SUBMISSION TO PRODUCTIVITY COMMISSION

CARING FOR OLDER AUSTRALIANS

DRAFT REPORT

MARCH 2011

Introduction

As an opening response to the Draft Report we would agree with many other commentators and analysts that the Commission has produced a bold and very welcome vision for the future of aged care in Australia.

A great many of the findings and recommendations reflect what the aged care industry, consumer organisations and others have been saying for some time now, that the aged care system is well overdue for major reform.

We congratulate the Commission on the Draft Report and in this submission will attempt to advance the thinking on some of the more detailed considerations.

The draft recommendations

We agree with many of the recommendations. This submission will therefore focus on those aspects where we either disagree or suggest there needs to be further clarification and/or development.

Recommendation 4.1: Principles guiding future policy change

We recommend that the aim of creating an appropriately resourced and sustainable aged care sector be an additional explicit principle.

Recommendation 1.3 (6.3): Removing restrictions on supply

While we agree the regulatory restrictions on the number of community and residential aged care places should be removed, we believe there is very strong support for supply restrictions on community care packages to be removed in Stage 2 of the reform implementation (realistically, from 2013). The effect of this change on the demand for and nature of care services should be reviewed before proceeding to remove supply restrictions on residential care in Stage 3.

There are other considerations in deciding when to deregulate residential aged care supply. Firstly, providers have very substantial investments tied up in existing services. There has also been a steady decline in occupancy levels across the country for reasons we could speculate about, though they remain unproven. There is also a great deal of work to be done in relation to costing and pricing, as well as proposed changes to the accreditation, complaints and prudential regulations that need to be considered before we could confidently commit to the deregulated supply of residential care. Furthermore, no financial modelling has been undertaken in relation to the Commission's recommendations regarding capital costs, accommodation charges and the related bond amounts, or the means testing and co-contribution regimes. The short to medium term effect on the 'market' of any future Aged Care Approvals Rounds, together with existing

provisional allocations of places (including new aged care facilities already under construction) also need to be factored into the thinking.

That said, deferring a decision on the timing of uncapping supply is no reason why a benchmark cost of care study and work on other proposals should not proceed as soon as possible.

We agree that the government should also remove the distinction between residential high and low care places.

Recommendation 1.4 (6.4)

Accommodation costs and the setting of bond amounts

We support the recommendation that regulatory restriction on accommodation payments should be removed. However, there are aspects of the recommended uncapping, but limiting, of accommodation charges and bonds that are problematic.

Firstly, as a point of context, we seriously doubt that bonds of '$550K to $750K and sometimes $1M+' are 'becoming somewhat of the norm' (p. 159). Nevertheless we agree that such sums are far in excess of the estimated replacement cost of residential care places.

To better understand the real cost of supply and its implications for accommodation bond amounts one needs to consider the various interacting factors that influence capital costs. In determining a price therefore, the following factors need to be considered (not in any order), not simply the replacement cost:

1. Land costs, which are obviously influenced by location;
2. the full construction cost, maintenance and replacement cost over the life of the building;
3. square metres of space per resident (both room size and total area) and design considerations that influence efficiency and OH&S requirements for staff working with increasingly frail residents (e.g. using and moving lifting equipment in the room and en-suite);
4. occupancy levels;
5. the number of Supported Residents and low bond paying residents;
6. the cost of borrowings;
7. a return on investment (which should at least equal the long term government bond rate).

Therefore, if the replacement cost was say, $230,000 a bed, the accommodation bond might need to be $350,000, having factored in all of the above considerations.

Periodic accommodation charge

Without knowing how a daily accommodation charge might be calculated, we remain concerned that given the choice, many more residents will elect to make a periodic payment rather than a lump sum bond. The average length of stay in high care is now around three years but less than one year for almost 30% of residents. In the absence of a formula for converting bond amounts to daily charges, we are unable to assess the likely impact of the proposed changes.

The effect of the loss of retentions should not be underestimated as they currently underpin a capital-related funding system. One of us estimates that the elimination of retentions would have a negative impact of $1.2 million a year. Even before a new charging system introduces a more appropriate pricing arrangement for accommodation, this example reflects the need to recoup $1.2 million that is already being sourced. On balance, the notion of retentions should continue to be offered as a matter of resident choice in return for a lower bond payment, much in the way retirement village residents can choose various payment and refund arrangements.

In order to maintain the financial viability of providers, a mix of lump sum bonds and periodic payments is necessary, particularly in any transition phase. If incentives are given to consumers that favour periodic payments then this may well affect providers' viability, cash flows and possibly negatively affect bank covenants.

If providers receive few or even no lump sum payments from residents, they may fail to achieve the necessary level of equity to secure sufficient borrowings to finance new projects or adequately maintain existing facilities. Financial institutions will not lend the full amount required to fund a capital project, or will do so at a much inflated interest cost due to the increased risk. It should not be assumed that not-for-profit organisations will have 'spare' assets against which they might borrow for their 'equity' component, particularly if they are building retirement accommodation as well.

Recommendation 1.5 (6.5): Supported Residents

We remain concerned with the concept of price-based competitive tendering in what are essential service areas. Our understanding of the result of tendering arrangements as they were applied some years ago to HACC services in Victoria and by the Australian Government in relation to respite services, reinforces the need for a re-think.
Provided the lead times are adequate, and in view of the proposed uncapping of prices and supply, there should be no reason why existing Extra Service providers should not be subject to the same requirements as all other providers in relation to the care of Supported Residents (say after 5-10 years).

However, there will need to be very real financial incentives for providers to build new residential care facilities in regions with high proportions of prospective Supported Residents and/or other older people with low asset levels (see comments below under *At risk groups*). Imposing an obligation to offer a specified proportion of places to Supported

Residents runs the risk of there being no or few new residential care projects in such regions.

In the case of existing facilities with high proportions of Supported Residents (some well over 50-60%), it needs to be recognised that the financial modelling would have been done on the basis of the existing bond funding arrangements. As a result, the new accommodation subsidy may need to be supplemented to ensure the ongoing viability of facilities in these regions.

Recommendation 1.7 (6.7): Basic standard of residential aged care accommodation

We understand the Commission has modified its position on this issue and is likely to change the recommendation in the Final Report. The comments below are included to assist the Commission in formulating its final recommendation regarding the basic standard.

We disagreed with the Commission's draft recommendation that the government accommodation payment should be based on the cost of providing a two bed room with a shared en-suite. All of our adult lives we share a bedroom with a partner or with no-one. Older people requiring residential aged care should not suddenly be expected to share with a stranger simply by virtue of their lesser means. Such a policy would result in a two-tiered system on the basis of relative wealth.

The current standard and community expectation is for a single room with en-suite. There are compelling human rights and care and safety considerations in the provision of single rooms. Older people are entitled to have their privacy and dignity respected and indeed, promoted. Having one's own accommodation also enhances a person's feelings of self-esteem and self-worth. A single room also affords the necessary access to privacy for family and friends when visiting a resident.

Residents should not be left in their rooms for long periods, be they in a share or single room. However, from a care perspective, residents with advancing dementia are better accommodated at night, and sometimes during the day, in a single room, to minimise the potential for disturbance of other residents. More aggressive residents are not well placed in share rooms, nor are residents receiving palliative care.

We therefore agree with the view of Grant Thornton Australia's National Head of Aged Care Services, Cam Ansell, that:

> 'To ensure the Commission's equity and access objectives are achieved in the long term, accommodation subsidies for supported residents should reflect modern design and construction standards and provide for pricing based on single en suited rooms. Financial modelling based on specified standards and location would facilitate the estimation of reasonable basic standard costs.'[1]

[1] Productivity Commission Report: Caring for Older Australians – Issues for Consideration, Grant Thornton Australia, March 2011, p.7

At risk groups

Besides Supported Residents, there are other groups potentially at risk of being financially unattractive to residential care providers unless the accommodation payment is set at a level (both in terms of level of subsidy and those who access the subsidy) so as to not present a disincentive to accepting them into care.

Older people with assets in excess of the asset threshold (currently $98,237.60) who are therefore outside the definition of a Supported Resident, but whose assets are less than the local approved providers' periodical accommodation charges (plus the assumed asset free level of $38,500 currently), will not be able to afford residential care and may not be 'affordable' from a provider's perspective.

Recommendation 1.8 (6.8): Additional services

We agree that the regulatory restrictions on additional service in residential aged care facilities should be removed. However, we see no reason why this should not also apply to community aged care services and to additional care in both residential and community care. Residents/clients could utilise their personal wealth to purchase additional personal and health care as well as services through their private income streams and/or by drawing on the Australian Pensioner Bond Scheme or, in the case of community care clients, an Equity Release Scheme. Such additional expenditure should not count towards the lifetime stop-loss limit.

With regard to the charging of 84% of the full pension for basic living expenses, we believe this is an appropriate charge at this point. However, we are not clear as to how key cost drivers such as the proposed carbon tax; employer superannuation increases etc. will affect future expenses. These need to be taken into account should the applicability of the percentage of pension be reviewed.

Recommendation 1.9 (6.9): Co-contributions and the means test

We support the Commission's preference for a comprehensive means test that would involve a combined income and assets test (including owner-occupied housing, accommodation bonds and the proposed Australian Pensioners Bond). We also agree with the concept of a threshold below which a simpler test would apply.

However, just how the means test would apply is unclear to us from the Report. On page 189, the Report refers to three levels of subsidy based on the level of assets: those with assets above the 80th percentile (currently $550,000) would receive the lowest rate of subsidy. Yet on page 195 it is stated that the maximum co-contribution of 25% would only be paid by someone with assets in excess of $1.6 million (and annual income under $20,900). These two statements about the lowest subsidy versus the highest co-contribution need to be reconciled somehow. We would therefore like to see in the Final Report, a clearer explanation of how the means test would determine the level of subsidy and co-contribution.

Section 6.5: Care costs and government subsidies

The Draft Report proposes just three levels of subsidy for personal and health care costs (p. 189) but we are unclear as to how this idea relates to the much more complex existing system of HACC funding, three levels care package funding and the Aged Care Funding Instrument (ACFI) with its 64 pay points.

Nevertheless, there is evidence from our collective experience that as many as 90% of residents fall with twelve or fewer general ACFI categories. The potential exists therefore for all prospective community and residential care recipients to be assessed against a much simpler but still multi-layered subsidy entitlement framework.

The imminent transfer of full responsibility for aged care funding to the Australian Government presents an historic opportunity for the subsidy system to be simplified, integrated and rationalised.

Recommendation 7.1: An Equity Release Scheme

To keep costs to a minimum for older Australians requiring access to the equity in their home, proceeds from funds invested in the Australian Pensioner Bond Scheme should be applied to the Equity Release Scheme.

One option is for the Bond Scheme to lend to the Equity Release Scheme at the same rate it is returning to investors (proposed to be at the rate of the CPI). Alternatively, the amount paid to the Equity Scheme could be all or part of the difference between the return to investors in the Bond Scheme and the actual earnings of the Scheme. In any event, all of the earnings of the Bond Scheme should be applied to the Australian Government's aged care programs, consistent with the principle applying to permitted uses of accommodation bonds by approved providers.

The Draft Report acknowledges that existing equity release schemes can be expensive, which acts as a disincentive for older people to utilise the equity in their homes to advantage. We are therefore proposing the above arrangement as a means of keeping the costs of a public scheme to a minimum and providing a positive incentive for older Australians to take advantage of their often considerable latent wealth.

Recommendation 8.1: The Australian Seniors Gateway Agency

Resourcing

The Report proposes that the disparate range of elements in the current system be replaced by an integrated Gateway Agency. We agree that this should happen but it is dependent on the States and Territories agreeing to a total handover of information, assessment and coordination resources from the Home and Community Care (HACC) Program and the Aged Care Assessment Program. This could be very difficult to quantify, as in South Australia for example, the Aged Care Assessment Teams (ACAT)

are embedded in the hospital system, with staff being shared between the ACAT and the hospitals. Furthermore, some States and Territories apply additional funds for the ACATs to conduct HACC assessments, although how much is truly State funding as opposed to shared Commonwealth/State HACC funding is unknown.

Structure and operation

We support the idea that a Gateway Agency should be structured on a regional basis, achieving a balance between easy access and ensuring that its functions are performed consistently and equitably. A major flaw in the regionalised and State/Territory health-controlled ACAT system has been the high degree of inconsistency in the application of assessment tools and response times. Assessment policies, practices and priorities vary significantly across and between the ACATs. Assessments may also be multidisciplinary in theory but our experience is that a great many are conducted by one member of a team.

We therefore agree that the creation of a single, national assessment authority is the most efficient and effective approach. The Draft Report does not explore the potential for establishing formal linkages between aged care and the health care system. We would like to see further consideration of ways in which the proposed Gateway Agency might interact with Medicare Locals and Local Hospital Networks in the future.

With the introduction of consistent assessment tools and protocols across the country and effective quality assurance processes, we see no reason why a single approved provider, or a consortium of providers, should not be able to be contracted as a regional Gateway Centre, as suggested on page 241 of the Draft Report. This would also fit with the concept of 'Lead Agencies' proposed in Attachment B of the Report.

We draw the Commission's attention to the attachment to our letter dated 5 November 2010, also co-signed by the Council on the Ageing (COTA). The second dot point under the heading 'The Gateway Network', states that COTA agrees that providers could act as Gateway Centres. The function would need to be sufficiently arms length from a provider's other business interests.

Base Assessment

We believe, as do others, that there should be 'no wrong door' when it comes to older people seeking base level care. If contacted directly, Approved Providers should be able to assist people with their base assessment, rather than having to refer them elsewhere.

Further assessment

Assessment of a person's needs is generally approached on the basis of what services are available (a menu-based approach). This can result in inaccurate assessments, inappropriate allocations of resources and clients not being satisfied with the outcome.

Independence-enhancing approaches to assessment on the other hand, seek to identify what it is that would enable a person to continue to live independently, regardless of what is immediately available. The result is real choice and a better match between what a person needs and what is provided, leading to more effective outcomes.

There are various assessment models that have been adopted by providers in response to the evidence that the promotion of independence is a key determinant of sustained community living for an older person. Approaches that emphasise independence include self management goal setting and other forms of client self assessment, either on their own or together with formal clinical assessments by health professionals. These models of assessment have been validated and demonstrated to be acceptable to clients. They have also been considered through quality review as being an acceptable response to aged care quality standards related to assessment processes. Such approaches are beginning to be used by some organisations and we offer one example in Attachment A.

Irrespective of the eventual structure of the Gateway network, the assessment tools must be based on achieving enhanced independence for the older person and their carer.

Community assessments versus the ACFI tool approach

ECH and Resthaven have both conducted trials to determine the applicability and usefulness of the ACFI assessment for Community Package clients. The overall findings from these trials concluded that the ACFI tool would not be applicable for Community Package clients. The conclusion was that the ACFI assessments would need to be substantially adapted to better reflect the care needs of community clients and therefore a better tool should be developed to identify non-ACFI care to clients.

Reassessment

The report mentions the issue of reassessments only in passing (p. 242). Under current arrangements, HACC reassessments are undertaken by the service provider with any resultant increase in care or service needs having to be managed within its grant limitations.

In the case of community care packages, the options are:

1. seek a reassessment of the client by an ACAT for approval of a higher level of care entitlement and subsidy (the provider may or may not be able to actually offer the higher care);
2. try as best to provide care to the client within the lower subsidy limitations;
3. cross-subsidise clients within the total subsidy entitlement;
4. the provider meets the additional costs; or
5. the client pays the full cost of the additional care and service.

For residential care the options are an ACAT reassessment to reclassify a resident from low to high care (following the first ACFI appraisal) or an ACFI reappraisal resulting from a 'major change' in a resident's care needs. In the case of the first appraisal, an

ACFI application can be lodged within 2 months but not within the first 7 days after admission and cannot be submitted within 28 days.

If the ACAT, provider-conducted community care re-assessments and ACFI appraisals are to be collapsed into a single system, the reassessment of clients/residents should be a matter for the approved provider, subject to an appropriate level of validation. The Draft Report reads as though providers would carry out the reassessments in residential aged care 'in the event of a material change in a client's condition' but not in community care. We believe that the system of re-assessment should be consistent across residential and community care, with approved providers being responsible in the case of both service types. The introduction of a model of independence-enhancing assessment protocols would protect against the risk of gaming or rorting as the approach is to identify what care and services are needed and what an individual older person can continue to do themselves. If a person simply has a preference for an additional service or more resource-intensive care than is strictly necessary, they should meet the additional costs themselves (see comments above in relation to Recommendation 1.8).

A validation program of some sort is implied by 'subsequent assessments would be reviewed on a risk managed basis.' The risk management of provider assessments in both residential and community care could be undertaken by the Australian Aged Care Regulation Commission (AACRC), using a model similar to Medicare Australia's National Compliance Program.

Care Coordination and Case Management

Many (particularly larger) approved providers provide care coordination as an integral feature of both their community and residential care services. These functions are already built into the cost structures of the services.

The Draft Report is suggesting that, in the case of community aged care, more intensive case management could be provided by independent agents. We assume the reasoning behind the suggestion is that specific-purpose case management services might ensure that such management would occur and that it would be independent of any one service provider. However, there is a risk of duplication with what service providers already do, which would simply add to the cost of the system.

We have no objection to independent case management but only a service provider can guarantee that care and services will in fact be delivered. Independent agents could therefore be a part of a reformed aged care system but should not be the only option open to older people. It is our experience that a great many of our existing clients would prefer to utilise the case coordination and case management services we offer, rather than having to seek out an outside agent. A related matter is that we assume the quality assurance and other accountability requirements applying to care co-ordination and case-management by approved providers would apply equally to independent case managers.

Recommendation 8.2: Single, integrated entitlement system

We agree that care services should be an entitlement, based on assessed need. Once the entitlement has been established and the price and co-contribution set, the financial value of the personal and health care entitlements should be portable across care types (e.g. across community and residential care). Such portability would, for example, facilitate the return of older people to life in the community following a period of residential care; or allow a person to elect to spend part of their entitlement on short term residential care – perhaps while recovering from an illness, injury or period of hospitalisation – before returning home with community-based supports.

Recommendation 8.4: Block funding

It seems inevitable that some degree of block funding will need to be introduced or retained. Many small and/or rural and remote services for CALD and Indigenous groups for example, simply could not survive on subsidy-based arrangements.

Some further consideration needs to be given to future funding of services such as Day Therapy Centres; community day programs; services and projects aimed at overcoming social isolation and loneliness; and community-based respite services.

We recognise that a principle outlined for the system includes acknowledgement of special needs groups such as those from culturally diverse backgrounds and their carers. The Draft Report does not comment adequately about how such groups of people would be catered for in the reformed system. This is an area where the report would benefit from some development of the particular needs and responses required.

Recommendation 10.5: Retirement Village Legislation

We would simply caution against the adoption of the most onerous provisions of existing State or Territory legislation to ensure that regulation is proportionate to the risks and necessary protections and does not add to costs.

Recommendation 12.1: Regulation – the future direction

We fully support the establishment of a new, independent regulatory authority in the form of the Australian Aged Care Regulation Commission (AACRC). Importantly, we are firmly of the view that the Commission should be headquartered outside of Canberra and most probably in Sydney or Melbourne. We believe such separation of location and function between the Department of Health and Ageing (DoHA) and the AACRC will lend a greater air of independence to the new Commission. Furthermore, the Accreditation Agency is already located in Sydney, as is the Administrative Appeals Tribunal. There may also be economic, recruitment and accessibility advantages by situating the Commission in either of Australia's two largest cities.

The AACRC has the potential to be a very large bureaucracy in its own right. The Commission has recommended that regulation policy development be separated from the

administration of regulation. We therefore recommend that the Accreditation (quality assurance) Agency remain separate from the AACRC,

With respect to DoHA's legitimate role as an administrative arm of the Executive Government, we assume it would continue to provide advice to government on policy matters.

As to prudential arrangements, if bond holdings are set to increase to the extent predicted by the Commission, there may be the need for a separate, dedicated prudential authority[2]. Paradoxically, if bond holdings decline a small, separate regulatory authority may be all that is needed.

Recommendation 12.2: AACRC and Gateway Agency appeal mechanisms

As a matter of process, all parties to a complaint should have recourse to a quick, low cost internal review of decisions before having to lodge a formal and potentially more costly appeal to a third party authority. Internal reviews of decisions by the AACRC's complaints authority and the Gateway Agency should be subject to statutory time limits.

The Draft Report recommends that all appeals in respect of decisions of the AACRC and the Gateway Agency should be heard by a yet to be established Aged Care Division of the AAT. We understand however, that AAT appeal processes can be lengthy and expensive. The Tribunal's most recent Annual Report indicates that:

- most cases were finalised without a formal hearing within 13 weeks for a first conference; and
- up to 40 weeks and more for a first formal hearing.

These timeframes are far too long for appeals against complaints decisions.

Recommendation 14.1: Reform implementation

Refer to comments in relation to Recommendation 1.3: Removing restrictions on supply.

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[2] Productivity Commission Report: Caring for Older Australians – Issues for Consideration, Grant Thornton Australia, March 2011, p. 8

Appendix A

The ECH Model of Enhancing Independence

Background

In early 2009, ECH Inc. began the implementation of an "Enhancing Independence" (EI) approach across its Community Packages.

Enhancing Independence is based on research that has been carried out interstate and overseas that tells us that many older people can achieve a significant improvement in independent living within a six to eight week period if they are able to access the right services and supports.

Importantly, the research also tells us that the improvements and benefits experienced from this short-term period of restorative services are maintained well into the future.

This philosophical approach supports independence and well-being in older people by introducing an initial restorative phase of intervention for approximately 6-8 weeks. An assistance plan is developed to provide services for a client for this initial 6-8 week period with a focus on enabling optimal recovery, before reassessing the client and developing an assistance plan for any ongoing services required. There is a consistent focus on maintaining an optimal level of functioning for the client to enable them to remain in their own home for as long as possible.

This initial 6-8 week phase may include service hours over and above the usual maximum, which are funded by ECH. The intention is that the client will rehabilitate over time and the number of service hours will gradually reduce for a majority of clients, financially compensating for any additional hours provided in the initial phase. ECH is also currently conducting a pilot for introducing the EI philosophy for Day Program clients.

The EI model is consistent with several of the key principles contained in the proposed Productivity Commission model, including:

- consumer choice;
- an approach that assesses for health promotion needs and the ability to improve independence and maintenance of independence;
- the recognition of the important role of the carer; and
- the promotion of well-being, healthy ageing, prevention programs and social inclusion activities and electronic records.

Mode of assessment

ECH is using a suite of assessment tools, including tools developed by ECH (which remain the intellectual property of ECH Inc.), as well as scored, standardised tools which allow the monitoring and measurement of client progress.

This suite of tools conforms to the model proposed by the Commission, whereby a number of assessment instruments can be drawn from a 'toolbox'.

Although it is a requirement for staff to complete a minimum number of assessments for all Community package clients and Day Program clients, staff also have the option of collecting additional information by administering additional assessments that are available electronically to ECH staff.

ECH's Community Client assessment is conducted in addition to four standardised assessments: the Barthel Index; the Lawton Brody Instrumental Activities of Daily Living (IADL) Scale; the Nottingham Extended Activities of Daily Living Scale (EADL); and the Timed Up and Go (TUG) test, to provide scores indicative of the client's ability to function independently within their home.

ECH's Community Client assessment is based on four major domains:

- activities of daily living;
- psychosocial health and well-being;
- physical health and well-being; and
- social and environmental considerations.

Within each domain, a subset of questions explores issues that are relevant to the provision of holistic services e.g. psychosocial health and well-being includes questions about mood, mental health, behaviours of concern, cognition, communication, vision, hearing, speech and English as a second language.

Background research has highlighted the gaps in existing community services assessments, including a focus in most assessment tools on instrumental and personal activities of daily living. There are few assessments seeking information about other relevant factors such as the impact of pain or sleep disturbance on independence and daily functioning. Development of the EI assessment attempted to address some of these identified gaps.

ECH has also developed an Initial Client Assessment, designed as a screening tool for all newly referred clients to Community Services. This initial assessment may provide the level of information equivalent to the 'Assessment level one' in the proposed model. ECH's initial assessment is designed to be administered over the phone, which would provide initial information for a rapid response pathway for urgent access to services. All other assessments have been developed as 'face to face' assessments, to be conducted electronically via a laptop in the client's home, which is consistent with the proposed model.

Similarities between the proposed model and ECH's EI approach

Promoting independence

The proposed model and ECH's EI model both assess for health promotion needs and the ability to improve independence and both certainly fit with the promotion of wellbeing, healthy ageing, prevention programs and social inclusion activities.

ECH's approach is also congruent with the proposed model, in that a suite of assessment tools has been developed and can be built upon, based on changing client need.

Holistic approach

ECH has reviewed the published literature on gaps in assessment tools and has recognised that to date many assessment processes have purely assessed functional ability. Therefore there was the need to veer away from purely functional based assessments and take on a truly holistic assessment process, by identifying all factors that may have a profound impact on an older person remaining at home, including psychosocial factors, housing tenure, carer status and physical health.

Standard toolbox of assessment tools

ECH currently uses a suite of assessments for Community Package clients, in addition to a range of assessments that can be used for Day Program clients. Staff are also able to access further assessment tools if they deem it necessary to further explore a particular topic, for example the Caregiver Strain Index.

The way in which the assessments have been developed is consistent with the proposed model, in that an initial question within a domain triggers a 'drop down' list of further questions if an issue is identified. If no issue is identified by the initial question, the assessment skips to the next topic.

Adopting a conversational approach to assessments

Questions contained in the EI assessments are not designed to be asked verbatim. Assessors need to possess adequate skills and competency in administering the tool by taking a conversational approach and demonstrating active listening skills in order to identify potential client goals.

Profiles, Domains and Items

The ECH EI assessments contain the following domains and questions:

Activities of daily living (ADL)	**Physical health and well-being**	**Psychosocial health and well-being**	**Environmental and social considerations**
Eating and drinking	Medical history	Mood	Social history
Mobility	Current medical status	Mental health	Environment
Skin and hygiene	Medication	Behaviours	Life profile

Toileting and continence	Pain	Cognition	Social isolation
	Technical care	Communication	Loneliness
	Sleep	Vision	Social networks
	Allergies	Hearing	Cultural
	Shortness of breath	Speech	Recreational
	Substance (mis)use	ESL	Financial
	Immunisation		Housing (including security of tenure)
	Oral health		Pets
			Carer issues

It should be noted that within the ADL domain, many of the questions are asked within the context of the standardised assessments. Therefore, the domains listed above are additional clarifying questions only. Issues such as instrumental activities of daily living (shopping, managing transport, driving, handling money, etc) are asked in the Nottingham EADL and IADL assessment tools. Personal activities of daily living questions are asked in the Nottingham and Barthel's assessment tools.

Limitations of the EI approach within the current aged care model (Community Packages)

Implementing the EI approach within the current funding levels and service hours associated with a package has proven difficult, especially when clients are well informed about what they are 'entitled' to with a Community Package. Many clients want to maximise their service hours, even though they may actually only need fewer hours of assistance.

This may result from ACAT assessors, hospital staff or other service providers establishing expectations of clients by describing how many hours of service/level of funding and/or what type of services are available to them. Therefore, some clients may have already planned out how they want their services to be implemented before ECH staff have been able to discuss a restorative approach with them.

Based on ECH's experience of rolling out the EI model and implementing comprehensive assessments with a staff group from mixed skill sets and backgrounds, we

would concur with the Productivity Commission's recommendation that assessors should be specialist assessors and that a minimum skill set would be required to appropriately administer assessments that would result in quality, needs-based community services.

Outcomes

The EI model has resulted in closer working relationships between community staff and Allied Health Professionals, as both teams work together on client goals.

A diagrammatic representation of the process follows:

Diagrammatic model of the Enhancing Independence process