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The Future of Community Care

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Report to the Community Care Coalition

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Glossary

Active service model	A model of care that focuses on maximising a client's independence.
Aged Care Assessment Team (ACAT)	ACATs help older people and their carers work out what kind of care will best meet their needs when they are no longer able to manage at home without assistance. An ACAT assessment is required to receive CACP or EACH services.
Aged care planning regions	Regional boundaries within Australia for the purpose of planning aged care services.
Aids and equipment program	Provides subsidised aids, equipment and home modifications to people who have been assessed as needing assistance to continue living safely and independently in their own home for as long as possible. The program may also assist families and carers.
Carelink Centres	Australian Government funded and managed information centres for older people, people with disabilities and those who provide care and services. Centres provide free and confidential information on community aged care, disability and other support services available locally, interstate or anywhere within Australia.
Certificate III aged care	The minimum qualification required for a community care worker.
Community Aged Care Packages (CACPs)	Community care services provided at the recipient's home that substitute for a low care residential place.
Community Care Coalition	A coalition representing the interests of service providers, clients (younger and older Australians with disabilities), as well as unpaid carers who provide much of the care for those needing it.
Dementia	A broad term used to describe memory loss along with changes to thinking ability, social skills and emotional responses. It is caused by deterioration in several areas of the brain. A person with dementia may find it harder to do previously familiar tasks, such as writing, reading, showering and using numbers. The most common type of dementia is Alzheimer's disease.
Domestic assistance	A community care service provided to clients, including home cleaning and maintenance tasks and meal preparation.
Extended Aged Care at Home (EACH)	Community care services provided at the recipient's home that substitute for a high care residential place.
Home and Community Care (HACC)	Community care services for older people, younger people with a disability and their carers to promote and enhance the independence of people in these client groups.
Informal carer	An informal carer is a person who provides care to someone voluntarily. Informal carers are often spouses or family members.

National Respite for Carers Program (NRCP)	An Australian Government respite program, which allows carers of older people and people with disabilities to have a break to look after their own health and wellbeing. The program provides information, counselling and support for carers, as well as assistance to help them take a break from caring.
Packaged care	Packaged care services are a combination of both case management and care coordination.
Personal care	A community care service provided to clients, including showering, nursing and administering medications.
Target population	The general community care target population is defined as people aged over 70 years, plus Indigenous people between 50 and 69 years.
Veteran's Home Care program (VHC)	Community care services to veterans and war widows/widowers with low care needs.

Executive summary

The need for reform

About one million older Australians and younger people with a disability receive community care. The services they receive — often for just one or two hours each week — allow them to maintain their independence and continue living in their own home, when otherwise they might need to move into residential care. Community care makes a real difference to their quality of life.

While Australia's community care system is an essential and valued part of many people's lives — older people, younger people with disabilities, and their carers — it remains the 'Cinderella' of the aged care system, receiving only 17 per cent of funding. It is estimated that more than 400 000 older Australians living at home have unmet needs for community care services. Some of these are existing clients, but many others are not even aware of the service options available to them.

Community care is in urgent need of reform. As this report highlights, there is a lack of accessible information, the system is increasingly complex, and linkages with the health system and primary care are poor. There is also a shortage of appropriate services for younger people with a disability. And while there are pockets of innovation and best practice, there is also a clear need for improvements in the responsiveness, flexibility and quality of services to meet the needs of clients.

Community care also faces pressure for reform from the profound demographic and social shifts in Australia. With the ageing of the population, over the next forty years the target population for community care will more than double. Further, the availability of family members to act as carers for loved ones will diminish in the future, due to the ageing of the carer population, greater participation by women in the workforce, increased rates of family breakdown, and a tendency to smaller families. At present, unpaid family and informal care accounts for 74 per cent of the support provided to older people and persons with a disability. There are 57 primary carers available for every 100 older persons needing care. By 2031, the availability of carers is expected to have fallen to 35 primary carers for every 100 older persons needing care — a reduction of 39 per cent — significantly increasing demand for formal care.

Not only will there be an increase in number of people seeking services, but future generations of older people are likely to have more complex needs and demand a higher level and quality of service than is currently common. For example, dementia will become more prevalent, the client group will become more culturally diverse, and the community will increasingly expect more choice and better value for money.

These many factors point to the need to ensure that community care can expand and develop in response to the increasing and changing demand. The purpose of this report is to explore strategies for reform of community care to improve the availability, responsiveness, flexibility and quality of services to better meet the needs of clients and carers now and into the future.

Clients' experiences and views

The findings of this report are grounded in the experiences and views of clients of community care and their informal carers, as told to us in a series of focus groups held around Australia.

Clients of community care services and their carers are very grateful for the community care services they receive and say they make a real difference to their lives. The benefit most commonly identified by both clients and their carers was that a majority of users could not manage to live independently at home without receiving community care. However, while clients and carers clearly value community care, they also pointed to a number of issues and problems around accessibility, quality and responsiveness.

A lack of information about community care is a major barrier to accessing services. This has the biggest impact on those who are not currently in the system. Many frail older persons are not aware of the community care options available to them. Others told us that they found the system complex and were confused about how programs interact. Several clients told us that hospitals and health care professionals only provided information on community care when the client or carer had reached a crisis point.

In addition, the clients and carers we spoke to indicated they had had *difficulties accessing particular service types*, including respite care and allied health services. Access to appropriate respite care was considered particularly important for the companionship it provides for clients and the necessary break it gives carers.

Clients tended to be more satisfied with the *quality* of community care services than carers. This may be explained by the role of the carer in organising community care services and communicating with service providers. The difference in satisfaction levels between clients and carers may also suggest that some of the needs that carers have for community care services are not currently being met. Several carers noted that their role as an informal carer is not suitably recognised as imperative to clients' ability to live independently at home.

There is a *desire for more flexibility* in the type of services provided, so that they better meet individual needs. Clients and carers have to fit in with the times that service provider can provide services rather than services fitting in with a client's daily routine. In addition, some of the rules governing what can be done as part of particular community care service types had an impact on the appropriateness of services provided.

Younger people with a disability and their carers highlighted that there was a lack of recognition by service providers that younger clients and carers are more likely to require community care services to be provided flexibly as many younger people work and have other commitments to balance with the services they receive. A number of younger people also highlighted that they had found it difficult to access appropriate respite services and other social activities.

A platform for expanding and developing community care

The report puts forward a platform for expanding and developing community care, based on three strategies. The strategies target ways to improve clients' access to more appropriate services (Strategy 1); give providers stronger incentives to meet clients' individual needs (Strategy 2); and provide clients with greater choice and control over the care they receive (Strategy 3). Strategy 1 is a set of measures that aim to improve the current system of community care, while Strategies 2 and 3 would entail more fundamental reform to community care.

Strategy 1: Improving access and appropriateness

Strategy 1 includes four elements that aim to improve clients' access to more appropriate services. The measures reflect clients' and carers' own priorities — these are the things that they believe will make the biggest differences to their experiences and those of future clients. They also draw upon ideas and suggestions made by industry experts and community care providers during consultations. The report highlights examples of good practice, and proposes that these examples be shared and adopted across the system.

Expanding the independence model of care

The first element of Strategy 1 is to promote and expand the independence model of care. A recent trend in community care provision is to focus on promoting and enhancing the independence of clients, rather than the traditional paradigm of responding to their dependence needs. This 'independence model of care' has been adopted by some jurisdictions and individual providers, but overall is not widespread.

At the core of the independence model is a commitment to early intervention and prevention. The idea of the independence model is not to replace services that are directed at 'support and maintenance', but to provide other services earlier to promote clients' independence, so as to reduce the need for ongoing support in the future. This would be highly valued by clients, who want to receive assistance before they reach a crisis point. It may also help to contain the future cost of community care, by reducing the number of clients with ongoing care needs, and possibly decreasing the average intensity of service provision per client.

Provided that trials remain supportive, it is recommended that the model be expanded to apply to the delivery of community care across Australia. Each State and Territory's systems would be modified to devote greater resources to early intervention and prevention. The experience of Victoria, which is planning to implement the model across its HACC program, will be instructive for other jurisdictions. Improved linkages with primary and acute care will be needed to identify clients earlier so interventions can be provided at the right time.

It is also recommended that case management be made available to a wider range of community care customers. At a minimum, case management services should be available to all higher care needs clients. Additional funding would be required to implement this reform, however this could be regarded as an investment in the system that could be expected to produce improved efficiency and lower average costs over time.

Improving respite care

The second element of Strategy 1 is to improve respite care. Respite care is important not only for clients of community care, but also those who act as their informal carers. Providing care can be very demanding and stressful — for many family members it is close to a full-time role. Respite care provides informal carers with a much-needed break, without which they may not be able to continue, and clients would have to turn to formal care for greater support. In this way, respite care can help to reduce the demands on the community care system.

Two reforms are recommended to improve clients' and carers' access to appropriate respite care. First, there is a need to change the nature of some respite services, to better match the needs of clients of community care and their carers. One specific gap is respite for younger people with a disability, who often have to utilise elderly respite care services that are inappropriate for their needs. This can be demoralising for clients and stressful for their informal carers. Older clients also expressed a desire for more active respite and centre-based day care. There needs to be greater adoption of new models of respite for individuals and groups, such as local cottage respite for older people and their carers and 'meaningful activity' respite (for example, men's sheds, community access activities, respite through recreation) for both older and younger people.

Second, provision of additional respite care places would ease the burden on the family members and friends who act as informal carers, enhancing their capacity to participate in work, education and community life. In consultations, clients and their carers reported that there were long waiting lists for respite care. In particular emergency in-home respite was difficult to access. External respite services may be taking on clients who would prefer a few hours of respite at home but are unable to access such services. Additional emergency in-home respite places may ease the pressure on external respite care. This change would require additional funding.

More tailored provision to younger clients with disabilities

The third element of Strategy 1 is to provide more tailored assistance to younger people with disabilities. Although HACC services are available to younger people with a disability, a number of these services are not well equipped to meet their needs. Many community care workers have not been trained to handle the specific complexities involved with younger clients or clients with a disability.

In addition to the reforms to respite care discussed above, there are three main ways in which community care services could be made more appropriate to the needs of younger people with a disability:

- provide a more flexible and responsive services, acknowledging that younger people with a disability often need to receive services that fit in with their work commitments. Good practice approaches to delivering services to younger clients should be identified and disseminated across the system;
- provide additional recreational and social programs specifically tailored to younger people with a disability, providing an environment where younger people can interact and socialise with people in a similar situation to themselves. Additional funding would be required to implement this option; and

- increase the level of training for community care workers, either by having all community care training programs include a module on caring for younger people with a disability at home, or ensuring those community care workers who care for younger people with a disability have undertaken training specifically focused on providing services to younger clients.

Better access and information

The final element of Strategy 1 is to provide better access to and information about community care. The community care system comprises many different types of services, offered at different levels of intensity, and often available from a choice of providers. There is a need to group together this information to enable easier comprehension and access by older people, their families, GPs and others.

Effective communication channels between community care providers, hospitals and GPs are needed to ensure that each is aware of and understand the services provided by the other. Strong linkages with hospitals and GPs are important because they are often in a position to identify transition points in a person's life that result in a change in the nature or level of care they require. Missing these transition points makes a decline in the client's independence more likely, and can adversely affect their health and well being. It is therefore critical that GPs and hospital discharge officers are well informed about the community care options that are available to clients.

The Australian Government should undertake a systematic evaluation of the Carelink program in terms of its role as a provider of information to clients and service providers. Research indicates that Carelink centres — established by the Australian Government to assist people to access general information about health and aged care services — are not widely utilised by older persons or younger people with a disability to gain information about community care services. Indeed, few even know of their existence. The review should also examine whether the objectives of the Carelink program should be refocused towards helping clients to navigate the system.

Peer education programs are a potentially useful way of improving the awareness of older persons, younger people with a disability and their families about available services and options prior to the onset of a crisis. In the first instance, such programs might be trialled with higher-risk groups such as those with chronic conditions, for whom the need for community care may be closer.

Strategy 2: Increased flexibility for providers

Current funding arrangements limit providers to providing only those service types for which they have obtained funding. The effect of such a system is to embed the status quo. Providers have little incentive to develop innovative methods of service delivery or to achieve productivity gains. More fundamentally, the focus of providers is on their inputs rather than the client.

This strategy aims to shift the emphasis of community care funding arrangements from inputs to client outcomes by giving service providers greater flexibility about how they can provide services, while at the same time creating stronger incentives for them to achieve the best possible outcomes for their clients. The strategy puts the onus on existing providers to drive the changes needed to make the sector more oriented towards and responsive to client needs.

Under the proposed reform, funding would be allocated to providers on the basis of the characteristics of their client population and the expected bundle of outcomes to be achieved. Once the desired outcomes for a client were defined and agreed, the provider would determine how to best achieve that outcome. This would encourage providers to engage more actively with clients to understand their individual situation and needs, and what community care could do to help them sustain their quality of life.

A risk associated with outcomes-based funding is that the desired outcomes may be difficult to define and measure. An imperfect accountability framework could produce perverse incentives for service providers to act in ways that are not in the best interests of some clients.

Providers would be regularly assessed for how well they had achieved client outcomes. This assessment would influence how each provider would be funded in the future. Providers would have an incentive to achieve desired outcomes for the greatest number of clients in a given period. This is unlike the current arrangements, which may encourage some providers to ‘lock in’ clients to the system so that they become a guaranteed source of ongoing funding. By rewarding innovative and more productive providers, the system would help manage the cost of future growth in demand for services.

Providers would be able to compare their performance with that of other, similar, providers. This would help all providers to learn from the best performers. Innovations and practices that help achieve good client outcomes would spread through the system.

Strategy 3: Consumer-directed care

Consumer-directed care is based on the premise that the client should be able to have choice and control over the care they receive from paid providers. The underlying rationale is that clients of care should be empowered to make decisions about the type and nature of the care they receive, and who provides it.

A number of different models of consumer-directed care have been adopted overseas. The models vary in terms of how much decision-making, control and autonomy are shifted from community care professionals and agencies to clients. Three main models are:

- *Cash or vouchers* — clients receive periodic cash allotments or community care-specific vouchers and are given discretion to select those services or goods they deem most essential. They can either manage the funds themselves or pay a small fee for an agent to manage the funds instead.
- *Assisted choice of provider* — case managers are assigned to clients to assess which programs they are eligible for, and how many hours of service they can receive. With this determined, clients are free to engage the providers of their choice to deliver services they have selected as best meeting their needs. The case manager assists them with these choices. Unlike the cash model, funding is distributed to providers.

- *Monitored choice of service and provider* — clients are able to engage the providers of their choice to deliver the clients' chosen services, with mandated guidance from case managers who not only determine their eligibility and assist them as above at the beginning of their care program, but also then monitor the quality and effectiveness of service provision over time according to an approved care plan.

In determining the most appropriate model for community care clients in Australia, one should consider the needs and preferences of clients and their carers. Consumer-directed care would not be appropriate for or desired by many clients. However, different models could be adopted for client groups with different capabilities and aspirations. For example:

- a case management approach is likely to be most beneficial for those clients that use multiple services and have complex needs; and
- an opt-in system of direct cash benefits or vouchers may be more suitable for those with less complex needs.

This strategy may be seen as a 'big and bold step', however participation would be optional and clients could return to standard service provision if this was preferred. Consumer-directed care would never fully replace the existing model of service provision, but rather would sit alongside it as one part of a reformed community care system.

As with many of the suggested reforms, any model of consumer-directed care would most likely be introduced in a controlled, local trial.

Workforce

In the context of putting forward strategies to expand and develop community care, it is necessary to caution that the viability of community care now and into the future is dependent on an available and skilled workforce.

Currently, the community care sector suffers from a shortage of trained nurses, doctors with skills specific to the elderly and other allied health professionals. The shortages are more acute in rural and remote areas and in certain special needs sectors. There is high turnover of employees, which has been attributed to low pay, lack of a career path, working in relative isolation, occupational health and safety issues and the age profile of the community care workforce. As an illustration of the low rates of pay for community care workers, in NSW a personal care worker with a Certificate III in aged care earns \$13.53 per hour. This hourly rate is less than that of a checkout operator in a supermarket yet requires TAFE certificate qualifications.

Shortages in the supply of community care workers are likely to become more acute in the future. One of the most important aspects of population ageing in relation to formal care is the slowing of growth in the labour force participation rate. As the potential pool of workers plateaus, competition for their services will increase. It will become harder — and more costly — for community care providers to attract the workers they need to meet rapidly growing demand.

It is essential that government — in partnership with the community care sector — act to address workforce shortages. In 2006, the Productivity Commission undertook a study of Australia's health workforce, which overlaps with the

community care workforce and is facing similar challenges. The Commission recommended four approaches to overcoming current shortages and to address the future pressures facing the system. These are equally relevant to community care.

- Reduce the underlying demand for health care through ‘wellness’ and preventative strategies — which is a consistent theme of our platform for community care reform.
- Short term increases in education and training places in some areas.
- A greater emphasis on retention and re-entry to help stabilise workforce numbers — as recent initiatives in the nursing area in some jurisdictions have shown.
- Improve the productivity and effectiveness of the available workforce, and its responsiveness to changing needs and pressures — which will increase the level and quality of the workforce services that can be supported by any given level of spending.

Chapter 1

Introduction

This chapter introduces the report, outlining the background to the project, an overview of the project's objectives and methodology, and a summary of the structure of the report.

1.1 The development of community care

In recent years successive Australian Government and State and Territory governments have pursued a general policy direction of 'ageing in place'. This has involved a greater emphasis on keeping elderly and frail people in their home or family settings for as long as possible. Community care and residential care are the backbone of the formal aged care system in Australia that complements and supports the care provided informally by family members and friends.

Consistent with this policy direction, community care has been an expanding element of aged care policy in Australia over the past two decades. An example of this expansion is the introduction of higher needs care packages. While progress has been made in expanding and developing the range of community care services available, it is an increasingly complex system and studies have shown that some clients are not accessing the care they need.

Evidence generally indicates that in Australia, community care programs need further resources and system reforms so that more services can be provided and improvements made to service quality and access.¹ While there is widespread agreement on the substantial contribution that community care programs make in allowing older and disabled persons to stay in their homes, there are concerns about the adequacy of current arrangements and the ability for our community care system to meet rising demands.²

With this in mind, the Australian Government initiated a comprehensive review of community care programs in 2002. This review resulted in a new strategy for community care – *The Way Forward*, which was released in August 2004.³ *The Way Forward* identified the need to improve access to services and create linkages to improve the quality and affordability of care. It also called for a streamlining of care programs. However, as noted by the Senate Inquiry into the Quality and Equity in Aged Care, a key limitation of *The Way Forward* was that it did not adequately address the interface between ageing and disability.⁴ Nor did it suggest ways for enhancing the support for informal carers and overcoming the declining pool of informal carers.⁵

¹ Senate of Australia, Community Affairs References Committee 2004, *Quality and Equity in Aged Care*, Canberra, Recommendation 39, p. xxii, also Victorian Government Department of Human Services 2006, *HACC 2006–09 Expenditure Priorities in Victoria: Consultation paper*, Senate Inquiry, p. 161

² Ibid.

³ Department of Health and Ageing 2004, *The Way Forward — A New Strategy for Community Care*, Canberra.

⁴ Senate of Australia 2004, op. cit., p. 166

⁵ Ibid.

Attention has been given in recent years to identifying problems in community care services — in particular the need to address the gaps and overlaps in service delivery, improve service quality and access, and reduce administrative burden. The *Vision for Community Care* released by Aged Care Services Australia and partners in 2003 helped raise awareness of the need for reform in this direction. However, despite their acknowledgement of the issues, governments have not yet developed a comprehensive action plan for reform. The Australian Government implicitly acknowledged this when it announced another review of Australian Government-funded community care programs in September 2006.

1.2 This report

Scope and objectives

This report was commissioned by the Community Care Coalition, a coalition representing the interests of service providers, clients (younger and older Australians with disabilities), as well as unpaid carers who provide much of the care for those needing it. (A list of Coalition members is at Appendix A.) The report examines the performance of the community care system in Australia, and identifies options for the future development and expansion of community care. It presents the findings of research undertaken with clients of community care and their carers, as well as from examining relevant literature.

Community care encompasses a wide range of formal programs and informal care providing support to all people in society — from maternal and child health programs, through family support to positive ageing programs. In this report, community care is defined more narrowly as it relates to supported people with a functional disability, primarily older people, and their carers. The report examines formal, government-funded community care, with a focus on the major programs funded by Australian and State Governments (see section 2.1).

The objectives of the report are to:

- explore issues surrounding the current community care system, including access, adequacy and equity of service provision;
- investigate the views of clients of community care services and their carers;
- identify examples of good practice in Australia and internationally; and
- identify options for the future expansion of community care — as a basis for informed community debate.

Methodology

The project method was designed to facilitate a comprehensive analysis of the current community care environment in Australia and to recommend options for reform. The project method had two stages:

- Stage one — a review of relevant literature and data on community care, consultation with the users of community care services, and analysis of the performance of community care.

- Stage two — further consultation with clients and carers on options for the future of community care, interviews with community care providers and experts in the field of community care, review and analysis of demographic projections and resource utilisation trends, and development of options for the future of community care.

An essential part of both project stages was reporting the views of clients and carers. Client and carer views were collected by conducting a series of focus groups across Australia. Information about the focus groups and other consultations is detailed in Appendix C.

Structure of report

The remainder of this report is structured as follows:

- chapter 2 provides an overview of the existing structure and performance of Government community care programs in Australia;
- chapter 3 details the experiences and views of clients and their carers on the community care services they receive;
- chapter 4 examines drivers of future change in community care and reviews projections of future growth in demand; and
- chapter 5 puts forward three strategies to expand and develop community care.

Chapter 2

Community care in Australia

This chapter provides an overview of the existing structure and performance of Government community care programs in Australia.

2.1 Sector overview

While many older people live in their homes either by managing on their own, or with help from family and friends acting as informal carers, more than 850 000 older Australians and younger people with a disability rely on a range of community care services. In some cases, people would not be able to remain living in the community without these services, and would instead need to move into residential care.

Many people access community care services to complement the support provided by informal carers, rather than as a substitute. It is not necessarily the case that having a informal carer reduces an individual's need for all types of formal assistance. Carers often act as advocates in organising and facilitating contact with health and community services, in addition to providing direct care.⁶

The number of government community care programs has increased over the past decade to better meet increasing community needs. There are four main programs that provide care to people living in their own homes.

- The Home and Community Care program (HACC) — community care services for older people, younger people with a disability and their carers to promote and enhance the independence of people in these client groups. The HACC program had 744 000 clients in 2004-05, representing the vast majority of community care recipients.
- Community Aged Care Packages (CACPs) — community care services provided at the recipient's home that substitute for a low care residential place. There were 31 000 CACP recipients in 2004-05.
- The Extended Aged Care at Home program (EACH) — community care services provided at the recipient's home that substitute for a high care residential place. There were 1 673 EACH clients in 2004-05.
- The Veteran's Home Care program (VHC) — community care services to veterans and war widows/widowers with low care needs. There were 74 620 VHC clients in 2004-05.

The number of HACC clients is an underestimate, as it is based on data reported by 82 per cent of funded service providers. This means that, in total, about 1 million Australians were using community care in 2004-05.

Further details about each of these programs are provided in Appendix B.

⁶ Australian Institute of Health and Welfare 2004, *Carers in Australia: Assisting Older People and People with a Disability*, AIHW Cat. No. AGE 41, Canberra: AIHW (Aged Care Series) p. 62.

In recent years there has been growth in all community care programs. The HACC program and CACPs have experienced growth of 25 per cent and 17 per cent respectively over the last four years. Specific Australian Government budget measures have expanded the EACH program six-fold since 2002. The VHC program experienced growth of 77 per cent over the last four years.

In February 2007, the Australian Government announced it would increase the number of community care packages provided over four years. There will be an additional 5600 CACPs and 1600 EACH packages provided, raising the Government's service provision target from 20 to 25 places per 1000 people aged 70 years and over.

Informal care

Despite the significance of government programs, it has been estimated that unpaid family and other informal care accounts for approximately 74 per cent of the support provided to older people and persons with a disability in Australia. Furthermore, 63 per cent of all care providers live with the person that they care for.⁷ The role of the carer involves some significant sacrifices, including foregone salary, costs of transport and loss of leisure time, as well as impacts on the carer's own health and well being.

The important role that carers play is recognised — albeit imperfectly — through the provision of a range of services aimed at reducing their load. Carers are an official target group of the HACC program. Services that specifically offer assistance to carers include respite care, counselling and education, and information services. Personal care, home maintenance and domestic assistance can also act as a support to carers by lightening some of their care responsibilities. Care coordination and case management can relieve carers from some of the time-consuming detail of comparing service options and identifying what is best for the person they care for.⁸ The Aged Care Assessment Team guidelines require formal aged care assessment to consider the needs of carers when making recommendations.

In addition to support services, financial support to carers is available in the form of the Carer Payment and the Carer Allowance.

Government expenditure

In 2005-06 the Australian Government spent \$7.2 billion on aged care services. Of this, about \$1.4 billion, or 19 per cent, was allocated to community care — \$858 million to the HACC program, \$368 million to CACPs, \$70 million to EACH packages and \$91 million to the VHC program. The majority of the remaining funding of aged care — \$5.3 billion — paid for residential aged care subsidies, an average subsidy per utilised place of \$34 000.⁹

In February 2007, the Australian Government announced it would provide extra funding of \$412 million over four years to provide more community care packages and additional respite care services.

⁷ National Centre for Social and Economic Modelling 2004, *Who's going to Care? Informal Care and an Ageing Population*, University of Canberra, Canberra, p. 28.

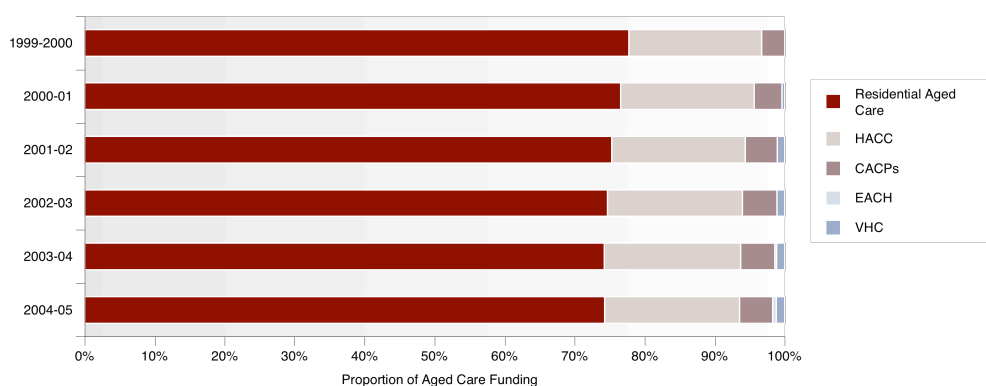
⁸ Australian Institute of Health and Welfare 2004, op. cit., p. 71.

⁹ Department of Health and Ageing 2006, *Aged Care in Australia*, Canberra, p. 4.

States and Territories provide some funding for residential aged care, but their primary contribution to aged care is through the HACC program. In 2005-06, State and Territory Governments contributed \$540 million to HACC, taking total Government expenditure on the HACC program to \$1.4 billion. Figure 2.1 illustrates the allocation of government expenditure, in real terms, between residential aged care and the four main community care programs over the period 1999-2000 to 2004-05. The proportion of funds allocated to community care has increased marginally over this period, however the majority of government funding — about 75 per cent — is still allocated to residential aged care.

Figure 2.1

GOVERNMENT EXPENDITURE ON RESIDENTIAL AND COMMUNITY CARE, 1999-2000 TO 2004-05



Source: Steering Committee for the Report on Government Services 2002-06, *Report on Government Services*, Productivity Commission, Canberra.

Workforce

Overall, people working in residential and community aged care make up about 1.4 per cent of the total Australian workforce. This includes professional care staff, nurses, personal care workers and administrative and general staff.¹⁰ Many providers of community care are not-for-profit organisations and have a substantial number of volunteers among their workforce.

It is widely recognised that there is a shortage of trained nurses, doctors with skills specific to the elderly and other allied health professionals. The shortages are more acute in rural and remote areas and in certain special needs sectors. The impact of the shortages is being felt in both the residential aged care and community care sectors.

Employees in the community care sector are often part-time or casual workers or contractors. There is high turnover of employees, which poses difficulties for staff replacement, especially in rural areas. High turnover has been attributed to low pay, lack of a career path, working in relative isolation, occupational health and safety challenges associated with working in the client's home and the age profile of the community care workforce.¹¹

¹⁰ Department of Health and Ageing 2002, op. cit., p. 8.

¹¹ Senate Community Affairs References Committee 2005, op. cit., Canberra, pp. 9-10.

Studies undertaken in Western Australia and Victoria support the idea that working conditions affect the supply of workers to the community care sector. A study of home care workers in Western Australia found that while most workers were multi-skilled people working flexible hours, they often received no penalty rates and were frequently employed on a contractual or casual basis (receiving no annual leave, sick leave, or other benefits offered to permanent staff). Many were not guaranteed minimum hours of work, were not paid according to their skills, and had limited access to paid training. In Victoria, community care workers identified pay increases for experience, regularity of work, and an increase in the base rate of pay as being the most important improvements that could be made to encourage them to stay working in the industry.¹²

As an illustration of the low rates of pay for community care workers, in NSW a personal care worker with a Certificate III in aged care earns \$13.53 per hour. This hourly rate is less than that of a checkout operator in a supermarket yet requires TAFE certificate qualifications.¹³

2.2 Current performance

To assess the performance of community care in Australia we draw upon the assessment framework presented in the Productivity Commission's *Report on Government Services*, which assesses the performance of a service in achieving its objectives in terms of their effectiveness, equity of access and efficiency.¹⁴ While limited, there are some data available to measure effectiveness in terms of the availability, timeliness, quality and affordability of services. However, there are insufficient data to reach any robust conclusions about the efficiency of community care service delivery.

Availability

There is a carefully structured planning process behind the allocation of aged care places (these are essentially residential aged care, CACP and EACH places) to Aged Care Planning Regions across Australia. This involves consideration of demography and aims to ensure that the growth in the number of aged care places is in line with growth in the aged population, taking account of people with special needs.¹⁵ Each year new residential and community care places are made available for allocation in each State and Territory.

At present, the Australian Government seeks to achieve and maintain a national provision level of 108 operational aged care places for every 1000 people aged 70 years and over. This is composed of 40 high care places, 48 low care places and 20 community care places.¹⁶

¹² P Angley and B Newman 2002, *Who Will Care? — The Recruitment and Retention of Community Care (Aged and Disability) Workers*, Brotherhood of St Laurence, p. 6.

¹³ Senate Community Affairs Committee, *op. cit.*, p. 8.

¹⁴ Productivity Commission 2007, *Report on Government Services 2007*, Canberra, pp. 12.19-20.

¹⁵ Department of Health and Ageing 2006, *op. cit.*, p. 6. People with special needs are defined in the legislation as people from Aboriginal and Torres Strait Islander communities; people from non-English speaking backgrounds; people who live in rural or remote areas; people who are financially or socially disadvantaged; and veterans of the Australian Defence Force or of an allied defence force, or their spouses, widows or widowers.

¹⁶ Department of Health and Ageing 2005, *Report on the Operation of the Aged Care Act 1997 — 1 July 2004 to 30 June 2005*, Canberra, p. 5.

Following the allocation of places to Aged Care Planning Regions, an open competitive process is conducted to assign responsibility for the places to approved service providers. Places are assigned to the service providers who can best meet the identified care needs of the community.¹⁷

Table 2.1 shows the actual use of community care services, compared to the Australian Government target.¹⁸ It shows that in 2005-06 there were 19.4 CACP and EACH places provided per 1000 people aged 70 years or older, just short of the Australian Government target of 20 per 1000 people aged 70 years or older. However there were only 17.4 persons receiving the packages. One in ten places that should have been available was not filled.

There is no relevant Government target for the provision of HACC services.

Table 2.1

COMMUNITY CARE PLACES AND RECIPIENTS, PER 1000 PERSONS AGED 70 YEARS OR OVER PLUS INDIGENOUS PERSONS AGED 50-69 YEARS, 2005-06

Program	Operational number of places	Recipients	Government target
CACP	17.8	16.3	20 places
EACH	1.6	1.1	

Source: Productivity Commission 2007 *Report on Government Services 2007*, Canberra, Tables 12A.11, 12A.12; Department of Health and Ageing 2006, op. cit., p. 47. Department of Health and Ageing 2005, op. cit., p. 5.

Another measure of the availability of community care services is the extent to which the target population's needs for assistance are being met. In 2003, 1.2 million people aged 60 and over living at home reported needing assistance with personal and domestic activities and transport. Almost 80 per cent of this group were receiving assistance from an informal care provider, and 57 per cent were receiving assistance from a formal provider.

Taking into account both formal and informal care:

- 788 000 people (64 per cent) said their needs were being fully met;
- 363 000 people (30 per cent) said their needs were being partly met; and
- 70 000 people (6 per cent) said their needs were not being met at all.

These figures indicate that in 2003, 433 000 older Australians had an unmet need for community care.

¹⁷ Department of Health and Ageing 2005, op. cit., p. 6. The allocation process is detailed in the *Aged Care Act 1997*.

¹⁸ The target population is measured as all persons aged over 70 years, Indigenous persons aged over 50 years, and persons under the age of 60 with an identified disability.

In February 2007, the Australian Government announced additional funding for CACPs and EACH packages, which it said would meet an increased target of 25 community care places for every 1000 people aged 70 years and over.¹⁹

Equity of provision

The rate at which particular subgroups of the target population for community care actually receive services provides an indication of whether community care services are provided equitably.

- 18 per cent of the female target population for community care receive services, compared to 11 per cent of the male target population. As females have a longer life expectancy, they are less likely to have a partner in their later years of life who could act as an informal carer. Male partners of older females who require care may also have less capacity to provide informal care.
- Community care has a greater focus on providing services to older members of the target population are much more likely to receive services — 51 per cent of persons aged 80 years or more access community care, compared to 20 per cent of people in their seventies and 6 per cent of members of the target population aged under 70 years. Many younger people with a disability draw upon disability services rather than community care.
- People from a culturally and linguistically diverse (CALD) background are not equitably represented in the HACC program — about 11 per cent of CALD members of the target population receive HACC, compared to 42 per cent of all recipients. People from a CALD background are equitably represented among recipients of CACPs and the EACH program.
- Overall, Indigenous members of the target population are represented in the HACC, CACP and EACH programs at about the same rate as non-Indigenous persons. However, given that Indigenous people have a higher level of need for health and welfare services, this suggests that community care may not be equitably meeting the needs of Indigenous Australians.
- The geographic distribution of community care recipients is closely aligned with the distribution of the target population, indicating that clients living in regional and remote areas receive an equitable share of services compared with those living in the cities.

These findings draw upon a range of data from the Productivity Commission, the Australian Institute of Health and Welfare, the Australian Bureau of Statistics, the Department of Health and Ageing and the Department of Veterans' Affairs. A full list of sources is provided in Appendix B.

¹⁹ Department of Health and Ageing 2007, 'Fact Sheet 2: More and better community care', www.health.gov.au/internet/wcms/publishing.nsf/Content/ageing-securing-the-future-factsheet-2, accessed 19 February 2007.

Timeliness

For community care services to be effective, they need to be provided in a timely manner. The best measure of timeliness is to assess the time between a community care assessment and the commencement of service provision. Table 2.2 shows the elapsed time between ACAT approval and access to CACP services in 2005-06. Only two-thirds of CACP clients commenced services within three months of their ACAT assessment. This indicates that significant improvements could be made on the timeliness of CACP services. Data are not available on the timeliness of HACC, EACH or VHC services.

Table 2.2

ELAPSED TIME BETWEEN ACAT APPROVAL AND ACCESS TO CACP SERVICES — 2005-06

Time period	% waiting
2 days or less	6.5%
Between 2 and 7 days	6.9%
Between 7 days and 1 month	25.0%
Between 1 and 3 months	29.2%
Between 3 and 9 months	25.5%
More than 9 months	6.9%

Source: Productivity Commission 2007, op. cit., Table 12A.36.

Quality of services

Quality of community care services can be measured through the reporting requirements of community care service providers. All HACC service providers are required to report against a series of quality standards (see Box 2.1). Service providers must be appraised over a three-year cycle and are provided with a quality rating out of 20 marks.

Box 2.1

THE HOME AND COMMUNITY CARE PROGRAM NATIONAL STANDARDS

The Home and Community Care national standards are outlined by seven major objectives:

- Objective 1 — access to services;
- Objective 2 — information and consultation;
- Objective 3 — efficient and effective management;
- Objective 4 — coordinated, planned and reliable service delivery;
- Objective 5 — privacy, confidentiality and access to personal information;
- Objective 6 — complaints and disputes; and
- Objective 7 — advocacy.

Source: Home and Community Care: A Joint Commonwealth and State and Territory Program (no date), *The Home and Community Care National Standards Instrument and Guidelines*, pp. 32-35.

The results of the most recent HACC national standards appraisal provide an indication of the effectiveness of community care services in terms of quality. Over the three years to 2003-04, 85 per cent of HACC service providers undertook a quality appraisal.²⁰ Table 2.3 shows that in the most recent HACC national standards appraisals, less than half of all HACC service providers received a score of 'High' and about one-quarter of providers received a score of 'Basic' or 'Poor'. This indicates there is room for a large number of HACC service providers to improve the quality of their services.

Table 2.3

**HACC NATIONAL STANDARDS APPRAISALS 2001-02 TO 2003-04 —
SCORES RECEIVED BY PROVIDERS**

Score	Number of appraisals	Proportion of total
High (17.5-20)	1236	46%
Good (15-17.4)	774	28%
Basic (10-14.9)	508	19%
Poor (less than 10)	188	7%
Total	2706	100%

Source: Productivity Commission 2006, op. cit., Table 12A.65.

The VHC program has also based its quality assurance standards on the HACC national standards, however, data on the appraisal outcomes are not publicly available. Similarly data on the outcomes of the quality reporting framework for the CACP and EACH programs are not yet publicly available.

Affordability

The affordability of community care services is imperative to providing access to services, especially as approximately 88 per cent of HACC clients receive some form of government allowance.²¹

All community care services may require a client contribution to pay for the services provided. However, the client contribution is calculated on an individual's ability to pay. The client contribution is determined at the assessment stage and can be altered by the service provider in consultation with the client. Typically, community care services are approximately \$5 per hour, with costs capped at \$20 per week for most individuals.²²

As discussed in Chapter 3, clients of community care services and their carers identified that, in general, the costs of community care service are reasonable. No clients stated that the costs of services limited their access to community care.

²⁰ Productivity Commission 2006, op. cit., p. 12.42. Note that not all HACC services are required to undergo external quality assessment, and some are exempt.

²¹ Department of Health and Ageing 2006, op. cit., Table A12, p. 28.

²² Information provided by consumers of community care and their carers in focus groups undertaken as research for this report.

Given the flexibility in the amount of the client contribution for community care services, community care services should be affordable for most clients. Client contributions should have a limited impact on access to community care. This is supported by the views expressed in focus groups, where clients of services and their carers reported that the costs of community care services are reasonable.

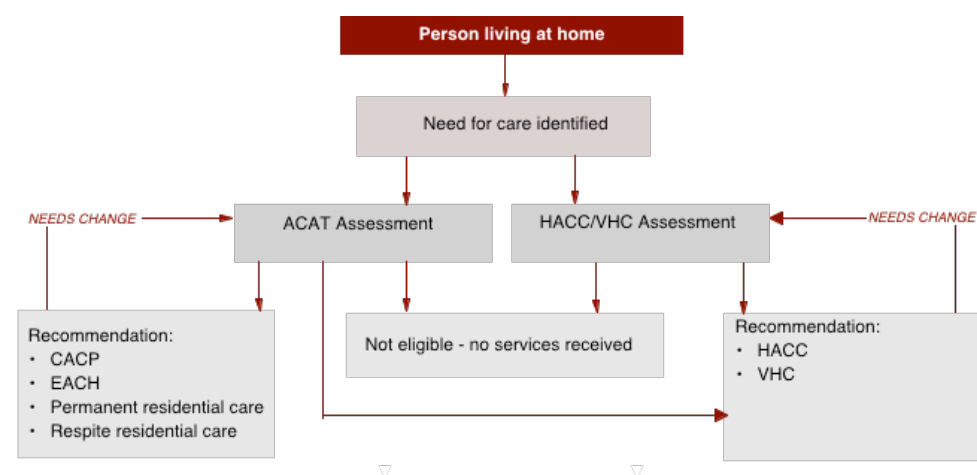
2.3 Linkages with other service systems

As people’s circumstances and capabilities change, they need to be able to change their care arrangements and access a range of government-funded services. While living at home, they may use a number of care services, and such services can be accessed whether or not they are receiving care from friends and relatives. From time to time, the frail aged and younger people with a disability call upon a variety of hospital and primary care services (for example, general practitioners) and allied health services, such as podiatry, physiotherapy and occupational therapy. In addition to the services available to people with care needs, services are available to support their carers.²³ The types of services they can access often depends on a formal assessment of their care needs.

The extent to which individuals can alter their care needs in order to meet their changing requirements is influenced on the ease with which they are able to access different types of services and the linkages between services systems, such as between acute health and community care. Linkages between different programs and packages within the community care service sector also impact on the degree to which clients can alter the care they receive. Figure 2.2 illustrates the degree to which the four main packages are linked and the process that is required to access additional or different services.

Figure 2.2

LINKAGES BETWEEN COMMUNITY CARE PROGRAMS



²³ Australian Institute of Health and Welfare 2003, *Australia’s Welfare 2003*, AIHW Cat. No. AUS 41, Canberra, p. 292.

The 2003 ‘Dubbo study’ of the health of the elderly found that a major cultural change was required within the hospital system to deal with those who have chronic, complex co-morbidities and who may have major social and environmental impacts on their health conditions.²⁴ Better connections to aged and community care, in addition to other non-acute health care services, are considered to be essential to this change. The Dubbo study suggested that options need to be developed for greater interaction between the hospital system and aged care in order to improve the level of service provided to older people by appropriate allocation of service types.

In *The Way Forward*, the Australian Government recognised that the residential aged care system, disability services and programs targeting veterans are important linkages at the national level that should be taken into account in the development of the national framework for community care.²⁵

The Australian Government Departments of Health and Ageing and Community Services are involved in discussions regarding the link between disability services and the HACC program. Similarly, discussions are also underway between the Departments of Health and Ageing and Veterans’ Affairs regarding the role of the VHC program in the national community care framework. Veterans’ Affairs has indicated an interest in working collaboratively to develop common arrangements across VHC in the areas of assessment, data and quality monitoring.²⁶

The *Way Forward* indicated a desire for developments in community care to be consistent with changes in residential aged care. This is considered an important service continuum for older Australians and systems need to be developed to allow a smooth transition for those people requiring support from both types of care.²⁷

To aid this, the Australian Government committed to develop a common assessment approach across community and residential care, consistent with recommendations arising from the *Review of Pricing Arrangements in Residential Care*. Additional funding has been allocated to ACAT’s to improve these linkages through the provision of more timely assessment and case management of transitions across community and residential aged care programs. A continuous client record is to be developed to provide appropriate referral records for both community care and residential aged care providers.²⁸

²⁴ J McCallum, L Simons and J Simons 2003, *The Dubbo Study of the Health of the Elderly 1988-2002 — An Epidemiological Study of Hospital and Residential Care*, The Australian Health Policy Institute at the University of Sydney, Sydney, pp.47-48.

²⁵ Department of Health and Ageing 2004, *The Way Forward — A Strategy for Community Care*, p. 28.

²⁶ Ibid.

²⁷ Ibid.

²⁸ Ibid.

Chapter 3

Clients' experiences and views

This chapter details experiences and views of clients and their carers on the community care services they receive.

3.1 Introduction

This chapter reports the experiences and views of clients of community care services and their carers, as told to us in a series of focus groups held around Australia. Participants were asked to comment — and complete a short written survey — on a number of aspects of community care services, including:

- how clients and carers use community care services;
- the benefits of using community care services;
- the adequacy of the care received; and
- how services could be improved.

While the short survey of clients and their carers has a very small sample size, it does provide an indication of people's views on community care. It would be valuable for the Australian and State and Territory Governments to undertake a more comprehensive survey of experiences, preferences and views of clients and carers, to inform future system developments and help service providers to deliver more appropriate, client-focused care.

3.2 Views on current community care services

Clients of community care services and their carers are very grateful for the community care services they receive and say they make a real difference to their lives.

The benefit most commonly identified by both clients and their carers was that a majority of users could not manage to live independently at home without receiving community care services. Some clients went on to add that without the community care service they receive, they would have to seriously consider residential care or moving in with family members to care for them more intensively. One client commented:

Without community care services there is no way I could live at home by myself, I would probably have to go to a nursing home.

Our survey found that 85 per cent of clients and 87 per cent of carers thought that community care services were very important to be able to live independently at home.²⁹ Full details of the questionnaire results are provided in Appendix C.

There were some significant differences between the views of clients and carers about the adequacy of community care services. Carers were more likely to report a need for a greater amount of services to meet their needs. While our survey found

²⁹ A 'very important' result as part of the survey included results of eight and above on a scale of one to ten.

that 58 per cent of clients thought the amount of services met their needs very well, only 29 per cent of carers thought the services met the needs of the person they care for very well.³⁰

Of those clients and carers who identified a need for a greater amount of services, most were only seeking a small increase in services (one or two hours per week). For example, one client commented:

I could do with another half an hour in the morning, just so my shower isn't such a rush.

The clients and carers we spoke to indicated a greater need for particular service types. Both clients and carers told us that respite services were particularly important services as they provide companionship to clients and allow carers time to spend with other family members and have a break from their caring duties. Several of those we spoke to reported they had had difficulties accessing respite care, placing a strain on both the client and the carer. One client was to one respite visit every three months, which had to be booked well in advance.³¹

Clients and carers also highlighted the need for greater access to allied health services — in particular, podiatry and physiotherapy. Although these services are available under the HACC program, they are rarely used and are not accessible in many locations.

Clients tended to be more satisfied with the quality of community care services than carers. Our survey found that 51 per cent of clients were very satisfied with the quality of community care services compared to 39 per cent of carers.³² This may be explained by the role of the carer in accessing community care services. In a lot of situations, particularly children caring for their elderly parents, the children — as carers — take on the role of organising the community care services and communicating with service providers and tend to experience the broader aspects of community care services, including the access and assessment processes which may come with greater levels of dissatisfaction. One carer commented:

My mother only knows the services she receives, but I am the one who has to talk to the service providers when a worker is sick or can't come to the house.

The difference in satisfaction levels between clients and carers may also suggest that some of the needs that carers have for community care services are not currently being met. Several carers noted that their role as an informal carer is not suitably recognised as imperative to clients' ability to live independently at home. A number commented that the cost to government of keeping a person in their own home is far less than the cost of providing residential care for those clients. One carer told us:

Our important role should be recognised, it is because [of me] that the government does not have to pay for my parents to live in a nursing home.

³⁰ A 'very well' result as part of the survey included results of eight and above on a scale of one to ten.

³¹ The Australian Government has since announced that over the next four years, an additional 10 000 days of respite will be made available through the National Respite for Carers program.

³² A 'very satisfied' result as part of the survey included results of eight and above on a scale of one to ten.

3.3 Information and access

Many clients of community care services reported difficulties in accessing services. In particular clients and carers identified a lack of information on community care services as a major barrier to access. This has the biggest impact on those who would be eligible to receive community care but are not currently in the system. Many frail older persons are not aware of the community care options available to them.

Clients and carers identified hospitals and health care professionals as the most common sources of information on community care services and the assessment process. However, several clients told us that health care professionals only provided information on community care services when the client or carer had reached a crisis point. Carers in particular highlighted that access to services before a crisis point would be beneficial for the clients and also for the carer. In Western Australia some clients were of the view that they had to overstate their needs so that they could receive services before a crisis point. One client commented:

During the assessment process you feel like you need to overstate your needs and portray a bleak picture, you avoid focusing on the things you can do, which is demoralising.

Not surprisingly, clients and carers said that access to community care services is easier for those who are receiving some services already. However information remained a problem, with many of those we spoke to were unaware of the range of community care services that are potentially available. Services such as home maintenance, nursing, gardening and respite services were far less well known. One carer commented:

I didn't realise there were more services available to us than the ones we already receive.

Our survey of existing clients and carers found that 35 per cent of clients and 60 per cent of carers thought that information on community care services ranged from 'not accessible' through to 'moderately accessible'.³³ It can be assumed that the issue of accessible information on community care services is more pronounced for those people who need services but currently do not receive them.

Beyond information issues, clients and carers identified the complexity of the community care system as a factor impacting access to services. It was highlighted that once a user or carer is referred to a service provider, there is often some confusion in navigating the community care systems in terms of:

- the number of service providers to negotiate with;
- understanding the program under which the services come from;
- understanding the process required to receive the services; and
- the number of separate assessments that may need to take place to receive different services.

³³ A 'not accessible' to 'moderately accessible' result as part of the survey included results of one to five on a scale of one to ten.

Some of those we spoke to said they were confused about the way programs interact. For example, the Aids and Equipment Program is funded separately to community care services, yet there is such a close relation that these services could be more conveniently provided together, removing the needs for multiple assessments. One carer commented:

It is difficult to understand how the system works and why so many different people call you to provide services, I am often confused about why they are calling me...

Clients and carers identified the length of waiting periods for services as limiting access to community care. The experiences of stakeholders varied in terms of the waiting period between an assessment and the commencement of services. However, it was common that waiting periods for services under a CACP or the EACH program were far greater than for HACC services. For example, one carer commented:

We had to wait 12 months for our CACP to come through after our assessment was approved.

The longer waiting periods for CACPs and EACH packages appeared to be due to the limited number of each type of package. One carer highlighted that the waiting periods for CACPs and EACH packages resulted in people being referred to the HACC program when their 'actual' needs were better suited to packaged care.

Many clients and carers identified that access to community care services depends on geographic location, the service providers available, and the funding that those service providers are allocated to provide community care services. It was noted that some service providers in some areas were more proactive in offering services to new users and informing current users of other available services. Other clients reported that their regular access to services had been limited by the availability of workers to provide the services.

The vast majority of clients and carers thought the costs of services were reasonable (approximately \$5 per hour of service) and no clients stated that the cost of services limited their access to community care. Many carers noted that the cost to government to provide community care services is far less than the cost of residential care.

3.4 Service flexibility

Both clients and carers believe that community care services are not sufficiently flexible. Clients and carers have to fit in with the times that service provider can provide services rather than services fitting in with a client's daily routine. Few service providers tailor services to an individual's needs. Instead, clients and carers found that clients were lumped into broad groups, for example:

- older users;
- young people with disabilities;
- Indigenous people; and
- people from a non-English speaking background.

This was more so the case with HACC services than for CACPs or EACH packages.

Clients expressed a desire for more flexibility in the type of services provided, so that they better meet individual needs. Some of the rules governing what can be done as part of particular community care service types — for example a carer providing domestic assistance cannot provide any personal care or perform outdoor tasks — had an impact on the appropriateness of services provided. One example reported to us involved a community bus provided for shopping, where no assistance was available for clients to take groceries from the bus into the home, meaning an informal carer needed to be present at the end of each trip.

Clients and carers advised that consistency of service is improved when it is provided by the same community care workers on a regular basis. This results in better quality services and a more individualised service.

Stakeholders were concerned that when their needs changed in the future, increased services may not be available. The short survey of clients and carers found that only 19 per cent of clients and 20 per cent of carers thought that the community care system was very flexible in providing services as needs change.

3.5 Workforce issues

Most clients and carers identified that community care workers provided services with compassion and a personable nature. One client commented:

The workers who come to my home are always pleasant, if they come often they become one of your friends.

However, it was also noted that there were unreasonable limitations to what workers could and could not provide. For example, one client commented:

It is very difficult for the worker to have all the cleaning done in one hour — she is always very rushed.

A major workforce issue that was identified by both clients and carers involved worker training. A number of clients and carers highlighted that there was a shortage of staff in general and in particular a shortage of well-trained staff. For example, clients with dementia — who require workers with a heightened skill set — are, at times, serviced by workers who do not have the required training.

It was also noted by some carers and some people who have previously been in the aged care industry, that the minimum training requirement for community care workers — the Certificate III in Aged Care — does not provide sufficient practical experience for new workers to be able to complete their work effectively and efficiently. In particular, a number of carers and community care workers identified that the Certificate III in Aged Care only allows for one week of practical experience over a six-month course. There is also a ‘fast-track’ course, completed within two weeks, which generally does not allow for any practical experience at all.

Some carers suggested that the shortage of community care staff and lack of well-trained staff stemmed from the low wages currently received in the community care industry. Existing wages were perceived as a negative factor in encouraging potential workers to join the industry.

3.6 Services for special needs groups

We asked clients of community care services from the following special needs groups — and their carers — about how the current community care service environment meets their needs:

- culturally and linguistically diverse (CALD) backgrounds;
- younger people with a disability; and
- clients located in regional and rural areas of Australia.

As part of the research for the report, we also intended to conduct focus groups to gather the views of Indigenous clients. Unfortunately our efforts to hold these meetings in time to meet the deadlines for this report were unsuccessful. We have relied upon other published sources to report the views of Indigenous clients and carers.

Most of the comments made by clients with special needs and their carers were of a similar nature to those made by other clients and carers. This section discusses only those views specific to the special needs groups.

Culturally and linguistically diverse

Clients and carers from CALD backgrounds reported that community care workers lack awareness of the cultural differences of clients and the special needs that go along with these differences. For example, a number of carers from CALD backgrounds reported that as their parents got older they reverted from English back to their first language. Community care workers struggled to communicate with these clients, highlighting a need for more responsive services (for example interpreters) for people from a CALD background. Others suggested that, based on their experiences, community care workers did not understand ethnic customs (for example, taboos regarding seeing a member of the opposite sex naked) and did not consider them when providing services.

Carers from a CALD background highlighted that in some ethnic cultures there is a focus on caring for your own family. As a result, older potential clients or new clients are initially more reluctant to access community care services and require some time for transition. One carer from a CALD background commented:

My father did not like new people in the house at first; he preferred to have me do everything for him. Over time he got used to the [community care] workers.

Another important factor for clients and carers from a CALD background was that information on community care services, both initially and ongoing, was harder to access. A number of carers from a CALD background identified that information was difficult to find and at times quite complex and hard to understand.

Younger people with a disability

The main issue identified by younger people with a disability and their carers was a lack of recognition by service providers that many younger clients of community care require services to be provided flexibly because they work and have other commitments to balance with the services they receive. One client commented:

I have to have my personal care first thing in the morning so that I can make it into work on time.

This can be particularly difficult for the many younger clients who receive higher levels of care. The younger people we spoke to expressed frustration at the lack of understanding from service providers and community care workers that they are not just a person with a disability, but a person with a life as well.

A number of younger people with a disability and their carers highlighted that they had found it difficult to access appropriate respite services and other social activities. Younger clients often feel that they are lumped in with respite services for older people. Those we spoke to indicated that there are only a small number of respite service providers that target the specific needs of younger people with a disability.

Indigenous communities

The views of Indigenous clients of community care services were captured by Queensland Health as part of a report to aid the development of a plan to better deliver HACC services to Queensland's Indigenous communities. Consultation with Indigenous communities revealed a number of shortcomings within the Indigenous communities. This has led to a number of specific strategies being developed, including:

- to increase the provision of HACC services to eligible Indigenous clients according to needs;
- to raise awareness of the HACC program in Indigenous communities in order to increase services to eligible clients;
- to identify clients' needs through culturally appropriate community consultations;
- to design the HACC program to respond to the needs of Indigenous clients in a culturally appropriate and relevant manner to ensure equitable access to HACC services; and
- an increase in the awareness of HACC workers about Indigenous cultures, community protocols and dynamics.³⁴

The Council of Social Service New South Wales conducted a conference on Indigenous issues in community care in 2006. This conference produced a number of recommendations on how community care services could be improved for Indigenous Australians. These included:

- the multiple caring role of Aboriginal carers must be recognised and acknowledged by government agencies and service providers;
- an Aboriginal male carer strategy and Aboriginal young carer strategy should be developed and resourced to address the needs of these growing populations;
- more case management for aboriginal people with disabilities should be provided;
- Indigenous coordination centres should always include issues for older people, people with disabilities and carers in their planning and project operations; and

³⁴ Queensland Health 2004, *Queensland Home and Community Care Program Aboriginal and Torres Strait Islander Service Development Plan*, Brisbane, p. 8.

- an Aboriginal workforce strategy should be developed and resourced. This should include career pathways, traineeships and scholarships for Aboriginal people in community care and disability services.³⁵

Regional and rural access to community care services

As part of the research for this report, we conducted focus groups with clients and carers in the regional areas of Orange, New South Wales and Townsville, Queensland.³⁶ Clients and carers in these areas reported that access to community care services was good in regional centres. A number of those we spoke to suggested that community care services in regional areas were more personal. Overall, clients in regional centres appeared to have higher levels of satisfaction with community care services than clients in metropolitan areas.

The problem area identified by clients and carers in regional areas was the outer regional and rural areas of Australia, where service options were perceived as being very limited. Further, clients reported there were inadequate community transport services to provide a means of transport from outer regional and rural areas to a regional hub where services could be accessed. One client commented:

The community transport service brings in people from Eyre and Ingham to Townsville to come to social events and annual meetings. People outside of the towns who would like to come have to make their own way, but that doesn't happen very often.

3.7 Improving community care services: the views of clients and carers

Clients of community care services and their carers identified a number of strategies for delivering improved services in the future:

- *More accessible, effective information on community care services.* Information on community care services should focus on three areas:
 - information for people who are new to community care and do not currently receive services;
 - information for people who currently use community care services, making them aware of other services that are available; and
 - information provided to people in a means they can understand, considering older people and people from a CALD background.
- *Improved linkages between community care services and other programs.* In particular, a focus on improving the linkages with health care services, residential care and the Aids and Equipment Program. For example, health care professionals and broader aged care community organisations be used/trained better to provide information on community care services and to identify the need for services early, before clients and carers reach crisis point.
- *Greater coordination in the administration of community care programs.* The aim should be to spend less on administration and more on service provision.

³⁵ Council of Social Service of New South Wales 2006, *Leading our way in community Care: Conference Report*, Sydney, p. 3.

³⁶ Three focus groups were held with consumers and carers in regional areas (Orange, New South Wales and Townsville, Queensland).

- *Greater funding for increased community care services.* In particular, a focus on funding for:
 - a greater number of CACP and EACH packages to reduce waiting lists and ensure that those that need a package are able to access one;
 - a greater number of respite and recreational activities, in particular for younger people with a disability so that they can experience community care services with people their own age; and
 - access to allied health services, including podiatry and physiotherapy, so that clients can access a broader range of services that are sometimes required to be able to live independently at home.
- *Increased flexibility of funding* to be able to better respond to emergency service requirements that lie outside everyday service arrangements.
- *Increased consistency of services* in terms of providing the same community care workers to the same clients. This increase in consistency decreases the administration currently required by the client or carer, improves the relationship and provides another form of companionship to clients.
- *Improved training for community care workers.* In particular, increasing the requirement for practical experience from one week as part of the Certificate III Aged Care. Also increasing the ‘fast track’ course to a greater period of time to capture some practical experience components.
- *A greater recognition of the role of carers* in assisting a client to live independently at home. This recognition could be in the form of access to the carer payment in a broader set of circumstances and to provide carers with access to training so they can understand better how to provide primary care and access community care services.

Chapter 4

Future demand: drivers, projections and trends

This chapter examines the drivers of future change in community care, of which the ageing population is the most significant. It reviews projections of future growth in demand, and shows that clients' needs will also become more complex, placing additional demands on the sector. The chapter concludes by examining trends affecting the community care workforce, which may constrain the capacity of the sector to meet future demand.

4.1 Introduction

Demand for community care services has increased steadily in recent decades and Government projections suggest that demand will continue to rise in the near to medium term.³⁷ In addition to population ageing, demographic changes will limit the number of informal carers, placing additional pressure on the formal community care system. At the same time, increasing complexity of care needs and higher expectations of the quality of services are expected to raise the cost of service delivery.

This chapter begins by exploring the key factors that will drive changes in the *level* of demand for community care into the future. The net effect will be substantial growth in demand. Section 4.3 reviews existing projections of the extent of this growth.

Section 4.4 considers emerging trends that are expected to raise the *complexity* of clients' future needs, compounding the growth in the number of services demanded. It also provides case studies of how some providers are tackling these trends.

Finally, section 4.5 examines issues affecting the community care workforce. Workforce shortages may constrain the capacity of the community care sector to meet future demand, as well as placing additional pressure on costs. Recent initiatives adopted in New Zealand, which is facing similar issues, may be instructive for Australia.

4.2 Drivers of future demand for community care

Ageing of the Australian population

Like many other countries, Australia's population is rapidly ageing. Longer life expectancy — due in large part to advances in social conditions and medical technology — have combined with falling fertility rates to produce marked changes in Australia's demographic characteristics.³⁸ Figure 4.1 illustrates that Australia's age structure has been transformed in the last generation. That transformation is likely to continue and its effects will be more widespread.

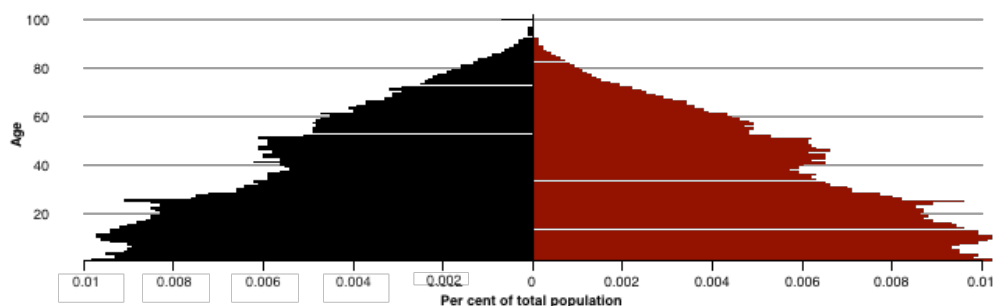
³⁷ The Treasury, 2002, *Budget Paper Number 5: Intergenerational Report*, Canberra, pp 8–10.

³⁸ Productivity Commission 2005, *Economic Implications of an Ageing Australia*, Canberra, p.5.

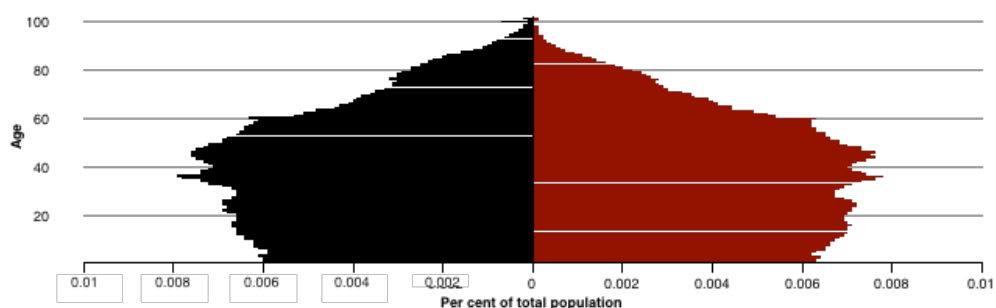
Figure 4.1

POPULATION PROFILES, 1971, 2006 AND 2041

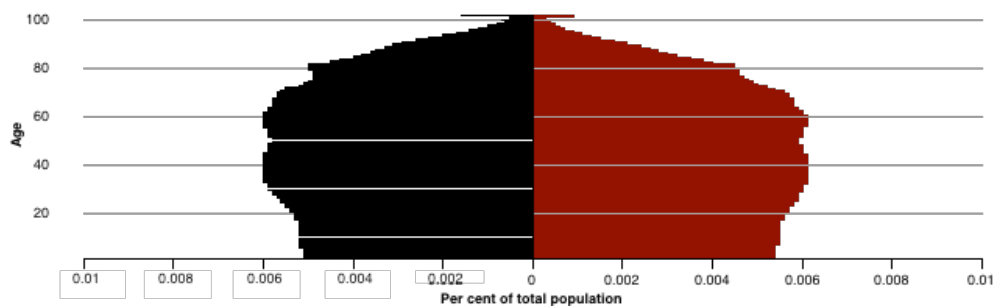
1971



2006



2041



■ Females ■ Males

Source: Productivity Commission 2005, *Economic Implications of an Ageing Australia — population data*, www.pc.gov.au/study/ageing/finalreport/data/index.html, accessed 1 December 2006.

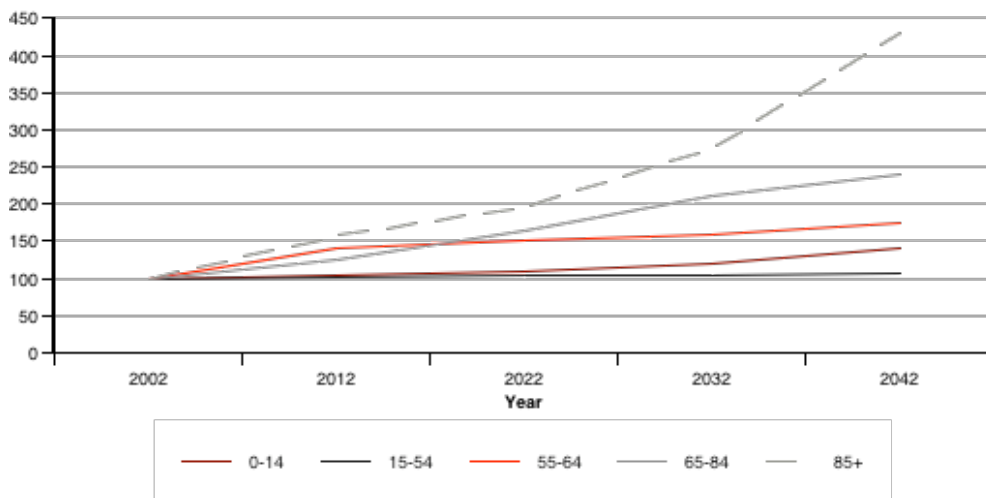
The resulting changes will be profound. While the number of Australians over the age of 54 is likely to double in the next forty years, the number of Australians under the age of 54 is likely to remain largely stable. The share of the population aged over 65 is projected to rise from 13 per cent to 24.5 per cent between 2003-04 and 2044-45.³⁹ Even more pronounced, the share of the population aged over 85 is expected to increase from 1.5 per cent to 5 per cent over the same period.⁴⁰ Figure 4.2 illustrates that this ageing effect is anticipated to accelerate over time.

³⁹ The Treasury 2004, *Australia's Demographic Challenges*, demographics.treasury.gov.au, accessed 28 November 2006, p. 18.

⁴⁰ Productivity Commission 2005, *Economic Implications of an Ageing Australia*, Canberra, p.7.

Figure 4.2

INDEX OF GROWTH FOR SELECTED AGE RANGES, 2002 — 2042 (BASE = 100)



Source: The Treasury 2002, *Budget Paper Number 5: Intergenerational Report*, Canberra, Chart 13.

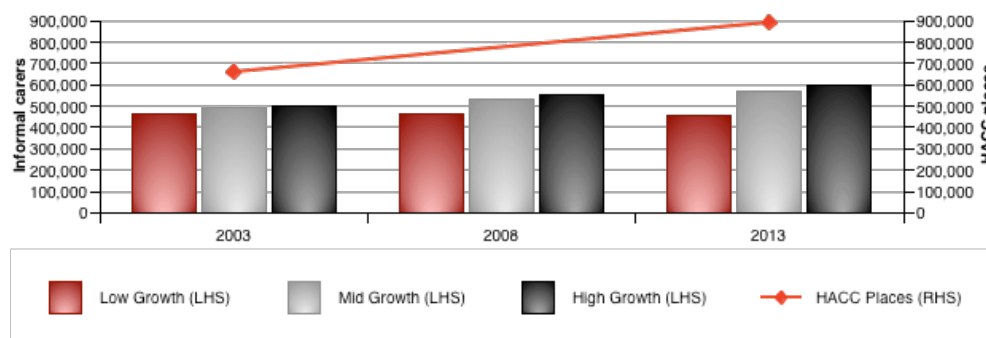
These changes are likely to have widespread effects on the future of community care. In addition to living longer, people aged 65 and older are much healthier than they were a few decades ago. On average, they have greater retirement incomes (although some vulnerable groups are still at risk of poverty) and are living alone more frequently.⁴¹ These demographic trends have contributed to an increased need for community care services.

Availability of informal carers

Another factor contributing to future growth in demand for community care is the predicted decline in the informal care sector. At present, unpaid family and other informal care accounts for approximately 74 per cent of the support provided to older people and persons with a disability in Australia. In the future, however, even the highest projection of future growth in the number of informal carers is lower than the expected rate of growth in demand for HACC places (Figure 4.3).

Figure 4.3

GROWTH IN INFORMAL CARERS AND DEMAND FOR HACC PLACES



Source: Australian Institute for Health and Welfare 2003 *The future supply of informal care 2003 to 2013: alternative scenarios*, AIHW cat no. AGE 32, Canberra, Table 12; and Productivity Commission 2005 *Economic Implications of an Ageing Australia*, Canberra, p. 184.

⁴¹ OECD 2005, *The Social Conditions of Older People: Achievements and Challenges*, IV 8. at p. 156

In 2001, there were 57 primary carers available for every 100 older persons needing care (with a severe or profound disability and living in a private residence). By 2031, the availability of carers is expected to have fallen to 35 primary carers available for every 100 persons — a reduction of 39 per cent.⁴² A number of demographic and social changes will limit the number of family members and others who can provide informal care. These include:

- the ageing of carers, especially those caring for disabled younger people;
- increased female labour force participation;
- increased rates of relationship breakdown; and
- a tendency towards smaller families.⁴³

The ageing of the population will affect the availability of carers. In Australia, 90 per cent of the carers for frail older people are aged between 60 and 69 years and 72 per cent of carers for people aged 70 years and over are spouses.⁴⁴

Over the period 1971 to 2002 female labour force participation rose from less than 40 per cent to 55 per cent, a trend that is projected to continue. This is particularly the case for females aged 45 to 54, who currently account for more than 40 per cent of female primary carers.⁴⁵ This could particularly impact on the availability of carers for younger people with a disability. However, there is no clear evidence that increased labour force participation translates to lower carer availability.⁴⁶

Family resources are reduced following the breakdown of relationships that ultimately result in separation or divorce and this may have implications for the provision of informal care. Most assistance tends to come from within generations rather than between them, therefore marital status is an important determinant of family resources for care and support. The current population of older people (those aged over 75) are most likely to have been married for life. However, Australia is on the threshold of a decline in family resources as higher proportions of families experience marriage breakdown and live their later years without spouses, the main carers and supporters of the aged.⁴⁷

Similar concerns have been raised regarding the tendency towards smaller families and childlessness. Smaller families mean that in the future there will be fewer family members for individuals to call upon for caring needs – fewer adult children to assist parents and fewer siblings to assist each other. However the effects of smaller families is not likely to start being felt until 2040. Until this time older generations in Australia will be largely “family-rich”.⁴⁸

⁴² National Centre for Social and Economic Modelling 2004, *Who's going to Care? Informal Care and an Ageing Population*, University of Canberra, Canberra, p. 30.

⁴³ Australian Institute of Health and Welfare 2003, op. cit., p.67.

⁴⁴ Australian Institute for Health and Welfare 2003 *The future supply of informal care 2003 to 2013: alternative scenarios*, AIHW cat. no. AGE 32, Canberra, p. 8.

⁴⁵ Australian Institute of Health and Welfare 2003, op. cit., p.68.

⁴⁶ Ibid., p.70.

⁴⁷ Ibid.

⁴⁸ Ibid., p.73.

Changing disability rates

There has been an increase in the level of disability in the Australian community that is not age related. Individuals with a disability are living longer than they have in the past, primarily due to advances in health care.⁴⁹ However, the impact on demand for community care services will depend on the severity of disability and the extent to which medical and technological advances allow individuals with a disability to live more independently.

Although evidence is mixed, both the Hogan Review⁵⁰ and the Productivity Commission have concluded that age-specific rates of severe and profound disability are likely to decline moderately in the future. The Productivity Commission found that the effect of a falling disability rate was significant, but only partially offsets the increase in the number of old people. For example, if there were no reductions in disability the number of low and high care residents is projected to rise by over 250 per cent between now and 2044-45. However, with a reduction in disability of 0.25 per cent annually, the increase in low and high care residents is projected to be around 215 per cent.⁵¹ A similar offset could be expected for community care also.

Substitution for more costly services

While population ageing is likely to increase demand for community care services, and the decreasing availability of informal carers will reduce the community's capacity to satisfy excess demand outside the formal care sector, there is evidence to suggest that future generations of older people will exhibit more complex needs and may demand a higher level and quality of service than is currently common. In addition, the cost of providing health and community services rises with the age of the user of those services.⁵²

The combination of all of these effects is likely to be a need for substantial increases in expenditure on the range of health and aged care services, as Figure 4.4 illustrates. As a result, Australian Government spending in the areas of health and aged care could double as a proportion of GDP if current policies are retained.

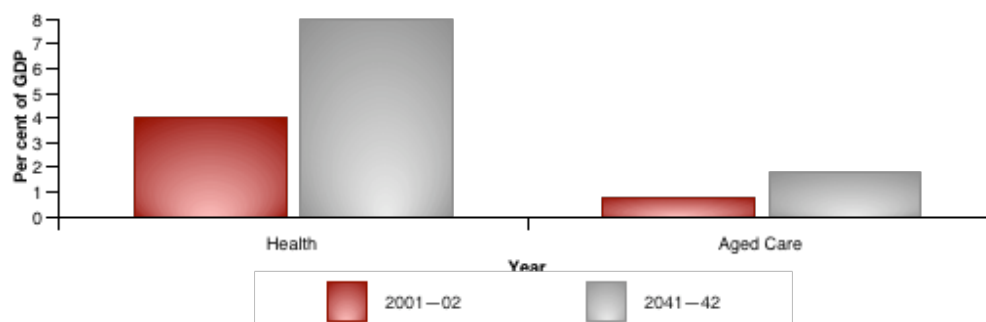
⁴⁹ Productivity Commission 2005, op. cit., p.8.

⁵⁰ Professor Warren Hogan, was commissioned by the Australian Government to undertake a review of pricing arrangements in residential aged care. His report, *Review of Pricing Arrangements in Residential Aged Care*, was published in 2004.

⁵¹ Productivity Commission 2005, *Economic Implications of an Ageing Australia*, Canberra, pp.178-9.

⁵² Productivity Commission 2005 *Economic Implications of an Ageing Australia — an illustrated guide*, Canberra, www.pc.gov.au/cs20050624/index.html, accessed 1 December 2006, p. 7.

Figure 4.4

PROJECTED AUSTRALIAN GOVERNMENT SPENDING BY CATEGORY

Source: The Treasury 2002, *Budget Paper Number 5: Intergenerational Report*, Canberra, Chart 19.

In an environment where the costs of providing care are increasing, policy responses that divert patients from primary or acute care to other, less expensive forms of care — such as community care — will be important. The Australian Government has recognised both the financial and social benefits of moving away from institution-based primary and aged care systems, encouraging people to remain at home and utilise community care services rather than entering residential aged care. Based on current trends and policy it is likely that there will be a shift in demand away from low-level residential care and towards community care over the next 10 to 15 years — in addition to the projected growth coming from population ageing.⁵³

4.3 Projections of future demand

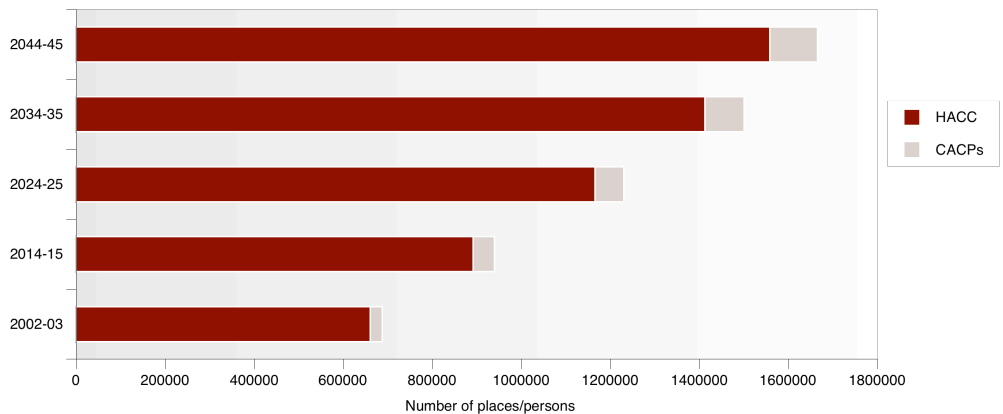
On current service patterns, the Department of Health and Ageing estimates that the number of people aged 85 and over who rely on community care programs will rise from 81 000 in 2002 to 140 000 in 2019. The number of people across all age groups who rely on community care services will increase from 650 000 in 2002 to almost 970 000 in 2019.⁵⁴

This accords with the level of demand projected by the Productivity Commission, which has estimated that the number of clients likely to require HACC and CACPs will more than double over the next forty years, as illustrated in Figure 4.5.

⁵³ Productivity Commission 2005, op. cit., p.179.

⁵⁴ Department of Health and Ageing 2003, op. cit., p.8.

Figure 4.5

PROJECTIONS OF PERSONS RECEIVING HACC AND CACP PROGRAMS

Source: Productivity Commission 2005, *Economic Impacts of and Ageing Australia*, Canberra, p.184.

In reaching the predicted level of demand, above, the Productivity Commission has taken into account projected population ageing and a limited increase in demand arising from a decline in the number of informal carers, and has assumed there will be greater use of high needs residential aged care places at the expense of less intensive forms of care, including community care. The latter assumption is not consistent with many of the conclusions of the Hogan report and may underestimate potential future demand.

4.4 Increasing complexity of demand

In the future, it is not only likely that there will be a greater number of clients needing community care, but also that their care needs will be more complex. This complexity reflects:

- emerging trends in population health, in particular an increase in the prevalence of dementia;
- increasing diversity in the community and the need for community care providers to arrange care programs that are sensitive to the needs of an increasingly segmented client group; and
- emerging social trends that are likely to increase the standard of care demanded by future community care users.

Rising prevalence of dementia

The prevalence of dementia among Australians may double every five years after the age of 65. Older people who have a form of dementia as their main clinical condition are more likely to have a profound or severe core activity restriction. People with dementia can require a high level of care and assistance with numerous personal tasks. For example, a recent study found that of all people with dementia living in a private residence, 63 per cent required assistance for personal care activities and 82 per cent required assistance for health care activities.⁵⁵

⁵⁵ Australian Institute of Health and Welfare 2007, *Dementia in Australia: National Data Analysis and Development*, Canberra, p. 93.

The prevalence of dementia among older people will increase by 22 per cent between 2002-03 and 2042-43.⁵⁶ This means a greater proportion of community care clients will have very complex needs, raising the average cost per client of delivering community care.

Increasing diversity

The ageing of particular sections of the population also has the potential to place additional pressure on the aged care system. People from culturally and linguistically diverse (CALD) backgrounds will form a large proportion of older Australians. Many of these people will experience some language reversion — this will be more likely and more acute if they develop a cognitive impairment — increasing the complexity and cost of service delivery.⁵⁷ Raising the awareness of these populations about community care appears to have been challenging in the past — older people from CALD and indigenous communities have been less likely to participate in community care programs, despite often benefiting more from such support than people from other groups.⁵⁸

Improving equity of access to those who have greater needs but lower representation in the system is a goal of both national and state governments. Several states have identified the challenge of providing community care to a diverse older population.⁵⁹ A number of innovative attempts have been made to encourage people from culturally diverse communities to use community care services. Two examples are the South Australian diverse communities projects (Box 4.1) and the Whittlesea senior citizens liaison program (Box 4.2).

⁵⁶ Ibid., pp.89-90.

⁵⁷ Ibid., pp.86-87.

⁵⁸ Senate of Australia, Community Affairs References Committee 2004, op. cit., p. 154.

⁵⁹ See, for example, Queensland Health, *A Brief Overview: Queensland Health's Directions for Aged Care 2004-2011*, p. 6 www.health.qld.gov.au/acru/aged_care/PDFs/287818_Summary_5.pdf, accessed 27 September 2006; Victorian Department of Human Services, *Home and Community Care Program: Victorian annual program plan 2005-06*, p. 3, www.health.vic.gov.au/hacc/downloads/pdf/hacc_annual_plan_0506.pdf, accessed 27 September 2006.

Box 4.1

CASE STUDY: SOUTH AUSTRALIAN DIVERSE COMMUNITIES PROJECTS

A number of local councils in northern Adelaide recognised that they shared a problem. In their areas, while the population of ethnically diverse older people was growing, demand for community care services among this cohort was steady. These older people were not seeking support services.

The councils established a project to understand why people from CALD communities were not using community care services. Many of the barriers to greater participation among CALD communities were found to be cultural, such as language difficulties and unfamiliarity with local services.

Knowing that these barriers existed, the councils were then able to improve the participation of people from CALD communities in community care programs by fostering partnerships with CALD community groups and tailoring communications to particular linguistic and cultural groups.

In the participating communities, there has been an increase in the engagement of older people from diverse communities in community care programs as a result of this project. The project has also been successful in raising awareness of the changing demographics within the local area, and has cast issues relating to ageing firmly into the community's focus.

Source: Australian Local Government Association, 'Local government response to diverse communities project', www.alga.asn.au/policy/healthAgeing/ageing/resources/innovativePractice/connectingWithSeniors/salisbury.php, accessed 27 September 2006.

Box 4.2

CASE STUDY: WHITTLESEA SENIOR CITIZENS LIAISON PROGRAM

Whittlesea is a local area in Melbourne with a large migrant population. A majority of the city's population speaks a language other than English at home. The community groups in the area are strong, and the local council saw an opportunity to use these community networks to increase understanding about the services offered by community care services.

The council established a Senior Citizens Liaison Network to facilitate information sharing between the various community groups within the area. The network helped support the active social networks that already existed in the area and contributed to the already vibrant lives of many of the older people in the city.

As part of the program, the council developed a multicultural resource kit for each of the larger communities in the area. This kit included details of the importance of older people maintaining an active lifestyle, and gave practical ideas on how to do this.

The result of these efforts has been that older members of the Whittlesea community are more fully integrated into all aspects of life, have enhanced ability to live independently at home, and enjoy increased companionship through greater social interaction.

Source: Australian Local Government Association, 'Local government response to diverse communities project', www.alga.asn.au/policy/healthAgeing/ageing/resources/innovativePractice/connectingWithSeniors/salisbury.php, accessed 27 September 2006.

Higher community expectations

Rising community expectations about the level of care may also act to raise the level and complexity of demand for community care services. A theme in much of the literature on community care is the importance of providing support that is targeted to the individual. Policies promoting more flexible and targeted approaches to service delivery will raise clients' awareness and expectations of service quality and value for money. In addition, the push to increase competition in a range of markets has reinforced attitudes among Australians wanting greater choice in the services they receive. As client outcomes improve, non-clients in the target population may become more likely to seek care services, and to be more demanding about their quality.

The Victorian Department of Human Services' *Well for Life* program provides a practical strategy for engaging both clients and professionals in striving to continually improve community care services (Box 4.3).

Box 4.3

CASE STUDY: VICTORIAN WELL FOR LIFE PROGRAM

The Victorian *Well for Life* program aims to improve the health of older people by identifying changes that could be made to the policies and practices in HACC Planned Activity Groups and Residential Aged Care agencies. By encouraging staff to change the way in which services are offered, the program empowers staff to focus on innovation in service delivery and design. In this way the program acts as a powerful tool for the continuous improvement of the community care services in the participating projects.

Well for Life takes a holistic approach to health, which draws on the skills and experiences of older people, their carers, aged care professionals and families to develop healthy living strategies that are tailored to the individual client. The idea is to focus on 'what works' for a particular person, recognising that this will differ from individual to individual.

One of the outcomes of this process has been to challenge taken-for-granted notions of what older people can and cannot do. Many of the participants in the program had very low expectations of their own health — and overall quality of life — as they aged. The success of *Well for Life* was founded in staff encouraging participants to exceed their own expectations regarding their mobility, capacity for exercise and diet. As clients' physical capacity increased, so too did their expectations of what they could achieve.

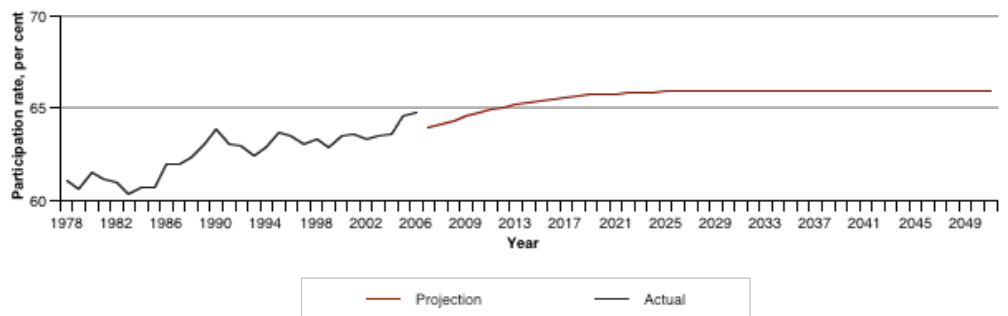
As part of the program, care providers were encouraged to take ownership of innovations in service provision. Providers shared information and collaborated to improve service provision across locations and providers. They built networks to facilitate information sharing. As a consequence providers gained a greater understanding of the overall service system and identified opportunities to refine service offerings through further collaboration.

Source: Victorian Department of Human Services 2005, *Well for Life Evaluation: Highlights from the evaluation of phase one projects*, Melbourne.

4.5 Workforce

Shortages in the supply of community care workers are likely to become more acute in the future. One of the most important aspects of population ageing in relation to formal care is the slowing of growth in the labour force participation rate that is likely to result in coming years. Over the last generation, Australia has experienced a large increase in labour force participation. Employers needing to expand their operations to meet growth in demand have been well placed to hire additional workers. Figure 4.6 illustrates that this trend will not continue.

Figure 4.6

AUSTRALIAN LABOUR FORCE PARTICIPATION RATE, 1977 — 2051

Source: ABS 2006, *Labour Force Statistics*, cat. no. 6202.0, AusInfo, Canberra, and Productivity Commission 2006, *Economic Implications of an Ageing Australia — population data*, www.pc.gov.au/study/ageing/finalreport/data/index.html, accessed 1 December 2006.

As the potential pool of workers plateaus, competition for their services will increase. It will become harder for community care providers to attract the workers they need to meet rapidly growing demand. Future workers will also need to be more highly skilled, to meet the more complex needs of clients, such as those with dementia. The cost of attracting scarce workers with the skills necessary for the community care sector are likely to increase substantially as a result.

It is essential that government — in partnership with the community care sector — act to address workforce shortages. In 2005, the Productivity Commission undertook a study of Australia's health workforce, which overlaps with the community care workforce and is facing similar challenges. The Commission recommended four approaches to overcoming current shortages and to address the future pressures facing the system, which are equally relevant to community care.⁶⁰

- Reduce the underlying demand for health care through 'wellness' and preventative strategies.
- Short term increases in education and training places in some areas.
- A greater emphasis on retention and re-entry to help stabilise workforce numbers — as recent initiatives in the nursing area in some jurisdictions have shown.
- Improve the productivity and effectiveness of the available workforce, and its responsiveness to changing needs and pressures — which will increase the level and quality of the workforce services that can be supported by any given level of spending.

⁶⁰ Productivity Commission 2005, *Australia's Health Workforce*, Research Report, Canberra.

Ideas from New Zealand

The New Zealand Government, facing similar issues, has recently undertaken initiatives to improve the recruitment, retention and support of home care workers and to develop more secure career paths in the sector.⁶¹ The New Zealand approach focuses on improving and providing structure to the care-giving workforce, and is expected to not only address workforce shortages, but also have a positive effect on the quality of service provided by community care workers.

Recommendations by the Health Workforce Advisory Committee (HWAC) to the New Zealand Ministry for Health to address home care workforce issues included:

- moving to a ‘packages of care’⁶² model to allow providers to guarantee set work hours for formal caregivers;
- implementing a mandatory home-based sector standard to which all home care providers will have to adhere and be measured against;
- linking funding increases to staff training and development; and
- formalising the career framework for the care-giving workforce.⁶³

The HWAC also recommended that a national career framework for community-based carers to be in place in all workplaces and for all staff, and for employers of care-givers to have contractually-linked incentives to ensure learning, training, supervision and assessment. It also stressed the importance of having an agreed service delivery model for community care with clear role requirements and competencies, as well as standards for a national qualification framework.⁶⁴ The HWAC argues that this will have a positive effect on the quality of service provided by community care workers.

⁶¹ Health Workforce Advisory Committee 2006, *Care and Support in the Community Setting* Discussion Paper, June, p. 3. The Quality and Safety Project, which ran from September 2003 to December 2004, identified greater risks to safety in home-based care as opposed to residential services.

⁶² Service providers saw the lack of a guarantee for ongoing work associated with the ‘per hour per client’ funding model as contributing to staff recruitment and retention and the casualisation of the workforce.

⁶³ Health Workforce Advisory Committee 2006, op. cit., p. 5

⁶⁴ Ibid. p.30

Chapter 5

Expanding and developing community care: a platform for reform

This chapter puts forward three strategies to expand and develop community care. The strategies target ways to improve clients' access to more appropriate services; give providers stronger incentives to meet clients' individual needs; and provide clients with greater choice and control over the care they receive.

5.1 Introduction

This chapter puts forward a platform for expanding and developing community care. The strategies that form the platform were developed on the basis of clients' and carers' experiences and views of the current community care system as discussed in focus groups (summarised in Chapter 3) and further informed by interviews with community care providers and experts in the field of community care (listed at Appendix B).

We also took into account the future challenges facing providers and governments (as discussed in Chapter 4). In summary, population ageing, rising expectations of government service delivery, a fall in the share of support provided by informal care, and an increase in the complexity of care will see demand for community care grow rapidly into the future. Governments and providers will need to improve the effectiveness and efficiency of service delivery if the community care system is to withstand cost pressures and continue to meet the needs of its growing client population into the future.

The chapter discusses three strategies for reform.

Strategy 1 is a set of measures that aim to improve the current system of community care, and in particular to improve clients' access to more appropriate services. The measures reflect clients' and carers' own priorities — these are the things that they believe will make the biggest differences to their experiences and those of future clients. The measures also draw upon ideas and suggestions made by industry experts and community care providers during consultations. We highlight examples of good practice, and propose that these examples be shared and adopted across the system.

The second and third strategies are:

- outcomes-based funding, giving increased flexibility to providers to achieve outcome targets for clients (*Strategy 2*);
- consumer-directed care, providing clients with greater choice and control over the care they receive (*Strategy 3*).

Strategies 2 and 3 entail more fundamental reform to community care. They reflect the need for stronger incentives for providers to seek better, more cost-effective outcomes for their clients. Such incentives are imperative to encourage providers to do more to meet clients' individual needs by providing the right services at the right time, while ensuring the cost of providing community care remains sustainable.

5.2 Strategy 1: Improving access and appropriateness

Overview

Strategy 1 is a set of measures that aim to improve the current system of community care, and in particular to improve clients' access to more appropriate services. As noted above, the measures in particular reflect clients' and carers' own priorities as identified in focus groups. There are four elements of reform:

- An expansion of the independence model of care;
- Improving respite care;
- More tailored provision for younger clients with a disability; and
- Better access to and information about community care.

It is notable that each of these reforms could be implemented today and, indeed, have been adopted in some parts of the system. An aim of this strategy, hence, is to promote and encourage greater take up of best practice.

Expanding the independence model

The first element of Strategy 1 is an expansion of the independence model of care. A recent trend in community care provision is to focus on promoting and enhancing the independence of clients, rather than the traditional paradigm of responding to their dependence needs. This new model of care has been adopted by some jurisdictions and individual providers, but overall is not widespread. Two prominent examples are Victoria's Active Service Model and the independence programs offered by Silver Chain in Western Australia, which are discussed below.

At the core of the independence model is a commitment to early intervention and prevention. In consultations, both community care providers and industry experts identified a greater emphasis on early intervention and prevention as a key reform needed to achieve better outcomes for clients. The idea of the independence model is not to replace services that are directed at 'support and maintenance', but to provide other services earlier to promote clients' independence, so as to reduce the need for ongoing support in the future. This would be highly valued by clients, who want to receive assistance before they reach a crisis point.

The independence model involves the provision of more individualised services that aim to meet clients' specific circumstances. Good assessment and case management services are pivotal to the independence approach, as providers need to understand and address the factors underlying a person's request for services. Assessment should include consideration of the situation and needs of informal carers, not just clients.

Victoria is proposing a more thorough assessment of the scope for improving a clients' ability to manage at home, by considering all relevant factors, particularly the reasons *why* the person is experiencing difficulty in coping in their home environment. With modern advances in rehabilitative techniques, ergonomic and

labour-saving equipment, and occupational therapy, a great deal can be done to help people cope with functional disability.⁶⁵

The independence model supports the development of a more client-focused community care system. Mike Rungie argues that older people simply want to continue to live well and, in the main, find their own solutions to life's challenges.⁶⁶ Service interventions should be positioned to enable clients to learn to manage their own conditions, rather than to assist the client when they can no longer manage. Most older people, Rungie says, still have the potential to improve and believe this, but the current system assumes they cannot, and is set up so that they won't.

The independence model was widely supported by clients, providers and industry experts. Anna Howe and Glenn Rees noted that the spread of the model across the system would be an important development towards controlling the future cost of community care, by reducing the number of clients with ongoing care needs, and possibly decreasing the average intensity of service provision per client.

Victoria's Active Service Model

The Victorian Department of Human Services has established an *Active Service Model Program* to increase the Victorian HACC Program's effectiveness in maximising client independence. Through more person-centred approaches to service delivery, the program aims to achieve two outcomes:⁶⁷

- to improve or maintain clients' capacity to do their own personal and domestic tasks, and to participate in social and community activities, such that their need for recurrent HACC services is delayed or reduced; and
- to change perceptions of the capacities of frail older people and younger people with disabilities among the community, the community care workforce, and the clients themselves.

To implement the model, the Department intends to collaborate with HACC service providers to enable them to move beyond a 'dependency' model where tasks are largely done for clients to a 'restorative' and 'capacity-building' approach. This will involve challenging the assumption that 'at a certain point older people become progressively less able to manage, and will inevitably need formal support services to take over the tasks of daily living.'⁶⁸ At a practical level, implementing the independence model might mean:⁶⁹

- assisting a client to shower themselves rather than doing it for them;
- making modifications in the home to improve mobility;
- helping clients learn how to cook for one;
- introducing clients to lighter and easy-to-use cleaning equipment rather than doing all cleaning for the person;

⁶⁵ J. Jacobson 2006, 'Future Directions in the HACC Program in Victoria', speech at the Ministerial launch of Priorities & Future Directions for the HACC Program in Victoria, 11 April.

⁶⁶ M. Rungie 2006, 'The Question: Are There Really Limits to Community Care?', paper presented to 1st ACSA National Community Care Conference, Sydney, 3-5 May.

⁶⁷ Victorian Department of Human Services 2006, *Victorian HACC Program: Active Service Model Project*, www.health.vic.gov.au/hacc/projects/asm_project.htm, Accessed 10 December 2006.

⁶⁸ J. Jacobson 2006, op. cit.

⁶⁹ Victorian Department of Human Services 2006, op. cit.

- improving clients' sense of self worth through social activities; or
- joining a strength training program to improve balance, energy and physical strength as well as the person's sense of well being.

The Department is taking a number of steps to further develop the model, including reviewing literature and identifying innovative practice; supporting and evaluating a limited number of pilots; and consulting with service providers, health professionals, academics and peak agencies. This work will inform a policy and funding framework in which active service principles underpin HACC assessment and service delivery in Victoria. This report is to be presented to the Minister in early 2007.

Silver Chain

Since 2000, Silver Chain, Western Australia's largest home care provider, has developed and implemented two home care programs focused on promoting people's independence. The two programs are described in Box 5.1.

Box 5.1

SILVER CHAIN PROGRAMS TO PROMOTE INDEPENDENCE

The Home Independence Program (HIP) is an early intervention program directed at optimising functioning, preventing or delaying further functional decline, promoting healthy ageing and encouraging the self-management of chronic diseases. It is available to people aged over 65 when they are first referred to home care services or at a point when their needs have increased and additional services are being requested. Beginning in 2000 as a pilot program tested with 42 waitlisted clients, HIP has grown to be a metropolitan-wide service that received 624 referrals in the last financial year.

The Personal Enablement Program (PEP) provides a rapid response to community care clients aged over 65 who are being discharged from hospital. Based on HIP, PEP is also designed to remove or minimise an individual's need for ongoing home support services by maximising their functional independence. Commencing as a metropolitan-wide service in March 2003, this program received 343 referrals in its first six months of operation. In the last financial year 1196 referrals were received and 989 completed the program.

Source: Silver Chain 2006, *Programs to Promote Independence at Home: How Effective Are They?*, October, www.silverchain.org.au, Accessed 9 December 2006.

The programs are based on a 'best practice' independent service model that re-enables individuals requiring assistance with activities of daily living to complete these activities independently or to minimise the amount of assistance they require. The programs have a number of components that help to achieve this objective in cost effective manner, including:

- comprehensive multi-dimensional assessment;
- goal-oriented care planning in partnership with the client;
- targeted evidence-based interventions to optimise functioning in daily living activities;
- education about principles of self-management, healthy ageing, use of medications and illness/accident prevention strategies; and
- gaining of family support for the promotion of independence.

Program evaluation

Just over 70 per cent of individuals referred to HIP and PEP go on to complete the programs. Of those who do not, fewer than 10 per cent are found to be inappropriate for the program, and approximately equal numbers withdraw or have their care cancelled because of changed circumstances. The average length of stay on the two programs (53 days for HIP and 49 days for PEP) is very similar despite the programs being originally designed with different time limits (HIP 12 weeks and PEP 8 weeks). For both programs, the intention is that an individual is discharged as soon as they have achieved their goals and are assessed as being able to maintain their improved functioning.⁷⁰

The service outcomes for clients completing the program can be assessed by comparing the home support services requested at the time of referral to the program with the services received after the program has ended. Among those who completed the programs, 62 per cent of HIP clients and 73 per cent of PEP clients needed no ongoing services at discharge. A further 19 per cent of HIP clients and 13 per cent of PEP clients had been referred because their need for services had increased, but needed the same services at discharge as they had been receiving at referral. The programs can therefore be assessed as being effective for 81 per cent of HIP clients and 86 per cent of PEP clients.⁷¹

Clients are also asked for their evaluation of the programs. The results show a high level of satisfaction with both.

Case management

Good assessment and case management is an important underpinning of the independence model. Presently, case management is used sporadically across the community care sector in Australia. While 70 per cent of CACP recipients use the services of a case manager, very few HACC or EACH clients receive regular case management.⁷² This includes many clients with higher care needs, who potentially have much to gain from a case manager's assistance to access the right type of services as their needs change. Good case management can also support a client's independence and confidence.⁷³ Glenn Rees noted that clients want to feel there is someone in the system to guide them through, no matter what stage they are at.

Active case management can deliver a range of benefits to the broader community care system as well as to individual clients. Good case management promotes more efficient use of available resources. A case manager with strong links to service providers can support innovation by directing the right type of clients to providers to a new program.

⁷⁰ Silver Chain 2006, *Programs to Promote Independence at Home: How Effective Are They?*, October, www.silverchain.org.au, Accessed 9 December 2006.

⁷¹ Ibid.

⁷² Australian Institute of Health and Welfare 2005, op. cit., pp. 164-171.

⁷³ Aged and Community Services Australia 2006, *Case Management and Community Care: A Discussion Paper*, Canberra, pp. 10-11.

Conclusion

At the heart of the independence model is a commitment to prevention and early intervention, better and earlier referrals from post-acute and primary care to community care, and more thorough assessment and case management services. As the independence model is a relatively new development in community care in Australia, there is limited evidence available about its effectiveness. It is, however, supported by an emerging body of research, and the results of the Silver Chain independence programs are particularly encouraging. The results of the evaluation of the Victorian pilots will be of great interest.

Provided that such trials remain supportive, it is recommended that the independence model be expanded to apply to the delivery of community care across Australia. The model would be applied to those clients who are assessed as being appropriate for services that seek to re-establish independence or reduce dependence on ongoing care. This initiative would be enhanced by measures to support informal carers to continue providing care in the home.

Each State and Territory's systems should be modified to devote greater resources to early intervention and prevention. The experience of Victoria, which is planning to implement the model across its HACC program, will be instructive for other jurisdictions.

It is also recommended that case management be made available to a wider range of community care customers. At a minimum, case management services should be available to all higher care needs clients. Additional funding would be required to implement this reform, however this could be regarded as an investment in the system that could be expected to produce improved efficiency and lower average costs over time.

Improving respite care

The second element of Strategy 1 is to improve respite care. Respite care is important not only for clients of community care, but also those who act as their informal carers. Providing care can be very demanding and stressful — for many family members it is close to a full-time role. Respite care provides informal carers with a much-needed break, without which they may not be able to continue, and clients would have to turn to formal care for greater support. In this way, respite care can help to reduce the demands on the community care system.

Currently, respite care services are available to clients of community care through three major programs:

- the HACC program, which provides in home respite care and access to external respite care centres that are generally catered towards elderly users. Approximately 16 500 HACC clients utilised respite care services in 2004-05;⁷⁴
- the National Respite for Carers Program (NRCP), which allows carers of older people and people with disabilities to have a break to look after their own health and wellbeing. The program provides information, counselling and support for carers, as well as assistance to help them take a break from caring. Funding for this program in 2003-04 was approximately \$99 million;⁷⁵ and
- Commonwealth Carer Respite Centres across the nation coordinate respite services, help carers to access respite when needed, and provide information and support for carers. This program is used to assist carers to obtain respite services funded through the NRCP.

In addition to providers of respite care in Australia, the Commonwealth Carer Resource Centres and Commonwealth Carelink Centres provide contacts in each State and Territory for carers to obtain information and advice on all aspects of caring and respite.

In consultations, Glenn Rees identified respite care as one of the priority service areas requiring reform. According to Rees, clients need respite services to be more flexible and responsive to ‘how, when and where’ clients want them. Several providers agreed that existing respite care services tend to be provided in the same way for all clients and that, in particular, there is a need for respite that is tailored to the needs of younger clients. Finally, some providers echoed the thoughts of clients and carers by raising concerns about a shortage of respite services, which they expected to become more pronounced as demographic change reduces the number of informal carers.

Proposed reforms

Two reforms are recommended to improve clients’ and carers’ access to appropriate respite care.

First, there is a need to change the nature of some respite services, to better match the needs of clients of community care and their carers. One specific gap is respite for younger people with a disability, who often have to utilise elderly respite care services that are inappropriate for their needs. This can be demoralising for clients and stressful for their informal carers. Older clients also expressed a desire for more active respite and centre-based day care. There needs to be greater adoption of new models of respite for individuals and groups, such as local cottage respite for older people and their carers and ‘meaningful activity’ respite (for example, men’s sheds, community access activities, respite through recreation) for both older and younger people.

Second, provision of additional respite care places would ease the burden on the family members and friends who act as informal carers, enhancing their capacity to participate in work, education and community life. In consultations, clients and

⁷⁴ Department of Health and Ageing 2006, op. cit., Table A16, p. 32.

⁷⁵ Department of Health and Ageing 2006, ‘Carers’. www.aodgp.gov.au/internet/wcms/publishing.nsf/Content/ageing-carers-index.htm, Accessed 7 December 2006.

their carers reported that there were long waiting lists for respite care. In particular emergency in-home respite was difficult to access. External respite services may be taking on clients who would prefer a few hours of respite at home but are unable to access such services. Additional emergency in-home respite places may ease the pressure on external respite care. A similar change to respite services was recently implemented in the United Kingdom as part of the Government's White Paper *Our health, our care, our say: a new direction for community services*.⁷⁶ In addition, more out-of-hours respite, including weekend and evening options, is needed to better support carers. These changes would require additional funding.⁷⁷

More tailored provision to younger clients with a disability

The third element of Strategy 1 is to provide services better tailored to the needs of younger people with a disability. Although HACC services are available to younger people with a disability, a number of these services are not tailored to meet their needs. Several providers acknowledged that younger clients with a disability have unique needs to which the existing system does not adequately respond. Many community care workers have not been trained to handle the specific complexities involved with younger clients or clients with a disability.

For example:

- community care services are often inflexible in terms of the time at which services are provided. For a younger person with a disability (or a younger carer) who also works, this lack of flexibility makes it difficult to receive community care services and may have to forgo the services in order to continue working;
- relatively few recreational and social programs are tailored towards younger people with a disability, limiting the opportunities for younger clients to socialise and interact with people of the same age group;
- community care service workers who lack training in disabilities may not be able to operate lifters that paraplegics use to get in and out of bed; and
- as noted above, there are few respite care or centre-based day care services that cater specifically for younger clients. Many younger people are forced to use services that are targeted towards the elderly.

Proposed reforms

There are three main ways in which community care services could be made more appropriate to the needs of younger recipients:

- provide a more flexible and responsive services, acknowledging that younger clients and carers often need to receive services that fit in with their work commitments. Good practice approaches to delivering services to younger clients, including from disability service providers, should be identified and disseminated across the system;

⁷⁶ UK Department of Health 2006: *Our health, our care, our say: a new direction for community services: a brief guide*

⁷⁷ In February 2007, the Australian Government announced it would fund an additional 10 000 days of respite services over the next four years.

- provide additional recreational and social programs specifically tailored to younger people with a disability, providing an environment where younger people can interact and socialise with people in a similar situation to themselves. Additional funding would be required to implement this strategy; and
- increase the level of training for community care workers, either by:
 - having all community care training programs include a module on caring for younger people with a disability at home. This approach would provide a general level of knowledge to all community care workers; or
 - ensuring those community care workers who care for younger people with a disability have undertaken training specifically focused on meeting the needs of younger clients and their carers. This would produce a more knowledgeable but smaller and potentially less flexible workforce with the skills required to provide services to younger people with a disability.

Improvements to respite services for younger people with a disability are discussed in the section above.

Better access and information

The fourth element of Strategy 1 is better access to and information about community care. The community care system in Australia is widely considered to be complex, fragmented and difficult to navigate — by clients, their carers and service providers. Improving access to information is therefore commonly identified as a priority for reform.

In 1999-2000 the Australian Government established the Commonwealth Carelink Program, a national network of centres designed to assist people to access general information about health and aged care services in each region. Centres provide free and confidential information on community care and other support services available anywhere within Australia. There are 65 information outlets across 54 regions nationally. Many shopfronts are located near, or within, shopping centres.

Based on the consultations undertaken for this report, the Carelink centres are not widely utilised by older persons or younger people with a disability to gain information about community care services. Another recent study undertaken by the Centre for Research into Sustainable Health Care has found that few older people or their family members have used a Carelink centre or even know of their existence.⁷⁸

As reported in Chapter 3, clients and carers identified a lack of information on community care as the major barrier to accessing services. This applies to both current and prospective clients of community care. Other studies have reinforced that many older Australians are unaware of the relevant services available to them and have difficulty knowing how to access information about the services and support they require.⁷⁹ Moreover, even if they are aware of them, they may not understand the services or how to obtain them, due to the complexity of multiple service types and overlapping programs.

⁷⁸ J. Cheek et. al. 2005, *Options, opportunities and older people: an exploration of care transitions of older people*, Centre for Research into Sustainable Health Care, July.

⁷⁹ J. Cheek and A. Ballantyne 2001, 'Moving them on and in: the process of searching for and selecting an aged care facility', *Qualitative Health Research* 11(1), 221-37; and J. Cheek, A. Ballantyne and G. Roder-Allen

In response to this, a peer education framework was developed in collaboration with COTA National Seniors in South Australia, with the aim of assisting older people and their families to better navigate the multitude of information available. Four key messages underpin this program:⁸⁰

- Getting help can lead to increased independence;
- Be prepared — know what is out there in case you need it;
- It takes time — plan ahead; and
- Be an active participant in decisions about your health — do what is right for you.

A training module for peer educators for the second key message was developed. This could be used as an example for the development of training modules based on the other key messages. Separate training modules for older persons might also be developed.

Linkages with other sectors

In consultations, clients and carers identified hospitals and health care professionals as important sources of information on community care services and the assessment process. However, clients identified that health care professionals only provided information on community care services when it is obvious that the client or carer is at a crisis point.

Strong linkages with hospitals and GPs are important because they are often in a position to identify transition points in a person's life that result in a change in the nature or level of care they require. Missing these transition points makes a decline in the client's independence more likely, and can adversely affect their health and well being. It is therefore critical that GPs and hospital discharge officers are well informed about the community care options that are available to clients.⁸¹ In consultations, several community care providers commented that GPs and other health professionals were not well informed about the options available in the community care system.

Conclusions

The recent Centre for Research into Sustainable Health Care study makes a number of recommendations regarding the information available to clients and their families about the community care sector:⁸²

- The community care system comprises many different types of services, offered at different levels of intensity, and often available from a choice of providers. There is a need to group together this information to enable easier comprehension and access by older people, their families, GPs and others.

2005, 'Factors influencing the decision of older people living in independent living units to enter the acute care system, *International Journal of Older People Nursing*, 14(3a), pp. 1-10.

⁸⁰ J. Cheek et. al. 2005, *Options, opportunities and older people: an exploration of care transitions of older people*, Centre for Research into Sustainable Health Care, July.

⁸¹ Ibid.

⁸² Ibid.

- Peer education programs are a potentially useful way of improving the awareness of older persons, younger people with a disability and their families about available services and options prior to the onset of a crisis. In the first instance, such programs might be trialled with higher-risk groups such as those with chronic conditions, for whom the need for community care may be closer.
- Effective communication channels between community care providers, hospitals and GPs are needed to ensure that each is aware of and understand the services provided by the other.
- The Australian Government should undertake a systematic evaluation of the Commonwealth Carelink program in terms of its role as a provider of information to clients and service providers.

5.3 Strategy 2: Outcomes-based funding

This strategy aims to shift the emphasis of community care funding arrangements from inputs to client outcomes. The objective is to give service providers greater flexibility by loosening some of the restrictions on how they can provide services, while at the same time creating stronger incentives for them to achieve the best possible outcomes for their clients. The strategy puts the onus on existing providers to drive the changes needed to make the sector more oriented towards and responsive to client needs.

As described in Chapter 2, community care funding in Australia is divided into several different programs. The largest program, HACC, is administered by State Governments, while other programs are managed by the Australian Government. Providers receive funding that is allocated to a specific program. As a whole, the programs do not provide a flexible continuum of care where clients can readily move from one program to another as their needs change.

There are additional restrictions imposed by the structure of the programs. Of particular concern are the funding arrangements for HACC. Funding is allocated to providers on the basis that they will provide a set number of particular service types to customers in a particular region. The intention of government appears to be to ensure that sufficient services of each type are provided in each region. There is only limited scope for providers to deviate from these planned patterns of provision, and such deviations must be reported.

Further, there are rules that define what type of activities can be undertaken under the banner of particular service types. A worker providing domestic assistance, for example, is not permitted to perform tasks outside or provide any personal care. While these rules may have been adopted for important reasons, such as occupational health and safety, they are an overly prescriptive approach of achieving the desired goals.

The restrictions in place under existing funding arrangements promote a ‘menu-driven’ approach to service provision. They do not encourage providers to innovate or to focus on how to best meet the needs of their clients. In consultations, providers strongly argued that the multitude of funding streams and restrictions on service types leave them with little flexibility to provide clients with a set of services that best meets their needs — especially as those needs change over time.

The key problem with the current arrangement is that the government is the customer rather than the community care client. The provider ... is too caught up with fitting in with government's needs and not their clients. If providers were more able to be consumer focused they would provide more innovative services such as preventative programs.

NSW community care service provider

This strategy seeks to address these issues. It proposes that providers receive funding to achieve outcomes for clients, rather than to deliver services. Providers support such a reform because they would have much more freedom to determine what type and combination of services would best achieve the desired outcomes of a particular client. This would be supported by a new accountability framework to measure performance and encourage quality improvement.

Proposed reforms

The current funding arrangements limit providers to providing only those service types for which they have obtained funding. The effect of such a system is to embed the status quo. Providers have little incentive to develop innovative methods of service delivery or to achieve productivity gains. More fundamentally, the focus of providers is on their inputs rather than the client.

Under the proposed reform, funding would be allocated to providers on the basis of the characteristics of their client population and the expected bundle of outcomes to be achieved. Once the desired outcomes for a client were defined and agreed, the provider would determine how to best achieve that outcome. This would encourage providers to engage more actively with clients to understand their individual situation and needs, and what community care could do to help them sustain their quality of life.

Providers would be free to innovate, to achieve outcomes through means outside the current menu of service types, such as assistance with pet care, or supporting clients to take a holiday rather than attend a respite centre. Service provision would also be more flexible — a domestic visit to a client could include half an hour of personal care and half an hour of domestic assistance, provided the carer was adequately trained to provide both service types, and the provider had measures in place to protect occupational health and safety. Program rules and guidelines would be modified to reduce barriers. Changes to the *Aged Care Act* regarding CACPs and EACH packages should also be considered to produce a more flexible continuum of care. The focus of both providers and the system would return to the clients, and how to best meet their individual needs.

At the end of each year (or some period), providers would be assessed for how well they had achieved client outcomes. This assessment would influence how each provider would be funded in the following period. Such an approach would provide greater incentives to adopt the independence model of care, as it could allow providers to achieve desired outcomes for a greater number of clients in a given period, which may, in turn, attract greater funding in the future. This is unlike the current arrangements, which may encourage some providers to 'lock in' clients to the system so that they become a guaranteed source of ongoing funding. By rewarding innovative and more productive providers, the system could help manage the cost of future growth in demand for services.

Providers would be able to compare their performance with that of other, similar, providers. This would help all providers to learn from the best performers. Innovations and practices that help achieve good client outcomes would spread through the system.

Issues for consideration

Performance measurement

To be effective, this strategy would need an effective accountability framework to promote good practice among providers. Governments would be responsible for ensuring that accountability requirements operate in a way that accurately captures and reflects the desired outcomes of community care.

A good set of performance measures would be central to implementing an effective accountability mechanism. One of the critical aims of performance measures is to encourage appropriate behaviours. Designing robust performance measures therefore requires significant choices to be made about the behaviours that are to be encouraged.

In the case of community care, the broad objective of the performance measures is to encourage providers to maintain clients' capacity to live independently at home. A number of more specific measures — such as a reduction in hospitalisation rates — would be needed to capture different aspects of this goal so as to be collectively appropriate to the majority of clients' individual circumstances. Determining the full set of measures is likely to be a complex task. The main risk associated with outcomes-based funding is that an imperfect accountability framework could produce perverse incentives for service providers to act in ways that are not in the best interests of some clients.

The link between the measures and behaviour is both prospective and retrospective. Providers who know their performance is going to be measured in a certain way can be expected to change their actions to perform as well as possible against those measures — provided that they expect to face adverse consequences for poor performance. Then, once data on outcomes are available, they should be able to use the information to identify their strengths and weaknesses and change behaviour accordingly.

The performance measures should therefore be designed to present:

- governments with the information they need to assess the performance of providers so they can take appropriate action in response; and
- providers with the information they need to identify their strengths and weaknesses and change behaviour accordingly.

As a minimum, the design and selection of future performance measures should be consistent with core criteria for measurement systems in the public sector (see Table 5.1). These criteria test whether performance measures are focused, appropriate, balanced, robust, integrated and cost-effective. Importantly, compliance with any performance measurement system must not impose an undue burden on service providers, many of which are not-for-profit organisations with a significant volunteer workforce.

Table 5.1

CORE CRITERIA FOR PERFORMANCE MEASUREMENT IN THE PUBLIC SECTOR

Criteria	Explanation
Focused	... on the organisation's aims and objectives.
Appropriate	... to and useful for the stakeholders who are likely to use them.
Balanced	... giving a picture of the range of objectives, covering all significant areas.
Robust	... in order to withstand organisational changes or individuals leaving.
Integrated	... into the organisation, being part of the business planning.
Cost-effective	... balancing the benefits of the measures against the costs of collecting them.

Source: UK Controller and Auditor General 2001, Measuring the Performance of Government Departments, HC 301 Session 2000-2001, March, p. 20.

Incentives in the absence of competition

Under the accountability system proposed for this model, a provider's record against agreed performance measures would influence how it is funded in the following period. In some regions and some markets, however, there will be a small number of providers, which will constrain the extent to which this principle can be followed. Providers in these regions and markets could be less accountable, and therefore have a reduced incentive to perform well to meet clients' needs. Governments may need to adopt other approaches with these providers if they perform poorly, such as requiring the development of quality improvement plans.

In 'deeper' markets where there is potential for competition between providers, the accountability system may lead to some rationalisation in the sector. Providers that achieve the best outcomes for clients would attract increased funding, while those that do not achieve better outcomes may receive reduced funding.

In all markets, it is in the interests of clients to minimise barriers to entry to new providers to raise the level of competition and strengthen provider incentives to meet the needs of individual clients.

Budget management

Funding providers on the basis of outcomes rather than inputs will make rationing services more difficult. As outlined above, it is proposed that providers would receive a funding allocation determined by the size and characteristics of their client population and the expected bundle of outcomes to be achieved. Providers would be responsible for managing their budget to ensure that the volume of services received by a client is commensurate with their ultimate need.

The overall budget for community care services will continue to be a constraint on the system. If the gap between demand for services and resources available becomes too great, then providers will have limited capacity to meet the needs of many prospective clients, regardless of the incentives they face.

5.4 Strategy 3: Consumer-directed care

This strategy involves taking a ‘consumer-directed’ approach to community care, in order to provide more opportunities for clients to direct their own care provision. The objective of the strategy is to improve the flexibility of the community care system, leading to better outcomes and a more efficient allocation of resources to areas of greatest need.

Consumer-directed care is based on the premise that the client should be able to have choice and control over the care they receive from paid providers. The underlying rationale is that clients of care should be empowered to make decisions about the type and nature of the care they receive, and who provides it.

Anna Howe states that ‘consumer-directed care’ is best understood by seeing it as the opposite of agency-directed care that is controlled by the service provider:

at its narrowest, consumer directed care means that the client, and their carers, where present, have a greater say in the planning⁸³ of care to be provided by agencies and in the delivery of services than is usually the case.

The United Kingdom has prioritised providing clients with greater choice regarding the home care help and support they receive. In line with this objective, local authorities offer direct⁸⁴ payments to clients to enlist the kind of care that best meets their needs (Box 5.2). As discussed later in this section, direct payment is one of many approaches to introducing client choice.

Box 5.2

CASE STUDY: DIRECT PAYMENT TO UK COMMUNITY CARE CLIENTS

Clients can choose to receive a direct payment and decide exactly how the money can be spent following a needs assessment by a social worker. This can include subsidising friends or family for their care-giving. The client’s choice of caregiver does not require approval however the client must provide audited accounts to the local authority at the end of the year.

Direct payments can be received for:

- assistance with personal care;
- respite care;
- assistance with household tasks;
- assistance with shopping; and
- assistance to follow leisure activities.

Those clients who choose to not take up direct payments still receive local council-managed care to help them live independently.

Source: Frontier Economics 2006, *Choice in the delivery of local government services: A Report prepared for the Audit Commission*, London, p. 53.

Currently in Australia, packaged care programs provide some scope for clients to exercise choice — in consultation with a case manager — regarding the composition of an individual’s package of services. In addition, the Carer’s

⁸³ A. Howe, *Is Consumer-Directed Care a Direction for Australia?* Report for Alzheimer’s Australia, www.alzheimers.org.au, Accessed 5 December 2006.

⁸⁴ Frontier Economics 2006, *Choice in the Delivery of Local Government Services: A Report prepared for the Audit Commission*, London. Direct payments have been in place since 1996 and were extended to older people in 2000.

Allowance and Domiciliary Nursing Care Benefit provide funds that could be used to purchase community care services.⁸⁵ Overwhelmingly, however, there are few opportunities for clients to direct or choose the type of community care services they receive, or from which provider they receive them.

Rationale

Interest in consumer-directed care as a strategy for reforming health care provision, particularly in the home or community setting, has resulted from a number of developments:

- recognition of the benefits to health and well being of encouraging more active patients to play a greater role in their own care;
- the belief that individuals are better placed than institutions to understand their preferences and needs, leading to better matching and more responsive services;⁸⁶
- the promise for government that if clients play a greater role in their own care provision, this will reduce the cost of delivering some service types, leading to a more direct, better tailored and more effective spend of money; and
- the belief that allowing clients to enlist the support of relatives or other informal caregivers will help overcome the problems in the community care sector to attract and retain community care workers.⁸⁷

The first of these two factors have provided the primary motivation for pursuing consumer-directed care.

A number of studies have found that increasing client choice and control has many important benefits for a variety of clients with diverse needs and characteristics. In a widespread study of consumer-directed home care programs for older and disabled people in Austria, Germany, France, the Netherlands and the United States, clients reported benefits to include significantly more choice over their services (when receiving cash benefits as opposed to agency services) and older people reported a better quality of life when they direct their services.⁸⁸ Of particular note is a Dutch study that found that clients who could direct their services reported that they ‘had significantly more influence over services, choice of provider, method and timing of service delivery, and freedom of choice than matched controls receiving care from agencies’.⁸⁹

⁸⁵ A. Howe, *Is Consumer-Directed Care a Direction for Australia?*, Report for Alzheimer’s Australia, www.alzheimers.org.au, Accessed 5 December 2006.

⁸⁶ Frontier Economics 2006, op. Cit., p. 11.

⁸⁷ D. Kodner 2003, ‘Consumer-directed services: lessons and implications for integrated systems of care’, *International Journal of Integrated Care*, 17 June.

⁸⁸ J. Tilly, J. Wiener, and A. Cuellar 2000, *Consumer-Directed Home and Community Services Programs in Five Countries: Policy Issues for Older People and Government*, disabilityworld.org/10-12_00/il/consumerservice/htm, Accessed 8 December 2006.

⁸⁹ Ibid.

Studies in the United Kingdom have made similarly favourable conclusions. The Joseph Rowntree Foundation found that when used, direct payments to older people to allow them to choose services and direct their own care provision enhanced their choice and control as well as the continuity and consistency of their care arrangements. By receiving direct payments, older clients said that they were more able to create and manage their services to meet their own priorities and in light of this, reported much higher satisfaction with their services.⁹⁰

There has also been growing support for view that consumer-directed care results in ‘better matched’ and more appropriate services. Individuals who need care are often better placed to understand their preferences and needs ‘than an institution that takes decisions on behalf of a large number of people’.⁹¹ Support for increasing consumer-directed care has also stemmed from recognising that the equity and efficiency of service delivery may be improved if better matching can be achieved across the target population and as a result services can be directed to those who most need them.⁹²

Providers and industry experts have mixed views on the merits of consumer-directed care. Some argue that increasing clients’ ability to choose is likely to result in more empowered and engaged clients who ultimately use fewer services. Others question whether clients are sufficiently informed to make choices that would lead to good outcomes. It was suggested that the option may be more useful for younger people with a disability.

Issues for consideration

There are two main considerations to be taken into account when introducing or enhancing clients’ decision-making power and control over the care services they receive:

- which community care clients are capable of taking on the management responsibilities of self-directed care — and do they want to?
- does the nature of the community care market allow client choice to be exercised effectively?

Client capability and preferences to exercise choice

Possibly the most significant factor when considering consumer direction is the threshold issue of which clients should be allowed to ‘self-direct’? This is particularly important given that clients of community care have varying needs and levels of capabilities in light of these needs. Some clients, for example younger people with disabilities, may be more suitable and more desirous of exercising choice and making decisions about their care than others, for example older people.

⁹⁰ The Joseph Rowntree Foundation 2004, *Making Direct Payments Work for Older People*. p. 231.

⁹¹ Frontier Economics 2006, op. cit., p. 11.

⁹² Ibid.

In the United States, there is growing support for the view that anyone eligible for ‘personal assistance services’, regardless of age or other characteristics should be able to *opt in* to receive a consumer-directed option of service provision.⁹³ Where a cash payment or voucher is involved, recipients need to demonstrate their ability to manage and account for funds, or they are provided with a certified fiscal agent to do it on their behalf.

This threshold issue becomes particularly challenging in the case of people with dementia or Alzheimer’s disease and any other condition that affects their capacity for decision-making and comprehension. In the area of disability services, a ‘modified consumer-directed model using a guardian or surrogate for those with limited cognitive capacity’ has been proposed, along with a ‘supported self-determination’ approach in which the recipient chooses a support team of family members, advocates, and professionals to assist in making these decisions.⁹⁴ Such an approach could be taken in community care for those clients who may be in some way cognitively impaired.

There has also been debate about how to cater for those older persons who, despite not being cognitively impaired, would prefer a case manager to take responsibility for the bulk of the organisation and decision-making about the community care services to be provided. As noted by Benjamin,

the preferences and experiences of those over age sixty-five may seem to differ in important ways from those of younger persons with disabilities. Older persons may be accustomed to services arranged by case managers and delivered by medically oriented home care agencies.⁹⁵

This is where flexibility of program design is important. Concerns about how to meet the diverse needs and wants of the community care clients can be allayed by allowing the clients *themselves* to decide, with the support of their informal carers, on the level of control they want to exercise over their care. That is, give clients the option of choosing their degree of responsibility over their care provision. Initial discussions of this approach in consultations with clients of community care suggest that this would be well-received.

The nature of the market and levels of choice

When introduced properly and in the right circumstances, choice can produce high-quality and more efficient services.⁹⁶ Whether clients can effectively exercise choice depends in part on the nature of the market and the different levels of choice that clients could be offered.

The UK Audit Commission emphasises that prior to introducing choice, an understanding of the distinction between choice and competition is essential. Introducing choice in a market without effective competition is very different to introducing choice into a competitive market.

- Choice *without* competition provides a ‘choice of offering’ — that is, clients choose the types of services that best meet their needs, but have limited or no choice of service provider due to the lack of competition.

⁹³ A. E Benjamin 2001, ‘Consumer-Directed Services at Home; A new model for persons with disabilities’ *Health Affairs*, vol. 20, no. 6, p. 85.

⁹⁴ Ibid.

⁹⁵ Ibid.

⁹⁶ UK Audit Commission 2006, *Choosing well: analysing the costs and benefits of choice in local public services*, Public sector National report, May, p. 2.

- Choice *with* competition allows clients to choose between service providers as well as offerings. It can take two forms:
 - competition *for* the market — where government pays for the service, and service providers have to compete for clients on the basis of quality; or
 - competition *in* the market — where service providers compete freely for clients who make their assessments on both price and quality.

There is limited potential for competition *in* the market for community care in Australia. While there are some private service providers, most clients rely on subsidised public provision to have their needs met.

Even when there is private sector involvement, demand for community care services exceeds supply in most areas, which restricts the capacity for clients to exercise choice of provider. Bruen has described the community care market as follows:

Most people have to take the first service that becomes available. In community care there usually only is one provider of a particular service in a region. ... Increasing consumer choice means increasing the supply until it exceeds demand. ... In community care this means having excess capacity available.⁹⁷

In such a market, introducing choice with competition *for* the market is unlikely to lead to better outcomes for individual clients or the system as a whole. Introducing choice could allow some providers to ‘cherry-pick’ clients with less complex needs. It could also result in increased costs and reduction in value for money.⁹⁸

If choice is to be introduced into community care in Australia, it is therefore most likely to be *without* competition. Clients would be allowed to choose the type of services that best meet their needs. Clients could elect to manage their own services, or have them managed by an agent. Introducing choice in this way would facilitate the provision of more responsive, flexible, individualised services, even in the absence of competition.

Rees has suggested that choice *with* competition could become more feasible by eradicating the delineation between community care and residential care.⁹⁹ If clients were allowed to choose *between* residential and community care, effectively in a single ‘market’, then providers of residential care and community care would effectively compete with one another. Providers would have a clear incentive to improve their responsiveness to clients’ needs and wants so as to retain clients. Under these conditions, choice could become viable.

Possible models

A number of different models of consumer-directed care have been adopted overseas. The models vary in terms of how much decision-making, control and autonomy are shifted from community care professionals and agencies to clients.¹⁰⁰ Three models are presented in Box 5.3.

⁹⁷ W. Bruen 2005, *Policy Update: Aged Care in Australia: past, present and future*, *Australasian Journal on Ageing*, Vol 24 No 3, September, p. 131

⁹⁸ *Ibid.*, p. 2.

⁹⁹ G. Rees 2004, ‘Centring Care and Policy around consumer needs’, transcript of a speech given to Southern Cross Homes WA.

¹⁰⁰ A. E Benjamin 2001, *op. cit.*, p. 82.

Box 5.3

MODELS OF CONSUMER-DIRECTED CARE**The cash or voucher model**

Clients receive periodic cash allotments or community care-specific vouchers and are given discretion to select those services or goods they deem most essential. They can either manage the funds themselves or pay a small fee for an agent to manage the funds instead. In a trial program in the United States most people have opted to use an agent.

There are various ways in which payments can be given to clients. A number of programs in the United States involve the issuing of vouchers for clients to obtain certain services and the enlisting of brokers or agents to commission services on the client's behalf and manage their payments. The United Kingdom, on the other hand, has introduced direct cash payments by local authorities for clients to enlist the kind of care they require.

Assisted choice of provider

Case managers are assigned to clients to assess which programs they are eligible for, and how many hours of service they can receive. With this determined, clients are free to engage the providers of their choice to deliver services they have selected as best meeting their needs. The case manager assists them with these choices. Unlike the cash model, funding is distributed to providers.

Clients are assessed for their preferences and ability to self-direct, and provided with training as needed on engaging and supervising service delivery. Those not considered good candidates for self-direction are referred to a community care agency to act on their behalf.

Monitored choice of service and provider

This is an extension of the assisted choice of provider model.

Clients are able to engage the providers of their choice to deliver the clients' chosen services, with mandated guidance from case managers who not only determine their eligibility and assist them as above at the beginning of their care program, but also then monitor the quality and effectiveness of service provision over time according to an approved care plan.

Source: A. E. Benjamin 2001, 'Consumer-Directed Services at Home; A new model for persons with disabilities', *Health Affairs*, vol. 20; K. Davis 2004, 'Will consumer-directed health care improve system performance?', Issue Brief, the Commonwealth Fund; D. Kodner 2003, 'Consumer-directed services: lessons and implications for integrated systems of care', *International Journal of Integrated Care*, 17 June.

In determining the most appropriate model for community care clients in Australia, one should consider the needs and preferences of clients and their carers. Consumer-directed care would not be appropriate for or desired by many clients. However, different models could be adopted for client groups with different capabilities and aspirations. For example, for those clients that use multiple services and have complex needs, a case management approach is likely to be most beneficial. Case managers could assist clients with managing their cash benefits and the clients could direct their case managers as to how they wish their care to be provided and possibly by whom, depending on the extent of competition in the local market. Services could be 'purchased' from different agencies, family members or another person.

For those with less complex needs or with strong support from informal carers, direct cash benefits may be suitable. Participation would be optional and would involve in the provision of cash or vouchers in lieu of services. These clients would have greater control and independence in terms of how they spend their payments, including for what services and to whom they pay for their service provision (for example, family or other informal caregivers). In most models overseas, the amount given in cash or vouchers is lower than the cost of delivering a standard bundle of services for which the client would be eligible.

The use of vouchers rather than cash would reduce the degree of choice that could be exercised by the client, but would provide government with greater assurance that payments were being used in ways that assist the client to continue living independently at home. This model may be seen as a ‘big and bold step’, however participation would be optional and clients could return to standard service provision if this was preferred.¹⁰¹ Consumer-directed care would never fully replace the existing model of service provision, but rather would sit alongside it as one part of a reformed community care system.

As with many of the suggested reforms, any model of consumer-directed care would most likely be introduced in a controlled, local trial.

¹⁰¹ A. Howe, *Is Consumer-Directed Care a Direction for Australia?*, Report for Alzheimer’s Australia, www.alzheimers.org.au, p. 12.

Appendix A

Members of the Community Care Coalition

Australian Council of Social Service

ACROD

Aged & Community Services Australia

Aged Care Association Australia

Alzheimer's Australia

Anglicare Australia

Australian Association of Gerontology

Australian Council of Community Nursing Services

Australian Local Government Association

Australian Meals on Wheels Association

Australian Medical Association

Australian Nursing Federation

Australian Society for Geriatric Medicine

Baptist Community Services

Carers Australia

Case Management Society of Australia

Catholic Health Australia

Catholic Welfare Australia

Federation of Ethnic Communities Council of Australia

Mental Health Council of Australia

The Returned & Services League of Australia Ltd

Uniting Care Australia

Volunteering Australia

Appendix B

Key community care programs

B.1 Home and Community Care

The HACC program is a joint Australian, State and Territory Government initiative under the auspices of the *Home and Community Care Act 1985*. The formal basis for the arrangements between the Australian Government and the States and Territories is a series of bilateral agreements, which are known as the HACC Amending Agreements.¹⁰² The HACC program provides the majority of community care services to older people and younger people with a disability. The service delivery model on which HACC is based is centred around providing ongoing support and maintenance to people in the community.

The overall objective of the HACC program is to enhance the independence of frail aged people and younger people with a disability, and their carers, and to avoid their premature admission into long term residential care. The program aims to:

- provide comprehensive, coordinated and integrated range of basic maintenance and support services;
- support independent living at home and in the community, thereby enhancing quality of life and/or preventing inappropriate admission to long term residential care; and
- provide flexible, timely services that respond to the needs of clients.¹⁰³

Allocation of resources to service providers

As joint contributors to the HACC program, the Australian Government and State and Territory governments are involved in agreeing operational guidelines and approving annual program funding levels.

Each year the Australian Government Minister makes an offer of funding to each State and Territory and they respond, indicating the level of funding they will provide for the program. These funds are then allocated to individual regions, based on measurable program outputs to be provided in each region including the mix, level and quality of services. The allocation of funds to each region is jointly approved by Australian Government and State and Territory ministers and is documented in their respective annual plans.¹⁰⁴

State and Territory Ministers decide on specific projects and funding allocations, they determine which service providers will provide services in each region and enter into contracts with these providers, which state the level of service output required.¹⁰⁵

¹⁰² Department of Health and Ageing 2002, *National Program Guidelines for the Home and Community Care Program 2002*, p. 2.

¹⁰³ Department of Health and Ageing 2002, *op. cit.*, p. 4.

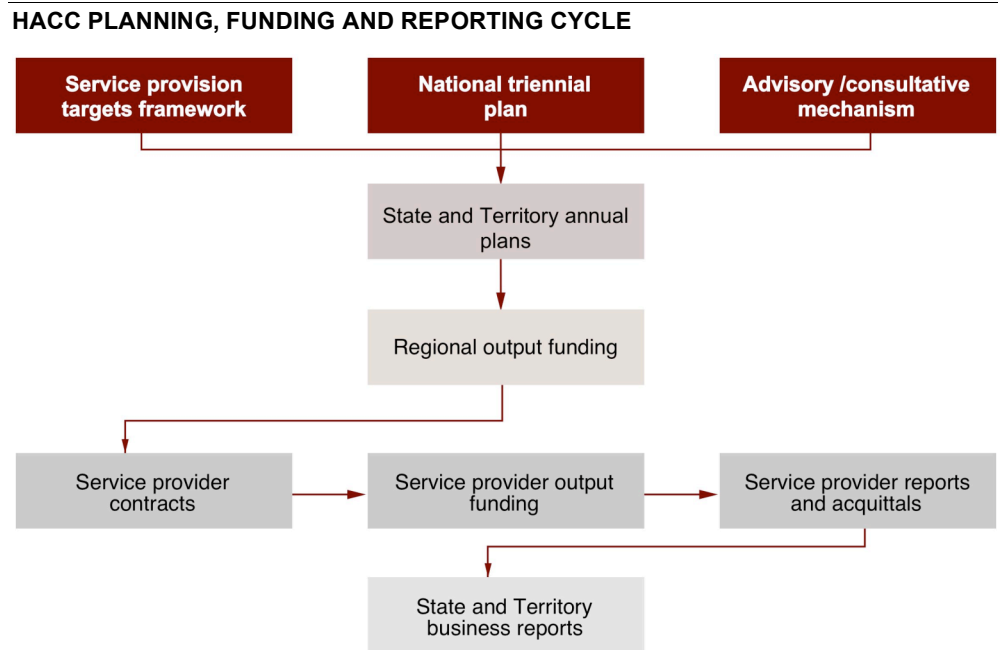
¹⁰⁴ *Ibid.*, p. 15.

¹⁰⁵ *Ibid.*

HACC service providers are required to provide reports to the State or Territory government on outputs achieved, which is collated into regional outcomes and provided to the Australian Government minister in a business report. These reports also include information on regional expenditure, service outputs and service quality against the priorities outlined in the annual plan.

The planning, funding and reporting process for the HACC program is illustrated in Figure B.1.

Figure B.1



Source: Department of Health and Ageing 2002, *National Program Guidelines for the Home and Community Care Program 2002*, Canberra, p. 12.

Evolution of HACC

In 1991, HACC National Service Standards were introduced to provide nationally consistent and reliable means of measuring and monitoring agency compliance with the standards. The Standards provide agencies with a common reference point for internal quality controls and outline expected outcomes for clients in seven key areas:

- access to services;
- information and consultation;
- efficient and effective management;
- coordinated, planned and reliable service delivery;
- privacy, confidentiality and access to personal information;
- complaints and disputes; and
- advocacy.¹⁰⁶

States and Territories are required to include the Standards in all service agreements. Monitoring and compliance with the Standards is now a major part of service reviews.

In 1994, the House of Representatives Standing Committee on Community Affairs conducted a review of the HACC program. This was followed in 1995 by a review for the Australian Government, State and Territory Ministers. These reviews led to four major areas of reform for the program:

- a greater focus on clients through linking funding more transparently to service outputs/outcomes for clients;
- improved assessment processes;
- regional funding of the program as a step towards the streamlining of Australian Government, State and Territory roles; and
- clarification of the interface between health and community care.¹⁰⁷

The development and implementation of the HACC Minimum Data Set in 2001 represented a significant change in the administration of the program and indeed the operation of the community care sector. The data that is now collected in relation to HACC services facilitates better strategic planning and performance monitoring in the HACC program.¹⁰⁸

¹⁰⁶ Department of Health and Ageing 2004, 'Improving Service Delivery', www.health.gov.au/internet/wcms/publishing.nsf/content/hacc-service.htm, accessed 25 October 2006.

¹⁰⁷ Department of Health and Ageing 2002, op. cit., p. 3.

¹⁰⁸ Ibid.

Community options (linkages)

In 1992, the Australian Government introduced the community options (linkages) program to provide brokerage and case management services to those HACC clients who have more complex needs. The aim of the program, similar to that of the CACP, is to provide intensive home based care to people who would otherwise require low level residential care.¹⁰⁹

Community options (linkages) programs provide access to the full range of HACC services, however, these services are linked through a case manager who draws from this suite of services to provide clients with the level and type of care that best suits their needs.

B.2 Community Aged Care Packages

In 1992, the Australian Government introduced CACPs to provide an alternative to low-level residential aged care for older people living in the community. The services provided as part of a CACP are principally to meet a care recipient's daily needs including personal assistance. The number of CACP packages available has increased significantly in recent years.¹¹⁰

CACPs are an Australian Government initiative and are legislated by the *Aged Care Act 1997* (the Act) and the Aged Care Principles 1997 made under the Act. The Act sets out a number of objects for the provision of all types of aged care, including care provided through the CACP program, namely to:

- promote a high quality of care;
- help recipients enjoy the same rights as all other people in the community;
- ensure that care is accessible and affordable for all recipients;
- plan effectively for the delivery of aged care services and ensure that aged care services are targeted towards the people and areas with the greatest needs; and
- provide funding that takes account of the quality, type and level of care.¹¹¹

A key feature of CACPs is the provision of individually tailored packages of care services that are planned and managed by an approved provider. The program requires all older people to be assessed by an Aged Care Assessment Team (ACAT). The services provided as part of a CACP are designed to meet people's daily care needs and may vary as an individual's care needs change.

CACPs are allocated to the providers of new or existing services through the Aged Care Approvals Round that ensures that growth in new community care places is in line with regional population growth and targeted towards the areas of greatest need. This planning system also considers the spread of services across the regions including services provided to people in their own homes and those in residential care with both higher levels and lower levels of need.

¹⁰⁹ Australian Institute of Health and Welfare 2005, 'Community Aged Care Packages compared to Community Options', www.aihw.gov.au/agedcare/nationalprogs/cacp/cacp_vs_cops.cfm, Accessed 26 February 2007.

¹¹⁰ From July 1 2004 to 30 June 2005 they increased by 1,925 to reach 30,973. See, Australian Institute of Health and Welfare 2006. *Community Aged Care Packages in Australia 2004-05: A statistical overview*, p. 3.

¹¹¹ Department of Health and Ageing 2004, *Community Aged Care Package Program — Draft Program Guidelines*, Canberra, p. 9.

Funding for CACPs is provided through the Community Care Subsidy and has been indexed annually in line with the Australian Government's indexation arrangements. The subsidy is paid directly to the approved provider based on the daily number of approved packages for which services are provided. In addition to the subsidy payments, CACP providers can also request fees from care recipients who are able to contribute to the cost of their care. The amount charged forms part of an agreement between the care recipient and the service provider.¹¹²

To effectively manage service delivery, the approved provider may assign day-to-day responsibility for case management to a coordinator attached to a service provider in the local area. The approved provider remains responsible for ensuring that the CACP service provider complies with the provisions of the Community Care Agreement, the Community Care Grant Agreement and individual care recipient agreements in place.

B.3 Extended Aged Care at Home

As an alternative to high-level residential care, in 2000 the Australian Government introduced the EACH program as a pilot program of 300 packages across 10 areas of Australia. In 2002 the EACH program was established as an ongoing program.¹¹³

The EACH program is an Australian Government initiative and is established under the Flexible Care Subsidy Principles 1997. These Principles provide for a payment agreement between the Department of Health and Ageing and the approved provider. This agreement regulates the EACH program by specifying a range of conditions which must be met by the approved provider for EACH subsidy to be payable.¹¹⁴

EACH packages aim to be very flexible and depend on the complexity of the care needs of the individual. Generally a person who requires high-level care could be eligible for an EACH package, and the types of services that may be provided as part of an EACH include:

- registered nursing care;
- care by an allied health professional such as a physiotherapist, podiatrist or other type of allied health care;
- personal care;
- transport to appointments;
- social support;
- home help; and
- assistance with oxygen and/or enteral feeding.¹¹⁵

¹¹² Ibid.

¹¹³ Ibid.

¹¹⁴ Department of Health and Ageing 2006, 'Extended Aged Care at Home Packages', www.health.gov.au/internet/wcms/publishing.nsf/content/ageing-commcare-each.htm, accessed 12 October 2006.

¹¹⁵ Department of Health and Ageing 2006, 'Extended Aged Care at Home Packages', [www.health.gov.au/internet/wcms/publishing.nsf/content/E06BA1D0B1F6FD0BCA256F19000F5C4D/\\$File/each.pdf](http://www.health.gov.au/internet/wcms/publishing.nsf/content/E06BA1D0B1F6FD0BCA256F19000F5C4D/$File/each.pdf), accessed 12 October 2006.

The Australian Government provides EACH care package approved providers with a daily subsidy per package to supply and coordinate care services. The individual services within an EACH package may be provided by a variety of organisations, but will be coordinated and planned by the approved aged care service provider who receives the subsidy to care for the person receiving the EACH package.¹¹⁶

To receive an EACH package an assessment must be conducted by an ACAT. Individuals may be offered an EACH package if:

- an EACH package is available in their area;
- they have been assessed as requiring high level care; and
- they have expressed a preference to be cared for at home.¹¹⁷

Once a service provider accepts an individual a package of services will be tailored to meet their needs, as assessed by the ACAT. The service provider will discuss the options available and a plan of care will be agreed upon.¹¹⁸

Fees may be charged for an EACH package of care. The amount charged forms part of an agreement between the recipient and the service provider. For older people on the maximum basic rate of pension, fees must not exceed 17.5 per cent of the maximum basic rate of the single pension. People on higher incomes may be asked to pay additional fees (limited to 50 per cent of any income above the maximum pension rate). The service provider must inform recipients of its fees policy. However, no one should be denied a service they need, based on an inability to pay fees.¹¹⁹

EACH Dementia program

In 2005, the Australian Government announced the EACH Dementia program, which provides coordinated and managed packages of care to frail older people with dementia who experience behaviours of concern. Eligible care recipients will have complex high care needs associated with their dementia, require high level residential care, but have expressed a preference to live at home and are able to do so.¹²⁰

These packages provide the same full range of services that 'general purpose' EACH packages provide. However, EACH Dementia packages offer service approaches and strategies to meet the specific needs of care recipients with dementia who experience behaviours of concern.¹²¹

¹¹⁶ Ibid.

¹¹⁷ Ibid.

¹¹⁸ Ibid.

¹¹⁹ Ibid.

¹²⁰ Department of Health and Ageing 2005, Extended Aged Care at Home (EACH) Dementia Program Draft Program Guidelines 2005, p. 7.

¹²¹ Ibid.

B.4 Veterans' Home Care

The VHC, introduced in 2001, provides community care, of a similar nature to HACC services, to veterans and war widows/widowers. The Australian Government Department of Veterans' Affairs (DVA) administers and manages the VHC program.¹²²

The broad objectives of the program are to:

- provide a comprehensive, coordinated and integrated range of basic maintenance and support services to eligible veterans;
- provide flexible, timely services that respond to the health care needs of eligible veterans;
- target eligible veterans not using services who are experiencing some difficulties with acts of daily living; and
- close the loop in DVA's provision of holistic health care and support to the veteran community.¹²³

This program extends the services that DVA provides to eligible veterans to include a range of home care services. Personal care, domestic assistance, home and garden maintenance and respite care are available to eligible veterans who are assessed as needing such services to enable them to live independently in the community.¹²⁴

The VHC program comprises three service delivery functions:

- regional assessment;
- regional coordination; and
- delivery of home care services to eligible veterans including personal care, domestic assistance, home and garden maintenance and respite care.¹²⁵

In most instances, DVA has contracted a Regional Assessment and Coordination Agency in each VHC region. DVA has separate contracts with service providers in each region to provide personal care, domestic assistance, home and garden maintenance and respite care. Following an assessment, the agency contacts a relevant DVA contracted service providers and authorises delivery of VHC services. Under contractual arrangements DVA pays the agency an annual fee per veteran for assessment/coordination and pays the service providers on a fee for service basis.¹²⁶

VHC is a preventive health program aimed at reducing the need for a range of medical services through the provision of better-targeted low-level home support services.¹²⁷

¹²² Department of Veterans' Affairs 2003, *Veterans' Home Care Guidelines — Towards Better Health for the Veteran Community*, p. 1.

¹²³ Ibid.

¹²⁴ Ibid.

¹²⁵ Ibid.

¹²⁶ Ibid.

¹²⁷ Ibid., p. 3.

B.5 Data sources

The following data sources were utilised to develop the findings on the equity of community care service provision in section 2.2.

Australian Bureau of Statistics 2005, *Australian Demographic Statistics*, cat. no. 3101.0, AusInfo, Canberra, Table 6, pp. 16-18.

Australian Bureau of Statistics 2003, *Disability, Ageing and Carers: Summary of Findings*, cat. no. 4430.0, AusInfo, Canberra, Table 1, p. 15.

Australian Bureau of Statistics 2001, *Aboriginal and Torres Strait Islander Australians*, cat. no. 4713.0, AusInfo, Table 2.3, p. 20.

Australian Institute of Health and Welfare 2006, *Community Aged Care Packages in Australia 2004-05: A statistical overview*, Tables 2.3, 3.1, 3.8, 3.13, 4.1, 4.8, 4.13.

Department of Health and Ageing 2006, *Aged Care in Australia*, Canberra, Tables A2, A3, A4 and p. 47.

Department of Veterans' Affairs 2006, *Veterans' Home Care Annual Statistics Summary 2004-2005*, Canberra, Tables 3, 5.

Productivity Commission 2006, *Report on Government Services 2006*, Canberra, Tables 12A.2, 12A.12, 12A.14 and 12A.16.

Appendix C

Consultation details

C.1 Summary of consultations

As part of stage one of this project, a series of focus groups were conducted across New South Wales, Victoria, Queensland and Western Australia to obtain the views of clients of community care services and their carers. A summary of the focus groups is provided in Table C.1.

Table C.1

LOCATION AND ATTENDANCE AT FOCUS GROUPS

Location	No. of focus groups	No. of clients	No. of carers	Total attendees
Orange	2	8	6	14
Melbourne	2	3	7	10
Townsville	2	3	2	5
Perth	4	6	27	33
Sydney	2	3	2	5
Total	12	23	44	67

In the second stage of the project, three further focus groups with clients and carers were held in Brisbane, Sydney and Melbourne. These focus groups discussed options for the future of community care. A total of 14 people attended these focus groups. At this stage we also held interviews with community care providers and experts in the field of community care. This involved interviews with the following:

- Dan Romanis, CEO Royal District Nursing Service, Victoria
- Stephen Muggleton, Executive Director, Blue Care, Queensland
- Bill Taylor, CEO, Royal District Nursing Service, SA
- Ross Bradshaw, Chief Executive, Silver Chain, WA
- Professor John McCallum, Deputy Vice Chancellor, Victoria University
- Glenn Rees, National Executive Director, Alzheimer's Australia
- Anna Howe, gerontologist
- Dr Mike Rungie, CEO, ACH Group, South Australia
- Mary Ann Bowyer, HomeCare Manager, RSL Care, Queensland
- Wendy Morris, Manager Sydney and Illawarra, Anglicare, NSW
- Therese Adami, General Manager, Kincare, NSW

- Lanna Ramsay, Director, Ozcare, Queensland
- Anna Schefe, Community Service Development Manager, Spiritus Care Services, Queensland

C.2 Client and carer survey results

Clients of community care services and their carers who attended the stage one focus groups were asked to complete a short survey of their views and experiences. Answers were received from 25 clients of community care services and 31 carers. The results of the short survey are detailed in Table B.2.

Table B.2

RESULTS OF SHORT SURVEY OF CLIENTS OF COMMUNITY CARE SERVICES AND THEIR CARERS

Response of clients of community care services	Nil	1	2	3	4	5	6	7	8	9	10
		Negative									Positive
How important are community care services to your ability to live independently at home?	-	-	-	4%	-	-	8%	4%	8%	12%	65%
How satisfied are you with the quality of the community care services that you are using?	-	4%	-	-	12%	15%	8%	12%	8%	8%	35%
Does the number of hours/occasions of community care that you currently receive meet your needs?	-	4%	4%	-	15%	4%	4%	12%	15%	8%	35%
How accessible is the information about the types of community care services available to you?	4%	4%	4%	4%	4%	19%	15%	4%	15%	8%	19%
Is the community care system flexible in providing you with different types of services as your circumstances or needs have changed?	23%	-	8%	12%	8%	4%	4%	15%	8%	-	19%
How well are community services tailored to meet your specific needs?	43%	-	-	43%	-	-	14%	-	-	-	-
Response of clients of community care services											
How important are community care services to the ability of the person you care for to live independently at home?	3%	-	-	-	3%	-	6%	-	6%	13%	68%
How satisfied are you with the quality of the community care services that the person you care for is using?	3%	6%	-	-	19%	6%	13%	13%	13%	10%	16%
Does the number of hours/occasions of community care that are currently received meet your needs?	6%	10%	6%	6%	19%	6%	-	13%	13%	6%	10%
How accessible is the information about the types of community care services available to you?	3%	3%	6%	3%	19%	29%	16%	6%	6%	-	13%
Is the community care system flexible in providing you with different types of services as your circumstances or needs have changed?	23%	3%	-	10%	13%	10%	13%	6%	6%	10%	10%
How well are community services tailored to meet the specific needs of the person you care for?	42%	-	-	25%	8%	-	8%	-	-	-	5%

C.3 Discussion questions

The following discussion questions were presented to focus group participants in stage one of the project. They covered four broad areas:

- understanding how you use community care;
- the benefits of using community care;
- the adequacy of the care you receive; and
- how services could be improved.

Understanding how you use community care

This section focuses on the views of users of community care services and their carers in terms of the community care services you currently use and how often you use the services.

1. What community care services do you (or the person you care for) currently access?
2. Do you know which community care program your services are provided under?
 - Home and Community Care (HACC)
 - Community Aged Care Package (CACP)
 - Extended Aged Care at Home (EACH)
 - Veterans' Home Care (VHC)
3. How many hours a week would you (or the person you care for) use community care services?
4. How much (if anything) do you pay to receive community care services?

The benefits of using community care

This section focuses on the views of users of community care and their carers in terms of the personal benefits from using the services provided, your satisfaction with the community care services you use and if the number of services provided to you or the person you care for are suited to your needs.

5. How did you (or the person you care for) start to use community care services?
6. How do community care services help you (or the person you care for) in your everyday life?
 - Help you with tasks you find difficult to do yourself?
 - Help in keeping you healthy?
 - Provide companionship?
7. What difference does this assistance make to your life (or the person you care for)?
 - Help you live independently?

- Help you remain active?
 - If the community services you currently use were no longer available, how would you manage living at home?
8. Which of the following accurately describe the community care services that you receive? (with follow up questions to explore initial yes/no responses)
- High quality service
 - Easy to access (special focus on this for Orange/Townsville forums)
 - Convenient
 - I feel respected
 - Meets my current needs
 - Flexible when my needs change

The adequacy of the care you receive

This section focuses on the views of users of community care services and their carers on the adequacy of the care they receive, in terms of the number of hours and the range of services.

9. Is the number of hours of care you (or the person you care for) receive suitable for your needs?
10. Is the range of services you (or the person you care for) receive suitable for your needs?
- Are there services that are provided through the community care program that you need but do not currently receive?
11. What would you do if you wanted more assistance through community care? Where would you go to find information on the services available to you?

How community care services could be improved

This section focuses on the views of users of community care services and their carers in terms of how community services could be improved, including, access to services, the number of services provided, the quality of services and the range of community care services provided.

12. Are there services outside the current community care program that you need and currently do not receive or need to pay to receive from a private provider?
13. How can current community care services be improved? In terms of:
- access to services when and where you need them (special focus on this for Orange/Townsville forums)
 - linkages between different services
 - how my care needs are assessed
 - flexibility when my needs change

- coordination with other service systems (housing, residential care, health care)
 - quality of services
 - cost of services
 - the range of services available under community care programs.
14. What would be the major change you would make to community care services to better meet your needs?

Forum-specific questions

15. How well do community care services meet the needs of younger/Indigenous/NESB people?
- What are the aspects of services that do/do not meet your particular needs?
16. How can community care services be improved to better meet the needs of younger/Indigenous/NESB people?