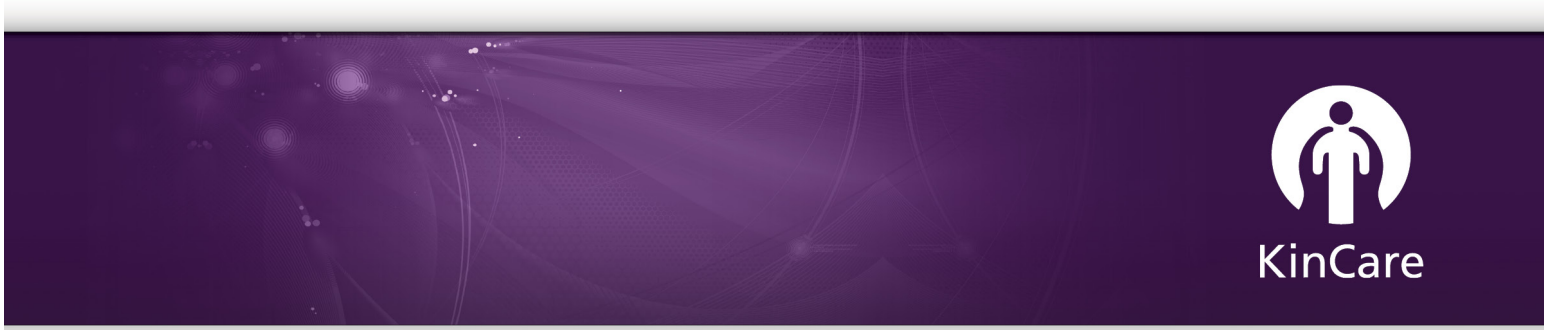
CARING FOR OLDER AUSTRALIANS



RESPONSE TO THE PRODUCTIVITY COMMISSION'S ISSUES PAPER

Jason Howie, Therese Adami, Helen Wilson

Synopsis

As Australia's population ages there is increasing pressure on health and aged care services. It is important to introduce reforms to the system to ensure it can respond effectively to increased demand and changing consumer expectations.

Two key themes should be the focus of reform initiatives. These are:

- Increasing Consumer Choice
- Integrating Aged Care Services into the Broader Health System

A variety of changes are needed across the system to implement these reforms effectively. Most of these are well recognised and have been the focus of several previous government reports on Aged Care.

In order to achieve the necessary reform of the system, changes will be needed to the regulatory environment and funding for aged care services. The system needs to be structured in a manner that will encourage innovation, efficiency and transparency, and that will require service providers to become more responsive to the needs and aspirations of older people.

In reviewing the Australian Aged Care system it is important to acknowledge that there are many positives. Successive Australian governments have invested in developing an aged care system that gives people a choice between residential and community care and that can respond to low care needs and more complex needs. However, demand and needs are changing and the system is suffering significant financial stress. In its present form, the system will not adequately meet future needs. As a result, the focus of this paper is to explore gaps and opportunities for improvement that will enable the system to better meet current and future demand.

KinCare specialises in community care services and provides services to over 4,500 clients across four states and territories. We have focused our submission on issues that directly relate to community care. We have only addressed issues relating to residential care where they have a direct impact on community care.

Overview of Document Structure

This document has four parts:

- A Background to KinCare
- Objectives of the System for Older Australians
- Context of Where We Are Now
- Outline of Issues and Recommendations

The focus of the document is around key issues and recommendations for community care and the broader health system. These cover many of the questions raised in the Issues Paper, but do not address these systematically in the order outlined in the issues paper.

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Background to KinCare

KinCare has been providing community care services to older Australians and their carers for almost 20 years.

The organisation was founded out of a desire to deliver high quality, consumer-oriented health services. We now offer services across the Australian Capital Territory (ACT), New South Wales (NSW), Victoria (VIC) and Western Australia (WA), employing over 700 staff and servicing over 4,500 clients.

We focus on improving health and quality of life for older Australians and are leading innovators in service models, personnel management and service management for community care services.

Our values include a commitment to providing the kind of care we want for our loved ones. To achieve this we believe services must firstly prioritise what older people and their families need and want. In this respect services need to be focused around:

- Listening to what older Australians and their families and carers want;
- Engaging older people and their families and carers in planning services; and
- Achieving high levels of customer service and satisfaction that create great experiences and outcomes.

We also recognise that most services for older people are subsidised by the Australian Government on behalf of the Australian community. Therefore it is also important that the objectives of our community in subsidising these services are achieved. These include:

- Providing acceptable lifestyles and choices to older Australians
- Supporting the valuable role of carers
- Improving the health of older people
- Reducing pressure on the health system
- Improving integration and efficiency across the health and social services system

We welcome the Productivity Commission enquiry and the opportunity to contribute our perspectives on Caring for Older Australians.

Objectives for Older Australians

Part 3 of the Productivity Commission Issues Paper notes that the starting point for designing a system of Aged Care is being clear about the objectives.

The objectives of Australia's aged care system have been outlined in a number of government, academic and industry papers. We broadly support these objectives particularly as they increasingly emphasise aged care as a part of the broader health system (National Health and Hospitals Reform Commission, 2009). These objectives can broadly be grouped into two groups:

- Consumer Related Objectives
- System Related Objectives

Consumer Related

The Department of Health and Ageing identifies the objectives of the aged care system as ensuring that "frail older Australians have timely access to appropriate care and support services as they age...through a safe and secure aged care system." (DoHA, 2009)

Important consumer-related objectives outlined in recent government reports such as "A Healthier Future for All Australians" and "Australia's Future Tax System" include:

- Flexible and responsive services that facilitate independence and choice;
- Providing access to aged care services for people experiencing financial or other disadvantage;
- Providing an adequate amount of aged care that provides a decent quality of life for older people;
- Guaranteeing an acceptable quality of care; and
- Responding effectively to the diversity of need in the Australian community.

These and other objectives are also supported in the Aged Care Act 1997 and Principles, Home and Community Care (HACC) guidelines and a variety of other government reports.

Health System Related Objectives

The government has also articulated a variety of objectives that relate to the system as a whole (Henry, 2010; National Health and Hospitals Reform Commission, 2009; Australian Government, 1997; Australian Government, 1997). These include:

- Integration between health and aged care services;
- Assigning resources and services on the basis of need;
- Providing accountability and transparency;
- Offering a diversity of services; and
- Ensuring services are efficient

It is important to ensure that the role of aged care services is considered in the context of the broader health system (National Health and Hospitals Reform Commission, 2009). Important decisions need to be made regarding where funds are invested. Aged care services are likely to be able to perform a very important preventative, early intervention and restorative role that goes even beyond that envisioned by the National Health and Hospitals Reform Commission (NHHRC) recommendations. Achieving this would have significant implications for the workforce requirements and cost of aged care services, but is likely to achieve significant system-wide savings. This would be a valuable focus area for future research and trials.

Context

In discussing the current context of Aged Care it is important to note that some programs are currently administered by the Australian Government and others by State and Territory Governments. In some states Local Government also plays an important role. The system is complex and there are quite significant differences in how programs are administered in each state and territory. These complexities are magnified when considering the interfaces aged care services need with other government departments and programs such as disability services, health services and housing services. It will be important to consider differences in each state as reforms are developed and implemented.

Furthermore, transitional arrangements are already being planned for the transfer of HACC services to the Commonwealth in most states and territories. It is presently unclear what this will mean for the programs generally, or how states such as Victoria and Western Australia that have chosen to retain control of the administration of HACC services will respond to any national policy initiatives. It is even less clear what this means for programs already directly linked with health services such as transitional care and state-based respite, early discharge and admission avoidance services, which have different names and administrative arrangements in each state.

Summary of where are we now

Successive Australian governments have invested in developing a flexible and responsive aged care system which has largely met the needs of the community to date. As demand increases, however, structural, financial and regulatory issues constrain innovation and threaten the viability of services.

It is timely to consider meaningful systemic reform of aged care to develop a system that is genuinely consumer-centred and achieves the objectives of consumers and the broader community.

Community care services deliver care and support in a client's home or assist a client living at home to participate in the community. Community care is increasingly the service of choice for older people. Community care includes well know programs such as Community Nursing, HACC, Community Aged Care Packages (CACP), and Extended Aged Care at Home and Extended Aged Care at Home Dementia (EACH/D); and smaller programs such as transitional care, early discharge and admission avoidance programs. There is little consistency in how these programs are funded and regulated which leads to fragmentation and a lack of integration between service types and between community care services and the broader health system.

There are a variety of service providers across the sector including Non-Profit Organisations, Churches, Government and Private services. Non-profit organisations, Churches and Government services heavily dominate community care in most states. The private sector is generally under-represented in community care services.

Identification of the need for reform of Aged Care is not new. Successive reports into residential and community care services, beginning with Hogan's report in 2004, have highlighted the issues.

However, the reports have also rightly acknowledged that implementing the necessary reform is complex. Some of the recommendations of these reports have been adopted; many have not.

Despite incremental change the financial position of the industry has worsened as funding indexation has not kept pace with costs. The funding and regulatory environment also continues to limit innovation. If these issues remain unaddressed the system will be unable to cope with increases in demand and expectations for aged care services over the coming years.

Issues and Recommendations

Consumer Choice

Current Situation

> "Features of the current aged care sector are significant regulation of supply and pricing, together with limited choice for recipients. These features restrict the delivery of care consistent with recipients' preferences." (Henry, 2010)

Aged care services should be designed to meet consumers need and preferences in an equitable, efficient and transparent manner that also achieves broader social outcomes.

At present the aged care funding system is developed around aged care "places" funded by the government. Service providers innovate and enhance services in order to be competitive through government tender rounds. There are opportunities to stimulate increased innovation and to strengthen relationships with consumers by reorienting funding approaches.

Aged Care Places have very high occupancy. Demand is high and places are limited. This means there is often little choice of provider in many regions and clients often have to take a place with the provider that has a vacancy.

Over the past five years there has been growing interest in consumer-directed care. Some providers already implement models that could be described as consumer-directed within the constraints of existing funding models.

Alternative Models

To resolve these issues it is important to place the consumer at the centre of service delivery. This involves increasing consumer choice and control. Models that achieve this are often referred to as Consumer-directed Care.

Some providers have begun piloting consumer directed care models and the Australian government recently tendered funds for a consumer-directed care pilot. These steps towards increased consumer-directed care are welcome and should be evaluated to begin to establish the foundation of a consumer-centred aged care system.

In order to implement reforms that will place consumers at the centre of the aged care system a partnership will be required between service providers, government and consumer representatives. There should be debate and testing of various consumer-centred models to ensure an approach is developed that will be sustainable and achieve the objectives of outstanding consumer outcomes, efficiency, transparency, and equitable access.

Consumer-directed service models can have many different forms. At one extreme, this could be a simple incremental change to the current system. This would involve simply mandating greater

user choice in service planning. In all other respects services would remain the same with funds allocated to providers through approval rounds. The current consumer-directed care trial is a simple incremental change of this kind and should be extended by applying a similar approach to low-care services. At the other extreme consumer-directed care could involve directly granting consumers funds to spend as they see fit. However, while this would achieve the objective of increased choice, it is unlikely to ensure quality and outcome objectives are achieved.

The best model sits somewhere between the extremes. It would attach funding to consumers and bring the best elements of private and non-profit innovation to the table while also acknowledging that aged care is an essential service and needs an effective regulatory and accreditation framework around access, protection of vulnerable people, quality and outcomes. It will be important to ensure consumers are much better informed of their rights and what to expect from services, and it may be necessary to develop a system of formal advocates for consumers who are very vulnerable and do not have strong family supports. Consumers need to be able to choose their service provider and easily switch between providers.

It will also be important to ensure the future aged care system is flexible. Service providers need the flexibility to offer different models to different target groups. Some very frail or vulnerable people may prefer a model where service providers play a stronger role in recommending services (as in the current system), while more active older people with a strong support system are likely to want to get more directly involved. Reducing regulation of supply and increasing the flexibility of service models as proposed by Henry would help achieve this.

Hogan, Henry and the NHHRC all recommend reducing and shifting the focus of regulation; Lifting constraints on the supply of places; and expanding the role of Aged Care Assessment Teams (ACAT – in Victorial ACAS) to assess eligibility for all aged care funding (Henry, 2010; National Health and Hospitals Reform Commission, 2009; Hogan, 2004). The NHHRC suggests that as a part of this change that ACATs are brought under Commonwealth control. Minimum standards should be mandated (Henry, 2010) and funding should attach to a person rather than a place. The person should then be able to choose their aged care service (National Health and Hospitals Reform Commission, 2009).

An effective system of independent assessment services that could assess need in a timely manner would be needed. This may be achieved by extension of the role of existing ACATs or broadening the number of assessment services.

The case for reform of this kind is very compelling, but it would need to be implemented gradually and with care to ensure appropriate incentives and regulations were put in place to protect special needs and other vulnerable groups. Appropriate regulatory protections would need to be in place in particular with respect to the very frail, people in rural and remote areas and people from an Aboriginal and Torres Strait Islander background.

It is also important to consider the likely impact on providers. For example, the reform would reduce budgeting certainty, which may reduce the attractiveness of operating for some organisations. There are also likely to be some initial costs as organisations readjust their management systems and communication processes to the new model. These issues could be adequately addressed by implementing well-planned transitional arrangements.

Increasing consumer choice could be implemented incrementally. Interim steps towards the goal would include:

- Increasing the supply of aged care places
- Better aligning the treatment of accommodation and care no matter what accommodation setting a client chooses
- Increasing the flexibility of care services so they can be provided in the setting of a client's choice to similar levels of funding irrespective of whether the place was funded as a residential or community care place.

There would be several important benefits from reform of this kind. These are outlined in the table below.

Table 1 Benefits of Preferred Model

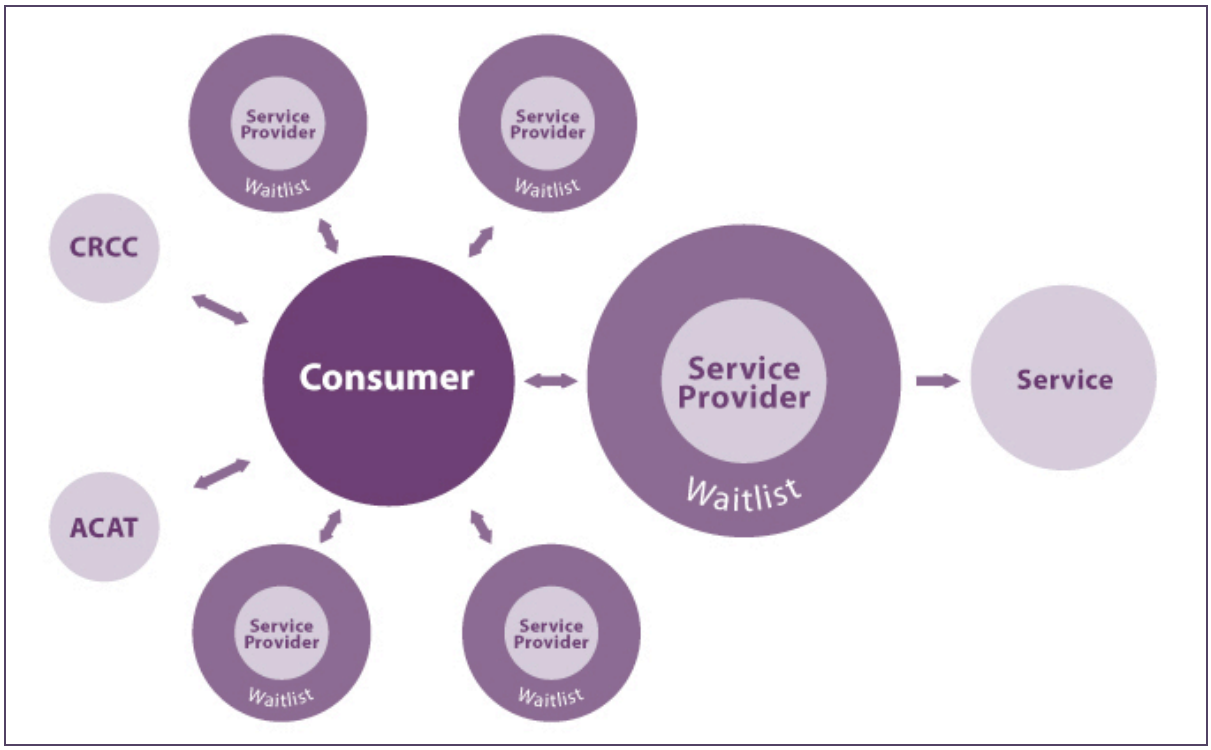
Item	Notes
Choice of Provider	Consumers would have real choice. They could choose their provider and change provider at any time.
Responsiveness to consumer demand	Providers would become much more responsive to consumer demand as they would need to be able to demonstrate a compelling service offering and very high levels of customer service. This would impact on everything from service offerings, to response times to phone calls and requests for services or changes to services.
New product and service offerings	Service model innovation would be stimulated across residential and community care.
Increased efficiency	There would be significant efficiency benefits for government and providers in reducing the need for large tender rounds. The system as a whole is also likely to become more efficient as it becomes focused on mandatory outcomes. Consumers would be more responsive to service models that helped restore their independence to the point they no longer needed service, as they would be confident they could access services again when they needed them.
Improved communication with the public	Providers would communicate their services more widely as they would be confident of being able to respond to the demand this generated.
Responsiveness to demand	The system would respond better to demand, which would eliminate the problem of vacant places in some regions while there are lengthy waitlists in others.
Reduced pressure on government for complaints management	Consumers would have more genuine choice and could change services if they were unhappy with service quality. Poor quality providers would not survive and would also be removed through accreditation processes. Service providers would understand that if they could not respond quickly and effectively to client complaints, the client and the funding attached to them would go elsewhere.

Finding the Right Service

Consumers are presently generally not well-informed about the aged care system (National Health and Hospitals Reform Commission, 2009; Henry, 2010). The system is complex and difficult to navigate.

The onus is on the consumer to find the right service. Information, assessment and referral services such as Commonwealth Respite and Carelink Centres (CRCCs) and ACATs in many regions generally provide consumers basic information and contact details of service providers. In an environment of limited supply this often leaves consumers having to call and follow-up several providers before they can find someone that can meet their need.

Figure 1 Current Consumer Experience



Various different solutions have been tried to address access issues. For HACC and disability services, some regions have created panels of service providers to divide funding amongst demand. For packaged care services, some ACATs have tested managing centralised waitlists. Access point trials (sometimes referred to as “one-stop shops”) using various models are presently occurring around the country. Anecdotal feedback indicates some of these are working better than others and we look forward to the evaluation of the access point trial projects. It is important to build upon the lessons learned from these trials and increase the scale and availability of these services.

All of these attempts to resolve these issues incur significant costs and will have limited success while supply is constrained.

Alternative Models

Structural reform of aged care is needed to create a sustainable solution to this issue. If supply constraints were reduced and funding attached to consumers, providers would be forced to communicate their services effectively, innovate, operate efficiently and ensure their services were simple to access.

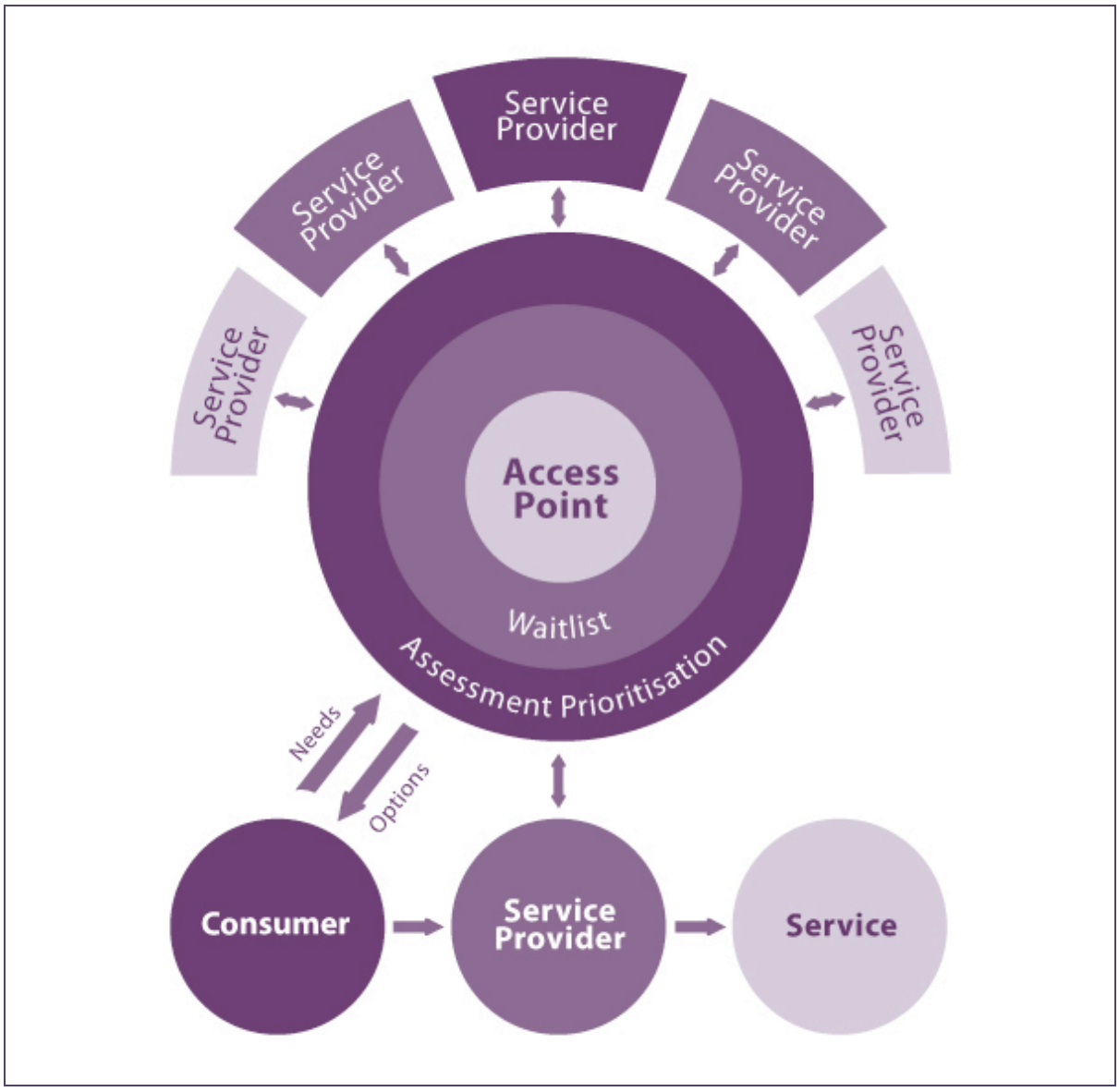
To illustrate this with an example: Under current arrangements, once a place is allocated to a provider, the provider attempts to fill the place in order to receive payment. In most regions the places are not difficult to fill as supply is limited. As a result providers have little need to promote their services outside of key industry referral points. If funding attached to the person, it would lead to more innovation and differentiation as providers sought to ensure their offering was more attractive to consumers than others' services. There would be more communication with the public and greater acknowledgement of government support.

Over time, as the model was implemented, this would reduce demand on industry Access Points as consumers would be better informed and be able to access the services they needed when they needed them. However, since the model would need to be implemented gradually and depends upon well-informed consumers, an interim solution is also important that provides more direct support to consumers.

A good interim solution would be to significantly strengthen key industry access points and to shift the onus of finding a suitable place for a client from the consumer to the access point. This would provide a mechanism for consumers to make one call and know they would be supported until they had succeeded in accessing the service they need. Access points could be funded on the basis of the outcomes they achieved in helping clients access the support they need in a similar model to employment services. An effective access point would:

- Assess the consumer's need
- Provide information about relevant services
- Present multiple options and discuss their merit
- Provide information about vacancies and waitlists
- Ask for consumer input and preferences
- Assist the consumer in accessing their preferred option until they had successfully accessed the service
- Follow-up to ensure the consumer was satisfied with the service outcome.

Figure 2 Proposed Service Model



Outcomes Focus

There has been a lack of attention to desired outcomes and measurement systems to assess how those outcomes are being achieved. Tentative moves in this direction have commenced in some states, but there remains significant progress to be made.

The current funding system is characterised by a greater focus on inputs than outcomes, particularly for lower-care services.

Alternative Model

Rather than regulated the service options, funding should be set based on a client's level of needs and service providers and clients should have flexibility to plan how the funds are allocated. Service providers should be accountable for the outcomes rather than the inputs.

This would open tremendous scope for innovation and being more responsive to client needs and preferences. Service providers should be required to demonstrate that their models are evidence-based and that outcomes are being achieved and evaluated.

One of the key challenges with this approach is deciding which outcomes to measure. This is inherently difficult as there are different expectations from different service types and at different stages of people's lives. This difficulty should not prevent starting down this path. The process could commence with some simple, high-level indicators such as:

- Carer stress
- Hospital admissions
- Falls
- Simplified quality of life measures

It would also be useful to measure the extent to which services are meeting the needs of special needs groups.

These measures could initially be used to start gathering and sharing industry data to encourage innovation from service providers. In the long-term, as experience was gained, some could be used to set minimum standards.

Integration with Health Services

Aged care services are an integral part of the broader health system. However, much of the aged care system has developed from welfare rather than health models. Relatively few aged care services have developed first out of a health background.

A health-oriented approach to community care involving multi-disciplinary teams can be very effective in preventing unnecessary functional decline, restoring function, promoting good health and facilitating early intervention.

There have been progressive steps towards greater integration between health and aged care and new programs such as transitional care and early discharge to help smooth the transition between hospital and community services. However, opportunities remain for much greater integration with HACC services in particular. HACC services are highly integrated with other Aged Care Services and have strong community networks. This would make greater integration with health services very valuable. However, the current funding and regulatory system does not provide the incentives for this to occur.

Older people access health services at a significantly higher rate than younger people (Australian Bureau of Statistics, 2004). Aged Care services have frequent contact with a large number of older people. The value of early intervention in preventing hospitalisations or reducing the severity and cost of hospital admissions is widely understood. There should be an expectation that aged care services are helping to facilitate early intervention. This has implications for the skills required in the aged care workforce and the cost of delivering services. The way HACC services are funded in many states can make it very difficult to have models of this kind delivered, as there is a greater focus on a narrow cost per hour of service than on cost per outcome or overall cost to the health and aged care system.

Aged care services are increasingly being engaged in early discharge and admission avoidance services. This recognises the important role these services can play and these programs should be extended.

Aged care services can play an important role in maintaining functional abilities or restoring function. Early discharge and transitional care programs in particular have focused on interventions of this kind. The current system of rationing services based on both need and allocated places to particular providers in each region acts as a constraint to this. For example:

- If restoring function means a person no longer needs a package and would have to transition to HACC services that have a waitlist and may require a different service provider, there is no incentive for the client, or a provider acting in the client's interests, to choose to do this.
- If restoring function means a client no longer needs services at all, but there is no guarantee they will be able to get back into services in the future as when they do need them there could be waitlists and they may need to choose a different provider, there is no incentive to choose this option.

It would clearly be an advantage to the system as a whole to invest a little more in restoring function and independence for older people and therefore reduce the ongoing need for service. Perversely, the current system of rationing and funding could actually increase demand for service and result in poorer client outcomes. Ie: the rationing stimulates demand – access a service as soon as you may have a need as you don't know how long it will take you to get a service; then once you have a service, don't let it go as you don't know how hard it will be to get back in.

Case Management

From a health point of view, GPs are expected to act as medical case managers. Where there is a need to coordinate between multiple health and aged care services, this can make sense, and many have been moving towards a more holistic view of their patients.

It would be beneficial to provide greater support to GP case managers for older clients living in the community. GPs generally have limited opportunity to observe clients functioning in their home environment. Very few do home visits, so they are forced to rely upon observations of their patient in a clinical setting and reports from family members, the client and other service providers. The quality of the GPs case management is dependent on the accuracy of reports from these sources.

Community care providers observe clients in their home environment on a regular basis. Better outcomes could be achieved if they were engaged formally in assisting GPs. For example, GPs could conduct a basic screen to identify needs associated with ageing and refer the patient to an Access Point for services or to a case manager[1] or community nurse associated with an aged care service for in-home observations, assessment and feedback. Community nurses could also be used to reduce visits to the GP's rooms for simple medication management, checking compliance with GP recommendations, and conducting routine observations. This could help manage GP workloads where GPs are already stretched. It would also be more cost-effective and attractive to patients. While there is some cost associated with travel for a nurse to visit patients in their home,

[1] This could be a case manager in a packaged care service or in a case management service such as Community Options or Individual Support Packages.

this is significantly lower than the cost of a community care organisation arranging transport and accompanying the patient to their appointment.

It would be helpful to better define where a GPs role ends. For example, in the same way a GP would go to a cardiac specialist for a heart-related medical need, it would be helpful to have an aged care case manager or community nurse who they could approach for information on community care and the needs of their patient in the community. Community nurses could support GPs with patients in the community in similar ways to a practice nurse in the GPs practice.

Case management for older people living in the community is generally done best in the home setting in the real context of family supports and the client's environment. Community care services generally are also in a good position to observe changes in a client's condition, needs, environment and supports. Greater engagement between these services and GPs could facilitate earlier intervention, better outcomes and lower costs to the health system. GPs and aged care case managers could also use community care services to help implement preventative strategies.

Measurement of Outcomes

The system needs to move towards an approach of mandating reporting of a limited number of outcomes and taking a more sophisticated approach to funding than purely measuring inputs. Even if the measures are imperfect it would make sense to start and then refine the indicators and expectations over time. This is particularly important in low-care services.

Alternative Models

A small number of key structural changes to the service system would facilitate much greater integration with health services:

- Assign funding in packages based on assessed need for current packaged care and basic care services. This would involve significant changes to the way HACC services in particular are funded and increased tiering of packaged care services.
- Ensure consumers are well-informed of what to expect from their services and the outcomes expected from services.
- Allow consumers to select their service provider.
- Provide funding for Registered Nurses to do health assessments ordered by a GP and provided to the GP either through Medicare or the Aged Care System.
- Allow registered nurses or community care case managers to assist GPs in case managing older people with complex needs in the community while keeping the GP informed about their patient.
- Increase integration of transitional care, early discharge and admission avoidance services with other community care services for older people (this presently occurs more effectively in some states than others).

Responsiveness to Diversity and Special Needs

As the Australian population is getting older, the older population is also becoming more diverse. There are significant emerging needs related to diversity.

It is important that special needs and service gaps are identified and addressed. Under existing models, gaps have been identified and prioritised. This has led to the development of targeted special needs group and a focus on some other important issues. Special needs recognised under the Aged Care Act include:

- People from an Aboriginal or Torres Strait Islander background
- People from a Culturally and Linguistically Diverse background
- People living in rural and remote areas
- People who are socially or financially disadvantaged
- Veterans
- Homelessness
- Care Leavers

Dementia is another important issues that has been given special policy attention.

There is an increasing population of people from a culturally and linguistically diverse background (CALD). In some regions of Sydney and Melbourne over 50% of people aged 70+ were born in a non-English speaking country. This will continue to increase.

In addition to growing in size, the CALD population is becoming more diverse. There are many small and emerging communities and emerging areas of unmet need in these communities.

CALD needs are presently met through a requirement that all providers respond to special needs groups and funding some places specifically for people from a CALD background. These initiatives have tended to be more effective for larger population groups than smaller and emerging communities. Funding specific CALD places has also proved inequitable (some CALD groups have much higher ratios of service access than others), and inflexible (the need in some CALD groups is actually declining but the number of places allocated to them remains static giving them disproportionate access to services). It is more effective to support multicultural approaches than places for individual cultural groups.

The Commonwealth Community Partner Program and Partners in Culturally Appropriate Care initiative have been very effective in analysing need and assisting providers in responding to the needs of other cultural groups. These initiatives should continue to be supported.

There is very significant unmet need in many Aboriginal communities. People from an Aboriginal and Torres Strait Islander background rarely access residential care and are also under-represented in community care. There are relatively few organisations that have the skills and capacity to provide complex aged care services in Aboriginal communities. Increased flexibility and incentives to address this enormous area of unmet need would result in a lot of service innovation around this need.

Sometimes people from an Aboriginal and Torres Strait Islander background need services delivered in a slightly different way with a different mix of services to meet their cultural and other needs and preferences. Many service types do not have sufficient flexibility for services to respond.

Funding services by region is also very problematic when Aboriginal communities spread across the boundaries of these regions. The community wants a consistent service offering for all their members, but often a service provider is only funded on one side of an arbitrary planning boundary

and not the other. This is very frustrating for Aboriginal and Torres Strait Islander communities and results in under-utilisation of services.

There are also other areas of special need. These include emerging needs and age related issues in regional areas, particularly some coastal communities; increasing care needs of veterans; and ongoing needs in rural and remote areas.

Alternative Models

Attaching funding to people would help resolve issues of service boundaries and ensure providers became more responsive to many niche groups. Some providers would choose to specialise in niche areas of need. For example, in major metropolitan areas with large concentrations of people from a CALD background some services would almost certainly specialise in responding to this need.

There would inevitably also be areas of unmet need. For example, it is very likely that needs of some small and emerging communities, rural and remote areas and Aboriginal communities would not be adequately serviced. These should be resolved through a combination of incentives and regulation. Those that are predictable should be planned for. Service providers should be required to accept clients who want their services and incentives should be provided to meet the most important areas of unmet need. Accreditation processes should ensure all service providers continue developing strategies to address the needs of special needs groups.

Addressing the needs of special needs groups is by definition complex. The needs of the consumer often extend significantly beyond what can be addressed simply by providing an aged care service. The needs of special needs groups need more holistic consideration, which will often require more formal cross-departmental involvement from government departments and service providers engaging across departments. For example, issues around older people who are homeless will generally require aged care, health services and housing services to work together to achieve a good outcome. It would be helpful to formalise relationships between these departments and to ensure service providers are better informed of how to engage with them.

Responsiveness to Individual Needs

There is some flexibility built into each aged care program. Packaged care services in particular can be tailored to individual needs by good providers. Basic care services such as HACC and Veterans' Home Care (VHC) often have very limited flexibility. This can sometimes mean that what a client really wants cannot be provided even if it could have been provided at no additional cost to the aged care system under more flexible program guidelines.

Alternative Model

Apply the principles of flexibility already in packaged care services to HACC and VHC services. A client would access the service with a value of funding attached based on their level of need. The provider and consumer could then more flexibly plan services around the lifestyle and preferences of the client so long as minimum standards and outcomes were being achieved.

Clients who want to pay for additional services to supplement the services that meet their assessed level of need should have improved flexibility to do so.

Continuity of Care

The Aged Care Act and Principles require providers to ensure consumers receive continuity of care. This tends to be viewed in a narrow sense of a provider ensuring that if the client's care needs change continuity is maintained until they can be assisted to access an alternative service.

Consumers view continuity much more broadly. Once consumers have established trust with a provider they would prefer to stay with that provider as their needs change unless they are in control of making a choice to switch provider. Continuity should also not only be considered within the aged care system, but between aged care and health services. Aged care should be seen as a key part of the health system.

In community care this is generally not possible. There are very few cases in which a single provider has the full spectrum of core community care services available (HACC-various types, VHC, Resite, CACP, EACH, EACH D, Community Nursing, Community Allied Health). When other community care services that link with the health system such as transitional care, early discharge and admission avoidance programs are considered this is even more limited. Even if the provider offers all those service types in some regions. The funding mechanism currently fragments funding and forces consumers to have multiple providers either at the same time or over time. Supply constraints can also force unnecessary changes of service provider.

Alternative Model

Supply constraints should be relieved and consumers given choice of provider. A useful interim step would be to take into account service footprints and assist services in offering a range of services in each region in which they operate through funding rounds.

Given choice and good information, consumers are best placed to determine what service model they prefer and services will respond to this demand.

Financing of Aged Care

Financing of accommodation, living expenses and care are presently handled differently depending on which aged care service a consumer accesses. Means tests are also applied differently across different service types. The financial incentives this creates can lead to consumers making decisions purely based on the financing system rather than their real preferences or selecting the most efficient option.

Hogan and Henry identify numerous examples of this. A person choosing to go into low-care residential accommodation pays a bond, but those in high care do not. Decisions people make about retaining or selling their family home impact significantly on their means tests. A person in a retirement village may not receive any subsidy for their accommodation while a person moving into residential aged care does have their accommodation subsidised.

Retirement Villages

The business model of some retirement villages gets the best financial outcome for the operator when clients turn over. This provides a perverse incentive not to encourage ageing in place and the delivery of packages of care in the villages (even though the villages have clusters of older people). Some of these retirement villages therefore tend to lead people towards residential aged care earlier than necessary.

Retirement village operators can exercise considerable control over access to community care in their villages through contract conditions and by acting as a filter for information to their residents. It is important that older people in retirement villages are made more aware of their rights and that

protections are put in place that require retirement village operators to allow community care to be delivered in the villages. Given retirement villages are developed with the specific intention of developing clusters of older people, retirement villages should have an obligation to provide information to their residents about the spectrum of aged care services available to them.

Retirement village models that do not depend on client turnover for their financial success should be encouraged.

Alternative Models

Hogan and Henry strongly recommend that financing of accommodation, living expenses and care be handled in a consistent manner across all aged care services to avoid perverse incentives to consumers that relate only to how the funding system works.

As a general principle, as argued by Henry:

- Accommodation should only be subsidised for people of limited means
- Living expenses should not be subsidised other than through existing means-tested income support mechanisms such as the pension
- Care should be subsidised, but the level of subsidy and application of consistent means testing needs consideration.

Henry argues that a distinction should be made between general care and health care services: That health care services should be free to all, while other general support services should be means tested. This needs careful evaluation. It can be difficult to distinguish between health and personal care services. For example, good hygiene is important in wound care and can help reduce UTIs. Support services generally, if targeted appropriately, can perform an important preventative and early intervention role. Inadequate general care can lead to a medical condition. Good social support can improve a person's health. It is also common for transitional care services and early discharge programs to be implemented after a medical event to support the health and recovery of an individual. All general aged care services actually have direct health cost implications. If consumers chose not to access general care services because of the cost due to a means test, this may perversely increase costs to the system as a whole. Therefore, careful modelling and studies should be done before introducing a means test to general care services for older people. It may be beneficial to consider all aged care services up to an individually assessed level of need to be health services, to ensure this benefit to the health system is retained. Services above the assessed level of need could then be means tested.

People should be able to make accommodation choices independent of concerns about their care. Funding needs to be structured in a manner that offers much more flexibility to the industry to develop new product offerings without needing to apply through special funding pools.

Structuring subsidies in this way and attaching them to consumers would open the door to much greater innovation in the delivery of both accommodation and care. Both Canada and Denmark have moved in this direction (ACIL Tasman, 2003). There are numerous models that are likely to be of interest to older people that are presently only being trialled in a very minimal way due to the nature of aged care funding in Australia.

For example:

- Danish model: Communities of older people in independent units with collocated nursing and care services. In some cases there is a mixed-use environment and social and retail services are available on the same site. Care is subsidised separately from accommodation (ACIL Tasman, 2003).
- Large housing clusters: building upon retirement village option but with more flexibility for clustering of care into the villages.
- Groups of older people in public housing with innovative care and support services by clustering services across several clients.
- Small housing clusters: a few residences co-located with some shared indoor and outdoor social spaces. Care able to be clustered into the housing.

There are many older people who are living in marginal accommodation or are homeless. Policy initiatives are needed to give the most disadvantaged better access to acceptable long-term accommodation. There needs to be better coordination of aged care services with state housing departments to ensure accommodation support is provided on the basis of need and that all older Australians have access to acceptable long-term accommodation.

Fragmentation of Funding

For most service types, providers are funded by number of places (or dollar value of funding for a particular volume of inputs) in specific geographic areas. This limits competition in any given area and along with supply constraints is a disincentive for providers to communicate about aged care services with the public. Fragmentation makes the system difficult to navigate for consumers and limits continuity of care as their needs change. A service provider may be funded for HACC Domestic Assistance and CACPs in a region; but may not be able to provide HACC Personal Care or Social Support, or continue to support a client as their care needs increase beyond what can be provided by a CACP.

Victoria is an exception to this for low-care services. In Victoria, the funding for HACC services has not been fragmented and has instead been concentrated with local councils. This model has been effective in making basic community care services simple to access for consumers. However, it does not encourage competition and innovation in service models.

Alternative Model

The current funding mechanisms have historically been used as a way of rationing service and ensuring 'equity' between regions. There are better ways to achieve both these objectives.

Access to services can be handled effectively at the point of assessing eligibility. Equity between regions is best measured by whether people can access the services they need and how long they may need to wait to access services rather by absolute ratios of places to numbers of older people. Equity in this sense would be assured if funding attached to consumers.

Removing supply constraints and encouraging competition between providers would solve the problem of service fragmentation. Well targeted incentives and regulation could ensure special needs were still met. Regulation should be simplified so the financial impact of choices around accommodation and care are similar across levels and types of care.

As an interim step, it would be beneficial to encourage service consolidation within existing funding arrangements.

Funding Model

Residential and packaged care services are funded on a very simple, outcomes based funding model. While it would make sense to get better at defining and measuring desired outcomes over time, this model generally works well. The biggest issue is not so much the general model as that it is applied differently across the different levels of residential care and community care.

In packaged care services organisations are paid for the number of clients they service up to a maximum of the number of places the provider has been allocated. Organisations are able to retain and reinvest surpluses. This provides incentives for innovation and efficiency.

Low-level community care services are funded on an inputs-based funding model with funds acquitted annually. While this meets the goal of accountability for funds and is simple to measure, it is generally not an efficient way to fund services and drives a focus on inputs at the lowest possible cost, rather than the desired outcomes. This is not efficient for the health and aged care systems as a whole.

As long as basic services are funded on an inputs model, many service providers will take a maintenance approach to service delivery as this achieves the lowest hourly cost of service delivery. It is important to recognise though that while this sounds like an efficient outcome, when viewed across the system as a whole and even specific aged care services it can create perverse outcomes. For example: a restorative approach involving more highly skilled staff and more intensive intervention for a short period is likely to be more expensive per hour even though over a year it is likely to service more clients at the same or less cost per client and achieve better outcomes. It is therefore harder to attract funding to a service model of this kind in many states even though it would be beneficial to the overall health system.

This issue can easily be extended, with even more significant implications to looking at costs across the system as a whole. Where aged care services are pushed to their lowest possible unit cost, they will not perform the important role they could in reducing costs to the health system as a whole. Aged care services should be expected to play a role in:

- Early intervention
- Referral
- Monitoring of compliance with health interventions
- Assisting with restorative or rehabilitative interventions
- Health promotion

This goal will only be achieved with a greater emphasis on outcomes rather than inputs and by allowing service providers to make decisions about reinvestment in services and to benefit from investments in efficiency gains. It is inefficient and detrimental to the service system for 100% of the investment in efficiency gains to accrue to the government and for service providers to be prevented from retaining any surpluses for discretionary investment in their services.

Alternative Model

The funding system would work better if there was more flexibility in services so service providers and consumers could tailor services to individual circumstances. There is reasonable flexibility in packaged care services, but very little in low care services. Integrating low-level care services into a similar model to packaged care would resolve this problem and stimulate innovation and investment in services.

Outcome measurement should be improved so that funding can be allocated to achieved a desired outcome rather than to provide an agreed amount of inputs. We recognise that this is challenging to implement due to the diversity of community care. However, if we start simple, but begin introducing simple universal outcome measures for community care we will develop a foundation to build on over the next 10 years.

Aged care services should be viewed as an integral part of the health system. In the medium term the additional benefit of early intervention and better health outcomes will more than offset the cost of more skilled staff and greater service planning required to achieve these outcomes.

Imbalance between residential and community care

As a result of historic funding ratios the government expends around $6.6 billion/year on residential aged care and around $2.9 billion/year on community care.

Community care is cheaper for the government (Grant Thornton, 2008) and there is a clear trend of consumer demand for community care in preference to low-level residential care (ACIL Tasman, 2003). Residential care is now roughly evenly split between low and high care places.

Alternative Model

Increasing demand for community care needs to be acknowledged through progressive adjustment of the ratios or giving providers greater flexibility to deliver care services for funded clients across accommodation types. Hogan (Hogan, 2004) suggested for example a 5 year period that allowed providers to incrementally convert some low-care residential places to community care places. A similar result could be achieved by maintaining places in their current accommodation settings but funding a much higher ratio of community care and high care places for several years.

Role of Government

It is currently common for government to be funder, regulator and provider. This can create a number of tensions with government as funder and competitor to commercial and non-profit providers; and government attempting to regulate itself.

Examples of this include: the NSW state government department that regulates HACC services also operates Home Care Service of NSW – the largest community care provider in NSW; the NSW state government operates some packaged care services; the NSW and ACT government operate community nursing services; local governments in Victoria operate HACC, some packaged care and some residential care services; and some local governments in WA operate HACC services and packaged care services.

There is a mixed market of non-profit and private sector organisations. The sector will be healthiest if this mix is encouraged. In general the sector is presently heavily skewed towards non-profit providers. In some regions less than 5% of community care places are delivered by private organisations. While there has been greater acceptance of private sector involvement in packaged care and residential care in recent years, there remains resistance to private sector involvement in HACC services in most states and territories and the funding models work against private sector involvement.

Alternative Model

It is widely acknowledged that the best outcomes are achieved when government acts as funder and regulator but not a provider. Government services should progressively be transferred to the non-profit and private sector to reduce the conflicts inherent in these arrangements, and to help the sector develop the scale it needs to attract high quality management, operate efficiently and invest in services.

This position may be arguable where the provider is a different government department or level of government than the funder and regulator as is sometimes argued in the case of local councils involved in HACC services. There may be a rational policy requirement to except some government services from this general approach, but this should be the exception rather than the rule. The transfer of HACC services in most states and territories to the Commonwealth is a good opportunity to evaluate these options.

Role of Families

Families and informal carers provide the bulk of aged care services in Australia. People can derive tremendous satisfaction by engaging with their loved ones in this way. However, without access to appropriate support when they need it, their caring role can become a source of stress and frustration.

Aged care services should complement the important role of families and support primary carers. Respite services are presently extremely fragmented. As a result the experience of carers of the aged care system is quite varied.

Alternative Model

Respite funding needs to be streamlined and simplified. Respite services can currently be provided through various initiatives of the NRCP program, packaged care, HACC services, VHC services and often other state-based health services and family support services.

A national program of respite services would be ideal. Funding should attach to the carer on the basis of their level of need. Service providers should then have the flexibility to plan services around the carers preferences so long as minimum standards and outcomes were achieved. Costs could be controlled by carefully setting eligibility criteria and means testing funding attached to carers.

Regulation

The aged care sector as a whole is presently highly regulated. Combined with the funding models for many service types this can act as a disincentive for investment and innovation.

Alternative Models

Recent government reports advocate a shift in the focus of regulation for Aged Care (National Health and Hospitals Reform Commission, 2009; Henry, 2010). We support these recommendations. Aged Care services are a part of the health system and an essential service. Well-targeted regulation is therefore important to ensure there is equitable access to services and that services are of an appropriate quality. The balance of regulation should shift towards access and quality rather than supply and price, with appropriate protections in place for disadvantaged groups.

There should be a combination of regulation and incentives around expected service gaps. If government reduces its role as service provider of last resort (where it presently plays that role) it will be necessary to ensure that all people needing services can still access those services. There are many programs and regions that government does not act as provider of last resort. Models from these regions for guaranteeing service access could be adopted.

An accreditation system should be introduced for community care as supply constraints are relaxed. A combination of good quality accreditation and the ability for consumers to easily switch providers would significantly reduce the need for government complaints handling. The accreditation system should be tiered with incentives to reach the highest levels of accreditation (for example reduced reporting requirements and longer periods until reaccreditation).

Workforce Sustainability

Over the next 20 years the number of older people requiring care is expected to double while the primary demographic of the current workforce will remain static. This will occur over a period that many other industries are also seeking staff and that the availability of informal carers is expected to decline.

The Award Modernisation process and recent pay rises have introduced new and challenging dynamics to this process. It is bringing better pay and conditions to employees in the industry which will help make the industry more attractive to staff. However, it has increased costs for community care providers by up to 10-15%. This is in stark contrast to indexation of around 1.7% in an industry already under strain from years of indexation not keeping pace with costs. Wages are the major input cost of community care. An increase of this size, this quickly, is impossible for organisations to absorb and will inevitably result in reduced services and further financial strain on providers. It is crucial that this issue is urgently addressed with realistic indexation that reflects movements in wage costs.

Proposed Solutions

Aged care needs to be made a more attractive environment for personnel. Community care is intrinsically appealing to many people. However, the inconsistency of the work leads many people away from the industry. People generally can't get a mortgage while working in community care. The industry needs to apply technology and improved workforce models to overcome these challenges and make community care attractive to a wider cross-section of people.

Sub-optimal scheduling means that in many organisations personnel are less than 50% utilised. Ie: many personnel want more work than they are getting. There are further inefficiencies in the system as a result of unnecessary travel between clients. The smaller the scale of a provider and the greater the geographic area they cover, the more time staff spend travelling between clients and the less they spend face to face with their clients.

If we assume a halving of the workforce ratio over the next 20 years, a significant portion of this could be offset for many organisations through scheduling optimisation and industry consolidation. It will be important for organisations to be able to achieve significant scale to attract the quality of management and scale of investment required to achieve this outcome.

Service Management

There are over 3,000 community care providers in Australia. This spreads management resources thinly across the industry. As funding continues to tighten economies of scale will also become increasingly important.

Proposed Solutions

It is important to develop policy settings that make consolidation and partnerships simple for organisations wishing to combine resources. Consolidation will lead to improved management capacity; increased investment in technology, better workforce utilisation and management efficiency. It will reduce the duplication of management teams and infrastructure investment that is currently deeply embedded across the industry.

Increased management capacity would be a real boost to the sector and would encourage further innovation in client experiences, IP development, personnel management and supporting infrastucture.

Technology

Community care organisations have generally been slow adopters of technology in comparison to other industries. Most organisations do now use client management and reporting systems but have not adopted technology as a key strategic initiative to drive efficiency. Technology is changing at a rapid rate. New opportunities are constantly emerging to improve management processes and enhance client care. However, while the industry remains very fragmented and the funding system has disincentives for investment, community care is likely to continue lagging other industries.

Proposed Solutions

In the short-term it would be helpful to fund technology adoption in community care in a similar way to what was done in residential care. In the longer term policy settings should encourage consolidation and organisations should develop sufficient scale to be able to maintain an investment program.

KinCare is presently working on innovative technology solutions in workforce management and scheduling, telephones, assessment and care planning, and service delivery systems. As demand increases and more flexibility in services is required it is critical that service providers implement flexible and scaleable systems. Government policy and funding should stimulate industry investment and decision-making rather than attempting to develop technology solutions.

Contact Details

For further information please contact:

Therese Adami

General Manager

Email: therese.adami@kincare.com.au

Phone: 1300 733 510

Jason Howie

CEO

Email: jason.howie@kincare.com.au

Phone: 1300 733 510

Helen Wilson

National Manager Coordinated Care Programs

Email: helen.wilson@kincare.com.au

Phone: 1300 733 510

VISIT OUR WEBSITE: http://www.kincare.com.au

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