



Community Care Programs: "The Future"

Discussion Paper 1

Prepared by

National Community Care Advisory Committee

August 2001

Aged and Community Services Australia

Aged and Community Services Australia (ACSA) is the national peak body for not-for-profit church, charitable and community providers of aged and community care services. ACSA's 1400 member organisations provide residential and community care services to over 200,000 older people throughout Australia.

A national Community Care Advisory Committee has been established in response to ACSA's growing representative role for the community care sector. Each State has a representative on the Committee:

- Paul Sadler (Chairperson), Chief Executive Officer, Aged & Community Services Association of NSW & ACT
- Peta Braendler, Community Services Policy Officer, Aged & Community Services SA & NT
- Richard Sadek, Board Member, Aged & Community Services Tasmania
- Peter Lorraine, Board Member, Aged & Community Services Western Australia
- Anne Livingstone, Community Care, Aged Care Queensland
- Sharon D'Rosario, Membership Relations Manager, Victorian Association of Health & Extended Care (VAHEC)
- Pat Sparrow (Executive Officer), Policy Manager, Aged & Community Services Australia

The Committee will identify and provide advice on addressing community care issues; and develop national policy positions on community care issues. Priority will be given to developing positions on the following issues:

- Community Care Program Reform
- Funding
- Respite care (availability, funding)
- Planning
- HACC Targeting
- Workforce Issues
- Quality Assurance
- Rural issues
- Ageing People with Disabilities
- Co-ordinated Care Trials
- GP's Case Management Role
- Palliative Care
- Rehabilitation
- Integrated Care Models (including MPS and RHS)

Contents

Background	3
Purpose of this Paper	3
Defining Community Care	3
The Scope of this Paper.....	4
The History of Community Care	5
Difficulties with Current Programs	7
Community Care Program Reform.....	8
Options for Community Care Programs in the Future.....	9
Option 1.....	10
Option 2.....	10
Option 3.....	14
Option 4.....	15
Option 5.....	16
Issues to Resolve.....	17
A Way Forward	18
Appendix 1	19
Appendix 2.....	20

Background

The community care sector in Australia is growing in importance and scope. According to the Productivity Commission, Commonwealth and State/Territory Government expenditure on community care services exceeded \$1.1 billion in 1999/2000.¹

There are many reasons for this growth, including:

- the preference of people in need of care to receive a range of supports in their own home;
- support from all levels of government for family carers; and
- government policies to restrict access to residential care in both the disability services and aged care arenas.

Community care is delivered in an increasingly complex environment. As community care has grown, so have the number of separate government programs funding the sector. The needs and expectations of clients and their carers have increased, as has the demand for services.

Purpose of this paper

As the key representative body for the aged and community care industry, ACSA is aware of the issues this complex environment creates on the ground for consumers of these services and the difficulties it presents for service providers.

This paper is designed to generate debate about how to streamline the community care system in Australia. The ideas do not represent a final policy position of Aged and Community Services Australia (ACSA) or its member State Associations.

Other discussion papers may be released following the consultation process on this paper.

Defining Community Care

Community care is a term used to describe a diverse range of services provided to a diverse range of people. The common ground is the provision of support to people who require it to remain successfully living in their own home and community.

People who use this range of services may be older people, younger people with disabilities, carers, people with a mental illness, people with acquired brain injury, people with chronic illness, and people with dementia.

Many of the recipients, including homeless people, people from culturally and linguistically diverse backgrounds and indigenous people have special needs that must be recognised in the delivery of services.

The people using services live in a wide range of different circumstances and locations. They may live in a metropolitan city or suburb, a regional farming

¹ Productivity Commission, *Report on Government Services 2001*, January 2001.

community, a regional city, a remote community or a mining town. Their location may influence the types of services and supports required to enable them to stay at home.

People may be living on their own or with a carer. They may require care for a short period only (eg on leaving hospital), for extended periods or for life.

The services community care encompasses include those funded by the Home and Community Care (HACC) Program, home/district nursing, Community Aged Care Packages (CACPs), Community Options Program² (COPs), Carer Resource Centres, respite care, Hospital in the Home, palliative care, rehabilitation, allied health, disability support services, specific disability services (eg MS Society), community health centres and active ageing programs. The services are predominantly provided in people's own homes or in a community centre.

People may need to use a combination of the above services and at other times they may need to access facility-based care services such as a hospital or residential care (eg for respite care).

General Practitioners (GPs) can often be a prime link in attending to people's health needs and referring people to services available to offer support. GPs are often involved when an individual needs to move from a community setting to either a residential care or hospital.

Many different types of organisation provide community care. Some providers are very large, with multi-million dollar budgets providing a mix of services. There are also small providers who have much smaller budgets (under \$100,000) and provide only one type of support such as community transport.

The links between all of these services are extremely important to ensure each individual is able to access appropriate support as they need it. Clients should be able to move between services with confidence and ease.

Unfortunately, these links do not always work as well as they should. In some cases links are poor because of structural or funding issues.

The Scope of this Paper

This paper primarily focuses on the services provided through government-funded programs that people may require as a result of their ageing or disability.

For the purposes of this paper community care is then defined as:

² COPs are referred to as Linkages in Victoria

“the provision of services and support which enable older people, younger people³ with disabilities, people with chronic illness and their carers, to continue to live in their own home and community.”

However, consideration is given to the interface of community aged care and disability services programs with the full range of services required to meet individual client needs.

Future design of, and funding for, community care services needs to give a stronger emphasis to the importance of the inter-relationships between these services.

The History of Community Care

Community care has been provided in some shape or form for more than a century. The first community care services were the home (or district) nursing services, which commenced at the end of the 1800s. Domestic assistance or home help services tended to emerge later. For example, the Home Care Service of NSW (Australia's largest community care service) commenced in the 1940s.

The 1950s and 1960s saw expansion of both professional and volunteer community services for older people. The first Meals on Wheels services started and hospital-based, community-focussed geriatric services commenced.

Home and Community Care Program

As the number of services grew, so did the number of separate funding arrangements. The Commonwealth *Home and Community Care Act 1985* consolidated four community care funding streams into a single program. Responsibility for the HACC Program was shared between the Commonwealth and State/Territory Governments, with the Commonwealth providing on average 60% of the funding.

The HACC Program was part of the Commonwealth's 1980s aged care reforms, aiming to expand community care and reduce access to, and expenditure on, nursing homes. Under HACC, the range of community care programs was expanded significantly.

New service types, such as community transport, community options (COPs) home modifications and respite care, were introduced. National HACC expenditure increased from \$154m in 1984/85 to a budgeted \$945m in 2000/01.

Over 4000 separate HACC services are now provided nationally, up from about 2300 at the commencement of the program.

Local Governments around Australia provide and fund many HACC services. This ranges from a quite substantial financial contribution in Victoria to relatively smaller levels of financial support in both New South Wales and South Australia.

³ Younger people refers to people less than 65 years of age.

Residential Care Trends

During the 1990s, the Commonwealth Government began to develop a range of new programs for community care. The first (and currently largest of the newer programs) was Community Aged Care Packages. CACPs were designed to provide low-level care in an older person's own home. The current Federal Government has significantly expanded CACPs, with 24,400 packages now funded. A pilot of higher level care at home – Extended Aged Care in the Home (EACH) – is nearing completion.

These care packages have evolved from residential care. It is likely that this blurring of community and residential care will continue as models of care are designed to meet consumers needs.

Commonwealth Only Funded Programs

Other Commonwealth-only programs have also been developed, including the National Respite for Carers (NRC) Program (incorporating Carers Respite Centres), Carelink and Assistance with Care and Housing for the Aged (ACHA).

Recently, some State and Territory Governments have commenced their own community care funding programs, particularly targeting carers.

Private Service Provision

The last few decades has seen the emergence of private sector services delivering community care. In some instances private organisations have been contracted to provide services on behalf of other organisations (eg local government HACC services). Individual consumers may chose to purchase all, or additional, support services from this source. The strength of this growing sector is demonstrated by the 1998 ABS *Disability, Ageing & Carers Survey* which shows that approx 65% of all people receiving assistance from formal providers do so from private (profit making) organisations. This study also shows that people tend to use private services in combination with others – 47% also used Government services while 13% also used the services of not-for-profit organisations.

Services & Funding

The complexity, and relative scope, of the existing programs is illustrated by the table of community care programs in Australia in Appendix 1.

Appendix 1 also highlights the different levels of expenditure on community care in various States and Territories.

Commonwealth and State government expenditure on HACC and NRC Programs per person (ie per person with a profound, severe or moderate handicap) varies between States. The Productivity Commission reports that in 1999-2000 it was highest in Victoria (\$670.20) and lowest in Queensland (\$456.87).⁴

⁴ Productivity Commission, *Report on Government Services 2001*, January 2001.

Most community care programs charge their clients a fee for service. The fee is often quite minimal. The HACC Program formally recognises income raised by fees in the funding arrangements between the Commonwealth and State Governments. At this stage there is no accurate data on the amount of revenue generated through fees.

Difficulties with Current Programs

This history outlines the type of services and support that are available now to older people, younger people with disabilities and their carers. It highlights the major developments, particularly during the 1990s, in creating new programs and funding streams as awareness of these needs grew.

The fact that a range of programs, funded by different levels of Government, have been created to support older people, younger people with disabilities and their carers may not be a problem in itself. In some ways it can be positive as it creates diversity of services and models of delivery that can enhance quality and availability for consumers as well as providing multiple funding sources for providers.

This can be contrasted with the experience of the residential aged care sector which is funded and administered by one level of government – the Commonwealth – and yet still experiences as many funding, regulatory and availability issues as community care.

The current system does however create a range of problems that can be summarised in four ways:

Lack of Coordination

- Confusion for providers, referrers & clients – resulting in separate programs such as Carelink to coordinate the uncoordinated programs!
- Poor integration between services – leading to difficulty in accessing information and navigating the system
- Inconsistent program requirements – e.g. for accountability, quality assurance and eligibility

Inflexible Program Rules and Boundaries

- Conflicting program boundaries – leading to both duplication and its opposite, service gaps into which some people fall
- Rigid conditions within individual programs eg specifying what is spent on specific types of services, for example within COPs services, rather than enabling services to be provided to meet client needs

Commonwealth / State rivalry

- Delays in approval of new funding
- Duplication of effort between Commonwealth and State Departments

Uncoordinated planning of new services

- Different planning cycles and processes, eg HACCC and CACPs.

These problems are not new and have been recognised before. A number of solutions have been proposed in the past and some of these are outlined in Appendix 2.

C Community Care Program Reform

Undoubtedly we need a national debate on the future of community care. It is clear that the service system must be reformed to ensure ongoing access to high quality services while streamlining program and funding arrangements for providers.

It is important that reform of programs only occur if it will improve the effectiveness and efficiency of service provision and quality of life for older people, younger people with disabilities, people with chronic illness and their carers.

The outcomes sought from any community care program reform are:

For Clients & Carers:

- Ability to access different care as needed with ease and confidence
- Improved quality of care
- National standards of care
- Increased independence and control over their own life
- Access to services in their local communities.
- Availability of culturally appropriate care services.

For the Service System:

- A simple, streamlined system able to flexibly meet the needs of older people requiring assistance.
- Simplified administrative and financial management of community care programs
- Improved co-ordination and continuity of care between interlinked programs of health, residential and community aged care, housing and disability services.
- Inclusion of health promotion and prevention strategies in service delivery.
- Improved management of clients' transition between services (including acute hospitals, residential care and community care).
- Incentives for a focus on rehabilitation and increasing independence
- Appropriate targeting and monitoring policies are in place to ensure that clients receive, and continue to receive, the most appropriate type of care.

For Governments:

- System management and cost efficiencies that will ensure the maximum benefit from public funds for services for people in need.
- Clarified and redefined Commonwealth / State relationships.

The reform options developed by ACSA must be able to support the achievement of these outcomes to be advanced as viable alternatives to the current system.

Options for Community Care Programs in the Future.

There are two ways to consider reform of the community care system in Australia.

One way is to critically analyse the services and programs available and undertake scenario planning and market research to establish the needs of the target groups into the future. This would potentially result in a different range of services being provided.

Another option, and the one taken in this paper, is to assume that the current mix of services and programs will be relevant for some time to come and will enable different models of service delivery to meet consumer needs.

To commence thinking and discussion on possible reform options, different models for management and funding of community care programs are presented as well as models which illustrate how programs could or should operate on the ground:

- Option 1 Administrative Streamlining (No Structural Change)
- Option 2 A, B, C Role Clarity based on Clients and their Needs
- Option 3 Client Purchaser
- Option 4 Community of Interest
- Option 5 Your Option

The models are not mutually exclusive as Models 1 and 2 A, B and C focus on the “behind the scenes” administration and arrangements while Models 3 and 4 concentrate on how the services look and are delivered on the ground.

These models should really be viewed as an entrée to reform – they do not represent all of the possible reform options or even a best or preferred option. It is hoped that through deliberation and discussion a preferred model or models for reform will evolve – bearing the hallmarks of industry’s collective expertise and experience.

It should also be noted that given the diversity of the field, our clients and Australia’s geography it may be that different models are required for different areas.

The reform we are striving to achieve is one that ensures a system that is flexible and does not administer a “one-size-fits-all” philosophy and approach.

All options should be viewed in the context of the broader service system and the need for inter-relationships between the full range of services available.

Option 1 - Administrative Streamlining (No Structural Change)

In this option all of the current programs remain in place and continue to be funded by the Commonwealth and State Governments. The difference will be the development of common data sets, reporting arrangements and quality assurance programs. A precursor for these developments is agreement to aligned eligibility criteria.

This streamlining will ease the administrative burden of service delivery and should direct more resources into direct care. Administrative streamlining should improve service co-ordination for clients.

Examples of reforms required to achieve the outcomes set out above include:

- Agreed assessment processes, targeting strategies and eligibility criteria.
- A single set of community care standards and agreed quality assurance processes.
- Consistent and coordinated planning processes and common planning parameters across diverse programs.
- Streamlined reporting requirements
 - Data collection
 - Accountability

Option 2 - Role Clarity based on Clients and their Needs

Three variations of administrative/management reform options have been devised. In each option community care services are divided into three categories according to the intensity of the clients needs – exceptional care, intermediate care and basic care - and the corresponding level of service provision. The client needs levels broadly follow the categories developed in the Howe/Gray study (see Appendix 2).

Option 2A

Care Levels	Responsibility/Roles
--------------------	-----------------------------

Exceptional Care Intermediate Care	Aged Care: Commonwealth Aged Care: Commonwealth	Disability Services: State Disability Services: State
Basic Care	HACC Program arrangements	

Description

- Integration between residential and community care levels of funding for more complex clients. This would involve packaging of services for both Intermediate Care and Exceptional Care clients at equivalent levels to that available in residential care settings. Nursing services would need to be included for Intermediate Care level.
- Commonwealth runs high-level services for aged care; States for disability services.
- HACC Program retained, with streamlined joint Commonwealth/State arrangements, but targeted explicitly to low-level services for both older and younger people.

Benefits

- Minimal impact on lower-level HACC & CACP services, maintaining commitment of volunteers to basic HACC services
- Consistency in residential and community care
- Allows partial integration with health, disability.

Major impacts

- HACC Program capped.
- Community Options and other high-level HACC and NRC services disaggregated at a funding level into disability and aged care streams.
- Basic level to intermediate level boundary requires careful management to avoid cost shifting and negative client outcomes.

Option 2B

Care Levels	Responsibility/Roles		

Exceptional Care	Residential aged care: Commonwealth	Residential disability services: State	Community aged and disability services: State
Intermediate Care	Residential aged care: Commonwealth	Residential disability services: State	Community aged and disability services: State
Basic Care	Residential aged care: Commonwealth	Residential disability services: State	Community aged and disability services: State

Description

- All community care programs transferred to States.
- Commonwealth continues to run residential care services for aged care; States for disability services.

Benefits

- Minimal impact on HACC services.
- Allows State-level integration with health, housing etc for community care.

Major impacts

- Capping for community care at State level with probability of inequities between States over time.
- Commonwealth community care programs transferred to State.
- May be inconsistency between residential and community care.
- Cost shifting between aged care and acute health sectors may occur.
- Cost shifting between residential aged care and community aged care may occur.

Option 2C

Care Levels	Responsibility/Roles		

Exceptional Care	Aged care: Commonwealth	Disability services: State	Nursing/allied Health: State
Intermediate Care	Aged care: Commonwealth	Disability services: State	Nursing/allied Health: State
Basic Care	Aged care: Commonwealth	Disability services: State	Nursing/allied Health: State

Description

Three-way split, with all services to older people going to Commonwealth; all services to people with a disability going to States; nursing and allied health funding from current HACC Program to State health programs.

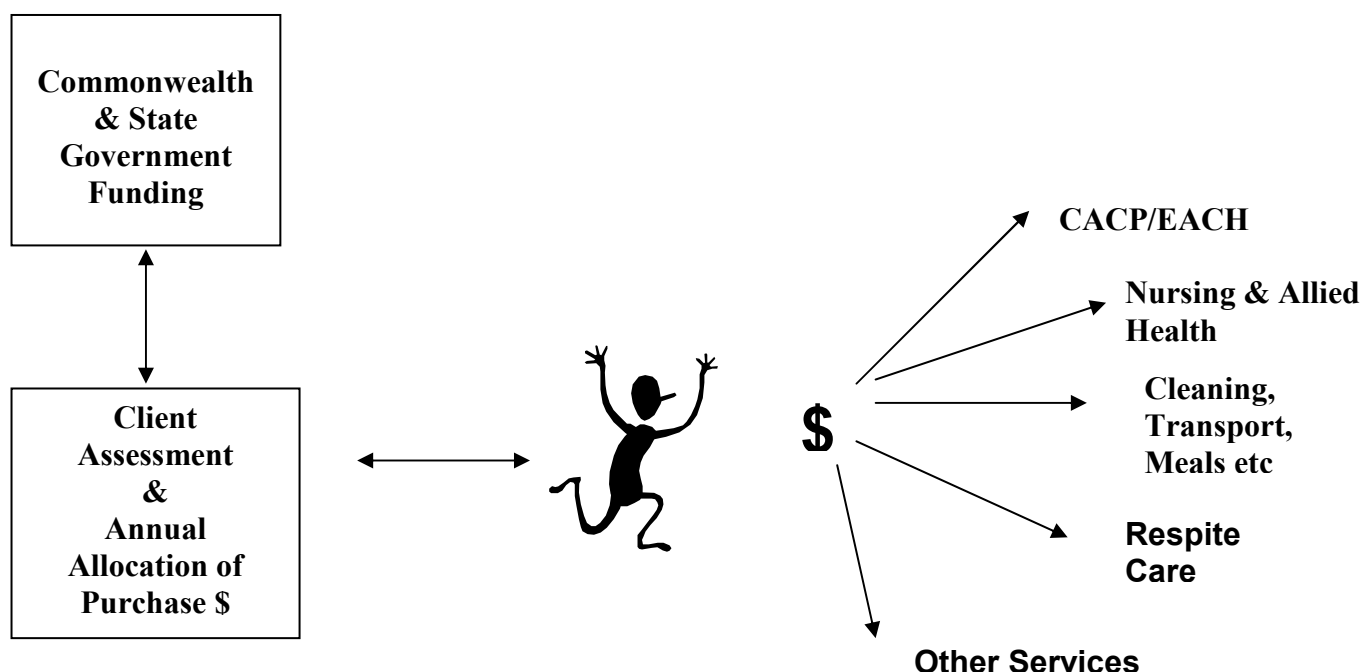
Benefits

Allows integration with health, disability, and residential aged care.

Major impacts

- HACC & NRC Programs split three ways
- More complex system for basic services
- May be more difficult to package services.

Option 3 - Client Purchaser



Description

Commonwealth & State Government funding for community care services are pooled and managed by one source. Client needs are assessed independently and support needs are determined. Clients are then given an annual allocation of funding with which they can purchase their own support directly from service providers. Clients may elect to appoint a broker (either an individual or a service) to purchase support on their behalf. One variation to this model would be to restrict direct client purchasing to exceptional care level clients (ie the model would operate with one or more of the other options).

Benefits

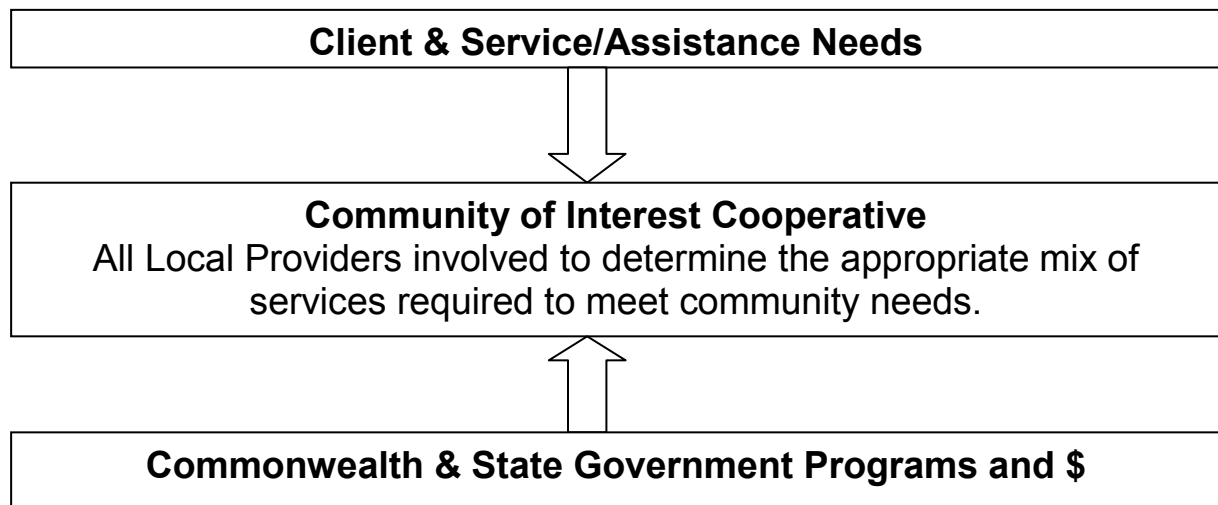
The client is in complete control of the services they use. Clients can choose their provider and mode of delivery. Their choice of service may be limited depending upon where they live, the needs they have and services availability. Market forces encourage the service system to respond to consumer demand.

Major impacts

- Service providers have to operate in a competitive way to attract clients.
- Government funding programs to providers do not exist. Regulation of services will be required.
- Requires the establishment of centralised assessment functions in local/regional areas.
- GST implications for clients and services under current GST legislation⁵
- Service infrastructure weakened (but this is ameliorated if client purchase is limited to those with exceptional care needs)

⁵ The GST free status of many current community care services is determined by the fact that they are directly government-funded.

Option 4 - Community of Interest



Description

Commonwealth and State Government funding for community care services are pooled and managed by one source – the Community of Interest Cooperative. This group of local organisations provides the full range of services and is able to determine the mix and amount required to meet the client needs.

The Cooperative will cover a defined geographic area or population. In some cases this may be a planning region but in some areas this would be too large and a smaller geographic area would be determined. The area determined should reflect a natural community of interest. The model could apply to services for a defined population, such as an Aboriginal community.

Benefits

- The local knowledge of service providers is utilised in determining the mix of services
- There is improved integration of services and planning locally.
- Clients only have one point of contact, but a range of discrete organisations cooperate to deliver services.

Major Impacts

- Service providers have to agree on assessment and service needs of individuals
- Funding programs still exist
- Easier to implement in rural areas/discrete communities.

Option 5 – Your Option

After reviewing the proposed options and considering all of the issues you may have your own option for community care reform. Record your thoughts here and remember to provide this as feedback on the paper so it can be taken into account in developing the industry's preferred approach.

Issues to Resolve

There will be difficult issues for any model, or combination of models, to resolve. These include:

Defining Community Care

- Role, function and focus is not always clear in the plethora of programs
- Mixed views about the place of preventative programs and targeted programs with specific eligibility criteria
- Need to resolve status of rehabilitation, palliative care and post acute care ('no growth' services under HACC)

Levels of government

- Who funds? At the moment, both Federal and State/Territory Governments provide funding, although the majority comes from the Federal Government. Local government also provides some funding in some places.
- Who administers? Will there be shared responsibility, as for HACC? With the GST revenue meant to be flowing to the States, perhaps there may be an argument for responsibility to transfer to the States in the future?
- Who monitors? At the individual service provider level? At the system level?
- Who provides? Is there a conflict of interest for States and local government if they are also funders or administrators?

What balance will there be between integration and disaggregation?

- Health / community care
- Residential / community care
- Disability services / aged care
- Rehabilitation & Sub Acute services/community care/acute care
- Housing and accommodation programs / care delivery programs
- Status of integrated health services such as Multi-Purpose Services

Capping levels of care

- Decisions will have to be taken about capping the amount of service that can be provided to individuals.
- A common assessment and resource allocation system will be required.

Dealing with clients at the boundaries

- Younger people with dementia
- Ageing people with longstanding disabilities

Culturally appropriate, integrated services

- Aboriginal & Torres Strait Islanders

Viability

- small services
- rural and remote services

A Way Forward

ACSA will be consulting broadly to achieve an industry view on the scope and model/s for community care program reform.

What's needed now?

- further consideration/identification of possible options;
- finding consensus on the need, benefit and directions of reform (if possible) among industry and consumer groups;
- commitment by Federal political parties to review community care programs; and
- involvement of State/Territory Governments.

Once such a view is reached ACSA will lobby Commonwealth and State Governments to implement the proposed solution and create an efficient, effective and flexible community care service system that delivers high quality care for all Australians who need it.

Acknowledgment:

This paper is based on a presentation by Paul Sadler, CEO, Aged & Community Services Association of NSW & ACT at the Annual ASA Community Care Conference, Sydney in March 2001.

Appendix 1

Community Care Programs in Australia 1999/2000 (\$m)

Government expenditure on Community Care, \$m, 1999-00

	<i>NSW</i>	<i>Vic</i>	<i>Qld</i>	<i>WA</i>	<i>SA</i>	<i>Tas</i>	<i>ACT</i>	<i>NT</i>	<i>Aust</i>
Community Aged Care Packages	51	38	26	12	13	5	3	2	150
Home and Community Care	271	248	148	84	75	24	12	4	866
National Respite for Carers	15	10	7	4	4	2	1	1	44
Total	337	296	181	100	92	31	16	7	1060

An additional \$218m (approx) was spent on other aged and community care programs such as assessment, Day Therapy Centres, capital. This is not available on a State by State basis.

Additional money is expended on other State and Local Government programs and these funds are not included in this table.

DVA funding is additional to that listed here and is estimated as \$147 million in a full financial year.

Appendix 2

Proposed Solutions to Community Care System Issues

HACC Efficiency & Effectiveness Review (1995)⁶

- This was effectively the Government response to the earlier Morris Review
- Joint Commonwealth/State/Territory administrators review of the HACC Program.
- Proposed (as an option) a three-way split of HACC:
 - Post acute care – Health
 - Disability services – State
 - Aged care – Commonwealth.

Council of Australian Governments – COAG (1995-6)⁷

- Proposed broader integration of health and community care services, including transfer of responsibility for aged care to the States.
- Foundered on the inability of governments to agree on taxation arrangements – the so-called vertical fiscal imbalance.
- Only major outcome was a series of Coordinated Care Trials.

HACC Targeting Study (1999)⁸

- Undertaken by Dr Anna Howe & Prof Len Gray on behalf of the national HACC Program.
- HACC Officials recently approved the model proposed in principle.
- Proposed a three-tier model of service delivery:
 - HACC Exceptional - 5% of clients
 - HACC Plus - 15-20% of clients
 - HACC Basic - 80% of clients
- Adopted by the Department of Veterans Affairs for the new Veterans Home Care Program.

McCallum model (2000)⁹

- Promoted recently by Prof John McCallum based on international models.
- Assumes separation of funding for accommodation and care.
- Assumes alignment of residential care and community care funding levels.

⁶ Department of Health, Housing & Community Services, *Efficiency and Effectiveness Review of the Home and Community Care Program*, 1995.

⁷ Council of Australian Governments, *Communique*, 14 June 1996.

⁸ Department of Health & Aged Care, *Targeting in the Home and Community Care Program*, 1999.

⁹ J. McCallum, 2020 Foresight, *Agendas*, Issue 18, Winter 2001.