
9 Care: Access, coverage and delivery

Key points

- Older Australians find the current aged care system difficult to navigate. Care services are limited and community care packages are relatively inflexible.
- A single agency that is responsible for aged care information, needs assessments and care coordination would help older Australians and their families make informed choices. These services should be delivered through a network of regional centres.
- While most older Australians receive timely assessments of care needs and access to services, there are significant delays for some.
- A reformed, nationally consistent system of assessments is required.
 - It would build on the current approach of Aged Care Assessment Teams.
 - The resourcing of assessments would reflect the level of anticipated need.
 - Low intensity community support services would continue to be accessed directly, or through entitlements or referrals.
- A model of care and support based on flexible service entitlements which are tailored to people's needs, rather than on providers funded for approved places and packages, will significantly enhance the delivery of continuous care.
 - The care entitlements should comprise elements of personal and specialised care that meet the changing needs of individual older Australians, together with carer support services.
 - Consumers should have choice of providers, with initial care coordination and more intensive case management available where warranted and requested.
 - The role of publicly-funded care advocacy to assist individual care recipients will need to be expanded, as will restorative care and rehabilitation.
- There is a strong and increasing preference for ageing at home.
 - The removal of quantity restrictions on the supply of care will allow services to be delivered more widely in all types of accommodation.
 - A greater role is likely for the delivery of palliative and end-of-life care in people's own homes and in congregate care settings.
- Improvements to the interface between aged care and health are needed, with a greater focus on in-reach services.

Participants to this inquiry argued that there are significant opportunities to improve the provision of publicly-subsidised care and support services, and that an expanded and more coherent focus is needed for aged care. Strengths and weaknesses of the current system are analysed in chapter 5. Many submissions said that the purpose of the aged care system should be to assist the physical, emotional and social wellbeing of the person, and provide opportunities for purposeful interaction with community and family. The Commission’s wellbeing framework developed in chapter 4 recognises both the importance of these objectives and that a publicly-funded system must also be sustainable.

In the Commission’s view, there is a need to develop an aged care system that better allows the principles of wellbeing to be reflected, particularly in the areas of information, needs assessment, and the provision of care and support. The new model would retain a strong emphasis on respecting individuals and their role in society, but it would also give them a degree of control and self determination (something that is not always possible under current arrangements).

This chapter sets out the main features of a new system, and discusses the Commission’s proposed reforms to:

- care access and coverage, including reforms to information, needs assessment and care coordination services (section 9.1)
- arrangements for improving care continuity and enhancing consumer choice (section 9.2)
- policy settings in a number of areas directly affecting care delivery, including accommodation, health and disability services (section 9.3).

Improvements in care quality resulting from implementation of the proposed reforms are discussed in chapter 10.

9.1 An aged care gateway: information, needs assessment and care coordination

For many older Australians and their families, the first time they access the aged care system is to search for information about what services are available and those to which they might be entitled. Often this is at a time of significant stress. The Commission was told that the current aged care system is difficult to navigate. ‘Complex’, ‘confusing’, ‘fragmented’, ‘overwhelming’ and ‘uncertain’ were terms used to describe the current system. Also, that attempts to make the best decisions about care services are ‘time consuming’ and ‘bewildering’.

To quote the daughter of two elderly parents who had worked in the community care sector for over 20 years:

Our family navigates the complex interfaces between the [Home and Community Care] HACC, Veterans' Health, Centrelink and Commonwealth community aged care support systems. While I would be considered a well informed consumer, this navigational act is at times overwhelming. (Dianne Beatty, sub. 413, p. 2)

National Seniors Australia (NSA) argued that:

The complex and myriad regulatory regime results in confusion for the consumer and stifles innovation. Also, there is little coordination between the structured components of the system and the informal support networks. This makes it difficult for older Australians to plan and take responsibility for their own care. (sub. 411, p. 18)

This section explores the 'front end' of the journey for older people who need formal care and support. There are three broad stages of this front end which, if reformed, could greatly help older Australians to retain control over their lives.

- The first stage requires information to be more readily available and easily understood. Information needs to be made available at both the community level and at a level that is specific to the needs of individual older people.
- The second entails the development of simpler and more accessible needs assessment processes. A single integrated assessment service would: help older people understand and make choices about their own care and support needs; determine their eligibility for subsidised services; inform them of their required co-contributions; and provide them with a set of care and support entitlements which they could take to approved providers.
- The third involves access to services from approved providers once the entitlements have been determined. Often these services can be contracted directly by the consumer or with the aid of an informal carer. But, where necessary, assistance may be required through the provision of low-level care coordination. In many cases, more intensive case management may also be needed.

Information services

Independence and self-control is built on a strong foundation of being aware of one's own needs. Understanding what services are available, and their quality and cost, is also important. Information is critical to building this foundation (box 9.1).

There are significant challenges in providing effective information for older Australians. People turn to care and support services, in the main, when they are experiencing an increase in their frailty and, for some, a reduction in their cognitive

capacity. Information is often sought in stressful circumstances, such as the loss of carer support or during recovery from an acute health episode. Information for these people, as for various disadvantaged groups, must be comprehensible and accessible. Many are not familiar with the internet but most have telephones. Importantly, partners, family and other informal carers who help them to navigate the system need to be able to clearly understand and explain the benefits and costs of the various care and support options.

Box 9.1 Participant's views on information — accessible and useable?

ACH Group:

In the new aged care older people and their families and advocates should be able to get information more easily — information should be independent, comprehensive, accessible by all in a diverse society, have many outlet mediums and backed up ways in which people can see how things work (e.g. resource centres). This information should enable older people to assess their own needs and to assist their access to services and supports. (sub. 111, p. 5)

The Council on the Ageing (COTA) Australia:

Work has already started on [improving information] with the allocation of \$36 million in new investment for the 'one stop shops' but there needs to be a greater sense of urgency around ensuring the information elements ... are pulled together in a way that facilitates individuals accessing the services they need. (sub. 337, p. 43)

Older People's Reference Group:

Unless people know what their choices are, how can they make good decisions? It should be much easier to understand what care programs are available in the community and in residential facilities. Less jargon, more accountability, more public information and more access points are needed. Local councils are well placed to provide details of options in their areas. General practitioners, and especially the proposed new primary health centres, are also suitable points of information. (sub. 25, p. 4)

Health Care Consumers' Association of the ACT:

Information and communication is essential ... We need information that helps with decision making; this means taking into account one's health status, hobbies and interests, community and family connections and financial means as well as lifestyle preferences. (sub. 326, p. 4)

Currently, information is provided on a broad range of topics and through a diverse range of sources. For example:

- there is an expanding number of organisations and sources of information that promote positive ageing — for example, information is provided by health insurers, retirement villages, care providers and superannuation funds. Peak ageing and aged care bodies such as COTA Australia, Alzheimer's Australia, NSA, Carers Australia and Palliative Care Australia also disseminate valuable

information. This information is spread across the system and tends to be targeted to particular groups or individuals. They offer guidance on how older people can maintain or enhance their wellbeing

- government agencies also maintain positive ageing and service access websites, ranging from the Australian Government Department of Health and Ageing's (DoHA's) website, www.agedcareaustralia.gov.au, to local government information services.

In the Commission's view, both healthy ageing and access to aged care services have equity and public good characteristics, and there is a case for public funding of an information platform that assists with both. On efficiency grounds, a streamlined approach to information provision reduces the search costs incurred by those seeking the information, and makes it easier to ensure the information is accurate and up to date. To achieve equity of access, investment is warranted in making the system user friendly.

Features of a consolidated platform

There is already a well developed network of government information portals and services in place. But there is a clear need for consolidation to ensure that such services (such as the current Commonwealth Respite and Carelink centres, the Agedcare Australia web-based information service, the seniors.gov.au website, Home and Community Care (HACC) funded information services, and information provided by Aged Care Assessment Teams (ACATs)) all feed off, and are linked to, an overarching single information platform.

The information platform needs to be targeted at two main levels:

- broad community education about healthy ageing and Australia's support and care arrangements, to help people plan and prepare for their own (or their parents and friends) later aged care needs
- specific information that helps older people and their carers to find and choose the particular services that can meet their immediate and ongoing needs.

This would give consumers far more clarity about where to begin when looking for authoritative information.

However, a common single information platform does not imply a single means by which older Australians discover information about aged care and healthy ageing — the one set of information should be available through many outlets.

The proposed information platform would provide both general information on the aged care system and information tailored to the individual. The platform would also be region-specific. Local information is needed on how to contact assessment services and on the availability, quality and cost of services delivered locally by approved providers. The nature of a proposed aged care access gateway that would provide this information is discussed further below.

Needs Assessment

Accurate assessment of a person's care needs is a necessary precondition for the delivery of appropriate care. As Davis et al. state:

Frail, older people with multiple problems and co morbidities, particularly those not under the direct care of geriatric services, are at risk of adverse outcomes. Appropriate assessment is required to address the complexities of health needs. Hence, the cornerstone of contemporary care for older people is assessment. (2009, pp. 168–69)

The often vexed circumstances in which assessments take place (for example, immediately after a health event) also mean that assessment can be a critical transition point for older people.

The assessment process can also be fundamental in avoiding inappropriate access to services, thereby limiting the overall fiscal cost of providing government-subsidised services. Currently, government controls operate through a mix of eligibility criteria, quantity restrictions and price (chapter 2). The Commission's proposed model removes the constraints on the supply of aged care and support services, so that people assessed as needing services will have access to these services. In turn, this makes the assessment of needs and the coverage of the system (which defines the eligibility criteria, the services that are subsidised and their resourcing) critical to managing the fiscal cost of aged care.

Assessment issues

The current assessment system's strengths include its multi-disciplinary approach and nation-wide coverage. However, as discussed in chapter 5 and in box 9.2, there are a number of significant problems with structures, outcomes and variability.

In light of these problems, there is a need for an improved national assessment process. This should result in more timely assessment and improved access to services. Greater consistency is also needed in assessments, resulting in similar outcomes irrespective of where people are located.

Box 9.2 Participant's views on assessments

COTA Australia stated:

Older people (and their families) often express frustration at having to go to separate services for information, screening, assessment and access to services. They have to make separate trips, separate phone calls and have to give the same information many times over. The current system of information and referral is under-resourced and quite fragmented, often resulting in people accessing the wrong services for their needs, and/or experiencing long delays that can be extremely detrimental. (sub. 337, p. 13)

DoHA identified the multiple and inconsistent assessment processes under the current system as an area of inefficiency:

There are ... significant issues of allocative efficiency in the current arrangements. For example, in (low intensity) community care, clients can face multiple and inconsistent assessment processes as they are referred to different organisations depending on their care requirements. In addition, service specific assessments may not be designed to identify other issues that the client (and their carer) may be experiencing therefore reducing the chances for appropriate and timely referrals within the system. (sub. 482, p. 50)

Others questioned the long waiting periods for assessment. For example, Just Better Care said:

In many areas throughout Sydney the waiting time for an ACAT assessment is six to nine months. The ACAT teams have been under-resourced for the past decade to deal with the growing numbers of older people they need to assess and the waiting times are unmanageable. (sub. 131, p. 1)

A further concern of providers was the number of inappropriate admissions to either low or high care through the ACAT assessment process. In this context, Mission Australia said:

Reforms are required to review the process of ACAT assessments for older people requiring formal care. Currently the ACAT assessments are not validated and the assessment may take just two hours. There is a feeling that the Department of Health and Ageing does not trust the assessment process of the residential aged care facilities. Residential aged care facilities conduct assessments over a four week period and as such are likely to be more accurate due to the longer assessment process yet must be validated. (sub. 117, p. 3)

Lack of consistency of needs assessments was also raised by many participants. For example, Aged Care Queensland Inc. said:

There is a perceived lack of consistency between Aged Care Assessment Teams (ACAT) across Queensland. Members advise that ACATs have different approaches to responding to referrals, managing waiting lists, interpreting ACAT guidelines and assessing clients. (sub. 199, p. 17).

A single (or joined-up) assessment process is likely to result in better outcomes for individuals and produce savings for the community. This process must be based on a common set of standardised and validated tools (or toolbox) for the assessment of aged care needs, and a mechanism to ensure that these are applied in a consistent manner by people with the appropriate skills.

Assessment tools

A national suite of standardised and validated assessment tools (see box 9.3 for one possible approach) should aim to achieve outcomes that:

- promote independence and build on an older person's strengths
- identify restorative options that accord with an individual's own aspirations
- identify when a more in-depth assessment is needed
- provide adequate follow up, with timing depending on the nature of the assessment
- use electronic records, attached to a more detailed e-health record, where possible
- support other aspects of care facilitation, such as identifying the need for a care coordinator to help with making appointments with care providers and helping choose an appropriate provider or providers, linking health and care providers and arranging transport.

This suite would be structured to enable a single initial assessment as a foundation, with various triggers that indicate the need for more complex assessments where required.

Box 9.3 A possible new suite of assessment tools

In considering the possible nature of a new suite of assessment tools, and in order to supplement its own analysis on this topic, the Commission contracted Applied Aged Care Solutions Pty Ltd (AACS) to provide an independent report on a new care and assessment model. The report is available on the Commission's website in appendix C of this report.

The approach proposed by AACS includes the following key elements:

- A system involving a central agency and hubs, which would provide a range of services including triage; information provision; management of needs identification; initial care planning including goal setting; actioning, coordination and monitoring of the care plan; and provision of independent advocacy for the clients.
- A layered funding model involving a base subsidy varying across low to very high levels of need; together with layered 'supplements' covering specialist areas (e.g. dementia/behaviour/mental health, health/nursing/continence, palliative care, rehabilitation) and 'care support' needs. The proposed supplements are aligned to the current specialist high care programs (CACPs, EACH, EACH-D) but the funding that would be allocated will only be directed at the 'marginal cost' in these areas over and above what is already taken account of in the base layer payment.

Initial assessments

The first of the tools in the national assessment suite would provide an initial assessment of an older person's core functions, such as their ability to undertake instrumental activities of daily living (IADLs) and activities of daily living (ADLs), their care setting and the level of informal carer support.

The initial assessment would be undertaken by or on behalf of the proposed Gateway and include the older person with the assistance of their carer, General Practitioner (GP) or other health care professional as appropriate. Initial requests for such an assessment could be made through a variety of means, including a form that could be filled out directly at a shopfront, online, by mail, or by phone.

Evidence suggests that, for both initial and later assessments, face to face contact is likely to yield more effective outcomes. Questions remain concerning the reliability of other alternatives, such as self assessment or assessment via the phone. In this context, the Peninsula Primary and Community Health Committee stated that telephone assessments:

... are not an effective means to determining, in conjunction with the community member, the best information or supports that would assist them to maintain and improve their functional capacity, independence, social connectedness and general health/wellbeing. (sub. DR 877, p. 2)

Similarly, North West Region CACP/EACH/ACAS Network stated:

Telephone assessment is a poor substitute for assessments conducted in a client's home. Home based assessments provide greater insight (in a shorter period of time) of the real circumstances of a person's abilities and living situations. (sub. DR 605, p. 3)

Royal District Nursing Service drew on experience both here and in New Zealand to argue that:

In many instances much extra information can be gleaned through observation of the client's physical environment, and physically checking their self-assessment of functional capacity. (sub. DR 546, p. 5)

While in the future the expanded use of alternatives should not be precluded, these approaches would need to be thoroughly trialled before being introduced more widely.

The initial assessment could also be an opportunity to assist an older person with advice on healthy ageing, falls prevention and care coordination. Preliminary care plans (including preventive and reablement measures), in consultation with the care recipient (and family), could be established. This would be an opportunity for the

older person to express their preferences for how their assessed services should be delivered.

Under the Commission's proposed model (outlined in greater detail below), direct access to some low intensity community support services would be retained without the need for a gateway assessment (figure 9.4). This part of the system would draw largely on the best practice formats currently used under the HACC program.

Further assessment

The initial assessment would also act as a screening tool for the Gateway to determine whether there is a need for a further, more comprehensive assessment. Regionally based multidisciplinary teams would undertake more complex assessments using a more sophisticated suite of assessment tools (including comprehensive medical assessments where appropriate (HealthCube, sub. 103)). The assessment would usually lead to determining a person's entitlement to personal care and specialised services. If not undertaken as part of the initial assessment, a person's financial capacity to make a co-contribution would also be assessed (discussed later in this chapter).

Periodic reassessment would continue to play an important role in matching care needs with service delivery. For someone whose initial assessment was as a consequence of hospitalisation, more detailed assessments should take place in their longer-term accommodation. Reassessments would be undertaken by residential and community care providers in many cases, as occurs under current arrangements. General oversight of reassessments would be conducted by the Gateway on a risk managed basis.

It is important that the audit of reassessments is comprehensive and robust. This is required to ensure accuracy of assessment and to minimise the scope for gaming the process. Should it be necessary, a charging regime for unwarranted reassessments may need to be introduced. This charge would apply to the person instigating the reassessment (such as a provider or consumer) if there was no material change in assessed condition.

Each reassessment, and the information it generates, would build on the electronic records of earlier assessments. This record would establish a case history of support and care as a basis for care coordination and, if required, case management. More detailed assessments would also include consideration of a wide range of supplementary care needs and supports, including those relating to: transport; oral health; higher level aids and equipment (discussed below); dementia care (including for those with younger onset dementia); specialist palliative and end-of-life care;

and additional needs relating to diversity (including cultural and linguistic services — chapter 11).

Carer assessments

The assessment process can play a critical role in leading to services which assist not only care recipients but also their carers. Several submissions discussed the importance of including carers at various stages in the assessment process. Carers Australia argued that:

... broad consideration should be given to the introduction of carer assessments in the aged care sector as an innovative approach to supporting carers in the aged care system... carer assessments would take into account the needs and opinions of carers regarding the support they require and would provide a clear process, with standards across the sector. This simple introduction could easily provide a tangible reflection of a conceptual change in the sector. (sub. 247, p. 16)

COTA Australia stated:

There should be separate carer assessments undertaken at both the basic and complex stages of a person's support and care assessment. This carer assessment needs to occur as soon as possible after the person they support and care for is assessed. If the person is in hospital the carer must not be assessed until the person returns home.

The carer assessment is the basis for a support and care plan for carer/s needs. The assessment identifies the carer's needs for training, support and respite.

Carer entitlements can apply whether or not the person they support and care for is actually receiving services but would need services if the carer was not there. This is important as a carer may need support when the person they are caring for has refused services. (sub. 337, p. 28)

Alzheimer's Australia WA said that:

... consideration of the needs and well-being of the caregiver are necessary components of a comprehensive dementia needs assessment. This approach is likely to facilitate and encourage more timely access by people living with dementia along their dementia journey to suitable services. (sub. 345, p. 10)

A consistent theme in submissions was that some form of comprehensive carer assessment can provide fuller information about both the care circumstances of older people and the broad range of their carer's needs.

Under the revised assessment arrangements proposed by the Commission, there would be several points at which carer assessments would take place:

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- through the Gateway as part of initial and more comprehensive assessments for older people receiving care, with detail being collected on current carer/s, and the nature of support they provide
 - via separate carer support centre assessments for the carer. This would involve assessing and providing for carer's needs in relation to dedicated services such as income support, advocacy, education and training, counselling and emergency respite
 - during any reassessment of care needs for the care recipient or the carer.

These arrangements would build on the foundation of several initiatives already underway, including the development of the revised Australian Community Care Needs Assessment and the Carer Eligibility and Needs Assessment.

Broader measures to support the role of carers, including the development of specialist carer support centres, are discussed in chapter 13.

The role of aids and equipment

Many inquiry participants argued that aids and equipment can play a critical role in the care process. In specific cases, such as macular degeneration (Macular Degeneration Foundation, sub. DR709), participants argued that the early provision of low level aids was fundamental in preventing further decline. Anna Howe (sub. DR856, p. 4) also referred to a significant body of evidence from both Australia and the United States on the effectiveness of aids and equipment.

Several submissions called for a greater consideration within assessments of the role of assistive and enabling technologies. For example, Independent Living Centre NSW stated there was a need to explicitly recognise and integrate:

... the importance of assistive technology across the life domains of communication, self care and mobility and enabling selection of assistive technology that supports the individual needs of each older Australians and any carers or careworkers who support them. (sub. DR778, p. 1)

A recently released study by DoHA looked at the role of assistive technologies in helping older people. It found that:

... the most effective assistive technologies identified in the literature include...aids, devices and equipment to improve ease of living, safety and physical function, where they are provided early and are supported by training, maintenance and follow-up support. (2008, p. 6)

The proposed Gateway assessment process would consider the need (on cost-benefit grounds via a test for reasonableness) for higher level aids and equipment or other

assistive and enabling technologies. This would use a schedule of higher levels aids and equipment, with entitlement to use but not ownership. This approach would supplement existing services delivered by a range of charitable and other organisations.

In providing for comprehensive care planning and case management supports, the Gateway would also provide the follow-up that has been identified as being essential if such technologies are to be effective.

Summing up

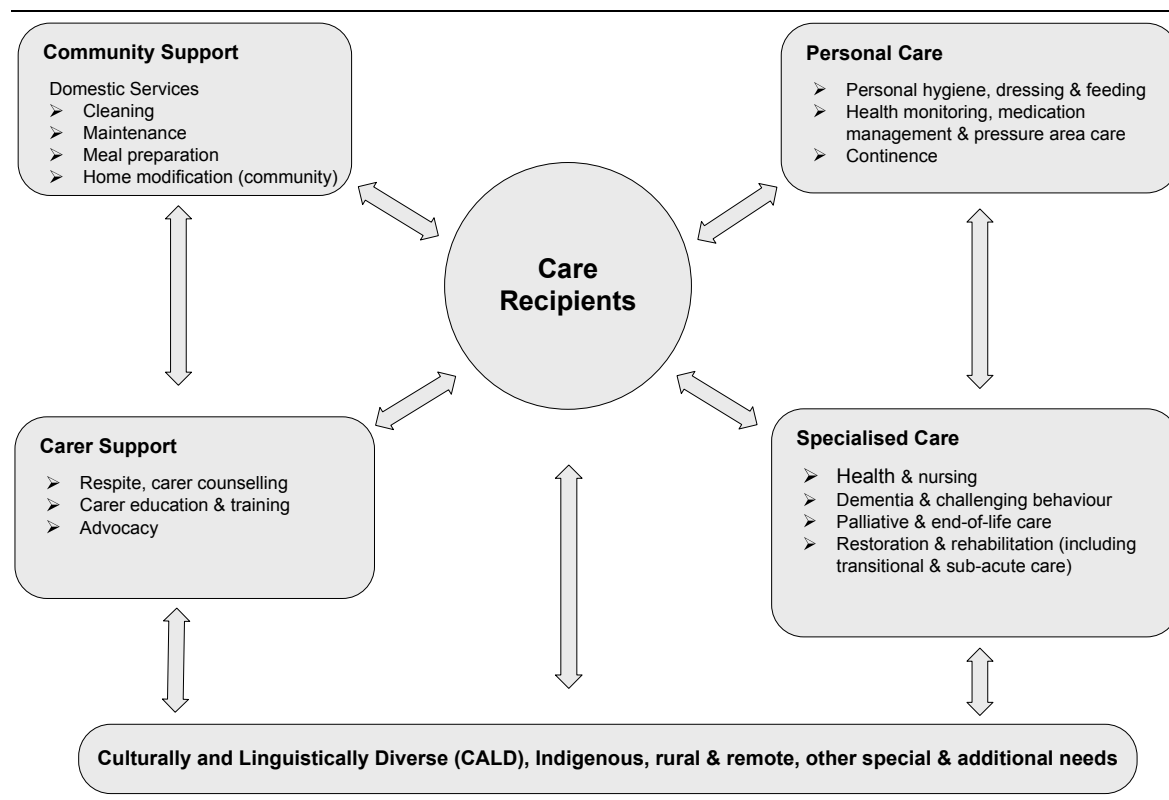
The main attributes of the Commission's broad proposed approach to needs assessment are shown in figure 9.1. An important feature is the translation of a needs assessment into a quantifiable entitlement to a range of care and support services.

There are several possible options for implementing this process, and one is outlined in a separate paper appended to this report at appendix C. The Commission is of the view that, put broadly, an integrated approach is required to determining the level of care service entitlements across both community and residential care (figure 9.1). In the Commission's view, the Gateway would draw on a range of services covering basic support, personal care, specialised care and carer support that best meet the assessed needs of the older person.

The main elements in this approach would be combined in various ways depending on assessed need. It is not necessarily the case, for example, that individuals would receive one element (for example, specialised care) only if they had also received another (for example, basic support) within their assessment. What is required is a combination of service elements that will best meet the person's current needs.

Further detail on this approach, and related proposed reforms to arrangements for accessing services, is provided in section 9.2.

Figure 9.1 Aged Care and Support: key elements in an integrated approach



A single national care gateway

A number of organisations provided thoughtful and detailed proposals for reforming information, assessment and care coordination services. One key element in several of the proposals was the need for a single gateway or portal of some form, so that older people did not have to navigate between a complex array of possible entry points into the aged care system. The Commission notes that there is strong agreement as to the broad design of a new system.

One of the more comprehensive proposals was that offered by COTA Australia. In essence, it advocated a two-level system, the first being a multi-purpose gateway for promotion, information, screening and basic referrals, and a second specialist Care Assessment Service for more complex assessments (box 9.4). The Commission has drawn on this model for its proposed reforms.

Box 9.4 Information and Assessment – COTA Australia’s Gateway proposal

COTA Australia argued the need for an aged care gateway, with a number of key services offered through this improved entry point.

The Gateway

The key initial functions performed by the Gateway would be to:

- undertake promotion of positive ageing and awareness of availability of support for older people
- provide people with information on relevant support and care services
- undertake basic screening and assessment to help direct people to the most appropriate services
- make direct referrals to basic support and care services and to more complex assessments for those with higher needs.

In COTA Australia’s view, the Gateway would be a valuable entry point for first time users of the aged care system, and be a point of continuing referral for individuals as they move into and out of the system across time.

Care Assessment Service

COTA Australia also proposed the establishment of a Care Assessment Service, drawing on features of ACATs, that would provide:

- a national specialist service, separate from health and aged care providers, that uses a standard set of assessment tools and processes
- comprehensive assessment prior to receiving more complex levels of support and care

COTA Australia argued that provision must be made for the assessment decisions made by the service to be appealed by users.

Source: COTA Australia (sub. 337, pp. 12–15).

Blake Dawson proposed a similar consolidated approach, which focused on the concept of what it called Senior Living Centres. They stated that:

We submit that the service that conducts professional assessments of the care and accommodation needs of older Australians should form the base for a broader service that also provides:

- (a) case management services, for those individuals who qualify for fully or partly funded services and their families and carers on an on-going basis;
- (b) information and advice for all older Australians and their families and carers who are considering senior living issues, options and services (irrespective of whether any qualify for fully or partially funded services);

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- (c) introduction and assistance with access to senior living social activities and networks;
 - (d) introduction and assistance with access to accommodation and care providers. (sub. 465, p. 40)

A further key feature of Blake Dawson's proposed approach was a greater local devolution of these service locations.

There have been several recent initiatives by the Australian Government and by the Council of Australian Governments (COAG) that relate to the concept of a gateway. They include the Government's recent reforms to aged care's front end (including the 'single number', 'front end' and aged care 'one-stop-shop' initiatives), the transfer of full responsibility for the Aged Care Assessment Program to the Australian Government in 2012-13 (COAG 2010b), and broader pursuit of the consolidation of service delivery.

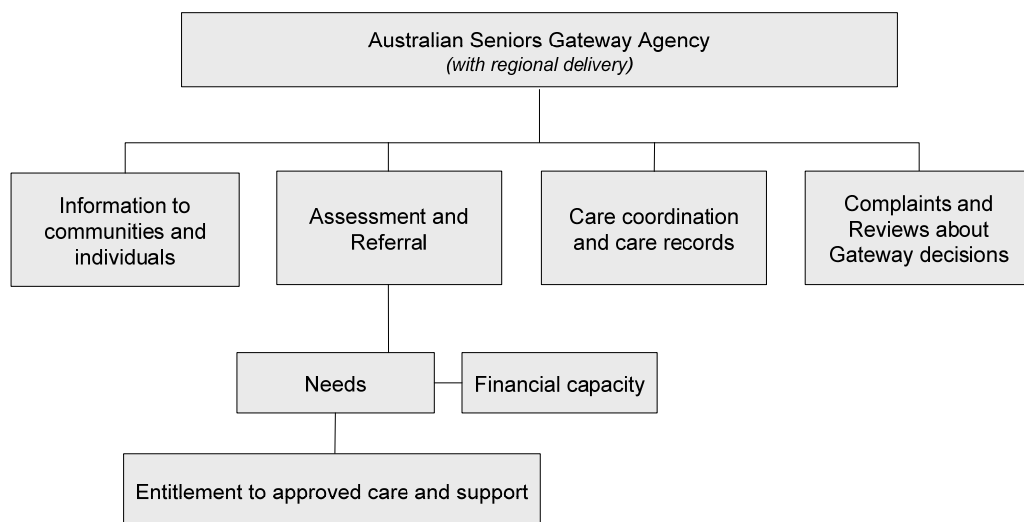
While these initiatives go some way towards a more unified approach, in the Commission's view there are good grounds for going further and introducing a comprehensive, centralised gateway which provides information, needs assessment and care coordination services. If adequately resourced and administered, the Gateway would ensure that processes for access are more streamlined and that the system is easier to navigate. It would be more efficient, by replacing a range of currently disparate elements in the system, including:

- many assessments for low level home-based services (currently undertaken by individual providers, whether they be local councils, charities, community organisations or others who are funded under the HACC program)
- higher level assessments (currently performed by ACATs) — and the overheads in each state and territory which administer ACATs
- the Commonwealth's Respite and Carelink Centres — which would be disbanded (with some elements reconfigured into new specialist carer support services)
- a number of websites maintained by various government agencies.

An integrated Gateway agency would require additional initial funding to further develop an electronic data base and other key infrastructure although there would also be a transfer of some resources from DoHA. There would also be longer run savings because duplication could be reduced, as set out above.

The agency would be separate from DoHA, with a separate Budget appropriation for its core services. It would take over all related operational activity from DoHA. The Commission’s proposal is shown in figure 9.2, and includes provision for the agency to arrange for assessments of financial capacity to make co-contributions (chapter 7).

Figure 9.2 **Australian Seniors Gateway Agency**



Many participants supported the proposed Gateway (box 9.5). Concerns, however, were expressed by some about the capacity of the Gateway and the potential for bottlenecks. Some thought that lower level services should be able to be accessed directly as well as through the Gateway.

An emphasis on local service delivery

Importantly the Australian Seniors Gateway Agency (the Gateway) proposed in recommendation 9.1 would deliver its services through a locally devolved network of Gateway centres. Each of these local centres would provide information, needs assessment and care coordination and draw heavily on local knowledge. While in many cases these would be directly administered by the agency, regional Gateway centres could be operated on a contract basis by other government or non-government agencies, should the Australian Government determine that this would be the most efficient and effective way to operate them. These regional centres could become the basis for the one-stop-shop outlets currently proposed by the Australian Government.

Box 9.5 The proposed Gateway: some participant's comments

The Repatriation Commission:

The establishment of the Australian Senior's Gateway Agency ... will address the call for a more seamless pathway from home into residential care. (sub. DR754, p. 5)

The Benevolent Society:

The matter of resourcing is critical. The proposed scope of the Gateway agency's role will require resources well beyond those currently provided to Carelink centres, if it is to offer anything other than basic call centre service. The information technology foundation of the Gateway will also be critical if it is to function well. Adequate resources will be needed to ensure service details are accurate and continually updated. (sub. DR805, p. 6)

MND Australia:

This agency will need to have formal links to disease specific and disability organisations for access to disease/disability specific information and support for people with chronic health issues, or with a disability, who are ageing. (sub. DR700, p. 2)

Catholic Health Australia:

The Commission notes that organisations such as Alzheimer's Australia also provide support, education and counselling for people with dementia and their families. Because of the more specialist nature of the support provided by such organisations, CHA considers that there is a continuing need for such activities to complement the Gateway's more generic information role, and not be supplanted by the Gateway Agency. (sub. DR748, p. 14)

Aged and Community Care Victoria:

ACCV supports the move to a Gateway concept provided there is adequate resourcing which can ensure local access, including in rural communities, as well as avoidance of delays in assessment ... It is essential that the Gateway does not end up with problems of capacity or bottlenecks. (sub. DR735, p. 7)

Multicultural Disability Advocacy Association of NSW:

How information is distributed and presented impacts on who receives and understands it. The establishment of a gateway agency must ensure that it actively engages multicultural communities and demonstrates best practice in multicultural marketing. (sub. DR816, p. 6)

Alzheimer's Australia:

The Gateway should have a networked approach with multiple entry points to accessing aged care. Individuals who need access to low-level services such as specialised support and counselling should be able to access them through the Gateway or by directly contacting NGO's like Alzheimer's Australia. The Gateway should be a source of information about social and clinical outcomes of care services to enable informed consumer choice. (sub. DR656, p. 7)

There are several options for defining regional areas for the purposes of locating Gateway centres. Given the importance of ensuring cohesion with the health sector, using similar regional definitions to those used for Medicare Locals (or Local Hospital Networks if appropriate) would appear worthy of further consideration. In this regard DoHA stated:

The Government's National Health Reform agenda places a strong emphasis on Medicare Locals and Local Hospital Networks in achieving integration between primary care, acute care and aged care services at the local level. In developing the new front end to aged care, a key area of focus is how to best link aged care services with these new structures in providing referrals to health care services and creating clear hubs, linkages and transition points through which older people can access a range of health and aged care services. (sub. DR694, pp. 2–3)

The Australian General Practice Network supported the integration of any proposed Gateway with Medicare Locals (box 9.6), stating:

Should the Government take a policy decision to implement the PC's proposed Gateway Agency, Medicare Locals would be ideally placed to work closely with the Agency in determining service needs and the most appropriate service models, as informed by local context, service infrastructure, population and workforce profiles. (sub. DR877, p. 8)

Catholic Health Australia (CHA) cautioned that in some cases the boundaries between Medicare Locals and Local Hospital Networks are not well aligned. They nevertheless endorsed some general alignment between the Gateway and these broader health areas, stating that:

On balance ... the primary determinate for the delineation of regional Hub boundaries should be to achieve maximum congruence with the boundaries of Medicare Locals and Local Health Networks in order to increase the potential for better coordination and integration of health and aged care services. (sub. DR748, p. 5)

Should this alignment occur, it is important that there is ongoing communication between administrators in the Gateway and those involved in setting and administering these broader health initiatives.

In the case of CALD communities, however, the broad areas set in recent health initiatives may not be suitable. Many such communities have limited numbers of people spread across a geographically large area. In these cases, the Commission has given further consideration to the introduction of multicultural hubs for the purposes of accessing some care and support services (chapter 11).

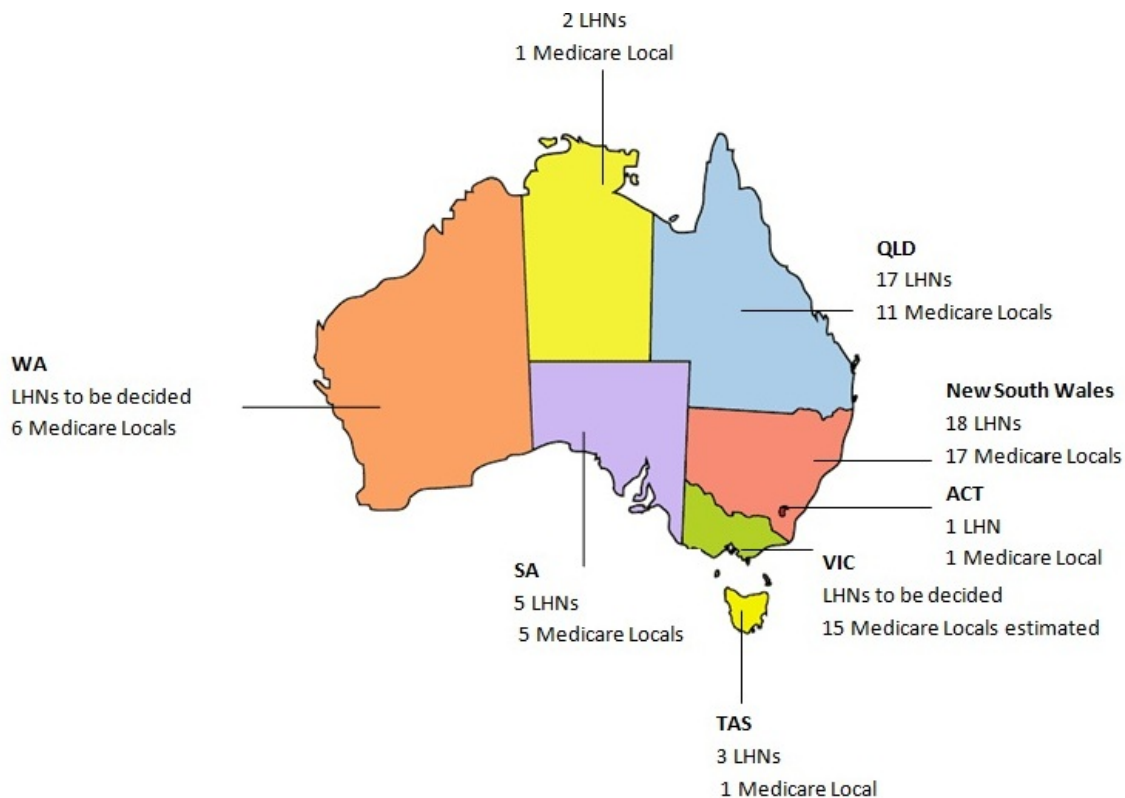
Regional definitions for the purposes of price setting and supported resident ratios are discussed in chapter 7.

Box 9.6 Medicare Local and Local Hospital Network areas

The Australian Government developed Medicare Local boundaries following consultations with state and territory governments and consideration of approximately 120 submissions from the health sector and the wider community. By December 2010, a total of 42 Medicare Local boundaries had been agreed across all states and territories with the exception of Victoria. At that time, the Commonwealth extended the time for the resolution of the boundaries with the Victorian Government. The first group of Medicare Locals and their associated branch offices will begin operating in mid 2011, with the remainder planned to start in mid 2012.

For Local Hospital Networks, 46 had been agreed by late 2010 across all states and territories except Victoria and Western Australia, including 41 geographically based networks and 5 state-wide networks, delivering highly specialised hospital services across some jurisdictions. The Commonwealth has also extended the time for the resolution of the boundaries with the Victorian Government. In Western Australia, Local Hospital Networks will not be established at this stage as Western Australia is currently not a signatory to the National Health and Hospitals Network Agreement. Local Hospital Network boundaries have been developed by state and territory governments through consultation with stakeholders and local communities.

The number of regions as agreed at 31 December 2010 are shown below:



Sources: Consumer's Health Forum of Australia (2011); DoHA (2011j).

Importance of flexible access

The Commission recognises that many older Australians and their carers will wish to directly access their local councils and privately provided services and other government supported services such as those that enhance social engagement and inclusion, or primary and preventative health care, without the need to go through the proposed Gateway. Similarly, many organisations such as Alzheimer’s Australia, Carers Australia and others provide services which those in need would continue to access directly. For a large share of government-subsidised aged care and support services, however, the Gateway will be the new streamlined access point, while working in a close cooperative manner with these other service providers.

Gateway assessors would determine the care needs of older people and their flexible service entitlements (and inform them and providers of the price the Government has set for the services). For those entering residential facilities, this entitlement would replace the initial Aged Care Funding Instrument (ACFI) assessment currently undertaken by providers. The Gateway assessors would also arrange for an assessment of the consumer’s capacity to pay, with a more comprehensive financial capacity assessment undertaken by Centrelink as detailed in chapter 7.

In recommending the establishment of the Gateway, the Commission is keen to ensure that a ‘no wrong door’ approach is also maintained. That is, older people should be able to continue to access information and appropriate care and support, particularly at low levels of needs, through a variety of ways, in their local area. Further detail on directly accessing such services is provided in section 9.3.

RECOMMENDATION 9.1

The Australian Government should establish an Australian Seniors Gateway Agency to provide information, needs assessment, care coordination and carer referral services. The Gateway would deliver services via a regional structure.

- ***A platform within the Gateway would provide information on healthy ageing, social inclusion and participation, age-friendly accommodation, and information on the availability, quality and costs of care services from approved providers, and how to access those services.***
- ***Assessments of the needs of older people would be undertaken for their potential entitlement to approved care services. The level of assessment resourcing would vary according to anticipated need.***
- ***Assessments of financial capacity to make care co-contributions toward the cost of services would be undertaken by Centrelink on behalf of the Gateway.***

- *The assessment of the individual could lead to an entitlement to a set of aged care services which the older person and their carer may access from approved aged care providers of their choice.*
- *The assessment could lead to a referral or an entitlement to community support services and carer support services where such services form an essential part of a set of services to meet complex needs.*
- *Initial care coordination services would be provided, where appropriate and requested, as part of the Gateway. Further care coordination and case management, which may form part of the entitlement, would be provided in the community or in residential aged care facilities by an individual's approved provider of choice.*

The Gateway would:

- *have a separate Australian Government Budget appropriation for the entitlement-based services that it approves*
- *be a Prescribed Agency under the Financial Management and Accountability Act 1997.*

The Gateway would operate via a network of regional centres to enhance local responsiveness, with operational regions defined with reference to those for Medicare Locals and/or Local Hospital Networks. These regional centres would offer the full range of information, needs assessment and care coordination services and their operation may be subcontracted to third party operators including other government agencies or non government or private entities.

Care coordination and case management by the Gateway and providers

In relation to care coordination, the main functions to be performed by care planners were described in general terms in several submissions. For example, one participant emphasised the need for planners with local knowledge, stating:

They would know what services were available. They would have all the data about local operators at their finger tips and national figures for comparison. They would be in a position to give expert local support and advice. They would provide the glue to coordinate hospital, disability services, nursing home and community. (J.M. Wynne, sub 368, p. 48)

Care coordination services should be provided at a number of points within the reformed system. Care coordination in the form of a preliminary care plan should be available to older people upon entry into the system through the Gateway. More complex assessments should include identifying whether intensive case management services are needed.

In the case of individuals receiving care in the community, these services could be provided by independent agents along similar lines to those case management services currently provided under the Community Options Program (box 9.7). Many community options providers could be well placed to offer such extended case management services. Case management would also continue to be provided in residential care facilities as part of the suite of services on offer by the residential care provider.

Box 9.7 The Community Options Program

The Community Options Program is a service funded under the Home and Community Care (HACC) Program. It provides individually tailored services to support people with complex needs wishing to remain at home in their local community.

There are a range of services offered in the program. They can include case management (coordination and monitoring of support); domestic assistance (support with household tasks); personal care (support with showering/medication); social support (support with shopping and accessing the broader community); transport to medical appointments and recreational activities; and respite.

Source: Footprints in Brisbane Inc. (2010).

Care records

Electronic records of an older person's needs assessment and service usage were considered by participants to be important for improving the quality of care of older Australians. For example, the Business Council of Australia said:

... the adoption of unique health identifiers and electronic sharing of health information — the current e-health measures — are fundamental to making the provision of health and aged care services seamless while improving quality and patient safety. (sub. 274, p. 11)

The Australian Medical Association also said:

The multidisciplinary nature of care that older people need — general practice, acute, emergency and sub-acute care — will be improved by the application of an electronic medical record. In particular, electronic discharge summaries and electronic medication management systems have the capacity to improve communication between health care professionals and across care settings, to improve continuity of care and reduce the potential for adverse events. (sub. 330, p. 11)

Other participants noted the scope for electronic records to remove inefficiencies. For example, UnitingCare Australia said:

E-health monitoring and support and single health records would streamline processes and help reduce red tape and ultimately ensure a higher level of care through more accurate record keeping. (sub. 406, p. 13)

Some progress has already been made in developing and integrating electronic records in aged care. In this context the Commission notes recent announcements by DoHA of further progress in rolling out the electronic Aged Care Client Record (DoHA 2010b).

Further development and rollout of electronic records has been recommended by several recent reviews, most notably the National Health and Hospitals Reform Commission (NHHRC). In its final report, the NHHRC proposed:

- increased use of electronic clinical records in aged care homes, including capacity for electronic prescribing by attending medical practitioners, and providing a financial incentive for the electronic transfer of clinical data between services and settings (general practitioners, hospital and aged care) subject to patient consent
- that hospital discharges include timely provision of good information on a person's hospital care to the clinical staff of their aged care provider, subject to patient consent (2009, p. 23).

In the Commission's view, linked electronic records would avoid the need for older people to repeat the same basic information to multiple people. The initial questionnaire would provide the base information for any further assessments and should be attached to the record. There would be protocols for who could update the information as care needs changed. The relevant information, subject to agreement from the client, would be attached to an e-health record, as would any advanced care plan, and be made available to all approved and relevant health professionals and care providers.

Reablement services and the Gateway

Several submissions responding to the Commission's draft report called for a greater focus on reablement. This included calls for a general strengthening of reablement approaches across aged care, and more specific calls to place reablement at the core of the Gateway assessment processes. For example, CHA stated that:

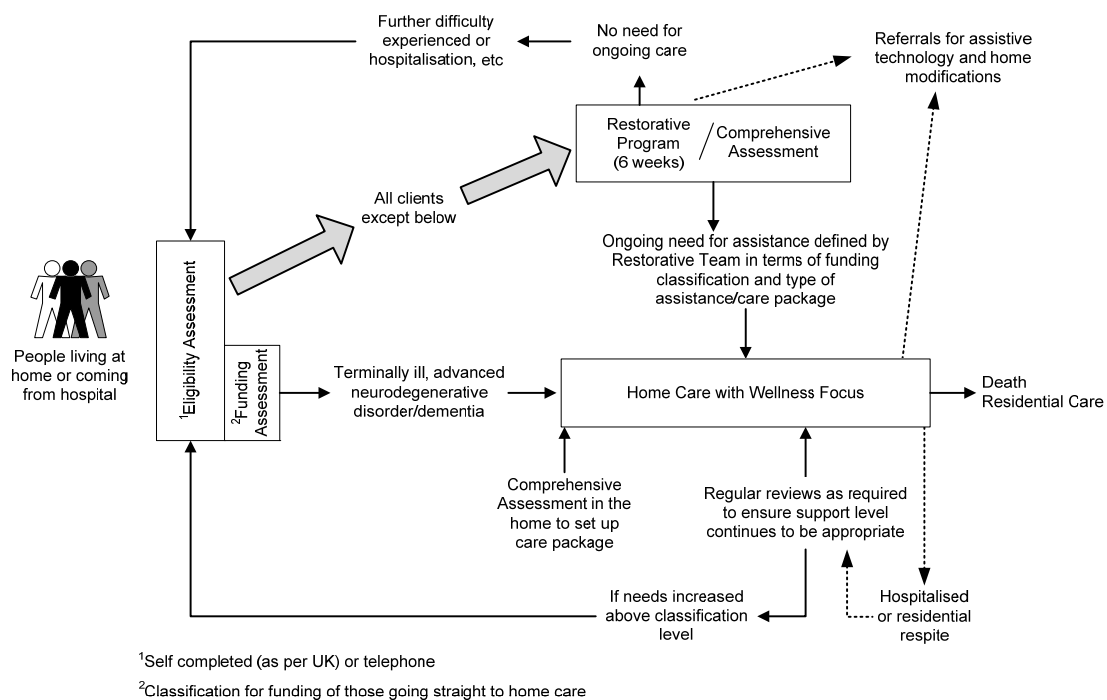
... consumer preferences should be tempered, without being directive, by the need to avoid dependency wherever possible and to promote and ensure a more active and effective early intervention and restorative approach. (sub. DR748, p. 13)

Gill Lewin supported a model:

... in which there are independence services as an integral part of the gateway. They would be basic entry level services available to everyone experiencing difficulties managing in the community who was not terminally ill or had an advanced degenerative disorder ... Eligible individuals who wished to receive the service would be referred after the initial eligibility assessment, the service would be limited to 6 weeks unless the care coordinator could support an extension on the basis that progress towards a client achieving their goals would be severely compromised. (sub. DR790, p. 6)

Further detail on this approach is shown in figure 9.3.

Figure 9.3 Possible design of an intensive reablement program



Source: Gill Lewin, pers. comm., 29 September 2010.

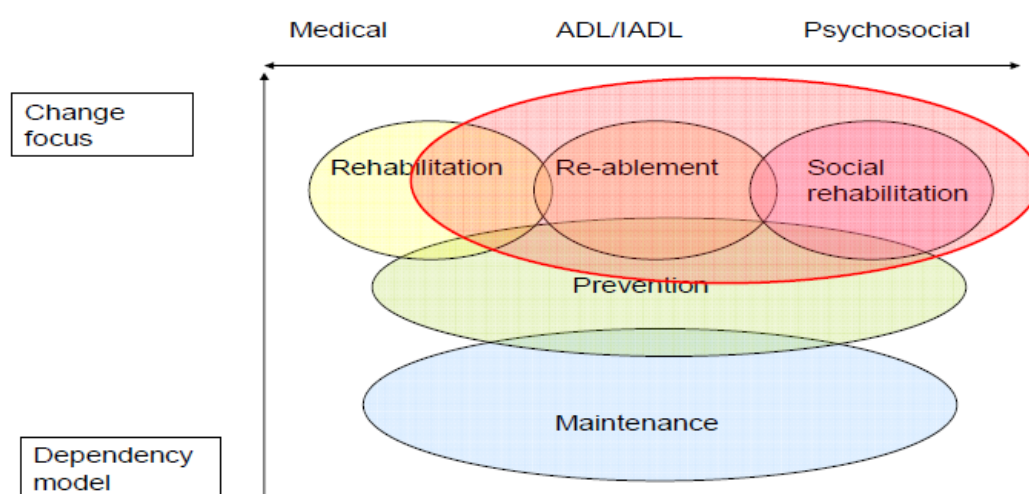
Examples of programs and therapies that might be provided as part of a more comprehensive reablement approach are outlined in Uniting Care Ageing NSW and ACT (2008, p.4). These include:

- Adequate support to re-learn or learn alternative methods to undertake a particular task (e.g. cooking classes)
- Physiotherapy to address an underlying issue that has led to restriction in mobility
- Connection and support to a range of capacity building options (e.g. local walking groups)

- The trial of different equipment (e.g., labour saving equipment such as new style cleaning gadgets)
- The provision of environmental modifications (e.g. grab bars and ramps), often facilitated by an occupational therapist
- Psychosocial education and support to assist individuals to cope and adopt strategies for the self-management of chronic illness
- Encouragement to participate in local health promoting activities and other activities to enhance health
- Health education about principles of healthy ageing, use of medications and illness/accident prevention strategies
- Reactivation and support to sustain social networks, via a short term process of social rehabilitation

While the service mix may vary, a key objective of reablement approaches is to move away from the delivery of care and support that encourages dependency (figure 9.4).

Figure 9.4 **A wellness/restorative approach and other approaches**



Source: Uniting Care Ageing NSW and ACT (2008, p. 4)

Greater emphasis on reablement is apparent in social service delivery in Australia and a number of other countries. In the United Kingdom, for example, recent guidance on adult social care released by the Department of Health emphasised the need for an intensive reablement phase (DOH 2010c). A major focus on reablement has also been apparent in New Zealand's Restorative Home Support Program, Western Australia's Home Independence Program and Victoria's HACC Active Service Model.

The rollout of a strong reablement service within the proposed broader Gateway reforms would have several advantages. It would embed a proactive approach directly within the system, and ensure that earlier, time limited intervention is provided where it is needed and where it can add considerable value. In addition, it would integrate a reablement approach within the assessment process, so that those who most need such services would receive them. For the reasons outlined in chapter 7, the Commission considers that reablement services should be highly subsidised, if not provided to recipients free of charge.

The reablement service should be subject to periodic evaluation to assess its efficacy. These evaluations would focus on the extent to which the service delivers net benefits to the community.

RECOMMENDATION 9.2

An intensive reablement service should be introduced to give greater focus on independence, rehabilitation and restorative care. Eligibility and entitlement for this service should be assessed by the Australian Seniors Gateway Agency.

9.2 Improving care continuity and enhancing consumer choice

Older Australians need a seamless range of services to assist them with ongoing care and support or rehabilitation if they become increasingly frail, lose the support of their partner or other carer, or suffer a significant health event. Services should be coordinated with their existing care services, with their primary health providers and with hospitals if they have had an episode of acute care.

Continuous care has for some time been a major goal of aged care planning and provision. The Organisation for Economic Co-operation and Development (OECD), for example, stressed the importance of continuous care in achieving better health outcomes and greater wellbeing for older people, particularly for those in the community (OECD 2005b, p. 11).

Providing for genuine continuity of care is not easy. The change in an older person's care needs is not always progressive. While many people's care needs do increase gradually, others may have episodic changes in need, followed by periods of rehabilitation and then a reduction in care need. There is also an increasingly diverse spectrum of care needs apparent among older Australians. As UnitingCare Ageing NSW & ACT put it:

... in addition to ... variation (in the *level* of care required), there is also increasing variation in the *nature* of the care required, with a focus on wellness and prevention involving a move from care in its most conventional, narrow sense to a wider concept that includes a broad range of interventions that are neither therapeutic nor essentially assistive ... There is also variation in the *duration* for which care is required, also due to differences in the duration of various kinds of intervention ... Finally, and related to these, there is growing variation in the range of *settings* in which it is desirable to provide care. (sub. 369, p. 14)

Further, there are considerable differences in the types of care continuums required by older people depending on their health status (for example, older people who have suffered a stroke or who have dementia, as shown in table 9.1). A system that meets such diverse and changing needs requires flexibility, effective communication and an absence of gaps between care programs, personnel and contexts.

Recent reforms of note

Recent reforms to aged care have, in part, been predicated on the need to provide greater care continuity. For example, COAG's National Health and Hospitals Network Agreement of 19 April 2010 announced considerable changes to arrangements for the funding and administration of aged care programs, including the transfer of funding responsibilities for HACC. It also stipulated that:

The Commonwealth and states share responsibility for providing continuity of care across health services, aged care and disability services to ensure smooth client transitions. (COAG 2010b, p. 49)

Many submissions to this inquiry commented favourably on the potential of these reforms to enhance the service continuum for older people. For example, the Aged Care Association Australia (sub. 291, p. 30) stated that the reforms 'will now provide the Commonwealth with the opportunity to integrate HACC, community care and residential care into a seamless service offering'. KinCare (sub. 324, p. 3) stated that 'COAG decisions to shift the funding and administration of Health and Aged Care services to the Australian Government open new opportunities for integrating and streamlining services'.

Table 9.1 Interventions on a continuum-of-care for stroke and dementia patients

<i>Type of intervention</i>	<i>Potential benefits in the case of:</i>	
	<i>Stroke</i>	<i>Dementia</i>
Prevention through risk management	Yes	No
Controlling severity of symptoms through drugs	Limited	Limited
Restoring functioning through drugs	Limited	No
Restoring functioning through physiotherapy	Yes	No
Occupational therapy to help patient to help themselves	Yes	No
Advice and help to enable patient to help themselves	Yes	Very limited
Advice and counselling to family carer	If necessary	Essential
Post-acute hospital care	Yes, where hospital treatment was required	Does not apply
Personal care service in own home	Yes, where symptoms severe but patient can remain at home	Yes when condition has become severe but patient can remain at home
Admission to long term residential care	In severe cases where rehabilitation unlikely and home care not possible	Yes unless family carer can provide extensive palliative care
End-of-life care	In severe cases only	Yes

Source: OECD (2005, p. 35).

Control of care subsidy and choice of provider

Under current arrangements, public subsidies for aged care services are typically paid by the Australian Government directly to a limited number of service providers. In this supply-constrained system, many people who are assessed as in need of care have to join a queue and take a funded care ‘place’ when it becomes available.

The care that is provided is generally a ‘package’ (other than for HACC), and the extent to which this fits an individual’s care needs varies. This limited choice has led a number of analysts, as well as many participants to the inquiry, to call for reforms that provide subsidies to consumers rather than providers, as a means by which to promote a more consumer-directed approach to care.

In a number of other areas of social policy there is a move away from traditional service-centred arrangements where providers and government officials decide what is best for care recipients towards giving people more choice and control. As discussed in chapter 4, older Australians generally value the opportunity to make choices about things that are important to them. At a time in their lives when they may be losing control over many aspects of their daily lives (because they require assistance with daily living activities), it is particularly important that they can exercise choice and maintain control over those aspects of their life where they can (see for example Langer and Rodin 1976). The importance of personal control was a key theme raised in submissions. A number of participants expressed frustration at not being able to influence care decisions under current arrangements (box 9.8).

Box 9.8 Participants express frustration at their lack of control and choice

Marjory Kobold:

I was very surprised, after working in aged care for 20 years and knowing how it all works, at how little I could influence 'the system' to effect changes to improve my father's care. (sub. 450, p. 2)

Dianne Beatty:

I, and others, regularly fail in our efforts to provide sensible answers to my father's reasonable questions about the reasons for the plethora of rules, individuals and agencies with whom we have to deal. ... they also are given little control or choice ... and don't understand service rules and rigidities which prevent them from choosing their most desired support. (sub. 413, p. 3)

Aged Care Crisis reported a comment it received:

Eating is one of the few pleasures left to some elderly folk and where are the inspectors at the vital times. Why should the residents be fed at 4pm so staff can go home and not cost extra in wages? Ask anyone if they eat their dinner at 4pm. (sub. 433, p. 37)

Tender Loving Cuisine:

Once we enter into our senior years we seem to lose the right to choose for ourselves. The elderly are often directed to certain goods and services usually provided by Government based care such as Home Care or Meals on Wheels. (sub. DR815, p. 2)

Law Institute of Victoria:

... the current residential aged care system offers consumers minimal choice, both in relation to the aged care facilities in which they live and in relation to the quality of their lives in residential care. (sub. DR897, p. 3)

Several participants argued that greater choice would be expected by consumers of aged care in the future, and that the system would need to respond to this expectation. CHA, for example, said:

There is a need to change the current highly regulated arrangements for the provision of aged care services in response to the higher expectations of current and future generations for choice, responsiveness and flexibility in the way they use aged care services, including choice over what services they receive, which accredited provider delivers the services and where they are received. (sub. 1, p. 10)

A common point made was that a more consumer-directed approach to care would empower care recipients and informal care-givers. For example, the National Aged Care Alliance stated that there was a need for:

... funding for care and support services linked to each recipient so that the recipient and their family can determine how and where they receive their care and support, including the option to control how their funding entitlement is used. (sub. 88, p. 6)

Many participants also argued that a consumer-directed approach would introduce more flexibility into the system and result in more appropriate care for the individual. In this context, Pam Graudenz stated:

As the population of older persons increase ... the 'one size fits all' is not going to be appropriate. There will be a need for more personalised and individual responses to the requirement for care. (sub. 70, p. 1)

The Home Nursing Group noted:

In order to maintain their independence, older people require numerous different services in varying combinations at different times (e.g. home and garden maintenance, cleaning, meals, transport, medication checks/assistance, nursing care, etc.). This requires a flexible pool of funding available to buy different 'baskets' of care for different people at different times. It also needs to recognise that "caring for the carer" will often be very important to ensure there is no deterioration in the health status for either partner. (sub. 6, p. 1)

In submissions on the draft report, many participants commended the Commission on adopting a consumer choice approach.

However, there were a number of submissions that also highlighted the risks of moving to consumer directed care (CDC). Some argued that, on the basis of risks to frail and potentially vulnerable older people, a cautious approach was required, with an emphasis on a thorough assessment of a person's abilities to manage a care budget. In this regard, the National Foundation for Australian Women stated:

There should be some capacity in appropriate conditions for direct control methods to be allowed, subject to assessment of the suitability of the individual or the carer to manage such budgets efficiently. (sub. 95, p. 34)

Other participants argued that a range of supports is required to assist consumers in transitioning to a more choice-based system. For example, Carmel Laragy stated:

My studies show that there needs to be information and support services available to inform choice and that adequate, but not overly intrusive review mechanisms are needed to ensure vulnerable people are not exploited or abused. Existing agencies need support to transition to individual service provision. Finally, more work is needed to understand how individual funding impacts on the workforce. (sub. DR818, p. 7)

Other submissions raised concerns about market power and attempts to gain greater market share by providers. For example, Anna Howe stated:

[Past findings suggest that] providers' interests in expanding greater choice of provider is driven in part by goals of increasing their share of service provision and funding, and that these interests may not always be the same as the interests of clients and their carers. (sub. 355, p. 3)

Other concerns raised included the scope for cost increases, the challenge of designing effective quality standards of care and whether entitlements for care would be appropriately spent.

Some participants focused on the limits of such an approach in regard to certain care levels or components of care. Several saw a greater opportunity to introduce choice for lower levels of basic support (such as community transport), but argued it would be inappropriate to provide greater choice at higher levels of personal and specialised care need due to the frail condition of people. Even for those higher levels, however, choice enables the older person to select a provider based on their cultural awareness, languages spoken, suitability of individual personal carers and timing of service delivery. Such choices enable older people to retain some control over their lives.

Assessment of issues

The Commission considered a number of key issues around the possible benefits and risks of introducing greater consumer choice into aged care. As part of its consideration, it has paid particular regard to:

- international experience in providing greater consumer direction in aged care
- recent developments in enhancing choice in aged care and other sectors
- key design issues, including whether care entitlements would be provided in a CDC system via vouchers or cash
- possible supportive services to consumers in a CDC system (such as information, care advocacy and care planning)
- implications for the supply side, including the impacts on providers and on care infrastructure more generally, of a move to CDC.

Overseas reform experience

A number of OECD countries have sought to enhance choice in aged care by introducing consumer-directed initiatives (table 9.2). The experience in these countries has been previously discussed in PC (2008) and is also detailed in appendix D.

Table 9.2 Personal budgets and consumer-directed employment of care assistants for eight OECD countries^a

<i>Country</i>	<i>Personal budgets and consumer-directed employment of care assistants</i>	<i>Payments to the person needing care who can spend it as she/he likes, but has to acquire sufficient care</i>
Austria		• Cash allowance for care
Germany		• Cash allowance for care
Luxembourg		• Cash allowance for care
Netherlands	• Personal budget for care and nursing	
Norway	• Care wage	
Sweden	• Carer's salary	• Attendance allowance
United Kingdom	• Direct payments	• Attendance allowance
United States	• Consumer-directed home care • Cash & counselling	

^a Includes those countries that have experience with arrangements allowing users more choice and flexibility with regard to the way care is provided, and for which sufficient information was available.

Source: Lundsgaard (2005).

Some countries offer older people personal budgets which, in some instances, allow them to directly employ personal carers. Other countries have provided older people with personal budgets which they can spend as they like, as long as they acquire sufficient care.

Evaluations of such schemes (see, for example, Carlson et al. 2007 for the US; Miltenburg and Ramakers 1999 for the Netherlands; Witcher et al. 2000 for the UK) generally show that many participants report higher satisfaction with care arrangements and their lives more generally; and a reduced likelihood of unmet needs, care-related health problems and adverse events.

However, despite the well documented advantages, participation rates in CDC are typically lower than the traditional agency-directed alternatives (Lundsgaard 2005). While these low participation rates may raise questions about the broader applicability of such schemes, as the Commission has previously argued (PC 2008) it is important to understand that even a relatively small number of active consumers switching between alternative services can induce providers to improve

services and encourage broader innovation and quality improvement (for example, by offering enabling or assistive technologies).

Recent developments in enhancing choice

CDC has been used widely in Australia in other social service sectors, including disability and child care.

Enhanced choice through greater consumer involvement in the design and delivery of disability services has been a feature of services in this sector since the mid 1980s. The strengthened client focus in these services has sustained a range of consumer and/or family direct support programs over many years in a social policy area with a number of similarities to aged care. The disability services sectors in most states and territories now offer a variety of programs or trials designed to promote independence and choice (Laragy and Naughtin 2009).

Recent reforms of Australia's child care system have also enhanced consumer choice, and the sector now responds more freely to changes in demand instead of places being administratively allocated. Further, the range of eligible carers has widened to include grandparents, relatives, friends and nannies (FAO 2007).

Beyond these social policy areas, interest in improving consumer choice has been part of wider policy debates across other industries. In particular, from the mid 1990s, National Competition Policy reforms were partly directed at making Australia's infrastructure industries more responsive to changing consumer needs and preferences. For example, the removal of regulatory barriers and fixed pricing regimes in the electricity and telecommunications industries sharpened incentives that improved the quality of services and increased the uptake of new technologies (PC 2005c).

Greater consumer choice in aged care has also been proposed in the past, and there are some aspects of choice in the current system.

Previous reviews have supported the idea of linking subsidies in aged care directly to consumers. The Hogan residential aged care review (2004b), for example, discussed vouchers and cash entitlements as a means of enhancing consumer choice. The final report of the NHHRC also recommended that subsidies be more directly linked to people rather than places in aged care (NHHRC 2009, p. 22).

At present, there are more limited forms in which consumer choice applies in aged care. For example, the introduction of community care packages such as CACP, EACH and EACH-D allowed a limited number of older people to choose to be cared for at home rather than enter residential care. More recently, the Government announced the roll out of consumer-directed packaged care and consumer-directed

respite care programs (box 9.9). These latter programs are focused on community care programs and have only limited applicability to residential care (focussed as they are mainly on respite). In announcing the rollout, the Government stated that an evaluation will be undertaken to explore the potential for implementing the CDC model more broadly across Australian Government community care programs (DoHA 2010f).

Box 9.9 The current consumer-directed care trial

In May 2010, the Australian Government commenced an application process for the funding of a limited number of consumer-directed care (CDC) packages and respite packages. Successful applicants for the packages were subsequently announced in mid 2010, with places initially allocated for a two year period (2010-11 and 2011-12).

A total of 500 (non-ongoing) CDC places were provided under the Innovative Pool Program as part of the trial. These align roughly with the community aged care programs that the Australian Government funds (CACP, EACH and EACH-D). A further 200 consumer-directed respite care places were also allocated in the first round with a focus on respite care provided under the National Respite for Carers Program.

The model adopted for the CDC packages is an individual budget based on a needs assessment and administered on the care recipient's behalf by an approved provider for an agreed percentage of the allocated budget. An individual budget will: be allocated to the care recipient; be based on a care recipient's needs as assessed by the packaged care provider and agreed with the care recipient; follow the care recipient's assessment by an ACAT, which determines eligibility for a specific level of packaged care (e.g. CACP); be held and administered by the packaged care provider for an amount agreed with the care recipient from the total budget; and be set for a one year period.

Sources: DoHA (2010f; 2010i).

Design considerations

There are several main design options through which a consumer-directed approach might be introduced into aged care. These include:

- an assessed person having an aged care entitlement and choosing from a range of approved providers to provide one or more of their services (perhaps with the assistance of an advocate or care coordinator funded by the Government)
- a voucher system where individuals choose an approved provider and negotiate a package of care that addresses their care needs
- a cash out option where people can take part or all of their assessed entitlement as cash and then purchase various services directly.

As international experience shows, the design features of any consumer-directed approach are critical to uptake, quality of service, consumer protection and effectiveness.

Cashing out an entitlement?

Of the three broad approaches, the Commission has most concerns about a *fully* ‘cashed out’ system, where individuals receive a subsidy via ‘cash’ and can determine to expend it in full in any way they see fit. Concerns include the possibility that individuals would underestimate the amount of their entitlement they would need to spend on care; and possible abuse of the funds by carers and relatives. A full cash out option in aged care would, in the Commission’s view, be unlikely to be taken up by a majority of consumers initially.

However, under the revised arrangements, some small cashed out element for incidental expenses or some specific elements of care may warrant further consideration. For example, in responding to the draft report, a number of participants identified respite services as a particular area where the expanded use of an entitlement in cash form may be appropriate. Alzheimer’s Australia suggested:

Conducting a trial of a cash option for both care and respite which could be modelled on the Commission’s proposals for the disability sector. (sub. DR656, p. 6)

COTA Australia stated:

... we are now proposing that carers should have the option to cash out their entitlement to respite and use the money to purchase services from a greater variety of people. We know many carers identify respite as a key service but then don’t use it and we think the ability to cash it out and source their own service would increase the take up. (sub. DR565, p. 5)

This could be of particular use for people with dementia and their carers, but would also have a broader applicability.

Further consideration of more flexible arrangements for respite, possibly through cashing out and/or via an approach which widened the range of people who could be registered to provide respite, would appear to have merit. One option would be to conduct an expanded trial of these and other possible variations for some respite services and to assess feedback from participants prior to their general introduction.

Any expanded introduction of CDC would also need to have flexible arrangements in place so that consumers could choose to entrust their care to a single provider. This would ensure that older people who did not want to be directly involved in

organising their services from several sources could take their entitlement to a single approved provider and receive their approved services.

Monitoring of quality of service would be a further vital consumer safeguard. The nature of this function is described in more detail in chapters 10 and 15.

RECOMMENDATION 9.3

A trial of more flexible arrangements for respite care, such as cashing out for respite services and extending the range of registered individuals who can be approved to provide respite, should be conducted as part of a broader introduction of an entitlement based approach to care services.

The role of support services (information, care advocacy and planning)

The provision of relevant, current and accurate information will be critical in supporting greater consumer choice. Older people will require information on available services, alternative providers, quality outcomes and sources of further assistance. The reforms to information provision proposed by the Commission will assist in providing an accessible set of regionally-based information with which to inform choice.

Nevertheless, consumers may also require additional assistance to navigate the system and to plan their care needs. There are two different responses required. One is the provision of care coordination and/or case management services, as discussed earlier, and the second is the provision of care advocates who represent the interests of the consumer.

In relation to care or consumer advocacy, much advocacy for the care recipient is undertaken by informal carers and family members. Nevertheless, there is a need for a more formal system of advocates independent of carers and family members.

The Aged-Care Rights Service stated:

An advocate is someone who stands beside a person and works solely on their behalf and at their direction. An advocate listens to their concerns, provides information and speaks on behalf of the person if that is what they want. Before taking any action, the advocate always seeks the person's permission. (sub. 322, p. 1)

A number of submissions called for a system that built on existing publicly funded programs, such as the National Aged Care Advocacy Program, but with greater funding of these functions and wider availability.

The Commission acknowledges the importance of care advocacy functions in a system with greater choice, particularly in relation to vulnerable consumers. A

balance would need to be struck in the proposed system between the need for adequate consumer support and the cost of any expanded publicly funded system of provision for advocacy. Nevertheless, this would appear to be a necessary precondition of any adequately regulated system involving greater consumer direction. Further detail on the proposed advocacy arrangements is provided in chapter 15.

The Commission's model of care and support in greater detail

The Commission's reformed model of care and support services seeks to provide greater continuity of care and empower older people to exercise greater choice. To achieve this, it is particularly necessary to move away from the current rigidly defined and discrete care packages (CACP, EACH and EACH-D). While the various main community and residential care programs are the result of considerable innovation historically, and have in many respects performed well in meeting the needs of clients, problems remain in terms of service gaps and inconsistencies of funding levels and eligibility criteria (chapter 5).

A large number of submissions commented on the adverse effects these gaps have on care continuity and choice. For example, Blake Dawson stated:

Our clients commonly raise concerns that the current distinction between low care CACPs and the high care EACH and EACH-D packages do not provide for a seamless transition from one kind of care services to the next for older Australians. (sub. 465, p. 28)

Hal Kendig called for reforms to remove service gaps, stating that a key priority:

... is to develop a single, integrated care funding program after review of HACC services, Commonwealth packages and carer support, and the care component of current residential care programs. The aim would be to overcome the fragmentation, gaps, and inconsistencies of current programs that have evolved in an incremental, opportunistic way. A single, integrated care and carer support funding program would increase the capacity to deliver flexible, effective support in whatever ways are most appropriate for communities and individuals. (sub. 431, p. 6)

Many other submissions made similar observations about the need for a single, integrated and flexible system of care provision that applies equally in community and residential settings.

The reforms to assessment processes and to broader eligibility and funding arrangements outlined in this report will go some way towards improving consistency across programs. However, the Commission's view is that these should be accompanied by a move away from a focus on discrete care 'packages' to an emphasis on a more unified, seamless approach.

Such an approach does not preclude the development of more multi layered levels of service entitlements for community care (to recognise short term fluctuations in actual hours of care required) but they would need to be closely aligned to the assessed needs of care recipients as described in this report. The current approach leaves too many gaps and discontinuities as a person moves from low level needs to more complex care requirements.

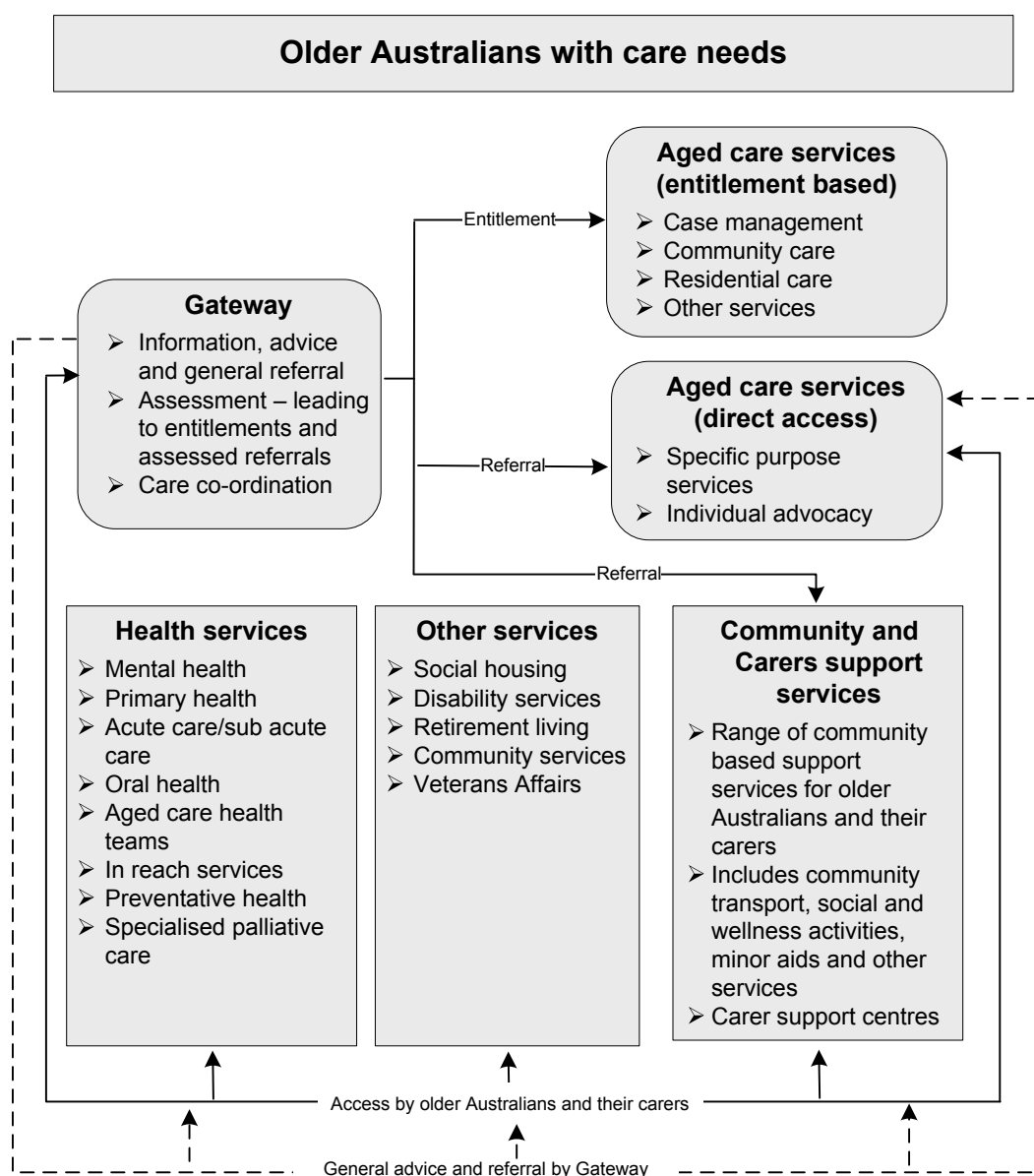
Revised arrangements for accessing services

Under the Commission's proposed system, there would be a distinction between Australian Government subsidised aged care services (the Australian Aged Care System) and community and carers support services (figure 9.6).

The Gateway would be the access point for the majority, but not all, of the formal care services (figure 9.5). These would be accessed largely on an entitlement basis and targeted to people with more complex care needs.

In making an assessment of entitlements, the Gateway would take into account the services that the older person already has access to, including informal care services. The entitlement provided to consumers as part of the Gateway assessment process should include a detailed statement of the care assessment, the care objectives, the type and intensity of services to meet those objectives, the total value of the entitlement, and the period of the entitlement. The value of the entitlement could be expressed as being at a particular level of entitlement with a set price point, together with any supplements. The value of the care entitlement would be paid for through a care co-contribution and a subsidy. An assessment of a person's capacity to pay would be made to determine their rate of co-contribution which would be applied to all entitlement services up to a lifetime (indexed) stop-loss level, beyond which no co-contribution would be required. Drawing on current arrangements, care entitlements across both residential and community settings would be based on a comprehensive aged care funding instrument.

Figure 9.5 Access pathways for services for older Australians and their carers



There would be a limited range of specific purpose services that will be directly accessible by older Australians and their carers or via a referral or an entitlement from the Gateway (box 9.10). While some of these services, such as individual advocacy and care for the homeless in dedicated facilities, would receive a level of block funding from the Australian Government, and many would receive funding support from other levels of government, many would also be partly funded by co-contributions.

Box 9.10 **Services covered under the different categories**

Aged Care Services only accessible through the Gateway assessment and entitlement process would include the following

- Personal and domestic care provided for older people who are no longer able to undertake some of the activities of daily living, and are unable to access these services through other arrangements. This includes feeding and routine medication, showering and dressing and light domestic activities such as cleaning.
- Health and nursing care provided to address health issues such as wound management, medication management, and preventive health care.
- Case management services, provided to those people who need assistance in planning and managing the services required to meet their age related needs. Case management, as defined by Case Management Australia, is a collaborative process of assessment, planning, facilitation and advocacy for options and services to meet an individual's health needs through communication and available resources to promote quality cost effective outcomes.
- Reablement services, provided to improve the capacity of the person to undertake activities of daily living, such as through occupational therapy and physiotherapy support to allow greater independence and can include assessing client's needs with the aim of lessening dependence on long term supports.
- Major aids and appliances required to enable a person to function. These would include respirators and oxygen, but not include mobility aids.
- Planned respite, including both day and residential care services that can be offered in the home or at a respite centre to provide carers with a break from their caring responsibilities.
- Palliative and end-of-life care.
- Home modification services provided to enable a person to stay in their own home where their home is assessed as otherwise meeting their foreseeable needs. This would include the installation of ramps and hand rails but not major renovations.
- Residential aged care services provided (with the exception of home modification and planned community respite) in a residential aged care facility.

Aged Care Services which can be accessed through the Gateway or directly

- Specific needs services that provide integrated aged services for particular client groups who would otherwise find it difficult to access appropriate aged care services. This includes specific services for homeless older people and Indigenous flexible care services. Gateway assessment will be needed for care beyond 12 weeks.

(Continued on next page)

Box 9.10 (continued)

- Transitional care services, which are time limited services available to people after an acute episode to restore the person's capacity to function in the community. The assessment will be made by the service and provided to the Gateway, with the person referred to the Gateway if they continue to have care needs beyond the period of transitional care.
- Individual care advocacy services providing independent representation to protect people's rights and to seek redress within the aged care system.

Community Support Services which can be accessed directly or by the Gateway providing an entitlement or general referral would include:

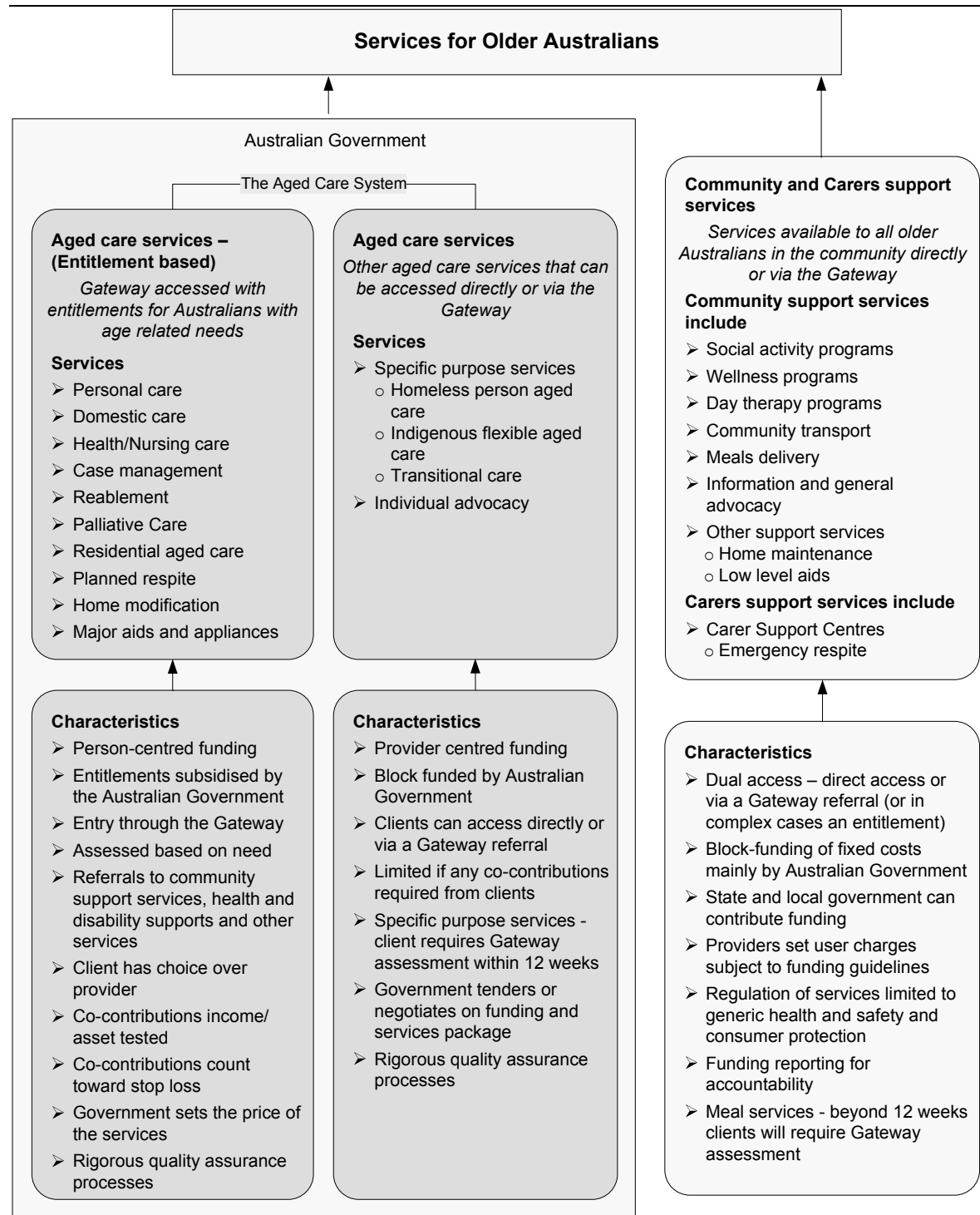
- Information and general advocacy services providing systemic and local information on the Gateway, Aged Care System, aged care providers and on community support services. Such services may be provided by local community organisations or community service agencies that cater to specific groups in the community such as CALD, GLBTI and Disability specific groups, support groups for people living with dementia, HIV and mental illness, and carers.
- Social activity programs that provide social engagements for older Australians in community settings.
- Wellness programs which aim to improve the health of older Australians such as exercise programs, dietary and lifestyle advice sessions.
- Day therapy programs which are centre based programs targeted to address needs of older people for specific types of activity involving allied health workers.
- Community transport which provides transport for older Australians to medical and other health related appointments, for shopping and conducting business activities and for social activities.
- Meals delivery including home delivered meals for short term needs eg arising from a return from hospital or rehabilitation, or longer term needs due to the loss of capacity or carer. While initially this service would be directly accessible, people receiving home delivered service for greater than 12 weeks would be referred to the Gateway for an assessment.
- Home maintenance services which allow a person to remain safely in their home by undertaking minor repairs and maintenance that the person can no longer undertake themselves, or assistance with organising such services.

Carer Support Services which can be accessed through the Gateway or directly include:

- Carer Support Centres providing services such as carer counselling, training and education and peer support and emergency or unplanned respite.
- Additional carer supports that are provided through other community service providers and support groups, including Carers Associations.

Older Australians with less complex needs would also be able to access community support services (such as social activities, community transport, home delivered meals) either directly or the Gateway could offer general advice and referral (figure 9.6).

Figure 9.6 The structure of the wider system of support for older



If the Gateway assessed that one or more of these services were an essential part of aged care services to meet complex needs, it could include them in the entitlement that could be taken to community support service providers.

These services would receive some block funding from the Australian Government (with many being existing HACC services), but would also receive entitlement funding, funding from state and territory and local governments, user charges and public donations. Carer support services would be similarly funded and accessible directly or via an entitlement from the Gateway. User charges for community and carers support services would not count toward the aged care lifetime stop-loss provision.

An important element in the proposed scheme would be that older people would be able to seek a review of their assessment if not satisfied or at any time seek a reassessment of their needs which could result in changes to their level of entitlement. Sometimes, such a reassessment could lead to a lessening of services where a person's needs have reduced such as after a period of reablement. In residential aged care facilities more ongoing reassessment will be undertaken by providers subject to appropriate validation and audit oversight.

Arrangements for special needs clients and rural and remote areas

There are some older Australians who find it difficult to access suitable services (such as homeless people and some Indigenous people) and for whom special purpose service models are required. For such client groups a service provider centred approach is more suitable. These services would be available directly to the older person but with the aid of the service provider. People receiving these services would require a Gateway assessment within three months of the commencement of the service. As the capacity to make co-contributions for the clients of these groups is likely to be minimal, there would be no co-contribution for this three month period. Beyond this, clients would be subject to the same co-contribution tests as other older Australians.

Where it is not financially viable for providers to establish services because of uncertainty and volatility in client numbers, the Australian Government will need to provide a base level of block funding to ensure that services are available, such as in smaller regional communities. This would apply to the aged care component of *regional or remotely based* multi purpose services. There are numerous models but generally they combine or co-locate health and aged services in small communities. The Commission is more supportive of the models which are driven by aged care than by the public health system. Aged care clients could access these services but

would require a Gateway assessment upon entry and would be required to pay co-contributions as assessed.

Where the operating costs of service delivery for some special needs clients or in particular locations (such as rural and remote areas) are significantly higher, a subsidy supplement may be appropriate. Such supplements, where deemed necessary by Government to ensure sustainable access to services, should be set at a level which covers the efficient supply of services by providers.

RECOMMENDATION 9.4

The Australian Government should replace the current system of discrete care packages across community and residential care with a single integrated, and flexible, system of care entitlements (the Aged Care System). The System would have the following features:

- ***it would cover services including residential care, community care (domestic, personal, nursing), reablement, planned respite, home modification, palliative care, high level aids and equipment, and care coordination***
- ***the Australian Government should approve a schedule of aged care services to be provided to individuals on an entitlement basis, according to the Gateway's assessment of their need. Individuals should be given an option to choose an approved provider or providers***
- ***the entitlement provided to consumers as part of the Gateway assessment process should include a detailed statement of the care assessment, the care objectives, the type and intensity of services to meet those objectives, the total value of the entitlement, and the period of the entitlement. In addition the consumer would receive a statement of their co-contribution obligation***
- ***the Australian Government would set the scheduled price of approved services based on a transparent recommendation by the Australian Aged Care Commission***
- ***the Australian Government should fund an expanded system of aged care individual advocacy by initially expanding funding and access to advocacy under the National Aged Care Advocacy Program.***

The Australian Government should also support a range of community support services which would be directly accessible by older Australians and their carers and through the Gateway. Such community support services would include funding from the Australian Government (including, for example, block funding for infrastructure and overheads) as well as user charges and financial and in-kind support from state, territory and local governments and the community. For some community services, where a person requires long term support, an assessment from the Gateway may be required.

9.3 Associated reforms

There are several further reforms that, in the Commission's view, are essential to secure a more continuous care system. These include:

- delivery of care across different forms of accommodation
- improvements to the interface between the aged care and the health and disability systems.

Delivery of care across different forms of accommodation

Home and community care services play a major role in allowing older Australians to remain living in their own accommodation (ACG 2007, p. 14). Sandra Hills, CEO of Benetas, stated:

If there is a lack of adequate care services available or people don't have their own social supports then the reality is that people often have no option but to move into residential care. (Aged Care INsite 2010, p. xx)

The provision of such care is a policy goal widely endorsed by the sector (NACA 2009, p. 4). Similarly, the sector is of the view that such care should be generally available to those in need of it, regardless of their type of housing:

Where older Australians require support or care, they will: have access to services in their own communities and homes ... [so that] Most people will receive care and support in their own homes, whether that is a 'family home' of long standing, or a retirement village, community or publicly owned housing, or a private dwelling chosen by people as their own later life housing option. (NACA 2009, p. 5)

However, some inquiry participants highlighted barriers which prevent care being delivered in certain types of accommodation: a situation which prevents some Australians wishing to age in their homes from doing so.

Lend Lease Primelife (sub. 76, p. 6) noted that the highly regulated supply of subsidised care packages means that retirement village residents do not get the same access to care services as those in residential care homes. Referring to this problem, CHA (sub. 1, p. 3) noted that reforms are needed to ensure ‘... access for all in need of care regardless of ... where they live’ and suggested the solution lay in:

Aligning care fees and subsidies for people receiving care in their own home with those applying in residential care for people with similar care needs in order to allow fair and equitable choice.

ECH, Eldercare and Resthaven (sub. 100, p. 4) also argued for the need to align care fees and funding across residential and community care such that they are not linked to accommodation, and that the funding be portable across residential and community care to enable two-way movement between the client’s preferred housing location.

National Disability Services (sub. 102, p. 7) drew attention to policy barriers to appropriate support that can distort older Australian’s choice of accommodation. It referred to research (NDS 2009) that identified a range of barriers, such as community aged care packages not being available to group home residents and the variable access to services for people living in different accommodation types.

Barriers such as these limit the ability of some older Australians requiring care from continuing to live in their current housing. This situation is inequitable and, to the extent that it forces them to move into residential aged care (or hospitals) where care delivery costs are higher, it is also inefficient and costly.

Where possible, access to care services should be neutral with regard to the type of accommodation in order to not distort the accommodation choice of older Australians or the efficient delivery of care.

The Commission proposes an orderly phasing out of supply restrictions over a period of five years (chapters 7 and 17). The primary aim of this reform is for older Australian’s who have assessed entitlements to care services to be able to choose between competing approved providers.

A second benefit of the reform is that it would allow care services to be delivered widely in all types of accommodation, subject to appropriate co-contributions. Where care delivery would be significantly more costly because of the attributes of the accommodation and its location, it would be reasonable to limit its provision. In the case of community care, for example, subsidised costs would be subject to a maximum limit (broadly equivalent to a current EACH-D package), with any care beyond that (such as 24 hour home nursing) being the responsibility of the client if they wish to remain in the community.

As proposed in chapter 7, the Australian Government should remove quantity restrictions on care services. This would allow services to be delivered widely in the accommodation of choice of the clients.

Improvements to the interface between aged care and health

A large number of participants highlighted problems with the interface between the aged care and health care systems. This was seen as a key factor in preventing older Australians from receiving appropriate and seamless care. For example, in its submission, COTA Australia noted:

... the interfaces between aged support and care and the health system often work poorly and sometimes to the severe detriment of older people (sub. 337, p. 41).

Many submissions argued that the lack of coordination between health and aged care leads to inappropriate or avoidable care and admissions to hospital. For example, Blake Dawson (sub. 465, p. 23) stated that poor coordination leads to inefficiency because of overlapping and duplicated services and gaps in service provision, resulting in older Australians not receiving services they need.

United Care Ageing (NSW) stated:

... the administrative and bureaucratic structures within which these services are provided differ, and the degree to which they are coordinated is very uneven. The result is that interventions that could be efficiently carried out in an aged care setting — for instance, for rehabilitation — are often carried out at what seems to be far higher cost in the health system (sub. 369, p. 17).

HammondCare also noted:

The inefficiency and cost of moving residents between residential aged care and the providers of sub-acute services is significant (sub. 168, p. 2).

In the case of medication management, the Aged Care Association of Australia noted:

... the inefficient systems used to administer medications result in aged care staff, GPs and pharmacists spending considerable time and effort on prescription writing, (including chasing new prescriptions when the current ones expire), owing prescriptions and double handling of excessive paperwork. Clearly this is an area for potential and significant productivity improvement for all three stakeholder groups. (sub. 291, p. 25)

There is considerable scope to increase the efficiency of these interacting systems through the use of information technology, such as the e-Health initiative (including e-prescriptions and e-transactions), that allows information to be shared and

accessed in an efficient but safe way. The introduction of aged care electronic records was advocated earlier in this chapter.

Some inquiry participants argued that providers are constrained from introducing technology because they cannot access the capital and recurrent funding to do so. Manor Court Werribee Aged Care Ltd, for example, noted:

We are reliably informed that the Aged Care sector has one of the lowest levels of investment in IT & technology, of any of the industry sectors in the country. Why is this the case? The answer is pretty simple.

- The providers cannot find the capital cost for the investment
- The providers can't find the recurrent funding to implement systems, and train staff. (sub. DR529, p. 4)

The Commission's proposed reforms will increase the level of funding for aged care providers (e.g. increase the level of government subsidies on the basis of the real cost of providing services) which should, in turn, provide greater incentives to increase the uptake of technology in the sector.

Participants argued that it has been increasingly difficult to find general practitioners who are willing to visit residential facilities and make home visits to community care recipients. ACAA stated:

It is generally recognised that securing sufficient GPs to visit aged care residents is problematic in many parts of the country.

There are a variety of problems ranging from small client numbers, poor remuneration, lack of consultation facilities, lack of GP confidence in treating the very old and lack of coordination of consultation times. (sub. 291, p. 23)

These issues are discussed in further detail in chapter 10.

Recent and further possible reforms

In 2009, the NHHRC proposed reforms to the hospital system that will have the effect of increasing the demand for aged care resources. These reforms, which were subsequently agreed to by COAG (2010b), aim to reduce the extent to which hospitals provide care to older people that could be provided more appropriately in individuals' homes and residential aged care centres. Elements of the reform agenda include:

- facilitating greater access to primary health care providers and geriatricians for residents of aged care homes (NHHRC 2009, p. 23, recommendation 52)

- strengthening access to specialist palliative care services for all relevant patients across a range of settings, with a special emphasis on people living in residential aged care (NHHRC 2009, p. 23, recommendation 55).

The benefits of improved coordination between the sectors are likely to be significant. For example, HammondCare stated that an acute hospital bed in NSW costed \$1223 per day compared with a HammondCare sub-acute hospital bed between \$650 and \$900 and an aged care bed around \$160 — a substantial difference as illustrated in table 9.3.

Table 9.3 Acute care and aged care access and cost

	<i>Hospitals and primary care</i>	<i>Aged care</i>
Access to entry	Relatively easy	Relatively difficult
Cost to government	Higher cost (uncapped)	Lower cost (capped)
Cost to private health insurers	Private health insurance coverage	No private health insurance
Services offered	Accident and emergency Acute care Sub acute care Other primary health care	Residential care Community care

Source: HammondCare (sub. 168, p. 3).

In addition to direct cost savings to the health budget, other benefits include:

- improved wellbeing of residents not having to move frequently between residential and acute care (and benefits to partners and others)
- an increased capacity for residential facilities to deliver higher level services, with attendant benefits to staff from higher skill sets and a wider scope of practice
- synergies for other residents from the proximate delivery of sub acute services
- an additional revenue stream to residential providers, diversifying their risks.

The use of electronic medical records, improved discharge statements from hospitals and the transfer of advanced care plans would improve the coordination of care between the two sectors.

Improved coordination will go some way to increasing the scope for sub acute services to be provided in residential settings. The proposals outlined in this report, which increase the flexibility of the aged care sector, reduce the burdens of regulation, encourage innovation, and establish a sustainable funding regime, will also assist to build momentum in this direction.

A further reform that would, in the Commission’s view, have merit in this context is the expanded use of multi-disciplinary teams (so-called in-reach teams) that are able to provide services to residential aged care facilities. Several submissions discussed positive outcomes from the use of these teams, which are generally run out of state and territory administered hospital emergency departments. For example, VincentCare stated:

... we have found a particular pilot program which has now received ongoing funding, to be of benefit. “In-Reach” covering inner Melbourne and “Out-Reach” covering outer metropolitan region is a program which provides a specialised medical advice service which has assisted facilities by minimising the transfer of residents into hospital ... The In-Reach/Out-Reach model has eradicated previous issues such as residents being discharged without a phone call to the facility, being returned without transfer information and requiring the facility to spend considerable time chasing up relevant information on behalf of the resident. (sub. 258, p. 21)

General Practice Victoria stated that:

The (In-Reach) service ... has been positively received by nursing homes, GPs and hospitals. (sub. 235, p. 5)

The use of such teams has been trialled in limited form in Victoria (box 9.11) and internationally has also been used in Canada and the UK (see, for example, Sczepura et al. 2008).

The Commission believes there are significant benefits in the expansion of in-reach services and the development of regionally based multi-disciplinary aged care health teams. Such teams would better utilise the professional health workforce, create a more responsive health service and develop professional expertise in the area of care for older people. They could provide not only services to older people in residential care facilities, but also to those living in the community. Expansion of these approaches should be actively undertaken by all levels of government where evaluations prove that the net benefits are as significant as initial indications appear. The design of such programs should ensure that they do not substitute for the ongoing responsibilities of residential and community care providers.

RECOMMENDATION 9.5

The Australian, state and territory governments should promote the expanded use of in-reach services to residential aged care facilities and the development of regionally or locally-based visiting multi-disciplinary health care teams (including from oral and mental health disciplines and dementia care specialists as appropriate).

Box 9.11 Clinical in-reach pilots in Victoria

The residential aged care clinical in-reach pilots were developed as part of the Victorian Department of Human Service's Winter Demand Strategy 2008. The aim of the in-reach pilots was to reduce the need for transfer of aged care residents to an emergency department if safe and appropriate care could be provided in their own home.

Each health service was given the flexibility to develop a program that accommodated existing strengths and capabilities and built on an existing service to utilise resources already available in the health service. Wide ranging, positive feedback from health services led to the extension of the pilots to run all year round and nine metropolitan and three regional health services were running the pilots in mid 2009.

An external evaluation of the pilots was completed in mid 2009. The evaluation found that the in-reach pilots met their main objective of assisting to avoid unnecessary travel of older patients to a hospital facility, were well regarded, accessible and met referrer (Residential Aged Care Services, General Practitioners and Ambulance Victoria) and hospital requirements.

Sources: DHS (2009); Larkins et al. (2009).

The role of sub-acute and transitional care

Further key areas where the interface between health and aged care can be improved are sub-acute and transitional care.

Sub-acute care involves the delivery of a wide range of services (such as high level palliative care, pain and wound management), and this may be increasingly feasible in many residential facilities and in the community. In supporting the increased delivery of these services in residential care, Wayne Belcher coined the term aged care hospital:

An aged care hospital service is generally more intensive than traditional nursing home (high care) but less than acute (hospital) care. It requires frequent (daily to weekly) recurrent patient assessment and review of the clinical course and treatment plan for a limited (several days to several months) time period, until the condition is stabilised or a predetermined treatment course is completed. (sub. DR759, p. 24)

KinCare argued that community delivery of such services was also increasingly feasible. It stated:

There should be an expectation that an increasing range of health services will be provided in the community and appropriate funding mechanisms to achieve this. Aged care services should become an alternative to services presently only funded in hospitals. Community care can become an alternative to hospital infrastructure in some circumstances in the same way it has become a strong alternative to residential aged care for many clients. (sub. DR896, p. 1)

As discussed above, sub-acute care provided in residential aged care facilities and the community may, in many cases, be far less costly than the equivalent service provided in a hospital setting.

Transitional care assists older people, following an acute care episode, with treatment in the home or like environment. Examples of low intensity therapy services provided via transitional care include: physiotherapy; occupational therapy; dietetics; podiatry; speech therapy; counselling; and social work. Personal care services may include assistance with showering, dressing, eating and eating aids, managing incontinence, transport to appointments, moving, walking, and communication (DoHA 2009i).

The Commission's proposed reforms in this and other chapters would considerably enhance the flexibility of care delivery in residential, community and other age friendly settings. In particular, they may allow improved access for consumers to flexible aged care services, including sub-acute and transitional services that are better integrated with local health services. They will also assist providers in delivering a more flexible range of such service offerings, and diversify their client and revenue bases.

To further assist this process, the fees paid to approved service providers for delivering sub-acute services should be sufficient to encourage their provision. These fees should be cost reflective, and should as a general rule be set at lower levels than those for an equivalent service provided in a hospital setting.

RECOMMENDATION 9.6

The Australian Government should set scheduled fees for the delivery of certain sub-acute services that are delivered in a residential aged care facility. These fees should be cost reflective and, in general, lower than the scheduled fee for the equivalent service provided in a hospital.

Interface with the disability sector

Concurrent with this inquiry, the Commission is undertaking an inquiry into disability care and support. That inquiry is scheduled to deliver its final report to the Australian Government in July 2011.

The Commission received several submissions advocating an integrated system covering both disability and aged care. For example, Pam Webster wrote:

Should Australia have an ‘aged care system’ as currently conceived, or could a broader conception of care and disability policy be more appropriate, with the needs of the aged being one part of this continuum?

I believe the two Inquiries need to work together and look carefully at the benefits of developing an integrated system that will meet the needs of all Australians no matter when, at what age or how they develop the need for care and support (sub. 178, p. 1).

While both the aged care and disability sectors provide support for people with disability, there are significant variations in the philosophies and goals in each sector, the services that people use and their aspirations. Further, while the probability of acquiring a disability is low, this is not the case for aged care. Many people who live long enough can expect to require some level of assistance. The majority of those who use aged care services have had previous employment, have owned a home and are now retired. Many people with a disability aspire to joining, or rejoining, the workforce.

The Commission is particularly aware that many more people with disabilities are living longer, whilst many young people acquire disabilities previously associated with ageing.

Irrespective of the funding source or assessment arrangements, all people with a disability and all older people needing care and support should receive services appropriate to their needs, on a fair and equitable basis.

People with disabilities should receive services from providers best skilled to meet their needs, however funded. So, for example, a person with a severe long term disability, such as multiple sclerosis, may be best served by specialist disability service providers to the end-of-life. On the other hand, people who experience younger onset of disabilities normally associated with ageing, such as severe dementia, might be best served by providers skilled in the support of older Australians.

Interface with the proposed NDIS

The Commission’s current inquiry into disability care and support has, in its draft report, proposed the establishment of a national disability insurance scheme (NDIS) for eligible individuals. Arrangements should be in place in the NDIS (and broader disability care system for non eligible individuals) and aged care system such that individuals receive an adequate level of care and support.

Many people who acquired their disability earlier in life are concerned that, as they age, they may fall between the cracks of two systems. They want to preserve the continuity of their support arrangements and the adequacy of funding. For example,

many people want the capacity to stay in their own homes (say a group home), to stay with the support workers they like and to use the service providers that best meets their needs, regardless of the system that accredits these providers.

The Australian Government has already committed to funding the disability support needs of such people under the National Health and Hospital Network Agreement (NHHNA) (COAG 2010b). It has agreed to funding specialist disability services provided under the National Disability Agreement for people aged 65 years and over (50 years and over for Indigenous Australians). Meeting this agreement is already factored into the Australian Government's budget commitments, and so lies outside consideration of funding for the NDIS.

That nevertheless leaves the practical issue of achieving continuity of care as people with disabilities age. The Commission proposes that, upon reaching the pension age or 50 years of age for Indigenous people (and at any time thereafter), the person with the disability could elect to stay with the NDIS or move to the aged care system.

- If a person elected to move to the aged care system, then they would be governed by all of the support arrangements of that system, including its processes (such as assessment and case management approaches).
- If a person elected to stay with the NDIS service arrangements, their support arrangements would continue as before, including any arrangements with disability support organisations, their group accommodation, their local area coordinator, or their use of self-directed funding. The NDIS approach to assessment would be used to determine their entitlements
- If a person over the pension age required long term residential aged care then they would move into the aged care system to receive that support, regardless of the age at which they acquired their disability.

For younger people with disabilities should they require access to aged care services then their costs of aged care and accommodation will be met by the disability care system (including where eligible, the NDIS).

Further supporting arrangements

These proposed interface arrangements would be supported by a number of other key measures.

For individuals requiring *aids and appliances* in the aged care system, and as outlined above, major aids and appliances may be funded by an entitlement for use. Low levels aids would continue to be available through community support

agencies or purchased from the market. Disability specific agencies could continue to supply aids and equipment in both circumstances together with other community or private agencies.

In regard to *price setting*, the Australian Aged Care Commission (AACC) will recommend to the Government a schedule of prices for aged care subsidies and for the supported resident accommodation payment. The AACC and the NDIS price setting agency would maintain close links to not only share analysis, but ensure consistency of prices for similar services.

While the *assessment tools* and methods will vary between the NDIS and aged care systems, the two agencies responsible for assessment in either system would sign a Memorandum of Understanding and exchange information. The regulatory agencies in both aged care and the NDIS would also agree to ensure consistency in approach, and to discuss standards. There would be data exchange between the agencies and systems. An approved provider in the NDIS would have an almost automatic status as an approved provider in aged care (and vice versa) via mutual recognition.

Some young people with disabilities will be using aged care services. So long as they meet the criteria for NDIS funding, the NDIS would pay the full cost of their “aged care services”. If a person was not eligible for NDIS supports, the person could receive aged care services once assessed by the Gateway agency, being regarded as a person with an age related condition. If receiving services under the aged care system, the person would be liable to a means test under the aged care co-contribution regime.

RECOMMENDATION 9.7

The Commission notes that the Australian Government has agreed to assume funding responsibilities for specialist disability services delivered under the National Disability Agreement for people over the age threshold.

In that context, the Australian Government should ensure that:

- ***a person with a disability eligible for and being supported within the disability care system prior to reaching the aged threshold should be able to be continue to be supported by services best able to meet their needs including through the disability care system***
- ***such a person may at any time after reaching the age threshold elect to be supported through the aged care system and be subject to that system’s arrangements and shall be deemed to have done so upon permanent entry into a residential aged care facility.***