels without changing provider and the option to manage their entitlement;
- removing quotas and lifting restrictions on what services providers can offer; and
- funding care recipients rather than places and allowing care recipients choice of residential or community care.

RECOMMENDATION

It is recommended that reform to increase consumer choice and responsiveness be accompanied by transition arrangements which provide for the phased introduction of reform measures, with clear timelines, in order to manage any risk to the continuity of services.

3.10 Complementary policy development

It is widely acknowledged that successful ageing also requires complementary policies at all levels of Government (Federal, State and Local) and age-friendly community attitudes. While this paper has focussed on the delivery of community aged care services, successful ageing and the effectiveness of community aged care services will also require policy development in other areas such as retirement incomes, health, transport infrastructure, housing provision, adoption of accessible and adaptable housing design guidelines and urban design. The provision of appropriate housing for pensioner-renters should be a particularly high priority for Governments. All of these factors bear on the welfare of older people, especially older people living in their own homes with the support of community care.

February 2010

ATTACHMENT

ISSUES RAISED BY FORUM PARTICIPANTS

A summary of the major issues raised by Forum participants in provided below, along with comments on reform implications.

ISSUE RAISED	REFORM IMPLICATIONS
1. Funding • Inadequate indexation for community care packages is resulting in reduced service hours per resident	• Seek more appropriate indexation than COPO or seek alignment of community care funding with care funding in residential care and peg future community care funding to care funding in residential care.
• Lower ACFI rates for former RCS 7 residents is putting pressure on community care, as will inadequate capital funding for high care.	• Increase the number of community care packages by discontinuing current rationing by quota and instead fund individuals as an entitlement based on need, and lift the current restrictions on the services providers may offer. • Address capital funding for residential high care by allowing greater flexibility in accommodation payments after removal of what services providers may offer has increased competition in supply and price. In the meantime, seek an increase in accommodation payments to levels contained in Access Economics' *Economic Evaluation of Capital Financing of High Care.*

2. Responsiveness, Flexibility and Individual Choice	
• Continuity of care not guaranteed in community care because CACPs and EACH are restrictive.	• Fund frailer care recipients on an entitlement basis and allow care recipients choice over where services are received (in their own home or in an aged care home), who delivers the service and what services are received.
• Successful community care needs access to other support services eg palliative care and sub-acute and restorative care.	• Support the National Health and Hospitals Reform Commission's recommended targets for increasing funding for post acute and restorative care and recommendations to increase and improve palliative care services in the community, including in aged care homes.
• Waiting lists/demand exceeds supply	• Provide funding to the frailer older individuals as an entitlement based on assessed needs, rather than the current quotas, and lift the restrictions on the services providers may offer; allow care recipients choice over where services are received and who provides them.
	• Individuals assessed with less frail aged care needs to be entitled to receive community care and support services and to enrol with an accredited provider of their choice.
• Allocations are geographically restrictive eg service areas confined to suburbs	• As above

• Planning ratios are restrictive	• Eliminate need for planning ratios by discontinuing rationing. Fund individuals as an entitlement based on assessed need instead.
• Tender processes are expensive and time consuming, and decisions are inconsistent	• Eliminate need for tender processes for services funded under the *Aged Care Act* for the more frail aged by funding individuals as an entitlement with choice of service, and lift current restrictions on what services providers may offer. • Eliminate need for tender arrangements for HACC for the less frail aged by funding service providers on a per capita basis linked to number of eligible care recipients enrolled (adjusted for means testing and client profile).
• Conversion of bed licences to packages is locally disruptive	• Elimination of service type quotas and lifting restrictions on services providers may offer would allow providers the flexibility to plan their service mix in response to the preferences of care recipients and their families.
• ACATs not operating effectively	• Transform the Aged Care Assessment Teams into a Commonwealth funded and administered national network of access, assessment and information centres for all aged care services whose performance would be measured against benchmarks to ensure that eligibility is determined fairly, consistently and quickly.
• Access Points Demonstration Projects may be a better way of referring people to services. Clients currently have to knock on too many doors before they get what they want.	• Integrate the Access Points Demonstration Projects (and Commonwealth Carelink Centres) into the above.

• Can GPs (or their surgery) become the single entry point provider?	• Commonwealth agreement to this arrangement would not be forthcoming as there is a view that GPs are not well placed to be impartial assessors of eligibility for Government subsidies in view of their personal relationship with their patients.
• Community care packages should be available on discharge from hospital	• Provide funding to individuals based on assessed need, remove quotas and lift restrictions on services providers may offer.
3. Quality reporting /administration	
• Overlap and duplication between levels of Government concerning quality reporting and monitoring	• As a first step to rationalising the current arrangements, bring all funding and administrative responsibilities for aged care under the jurisdiction of the Commonwealth.
• Quality focus should be on continuous improvement, not just compliance	• Ensure that the reporting against the standards to be included in the National Quality Reporting process has an emphasis on continuous improvement rather than compliance, including allowing flexibility in how providers achieve the standards.
	• As per above, expedite the implementation of consistent national standards and reporting across all community care by bringing all funding and administrative responsibility for aged care under the jurisdiction of the Commonwealth.
• Output based funding in HACC not necessarily conducive to achieving good outcomes for clients	• Introduce an accountability measure around the level of success in reducing care recipients' care dependency through wellness/restorative measures.

4. Independence and wellness	
• Incorporate the independence model (supported by increased care coordination) into HACC programs in all States in order to achieve reduced dependency of clients and improved wellness, including for clients with chronic conditions.	• Work with innovative service providers (eg Silver Chain) to assemble the evidence base for incorporating a wellness approach in HACC based on intensive multi disciplinary action for presentation to relevant Government representatives. • Facilitate the use of the independence model by adopting a per capita funding mode for the care and support of the less frail aged.
• Expand care coordination role to support a wellness/independence approach to community care	• Adoption of the per capita funding model would provide greater flexibility to tailor services to the assessed needs of clients, including through use of care coordination.
• Incorporate physiotherapy with a restorative /independence focus into CACPs	• Extend the scope of services under CACPs by including physiotherapy and other allied health as permissible care services.
• HACC program output measures need to change to reflect a wellness/independence approach to community care	• See related item in Section 3 above.
5. Pastoral care	
• There is a need to enhance the role of pastoral care in community care	• Develop and introduce a standardised training regime to support pastoral carers in Catholic community care services. • Explicitly recognise and fund the cost of pastoral care as a component of aged care subsidies.

6. Informal carers • The important role of informal and family carers needs to be better supported	• Increase the number, range and flexibility of respite services, and include an active independence and wellness focus.
7. Assistive technology • There is a need for Government incentives to purchase and implement assistive technology, including the capacity to make appropriate use of e health initiatives being promoted by Governments.	• The acquitable output based funding model used in HACC is not amenable to capital investment in assistive technology. HACC payments need to include specific provision for capital to fund the adoption of assistive technology linked to the achievement of improved outcomes. • Alternatively, the per capita funding arrangements could include a capital component.
8. Mental health • Case management in community care is a means for supporting mental health and drug and alcohol health service.	• Demonstrate benefits and potential for expansion to funders of mental health and drug and alcohol services. The capacity to adopt an independence model under per capita funding arrangements for the less frail aged would strengthen the capacity of providers to present a case to service this group of clients.
9. Partnerships • Lack of partnerships with other service providers eg primary care providers and acute care	• Funding HACC providers on a per capita basis provides a more flexible basis for establishing partnerships and protocols with primary and post acute health care providers.