Town of Gawler
Corporate & Community Services Committee Meeting Agenda
12 September 2017

ATTACHMENTS UNDER SEPARATE COVER

Item 7.2 – Aged Care Reforms Discussion Paper Submission

ATTACHMENT 1	Discussion Paper – An integrated care at home program – July 2017
ATTACHMENT 2	Town of Gawler – Submission to Discussion Paper - An integrated care at home program
ATTACHMENT 3	Seniors Collaborative Action Project – SCAP Submission – Integrated care at home discussion paper

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Future reform – an integrated care at home program to support older Australians

Discussion paper

July 2017

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1. Purpose of the discussion paper

The Australian Government recognises that older Australians want better choices and improved access to services which will enable them to continue to live active and healthy lives in their communities.

This discussion paper seeks your views on how future reform can best support older Australians to remain living at home and in their communities. Your feedback will be used to inform government decisions on an integrated 'care at home' program.

Important reforms in home care were introduced in February 2017 to give consumers more choice in selecting a home care provider. There is now also a nationally consistent process for assigning home care packages to consumers. We would also welcome your views and feedback on these recent changes.

To allow the changes to bed-down and prepare the way for future reform, the Government has recently announced that funding arrangements for the Commonwealth Home Support Program (CHSP) will be extended until 30 June 2020. This will include an extension of agreements with service providers and Regional Assessment Services (RAS), with new funding conditions to provide a greater focus on activities that support independence and wellness and provide more choice for consumers.

The paper canvasses a range of policy options for future care at home reform that could be progressively implemented over the next few years. The policy objectives and reform options have been developed in response to what we have heard from the sector. While some specific suggestions for reform are outlined in the paper, no decisions have been made about specific program or implementation arrangements.

Before making decisions on future reform, the Government wants to hear further from the sector on what you believe is the best way forward. Future reform will also be guided by the Aged Care Roadmap and the independent Aged Care Legislated Review (due to report in August 2017).

Once the scope and priorities for future reform are settled, there will be further co-design and consultation with the sector on implementation and transition issues.

Terminology

The term 'care at home' is used throughout the paper to collectively refer to home support and home care arrangements.

'Consumer' refers to both existing and prospective recipients of home support and/or home care services, and their informal carers/nominated representatives.

'Block funding' also means 'contract-based funding to providers'. At present, block funding mainly refers to services or supports that are funded through grant agreements under the CHSP.

2. Reform context

2.1. The current care at home system

The care at home system currently supports around one million older Australians each year. The majority of services are funded by the Commonwealth Government through the Home Care Packages Program ($1.5 billion in 2015-16) and the home support programs ($2.4 billion in 2015-16). The home support programs include the CHSP and the Home and Community Care (HACC) Program in Western Australia. From July 2018, there will be a national home support program across all states and territories[1]. The following table presents an overview of the two main programs.

Table 1: Overview of Home Support Program and Home Care Packages Program

	Home Support Program	Home Care Packages Program
Program focus	Entry level support to assist older people to remain living at home	Co-ordinated packages of care (4 different levels of subsidy) to support older people with more complex care needs to remain living at home. Consumers may also be eligible for additional supplements.
Eligibility	Frail older Australians aged 65 years or older (or 50 years or older for Aboriginal and Torres Strait Islander people)[2]	No minimum age requirement (but the average age of entry was 80.2 years in 2015-16)
Access	Regional Assessment Services (RAS) undertake an assessment and refer consumers to service providers	Aged Care Assessment Teams (ACATs) undertake an assessment. Approved individuals are prioritised for care through a national system based on their relative needs and the date they were approved for care
Number of consumers	Around 925,000[3] (2015-16)	88,875 (2015-16)
Level of funding	$2.4 billion[4] (2015-16)	$1.5 billion (2015-16)
Funding model	Block funding (grants) to service providers No income testing of consumers; limited and variable consumer contributions or fees	Individualised budget for each consumer Subsidy and supplements are paid to an approved provider chosen by the consumer Income testing of consumers and subsidy reduction, plus fees
Legal basis	Grants program	Legislative program (*Aged Care Act 1997* and Principles)

[1] The Victorian HACC Program became part of the CHSP in July 2016. The WA HACC Program will transition to the CHSP from July 2018.
[2] Also includes prematurely aged people 50 years or older (or 45 years or older for Aboriginal and Torres Strait Islander people) who are on a low income and who are homeless or at risk of homelessness.
[3] Comprises around 640,000 CHSP consumers and 285,000 Victorian and Western Australian HACC consumers.
[4] Comprises Commonwealth Government contribution of $2.06 billion, and Victorian and Western Australian Governments' contribution of $394.6 million to support the jointly funded HACC programs in their states.

2.2. Flexible care programs

The Government also funds various 'flexible care' programs which provide alternatives to mainstream home care and residential care. These programs typically operate across different care settings and some are jointly funded by Commonwealth and state and territory governments.

The flexible care programs include the:

- National Aboriginal and Torres Strait Islander Flexible Aged Care Program
- Short-Term Restorative Care Program (including Transition Care)
- Multi-Purpose Services Program
- Innovative Care Program.

Further information about these programs is available on the department's website at agedcare.health.gov.au/programs/flexible-care.

While some of the issues and questions canvassed in this discussion paper are relevant to the flexible care programs (e.g. how best to provide access to services in rural and remote areas, and how to embed reablement and restorative care approaches in assessment and service delivery), these programs are not the primary focus of this paper.

2.3. Reforms to date

There have been significant reforms to the care at home programs in recent years. The main changes are listed in Table 2.

Collectively, these reforms have sought to:

- support more people to remain living at home
- provide more choice and control for consumers, particularly in home care packages
- make the system more sustainable, with consumers contributing to the cost of their care where they can afford to do so
- improve access to care – through a single entry point (My Aged Care), independent assessment and, in home care, a national approach to prioritising access to home care packages
- streamline and simplify program arrangements – with a national home support program rather than separate programs in each state and territory, and removing the need to apply for home care places through the Aged Care Approvals Round (ACAR).

Table 2: Overview of recent care at home reforms

Year	Reform initiative
2012	Commencement of Commonwealth HACC Program – replaced the former state-based HACC programs in most jurisdictions. Separate HACC programs continued in Victoria and WA Significant expansion of the aged care provision ratio, including a shift in the balance of care towards more home care[5]

[5] Increase in the target aged care provision ratio from 113 to 125 places per 1,000 people aged 70 years and over by 2021-22, including an increase in home care places from 27 to 45 places over the same period.

Year	Reform initiative
2013	Introduction of My Aged Care website and contact centre (with limited functionality)
	Commencement of Home Care Packages Program – new package levels and introduction of consumer directed care (CDC) for all new packages. Replaced the Community Packaged Care Program
2014	Introduction of income testing arrangements in home care (as part of a range of financial reforms across the aged care system)
2015	Introduction of the CHSP – consolidated the following programs: • Commonwealth HACC Program • Planned respite from the National Respite for Carers Program (NRCP) • Day Therapy Centres (DTC) Program • Assistance with Care and Housing for the Aged (ACHA) Program
	Expansion of My Aged Care, which included the introduction of the RAS and a nationally consistent and holistic screening and assessment process
	All home care packages required to be delivered on a CDC basis
2016	Victorian HACC Program transitioned to the CHSP
2017	Commencement of *Increasing Choice* reforms – funding for a home care package follows the consumer, a national system for prioritising access to packages, and simplified approved provider arrangements
2018	Western Australian HACC Program will transition to the CHSP

The reforms to the care at home system and aged care generally have been influenced by several key reports and reference documents, including the Productivity Commission's 2011 'Caring for Older Australians' Inquiry, the National Aged Care Alliance's (NACA) 'Blueprints for Aged Care Reform', and more recently, the Aged Care Roadmap developed by the Aged Care Sector Committee.

While these documents have considered reform options from different perspectives, they share a vision of an aged care system that is simpler, more consumer-driven, market-based, affordable and sustainable, responsive to diverse needs, and focussed on promoting wellness and independence.

Comments

We would welcome your views and feedback on the February 2017 *(Increasing Choice)* reforms.

2.4. Further care at home reform

With the changes introduced in recent years, the aged care system is moving towards a more consumer-driven, market-based and nationally consistent system. The Aged Care Roadmap identifies that further reform is necessary to ensure that the system is best placed to meet the needs of an ageing population in an efficient, fair and sustainable way. Consumer expectations are also changing. The 'Baby Boomers', who begin to turn 80 in less than a decade, will have different expectations of how their care is provided and, like previous generations, they will want the choice to remain living at home in their communities for as long as possible.

While significant changes have been made within both home care and home support, the care at home system is still largely operating as separate programs independent of each other – with different rules,

service offerings, funding models, administrative arrangements and accountability requirements. Generally, consumers do not have the same choice and control in the CHSP as they have with home care packages.

There are currently disincentives for some people to move into more appropriate forms of care, particularly in moving from entry level CHSP services to a home care package (section 4.7.1).

Further, the movement between home care and residential care, and the interface with other programs, is not as smooth as it could be. Consumers who are vulnerable or with diverse needs, including older people with disability and those with changing care needs (e.g. short-term and episodic), are not always well supported as they access services or move through the system.

There are some innovative examples of assessment and service delivery models supporting reablement and wellness approaches but, overall, the care at home system is still largely geared towards ongoing service provision. Ensuring that the system is able to support short-term, episodic and ongoing care needs will be an important element of future reform.

2.5. An integrated care at home program

The Government has announced its intention to establish an integrated care at home program in the future. This may involve changes to the existing home care and home support programs – with a range of reform options, from improving the way that the current arrangements operate and work together, to establishing a new integrated program combining the two current programs. No decisions have been made about program structures, funding models or implementation arrangements for the next stage of reform.

The department has undertaken preliminary consultations on policy objectives and reform priorities (section 2.8). However, before making decisions on future reform, the Government wants to hear further from the sector on what you believe is the best way forward. Future reform will also be guided by the Aged Care Roadmap and the independent Aged Care Legislated Review.

2.6. Aged Care Roadmap

In April 2015, the then Assistant Minister for Social Services asked the Aged Care Sector Committee to develop a 'Roadmap' that sets out future reform directions for aged care.

The Aged Care Roadmap[6] identifies short, medium and longer-term goals to make the aged care system more consumer-driven, market-based and sustainable.

One of the key destinations identified in the Roadmap is an integrated care at home program – a combined Home Care Packages Program and CHSP comprising:

- predominantly individualised funding that follows the consumer
- additional government assistance where there is insufficient market response
- block funding (grants to providers) where considered most appropriate/efficient.

The Roadmap envisages that the integrated program would also include:

- a single assessment process for eligibility, care needs and funding levels for care at home
- integrated fee arrangements.

[6] Aged Care Roadmap, April 2016, agedcare.health.gov.au/aged-care-reform/aged-care-roadmap

2.7. Legislated Review

The Legislated Review, currently being undertaken by Mr David Tune AO, PSM, is looking at how the aged care system has changed and adapted over the last five years, the impact of aged care reforms to date, and will consider where further changes could be made in the future. The Review is addressing nine key matters, including whether the number and mix of aged care places should continue to be controlled, if further steps should be taken to shift towards a consumer demand driven model, and the effectiveness of arrangements for means testing, facilitating access to services, and protecting equity of access for different population groups. The final report is due by 1 August 2017.

2.8. Consultation to date

The Government is committed to working with the sector on improving the aged care system. The department has undertaken preliminary consultation workshops and meetings with a range of peak groups representing consumers, carers and service providers across home care, the CHSP and residential care. State and territory governments have also been consulted.

Stakeholders are supportive of the policy objectives of future care at home reform (section 3.1). There was general agreement that we need to improve the way in which the care at home system operates, including reducing gaps, duplication and inequities within and between the programs. Stakeholders also noted that significant improvements have been made to My Aged Care, but further work is required to enhance functionality and improve overall performance.

Some sector leaders have strongly advocated that future care at home reform has to occur within the framework of the Aged Care Roadmap, and that siloed reform steps will not work properly on their own unless in concert with overall aged care reform.

However, there are different views in the broader sector about the best way forward. For example, while the Roadmap advocates for a predominantly individualised funding model, many CHSP providers believe that home support services are more effectively delivered by block funding. Some stakeholders have also suggested that the best reform path may not necessarily be a single care at home program. Rather, we may need programs that work better and more seamlessly together.

3. What type of care at home program do we want in the future?

3.1. Policy objectives

We want a program that:

- delivers high quality support and services to those who need it, when they need it
- provides the greatest possible choice and control for consumers
- encourages independence and wellness as standard practice that is integrated into assessment practices and service delivery
- is accessible and easy to navigate for the wide diversity of consumers
- is affordable for consumers, and financially sustainable for providers and government
- is safe for consumers and enhances their quality of life
- recognises, embraces and is responsive to diversity
- minimises red tape and unnecessary regulation.

Building on the strengths of the existing programs, we also want to:

- continue to support volunteers and social connectedness in communities
- encourage innovation and increased use of technology
- support the sector to develop the skills and capacity to deliver quality care
- build stronger connections between the aged care, health and disability systems.

Question

Are there any other key policy objectives that should be considered in a future care at home program?

3.2. How can we best achieve the desired policy objectives?

The department is seeking your views on how the desired policy objectives might best be achieved, and how future reforms or changes might be sequenced.

We believe that future reform needs to be phased rather than implemented at a single point in time, but we do not have a fixed view on specific program structures or funding models.

Sections 4 and 5 outline a range of possible reform options that could be implemented over the next few years. The options are intended to support discussion with the sector to inform advice to Government on future reform, and do not represent a preferred or settled approach.

There are some key issues to be considered in the implementation of the reforms:

- Timeframes and sequencing – future reform could be phased over several years. This will enable some elements to be implemented earlier, allow the sector to adapt to the changes, minimise disruption, and afford the opportunity to build on key learnings. Decisions about timing and sequencing will be influenced by a range of factors, including the extent of ICT and legislative changes required, whether new arrangements require significant contracting or tendering processes, and the amount of change involved. An important issue is how much time the sector would need to adjust and transition to new arrangements, including changes in funding models.

- Funding – future reforms will need to be funded from within the existing aged care budget envelope. Therefore, there may need to be trade-offs to implement some measures, e.g. re-balancing government investment between residential care and individualised funding and block funding for care at home services.

3.3. Timeframes for reform

The Government recently announced that CHSP arrangements will be extended until 30 June 2020 (see below). This will enable service providers to plan and make business decisions beyond June 2018 (June 2019 in Victoria) when the existing agreements are due to expire.

The Government is likely to consider decisions about future care at home reform in the first half of 2018, following consultations with the sector and consideration of the independent Legislated Review.

The following information sets out indicative high level timeframes for future reform. More detailed information, including specific timeframes and milestones for implementation and transition, will be developed once decisions have been made on the overall scope of the reforms and the individual elements.

Now to June 2018

- Extension of CHSP and RAS arrangements (announced in the May 2017 Budget)

  CHSP

  - The department will negotiate new funding conditions with existing CHSP providers. The changes to conditions will aim to ensure that service delivery is more focussed on understanding consumer strengths and goals, provides increased choice for consumers and a greater focus on pathways and activities to support independence and wellness. There will also be a stronger emphasis on reablement where appropriate.
  - Details of the new conditions will be discussed with the sector over the coming months with input from the wellness and reablement project (section 4.5.1).
  - Reporting requirements may also need to be revised to ensure they better reflect consumer outcomes and the new funding conditions.

  RAS

  - The department will also negotiate new funding conditions with RAS to support the CHSP agreements and ensure a greater focus on supporting independence and wellness, including the effectiveness of assessment arrangements in regional and remote areas.
  - Outcomes of the Legislated Review and evidence to date of the effectiveness of the model in remote Australia will be taken into account in considering future assessment arrangements and the timing of any changes.
- Co-design on the parameters and policy design for care at home reforms
- Legislated Review (due to report in August 2017)

July 2018 to June 2020

- Commencement of modified CHSP and RAS arrangements (July 2018)
- Transition from HACC to CHSP in Western Australia (July 2018)
- Single Aged Care Quality Framework, including for CHSP and home care (from July 2018)
- More detailed co-design on implementation and transition arrangements for care at home reforms
- Progressive implementation of care at home reforms
    - Some reforms could be introduced in 2018 or 2019, particularly those that do not require significant changes to current ICT systems (i.e. My Aged Care and the DHS payment system) or to the existing legislative framework (*Aged Care Act 1997*) – e.g. changes to the mix of home care packages or a new package level.

From July 2020

- Further implementation of care at home reforms
    - More significant changes could be introduced from July 2020 – e.g. potential changes to the mix of individualised and block funding, possible establishment of an integrated assessment workforce nationally.
- Broader structural reform that supports consumers to self-manage their care and to simplify payment arrangements for providers (see section 5). This would require major changes to the current ICT systems and significant legislative changes.

3.4. Transition

Implementation of the reforms will require effective planning, ongoing engagement and communication with stakeholders, and appropriate transition arrangements. As with recent reforms, the department intends to work closely with the sector, including peak bodies representing providers, consumers and carers. This will include co-design and consultation with a NACA advisory group on implementation, planning, communication and transition issues.

4. Reform options

4.1. Overview of reform options and questions

This section outlines a range of possible reform options that seek to achieve the following outcomes, underpinned by the policy objectives (section 3.1):

- An integrated assessment model
- Better meeting of consumer demand
- Greater consumer choice and flexibility
- Supporting independence and wellness
- Using resources more effectively
- Increasing sustainability
- Supporting vulnerable people and those with diverse needs.

The options build on feedback we have received from stakeholders, but are not intended to be exhaustive. We would welcome your views on other ways in which we might improve the care at home system. This paper also invites feedback on some broader reform questions (section 6).

In addition to your feedback on this paper, some of the options will be informed by other work underway, including the Legislated Review, and two commissioned projects that are examining existing care at home approaches to wellness and reablement, and consumer contributions in the CHSP.

4.2. An integrated assessment model

The Aged Care Roadmap identifies the establishment of an integrated assessment workforce as an essential building block for a future care at home program and the aged care system more broadly. Stakeholders have also identified this as a key reform priority in the consultations to date.

The department acknowledges these views and will also be looking to the outcomes of the Legislated Review to inform the future direction of assessments. The RAS will continue to be the assessment entry point to the CHSP from 2018. However, changes to support improved access, including in regional and remote Australia, will be made in areas where the current model is not effective or where there are opportunities to implement changes in particular regions ahead of broader national changes.

There are agreements in place with states and territories for ACAT operations until June 2018. The department will hold discussions with each jurisdiction on future arrangements for ACATs later this year.

Question

What do you believe could be done to improve the current assessment arrangements, including addressing variations or different practices between programs or care types (e.g. residential care, home care and flexible care)?

4.3. Better meeting of consumer demand

4.3.1. New higher level home care package

To support consumers with higher care needs to remain living at home, a new home care package level (higher than the current level 4) could be introduced.

Assuming that the average cost for the care of people in residential aged care is an appropriate reference point, the package could be priced up to $60,000 per annum (noting that the average level of

Australian Government payments for permanent residents in aged care homes was $63,400 per resident in 2015-16).

While preliminary consultations have indicated support for a higher level package, as an alternative to residential care for some consumers, a key issue is how such packages would be funded.

For instance, making available 5,000 new packages at an average cost of $60,000 per annum would cost an additional $300 million per annum. One option would be to reduce the number of residential care places released in the future in order to fund new home care packages at a higher level. This would mean lowering the current residential care planning ratio and increasing the home care planning ratio.

4.3.2. Changing the current mix of home care packages

The Government currently manages the supply of home care packages by determining how many packages are released at each level to meet the overall target provision ratio[7] for home care within the available expenditure. At present, the majority (around 70%) of home care packages are lower level packages (mostly at level 2). As a result, there is currently a mismatch between the number of packages at each level and assessed consumer need.

Home Care Package	No. of packages	Proportion of all packages	Basic subsidy p.a. (not including supplements)
Level 4	16,918	21.4%	$48,906
Level 3	7,369	9.3%	$32,171
Level 2	52,415	66.4%	$14,633
Level 1	2,254	2.9%	$8,045
Total	**78,956**	**100%**	

As at 30 June 2016. Source: 2015-16 Report on the Operation of the Aged Care Act 1997

Since the introduction of the Increasing Choice changes in February 2017, the department has released over 18,000 home care packages (during March and April), and will continue to release packages at regular intervals. The department will monitor wait times and the take-up of packages at each level, and will take this into consideration for future releases. The department expects to publish estimated wait times in the second half of 2017.

Some stakeholders have suggested that the supply of home care packages should be more flexible and responsive to demand, including at higher levels. However, supporting more packages at higher levels within current available funding would reduce the total number of packages (and therefore the number of consumers receiving care) because packages at different levels cannot be substituted on a one-for-one basis.

For example, current funding for 2,300 level 1 packages (around $18 million) would only support around 370 new level 4 packages or 560 new level 3 packages. The overall impact would be 1,700 to 1,900 fewer packages funded each year. Similarly, re-directing funding for 10,000 level 2 packages would only support around 3,000 new level 4 packages or 4,500 new level 3 packages.

[7] By 2021-22, the target for home care packages will increase to 45 packages for every 1,000 people aged 70 years or over, which on the currently projected mix of packages will be around 140,000 packages.

Other approaches have also been suggested by some stakeholders. These include:

- re-configuring the current package levels, so that there is a more even 'jump' between the subsidy amounts at each level – noting this would require grandfathering and transition arrangements, or
- increasing the subsidy amounts payable for the existing four package levels, so that more hours of care and support can be provided at each level – noting this would require a re-direction of funding from other aged care programs, or a reduction in the overall number of packages funded.

Questions

Would you support the introduction of a new higher package level or other changes to the current package levels? If so, how might these reforms be funded within the existing aged care funding envelope?

4.4. Greater consumer choice and flexibility

4.4.1. Changing the current mix of individualised and block funding

At present, care at home services are funded through two funding models:

- individualised funding in home care packages – through subsidies paid to approved providers in respect of individual consumers. Each consumer has an individualised budget, expenditure is visible to the consumer through a monthly statement, consumers can direct their package to their preferred provider, and funding follows the consumer if they move or change provider.
- block funding in the CHSP – through grants paid to providers. Budgets are managed at the organisation level, rather than for individual consumers.

Some providers already receive funding through both models, e.g. around 40 per cent of home care providers also deliver CHSP services. There are approximately 500 home care providers compared with approximately 1,700 home support providers[8].

Across the two programs, around 40 per cent of government funding is currently provided on an individualised funding basis, and 60 per cent through block funding.

Some stakeholders have suggested that more services, including some CHSP services that are currently block funded, could be funded through an individualised funding model in the future.

Benefits of individualised funding

An individualised funding model potentially offers more choice and control to consumers, including choice of provider, access to a wider range of services, and greater transparency about costs. It also provides opportunities to deliver services more efficiently in a market-based system, encouraging innovation and quality.

Benefits of block funding

Some stakeholders have suggested that some services may be better supported through block funding as these arrangements provide more flexibility to support a range of consumers with differing needs, including vulnerable consumers.

[8] Includes both CHSP and HACC providers in Victoria and Western Australia in 2015-16.

Examples might include:

- high volume / low cost services, or in other circumstances where it is less efficient to fund services through an individualised budget for each consumer, e.g. short-term or episodic services
- services that are highly dependent on volunteers, e.g. meals and social support – some stakeholders believe that moving to an individualised funding model would make it more difficult for organisations to attract and retain volunteers, leading to reduced social connection for consumers and service provision that is less cost-effective overall
- services that are primarily delivered in group settings, e.g. centre-based respite and social support group services.

Block funding (at least in part) could also be considered for:

- services with a significant capital component, e.g. transport
- higher cost items (often one-off), e.g. home modifications, aids and equipment
- locations where demand for services is very low or highly variable, e.g. remote areas
- services for specific population groups with specialised needs.

Supporting consumers with lower care or support needs

A key issue is how to support consumers who require relatively modest levels of support, noting that the average cost of services for many home support consumers[9] is significantly less than the subsidy payable for a level 1 package (currently around $8,000 per annum).

Some stakeholders have suggested that, for consumers with relatively simple care or support needs, the costs of administering a package could negate some of the benefits of having an individualised budget and greater choice of provider.

The proposed changes to the payment system (described in section 5) provide an opportunity to introduce new types of 'low cost' packages, or more flexible arrangements which enable a consumer to self-manage an account and purchase services from one or more service providers. However, there may also be other options such as providing vouchers to consumers.

Questions

Which types of services might be best suited to different funding models, and why?

What would be the impact on consumers and providers of moving to more individualised funding?

Are there other ways of funding particular services or assisting consumers with lower care or support needs, e.g. a combination of individualised funding and block funding, vouchers, etc?

[9] Data from the former Commonwealth HACC Program showed that the average expenditure was around $2,500 per consumer per year, and that the majority of HACC consumers (around 80%) had expenditure of less than $2,500 per year. Equivalent CHSP data is not yet available.

4.5. Supporting independence and wellness

4.5.1. Refocussing assessment and referral for services

Overall, the current care at home system is still largely geared towards ongoing service provision, with an emphasis on services to address symptoms of functional decline. However, not all consumers require ongoing services. The need for formal care may be triggered by an illness or accident or a sudden change in informal care arrangements (e.g. carer illness, death of a spouse). The program must be able to support short-term and episodic care, as well as ongoing service provision, in order to give older people every opportunity to maintain or regain their functional independence.

A key theme from consultation with stakeholders to date has been that an independence and wellness focus should be embedded in the assessment process. Embedding a reablement or restorative approach to initial assessment aims to increase the capacity of consumers to remain independent for longer and reduce the reliance on receiving ongoing service provision upon entering the system.

During the initial assessment process, older people could be assessed for their potential to benefit from reablement and restorative care approaches and then referred to access intensive reablement or restorative services on a time-limited basis. Their need for ongoing services could be re-assessed after a defined period of time. Reablement and restorative approaches would include assessment for assistive technology that could support people to undertake functions independently.

Where ongoing services are required, there are still opportunities to support independence. For example, provision of mobility and communication equipment can reduce social isolation and help people access their community, and teaching consumers about nutrition and meal preparation can help reduce their need for other ongoing services.

All Commonwealth funded care at home programs are expected to operate within a philosophy of wellness and reablement. The department is currently undertaking a project to gain a better understanding of how wellness and reablement approaches are being implemented, which will inform future strategies to embed such approaches in the care at home sector. Future care at home reform will take into account the outcomes of this project, which is expected to conclude in mid-2017.

Questions

Should consumers receive short-term intensive restorative/reablement interventions before the need for ongoing support is assessed? If so, what considerations need to be taken into account with this approach?

How could a wellness and independence focus be better embedded throughout the various stages of the consumer journey (i.e. from initial contact with My Aged Care through to service delivery)?

4.6. Using resources more effectively

4.6.1. Ensuring that services are responsive to consumer needs and maximise independence

The Government currently funds a range of supports and services to assist older people to remain living at home, although there are different approaches to what types of services are funded in the two programs.

Home care services are meant to be delivered on a CDC basis (within the available budget for the package and based on the individual care plan agreed between the consumer and the provider). However, the extent to which providers offer genuine choice to consumers currently varies. A wide range of services can be provided with some exclusions, e.g. funding cannot be used as a source of general income for the consumer, for the purchase of food, or used as payment for permanent accommodation. The exclusions are set out in Schedule 3 of the *Quality of Care Principles 2014*.

In the CHSP, funding is provided for a range of services/activities within categories set out in the CHSP Program Manual. Service providers are funded to deliver outputs against particular service types, in line with a consumer's support plan, with some limited flexibility to deliver other types of services. The funded outputs may not accord with consumer demand.

Questions

How do we ensure that funding is being used effectively to maximise a person's ability to live in the community and to delay entry to residential care for as long as possible?

For example, should funding be targeted to services or activities where there is a stronger connection with care and/or independent living? Are there examples of current services or activities that you believe should not be funded by government?

How do we maximise the flexibility of care and support so that the diverse needs of older people, including those with disability, are met?

4.6.2. Accessing services under different programs

In a system where resources are limited, care and services should be focussed on those who are most in need, in terms of frailty and functional impairment. The CHSP currently represents the entry tier along the continuum of care options in the aged care system, and is intended to deliver small amounts of timely low level home support, underpinned by a focus on wellness and reablement.

The care needs of home care consumers are generally addressed through their home care package. However, under special circumstances, a home care consumer may access additional CHSP services on a time-limited basis – the costs of these services are not deducted from their individualised budget. Such circumstances include:

- where the consumer's budget is already fully allocated and they are receiving services through a level 1 or 2 package, the consumer can access additional allied health and therapy services, or nursing services from the CHSP on a short-term or episodic basis
- where the consumer's budget is already fully allocated, and their carer requires it, a home care consumer can access additional planned respite services from the CHSP
- in an emergency, where the consumer's budget is already fully allocated, additional services under the broader CHSP can be obtained on a short-term basis.

Where a consumer receiving services through a home care package also accesses the CHSP, they are using services that could otherwise be provided to another consumer who may only require entry level support to remain independent[10]. In some cases, this could be inequitable, particularly if the home care consumer is already receiving services at their assessed package level.

Questions

Under the current program arrangements, does allowing some consumers to access both programs promote inequity, particularly if other consumers have to wait for a home care package?

Until an integrated care at home program is introduced, is there a need to more clearly define or limit the circumstances in which a person receiving services through a home care package can access additional support through the CHSP? If so, how might this be achieved?

[10] The CHSP Manual 2017 encourages CHSP providers to only supply additional CHSP services to home care consumers where they have capacity to do so without disadvantaging other current or potential CHSP consumers.

4.7. Increasing sustainability

4.7.1. Consumer contributions

The Aged Care Roadmap says that 'a fiscally sustainable aged care system requires consumers to contribute to their care costs where they can afford to do so'[11]. This view has also been articulated in the Productivity Commission's Inquiry and the NACA Blueprints for Aged Care Reform.

Consumer contributions currently vary greatly depending on the care type and do not consistently take account of consumers' capacity to contribute to the costs of their care. Even where consumer contributions apply, they are not consistently charged by providers.

In the care at home system, many stakeholders have emphasised the need to address the inconsistent approach to consumer contributions between the CHSP and home care, as well as the variation in charging practices within each of the programs. The lack of a consistent approach to consumer contributions/fees means that:

- consumers with the same or similar needs may pay different amounts for the same services
- there are often financial disincentives for consumers to move from CHSP services to home care packages, resulting in some consumers either not receiving the level of care appropriate to their needs or receiving a level of care beyond the intended scope of the CHSP
- consumer contributions for CHSP services and the basic daily fee in home care do not contribute towards annual and lifetime caps[12].

Contributions in the CHSP

In the CHSP, there is a principles-based approach to user contributions, rather than a mandatory fees policy. Service providers develop and implement their own user contribution policy, guided by the principles in the 'Client Contribution Framework'. The current variations in consumer contributions, in part, reflect historical differences in charging practices across the former state-based HACC programs. Feedback from CHSP providers has revealed that some providers are currently only charging nominal or no fees, and some have found fee collection to be challenging, particularly with consumers who were grandfathered from the HACC programs and still hold the expectation that services will be provided free of charge.

The department is currently undertaking a project to examine how the Client Contribution Framework is being applied, and what further support might be required to assist CHSP providers in implementing contribution arrangements.

Contributions in home care

In home care, consumers can be asked to contribute to the cost of care via:

- a basic daily fee (of up to 17.5% of the single basic Age Pension; currently around $10 per day) which is charged at the discretion of each provider
- an income-tested care fee, if their income is over a certain amount (government subsidy paid to the provider is reduced accordingly).

Fees are charged on a daily basis regardless of whether services are delivered on all days and this causes confusion for some consumers. There is also little transparency of fee charging practices or the costs attributed under the package until a service provider is chosen. Some providers do not charge the basic daily fee or income-tested care fee, or only a proportion, and comparing prices for services is difficult.

[11] Aged Care Roadmap (2016) – Aged Care Sector Committee, p.23.

[12] There are annual and lifetime caps that apply to the income tested care fee in home care. Once these caps are reached, the consumer cannot be asked to pay any more income tested care fees for the remainder of the relevant period.

Legislated Review

The independent Legislated Review is currently considering the effectiveness of fee arrangements across the broader aged care system, including some of the issues raised above. Given this, specific reform options related to consumer contributions in home care and the CHSP are not canvassed in this paper.

4.8. Supporting vulnerable people and those with diverse needs

4.8.1. Supporting specific population groups

As noted earlier, there have been significant reforms to the way that home care services are provided to consumers in recent years, particularly the introduction of CDC including individualised budgets in home care packages. The home care reforms introduced in February 2017 provide further choice for consumers – by allowing consumers to choose and change their home care provider with portability of funding.

While increased consumer choice and control is generally supported as a key policy objective, some stakeholders have raised concerns that the CDC models and administrative arrangements that involve individuals exercising choice and control (or interacting with national service delivery systems) do not work well for some population groups, e.g. some Aboriginal and Torres Strait Islander people, and people who are homeless or at risk of homelessness.

Question

How can we make the care at home system work better for specific population groups, particularly those whose needs are not best met through current CDC models and administrative arrangements?

4.8.2. Supporting informed choice for consumers who may require additional support

It is recognised there is a need to move from sector supports largely directed through providers to directly supporting consumers, as aged care continues to move towards a consumer-driven, market-based system. Some consumers may require additional support to access services and to make informed choices and exercise control over their care. Given the significant transitions envisaged in the Aged Care Roadmap for consumers, it is timely to re-frame the supports that may be needed to enable consumers to effectively participate in a market-based system.

For example, stakeholders have identified access to independent advocacy services and peer networks as fundamental supports for consumers and carers. Other supports, such as trusted and independent 'system navigators' to walk alongside consumers to support formulation of goals and identify suitable providers, have been suggested. The sector has also proposed 'systems wranglers' to work across systems and services to help ensure that older people are able to access the services they need. These supports would help build the capacity of consumers to be better informed and exercise choice and control.

Question

What additional supports could be considered to ensure that people with diverse needs can access services and make informed choices and exercise control over their care?

4.9. Other elements of care at home reform

4.9.1. Will the national approach to prioritising access to home care packages be extended to home support services?

There is now a national system for prioritising access to home care packages (introduced as part of the Increasing Choice changes in February 2017). The department is closely monitoring the operation of these new arrangements. At this time, there are no plans to extend the national prioritisation system to other types of aged care services.

4.9.2. Future approach to provider registration

The Aged Care Roadmap envisages moving to a single provider scheme that recognises organisations registered or accredited in similar systems, with different categories of registration depending on the scope of practice of the providers. The Roadmap also envisages a single set of aged care standards, differentiated by service type, for the delivery of quality aged care services.

The department is currently working with the sector to develop a single quality framework for aged care that focusses on arrangements that support the quality of care delivered by providers after they commence providing services.

This work includes the development of a single set of aged care standards that apply to all aged care organisations and new streamlined processes to assess service providers' performance against the new standards. Options being considered include:

- a safety and quality declaration by organisations providing low-risk services readily available to the broader population
- opportunities for increasing the Australian Aged Care Quality Agency's capacity to recognise compliance with other similar quality standards.

These options are closely linked to the changes proposed in the Aged Care Roadmap and complement the current arrangements for approval of service providers, before they commence providing aged care services funded by the Government.

Subject to agreement of the Australian Government, and amendments to the legislation, the new standards and streamlined assessment process will be implemented from 1 July 2018.

There is interdependence between the provider registration and reforms being progressed through the single quality framework as well as the reforms to the care at home system. Consequently, consideration of the Roadmap's suggested changes to provider registration will likely be deferred until after implementation of the single quality framework.

4.10. Other suggestions for reform

As noted earlier, the options outlined in this section are not intended to be exhaustive. We would welcome your views on other ways in which we could achieve the reform objectives. We would also welcome views on the relative priority of various reform options, including how changes might be sequenced.

Question
Do you have other suggestions for care at home reform, or views on how changes might be progressively introduced or sequenced?

5. Major structural reform

5.1. The Aged Care Roadmap's vision for greater consumer choice and control

The Aged Care Roadmap envisages future arrangements that would allow consumers to receive payments for care at home services directly, or to direct payments to third parties of choice, e.g. service provider/s or care co-ordinators.

This would give consumers more choice and control over their care, but would be a significant change from the current arrangements (including ICT functionality). At present, home care subsidies are paid to a single approved provider chosen by the consumer. While CDC in home care provides some flexibility for an approved provider to sub-contract or broker services from another service provider, the consumer is not able to direct payments to more than one service provider out of their package budget. This effectively limits the consumer's ability to fully or partially self-manage their package. At present, subsidy payments can also only be made to a provider – not paid directly to a consumer or to another person nominated by the consumer such as a carer or family member.

The Roadmap further envisages that there would be predominantly individualised funding that follows the consumer, with additional government assistance where there is insufficient market response and some block funding (grants to providers) where considered most appropriate and efficient.

5.2. What would be needed to give effect to these structural reforms?

The Government has announced its intention to replace the ICT systems supporting health and aged care payments under the Government's 'Modernising Health and Aged Care Payments Services Program'. This provides an opportunity to develop new ICT capabilities, integrated with My Aged Care, to support consumer choice and to simplify arrangements for providers. For example, the new system could enable consumers to find, compare, book, pay for care and manage their account online (such as through a consumer 'dashboard') and allow payments to be made to more than one provider as soon as services are delivered. This would replace the current provider-focussed system of monthly provider claims with payment of advances and acquittals.

Implementation timeframes and the sequencing of payment system changes across the various health programs (e.g. Medicare, Pharmaceutical Benefits Scheme) and aged care are currently being developed.

Major ICT changes affecting how aged care payments are calculated and made would need to be supported by legislative amendments.

Question

Are there other structural reforms that could be pursued in the longer-term?

6. Broader aged care reform

6.1. Issues and questions for consideration

We also welcome your views on the following matters that are relevant to both future care at home reform and broader reform of the aged care system.

6.1.1. Informal carers

The Government recognises that informal carers are a key part of the overall care system. Informal carers also have a significant role in supporting consumers in making decisions on the care they receive. In 2015, there were over 420,000 primary carers caring for people aged over 65 years[13]. In consultations to date, stakeholders have particularly identified the importance of being able to access respite services (especially planned respite) and the need to support the broader family unit, not just the consumer and carer/s individually (e.g. through increased carer involvement in the consumer's needs assessment).

Question

How might we better recognise and support informal carers of older people through future care at home reforms?

6.1.2. Technology and innovation

Technology and innovation offer opportunities for productivity gains, improved quality of care and safety, as well as enhanced quality of life. There is the potential for innovative use of technology to support people with a wide variety of needs, including at the higher end, to live safely and independently in their own home and to make choices about their care. As noted in the Productivity Commission's Inquiry, it will be important to remove barriers to adopting cost-effective technology.

Questions

How can we best encourage innovation and technology in supporting older Australians to remain living at home?

What are the existing barriers, and how could they be overcome?

6.1.3. Rural and remote areas

There are unique considerations for service delivery in rural and remote areas, which have implications for service availability. Services located in these areas are also sometimes less viable. The Aged Care Financing Authority has found that such services are more likely to experience high cost pressures (e.g. workforce costs, travel/freight costs), among other challenges including access to appropriately skilled staff, limited internet coverage, and smaller consumer bases (resulting in smaller scale services)[14].

Questions

How can we address the unique challenges associated with service delivery in rural and remote areas?

What other service delivery and funding models could we consider for providing care at home services to consumers living in rural and remote areas, including examples of innovative local community models?

[13] Australian Bureau of Statistics, 2015 Survey of Disability and Aged Care, abs.gov.au/ausstats/abs@.nsf/mf/4430.0

[14] Aged Care Financing Authority's *2016 Annual Report* and *2016 Report on Issues Affecting the Financial Performance of Rural and Remote Providers.*

6.1.4. Regulation

Both the Productivity Commission's Inquiry and the Aged Care Roadmap have identified the need for a lighter touch approach to regulation in order to drive competition, increase innovation and responsiveness to the diversity of consumers' needs and preferences.

Question

How can we further reduce regulation to allow for innovation while ensuring that essential safeguards remain in place?

6.1.5. Aged care and health systems

The aged care and health systems do not work seamlessly together, and to make them do so is beyond the scope of this exercise. However, as NACA has noted, our future policies and systems must be designed to ensure that people receive care and support in the most appropriate settings, are supported to transition between service settings, and are able to receive services from multiple systems at one time in an integrated way that minimises duplication. It is important that we look to progressively move towards a more integrated continuum of care across the health and aged care systems.

Question

What are some examples of current gaps or duplication across the aged care and health systems, and how could these be addressed?

7. Next steps

7.1. Making a submission

You are invited to provide feedback on the options proposed in this paper, as well as on the broader reform questions. Your views on other ways in which we might improve the care at home arrangements are also welcome.

You can submit your comments via the department's Consultation Hub at consultations.health.gov.au. A submission template is available to download from the Consultation Hub. Submissions are due by **21 August 2017**. Submissions received after this time may not be considered.

7.2. Future updates on reform

Future updates on care at home reform will be published on the department's website and communicated to the sector via e-mail. Please visit the department's website to subscribe to announcements and the Aged Care Providers eNewsletter to keep up to date.

Thank you for participating

Submission template

Discussion paper:

Future reform – an integrated care at home program to support older Australians

Submissions close on 21 August 2017

Instructions:

- Save a copy of this template to your computer.
- It is recommended that you read the relevant pages in the discussion paper prior to responding.
- You do not need to respond to all of the questions posed in the discussion paper.
- The numbering of the questions in the template corresponds to the numbering in the discussion paper.
- Please keep your answers concise and relevant to the topic being addressed.
- Upload your completed submission on the Consultation Hub. Alternatively, if you are experiencing difficulties uploading, you can email your submission to: agedcarereformenquiries@health.gov.au

Thank you for your interest in participating in our consultation.

Tell us about you

What is your full name?

First name ***Sanna***

Last name ***Brannan***

What is your organisation's name (if applicable)?

Town of Gawler

What stakeholder category/categories do you most identify with?

☒ Commonwealth Home Support Program[1] service provider	☐ Peak body – consumer
☐ Home Care Package service provider	☐ Peak body – carers
☐ Flexible care provider	☐ Peak body – provider
☐ Residential aged care service provider	☐ Seniors membership association
☐ Aged care worker	☐ Professional organisation
☐ Volunteer	☐ Disability support organisation
☐ Regional Assessment Service	☐ Financial services organisation
☐ Aged Care Assessment Team/Service	☐ Union
☐ Consumer	☒ Local government
☐ Carer or representative	☐ State government
☐ Advocacy organisation	☐ Federal government
	☐ Other Click here to enter text.

Where does your organisation operate (if applicable)? Otherwise, where do you live?

☐ NSW	☒ SA
☐ ACT	☐ WA
☐ Vic	☐ NT
☐ Qld	☐ Tas
☐ Nationally	

*May we have your permission to publish parts of your response that are **not** personally identifiable?*

☒Yes, publish all of my response

☐No, do not publish any part of my response

[1] Includes Home and Community Care Providers in Western Australia

Section 2. Reform context

2.3 Reforms to date

Comments

We would welcome your views and feedback on the February 2017 *(Increasing Choice)* reforms.

Refer to page 6 of the discussion paper

While the concept of funding being allocated to the home care package recipient has merits, there appears to be ongoing confusion from people being approved and allocated a package around why they have been offered packages below their approved level, what they need to do after being allocated a package and/or how to even locate approved package providers.

In addition, the inconsistency of fees being charged by providers adds to the confusion and inequity of services.

The large increase in cost from CHSP services also means that many consumers are opting not to take up lower level packages, choosing instead to keep receiving CHSP services.

Section 3. What type of care at home program do we want in the future?

3.1 Policy objectives

Question

Are there any other key policy objectives that should be considered in a future care at home program?

Refer to page 9 of the discussion paper

Consideration needs to be made as to the timeliness of future reform announcements. Local Government requires sufficient time to plan for any change and a delay in announcements poses the real risk of providers leaving the sector unnecessarily. This is particularly true for Local Government who generally have a lower appetite for risk. In addition, there needs to be some guide as to what the new CHSP funding conditions will entail and how this will be reported back to enable adequate time to train for and implement any required change to business practices. This includes the IT requirements to ensure that existing IT programs remain compatible with proposed changes, particularly if a payment system similar to NDIS is implemented. Providers have already spent considerable funds updating client management systems to ensure they are compatible with DEX.

The focus on wellness and supporting independence begins largely with the RAS assessment. There needs to be clearer indicator on the referral pathway as to expected service duration and how the identified goal is linked to increasing consumer independence. This in turn will provide a much clearer indicator to CHSP providers, to ensure they remain providing services at an entry level and with a focus on wellness.

While future reforms are to be funded from within the existing aged care budget, consideration and planning needs to occur as to how to successfully transition people from the Commonwealth Home Support Programme and into Home Care Packages. This may include a review of mandatory fees and charges to ensure that there is not such a disparity between the cost of services for consumers.

One key policy area that requires further consideration is the lack of recognition for carers within the system. With an increasing number of people caring for older relatives, there needs to be some support/safety measures in place to ensure that they have access to support and care when needed, enabling them to continue in their caring role. The current system does not provide this is carers.

Section 4. Reform options

4.2 An integrated assessment model

Question

What do you believe could be done to improve the current assessment arrangements, including addressing variations or different practices between programs or care types (e.g. residential care, home care and flexible care)?

Refer to page 12 of the discussion paper

While an integrated assessment model would benefit consumers and providers, how this is implemented within current budget constraints needs to be considered. The relevant skills and knowledge required, make it cost prohibitive to have an ACAT style assessment for all aged care services. It could potentially also lead to significant delays in assessments being undertaken, leaving consumers at risk.

However, an integrated assessment process would ultimately result in more consistent assessments and referral for services, ensuring a greater level of equity for all. It will also potentially assist people to transition into the correct level of care required for their needs.

4.3.1 New higher level home care package │ 4.3.2 Changing the current mix of home care packages

Questions

Would you support the introduction of a new higher package level or other changes to the current package levels?

If so, how might these reforms be funded within the existing aged care funding envelope?

Refer to pages 12 – 14 of the discussion paper

Rather than the introduction of a higher level care package, there needs to be a review of existing packages to ensure that there is a correct allocation to levels based on assessed need. While the majority of packages are allocated at a level 2, there needs to be consideration made as to the number of people who are currently accessing packages below their approved rate (or not receiving services at all whilst waiting for their approved level to become available).

There may need to be a review of how people are being assessed for Home Care Packages to ensure approvals align more closely with what is available, ensuring those with the greatest need have access to higher levels of care.

In addition, more needs to be done to address those who are accessing a services from a number of different CHSP providers (many of which are under grandfathered arrangements), who should be accessing package care. In some cases, these people are having access to more services than those on a low level package and will not transition due to cost. This is hidden by the fact that even if people register with MAC, if they are already receiving a service from a provider, they are not re-referred for that service type, masking the amount of assistance that they are actually receiving. More work needs to be done to address those being over serviced through the CHSP.

4.4.1 Changing the current mix of individualised and block funding

Question
Which types of services might be best suited to different funding models, and why?

Refer to pages 14 – 15 of the discussion paper

Individualised funding suits those requiring on-going and/or long term support or services. It would be difficult to determine individualised funding levels for those who required single or ad hoc services to help them remain living independently. Allocating an amount above their need poses the potential for people to utilise services simply because they have additional funds and not because they require that level of support. One example of this, is that through our Program, we have many consumers with limited family supports who only access an annual service. This may be a check of smoke detectors and battery replacements or assistance with higher level cleaning once a year. Allocating a budget of even $500 means they will have excess funds.

Question
What would be the impact on consumers and providers of moving to more individualised funding?

Refer to pages 14 – 15 of the discussion paper

The risk may result in a number of providers withdrawing from service provision. This may not just be the result of the loss of block funding, but also the fact that the cost and administrative burden of coordinating such low individualised budgets may increase the cost of delivering care or make it a non-viable option. Additionally, the impact for staffing would be significant, potentially moving from a relatively permanent staffing structure to one which is more likely to be casual and more transient.

As noted earlier, the provision of an allocated amount of funding increases the risk of people with relatively low level needs having access to funding above their needs resulting in people accessing services that may not be needed. This in essence goes against the focus of the reforms, which are to promote independence.

An individualised budget for consumers may also increase the risk that they will not consider the services they purchase from a restorative or reablement focus.

In addition, individualised funding may result in a more open market place, where it will become increasingly more difficult to maintain and/or measure quality standards of Providers.

Question
Are there other ways of funding particular services or assisting consumers with lower care or support needs, e.g. a combination of individualised funding and block funding, vouchers etc.?

Refer to pages 14 – 15 of the discussion paper

Click here to enter text.

4.5.1 Refocussing assessment and referral for services

Questions
Should consumers receive short-term intensive restorative/reablement interventions before the need for ongoing support is assessed?
If so, what considerations need to be taken into account with this approach?

Refer to page 16 of the discussion paper

A comprehensive integrated assessment model should be able to determine if short term assistance or ongoing service provision is required. This needs to be conveyed to providers as part of the referral process, including identifying what tasks the consumer requires assistance with, rather than a referral for simply domestic or gardening assistance. When a referral is not specific, Providers are reliant on consumer choice, which at times may be a want over a need. The comprehensive assessment should identify how they have assessed that a particular referral will provide restorative or reablement benefits.

Question

How could a wellness and independence focus be better embedded throughout the various stages of the consumer journey (i.e. from initial contact with My Aged Care through to service delivery)?

Refer to page 16 of the discussion paper

There needs to be a consistent understanding of how wellness and independence is measured and reported on.

With regards to how this is embedded throughout the consumer journey, it does need to begin with the initial contact. Eligibility needs to be focused not on what a consumer can no longer do, but what difference having some identified level of support could have to increase their independence.

While RAS and ACAT measure these differently, so do the different RAS providers. There needs to be more consistency in how this is assessed and fed back to service providers. Referrals need to include not only the identified consumers' goal, but how referral to that service type will assist to increase wellness and independence. Also, with an individualised budget, there runs the risk that consumers may not value the services and supports that promote wellness and independence. As a result, they will choose to "purchase" services that they want as opposed to what they may need.

Having a consistent message and language from initial contact to service provision, will ensure that the consumer is more familiar and understands the purpose of the reforms, rather than viewing access to aged care services as a right.

4.6.1 Ensuring that services are responsive to consumer needs and maximise independence

Questions

How do we ensure that funding is being used effectively to maximise a person's ability to live in the community and to delay entry to residential care for as long as possible?
For example, should funding be targeted to services or activities where there is a stronger connection with care and/or independent living? Are there examples of current services or activities that you believe should not be funded by government?

Refer to pages 16 - 17 of the discussion paper

As noted above, this needs to be considered when allocating an individual budget, where a consumers needs may differ from their wants.

A true individualised budget may also be better served in an NDIS model, which allows consumers (or participants) funding allocated to different service types and they can choose who provides it. This means that an individual approved HCP provider does not have control of the budget and it is wholly at consumer control. While the current model allows brokerage of services, this message may not always be shared with consumers and any additional costs or charges incurred as a result of this, may make it unviable.

Question

How do we maximise the flexibility of care and support so that the diverse needs of older people, including those with disability, are met?

Refer to pages 16 - 17 of the discussion paper

There needs to be more flexibility in the CHSP, so that funding is not allocated to a number of outputs per service type, which may not be reflected by the number and type of referrals received. Eg. It should be easier to transfer funds between service types to meet demand.

4.6.2 Accessing services under different programs

Question

Under the current program arrangements, does allowing some consumers to access both programs promote inequity, particularly if other consumers have to wait for a home care package?

Refer to page 17 of the discussion paper

The current system does promote inequity. It is also difficult for a CHSP provider to determine appropriate levels of service to consumers also accessing HCP's. In addition, ensuring priority to those consumers who are only in receipt of CHSP services, is difficult to manage once a HCP consumer is already accessing services.

Also, there is inconsistency in how this is being delivered, making it difficult for consumers to understand, especially where one neighbour may have access and another doesn't, despite the circumstances being similar.

Questions

Until an integrated care at home program is introduced, is there a need to more clearly define or limit the circumstances in which a person receiving services through a home care package can access additional support through the CHSP? If so, how might this be achieved?

Refer to page 17 of the discussion paper

Yes. Once a consumer accepts a Home Care Package at any level, they should automatically become ineligible for CHSP services. HCP's should not be allocated at a level lower than what might place a consumer at increased risk. (eg. A consumer may be approved at a level 4, but it is identified that services at a level 2 may be appropriate for an interim measure). This should be noted as part of the approvals process.

4.8.1 Supporting specific population groups

Question

How can we make the care at home system work better for specific population groups, particularly those whose needs are not best met through current CDC models and administrative arrangements?

Refer to page 19 of the discussion paper

Having additional funding allocated to enable consumers to purchase care coordination without restricting their access to home care services. This funding could sit separately from the package to ensure they can access an independent advocate and/or supports required to enable choice and control.

4.8.2 Supporting informed choice for consumers who may require additional support

Question

What additional supports could be considered to ensure that people with diverse needs can access services and make informed choices and exercise control over their care?

Refer to page 19 of the discussion paper

Similar to the NDIS, where there is funding is allocated to Local Area Coordinators to ensure additional supports are provided to assist people with additional needs to develop their plans and access mainstream services where appropriate.

This would need to be independent from case management, which is managed by the Provider. This should be provided by an independent advocate role.

4.10 Other suggestions for reform

Question

Do you have other suggestions for care at home reform, or views on how changes might be progressively introduced or sequenced?

Refer to page 20 of the discussion paper

There needs to be more community consultation and promotion of any changes that occur. With the 2015 and 2017 reforms, Service Providers were (and still continue to be), the first point of contact. People became confused and service providers spent significant amounts of time explaining and supporting people to navigate through the reforms.

There also needs to be some improvement in the coordination of home modifications. The insufficient number of OT's results in some significant delays, particularly when it forms part of the reablement process. In some cases, OT drawings for home modifications are not being received until after a consumer has recovered from a fall/incident.

Section 5. Major structural reform

5.2 What would be needed to give effect to these structural reforms?

Question
Are there other structural reforms that could be pursued in the longer-term?

Refer to page 21 of the discussion paper

Sufficient time to enable providers and consumers to transition into the structural changes.

Section 6. Broader aged care reform

6.1.1 Informal carers

Question
How might we better recognise and support informal carers of older people through future care at home reforms?

Refer to page 22 of the discussion paper

A recognised carer should be able to register with My Aged Care, particularly when it relates to respite and general carer support. Carers should be recognised in their own right.

6.1.2 Technology and innovation

Question
How can we best encourage innovation and technology in supporting older Australians to remain living at home?

Refer to page 22 of the discussion paper

Technology will be increasingly important in the future. However, consideration needs to be made as to limitations that the current user group experience. Many have limited to no experience in the use of technology as a communication tool and have little confidence and/or willingness to learn.

Question
What are the existing barriers, and how could they be overcome?

Refer to page 22 of the discussion paper

Introducing tools they are unfamiliar and/or uncomfortable with may pose a barrier. We are already experiencing this, with access to My Aged Care only available via phone and internet. As a service provider, we are having to spend increasing time to help register new consumers who do not use the internet and have hearing impairments.

6.1.3 Rural and Remote areas

Question
How can we address the unique challenges associated with service delivery in rural and remote areas?

Refer to page 22 of the discussion paper

Click here to enter text.

Question
What other service delivery and funding models could we consider for providing care at home services

to consumers living in rural and remote areas, including examples of innovative local community models?

Refer to page 22 of the discussion paper

Click here to enter text.

6.1.4 Regulation

Question
How can we further reduce regulation to allow for innovation while ensuring that essential safeguards remain in place?

Refer to page 23 of the discussion paper

Click here to enter text.

6.1.5 Aged care and health systems

Question
What are some examples of current gaps or duplication across the aged care and health systems, and how could these be addressed?

Refer to page 23 of the discussion paper

TCPs and people already accessing CHSP services. An integrated assessment process could identify additional short term supports required during periods of convalescence, ensuring no disruption to services.

Any further comments?

Other comments

Do you have any general comments or feedback?

Emphasis needs to be made regarding the timeliness of announcements. Local Government requires significant time to plan and/or prepare for any changes. The late notice given regarding the extension of funding to 2020, had many beginning to consider their future role as an aged care service provider. There was increasing pressure for Council to make a decision with limited information available. As a result, consideration was made to withdraw from the space. If this was to occur, a decision needed to be made early enough to allow for communication with consumers and support to transition to another provider.

In addition, the reforms do not factor in the high levels of in-kind support that Local Government has historically contributed to HACC and CHSP funded services. Working at a grass roots level, the financial and in-kind support from Councils have ensured that local services are responsive to local community need. It has been instrumental in ensuring the success of these programs and ensured accessibility to some of the most disadvantaged within the community. The risk associated with changed funding arrangements may result in the loss of community based services which connect and build the capacity of local communities.

In addition, Local Government carries significant expenses and the cost of Council business and services is shared across the organisation. As a result, there are some high overheads that the Council

contributes in-kind support for to enable the provision of services. If the sector was to move towards a fully open market place, Councils need to apply Competitive Neutrality principles. This means that there can be no subsidisation of services within a competitive business market and the full cost of service delivery must be taken into account (including in-kind costs). Councils would therefore need to consider if it was a financially and competitively viable option for them to remain as a service provider, despite their strong local connection and their trusted and valued role in the community.

Submission template

Discussion paper:

Future reform – an integrated care at home program to support older Australians

Submissions close on 21 August 2017

Instructions:

- Save a copy of this template to your computer.
- It is recommended that you read the relevant pages in the discussion paper prior to responding.
- You do not need to respond to all of the questions posed in the discussion paper.
- The numbering of the questions in the template corresponds to the numbering in the discussion paper.
- Please keep your answers concise and relevant to the topic being addressed.
- Upload your completed submission on the Consultation Hub. Alternatively, if you are experiencing difficulties uploading, you can email your submission to: agedcarereformenquiries@health.gov.au

Thank you for your interest in participating in our consultation.

Tell us about you

What is your full name?

First name ***Debra***

Last name ***Anderson***

What is your organisation's name (if applicable)?

Seniors Collaborative Action Project

What stakeholder category/categories do you most identify with?

☐ Commonwealth Home Support Program[1] service provider	☐ Peak body – consumer
☐ Home Care Package service provider	☐ Peak body – carers
☐ Flexible care provider	☐ Peak body – provider
☐ Residential aged care service provider	☐ Seniors membership association
☐ Aged care worker	☐ Professional organisation
☐ Volunteer	☐ Disability support organisation
☐ Regional Assessment Service	☐ Financial services organisation
☐ Aged Care Assessment Team/Service	☐ Union
☐ Consumer	☐ Local government
☐ Carer or representative	☐ State government
☐ Advocacy organisation	☐ Federal government
	☒ Other Sector Support & Development - Collaborative Project

Where does your organisation operate (if applicable)? Otherwise, where do you live?

☐ NSW	☒ SA
☐ ACT	☐ WA
☐ Vic	☐ NT
☐ Qld	☐ Tas
☐ Nationally	

*May we have your permission to publish parts of your response that are **not** personally identifiable?*

☒Yes, publish all of my response

☐No, do not publish any part of my response

[1] Includes Home and Community Care Providers in Western Australia

Section 2. Reform context

2.3 Reforms to date

Comments
We would welcome your views and feedback on the February 2017 *(Increasing Choice)* reforms.

A survey of 100 South Australian service providers regarding Stage 1 was conducted in April-May 2017 by the SA Collaborative Projects with the following key points being raised:

Whilst the majority of respondents indicated that they understood the National Prioritisation process for Stage 1, some comments indicated that the MAC Contact Centre does not have the same level of understanding. Also the lack of information regarding waiting times was frustrating for both service providers and consumers, and there was a perception that there are less packages being allocated in SA.

The new system has not addressed the perennial problem of a lack of level 3 and 4 packages.
"There are not enough L3 and L4 packages available so clients are forced to go to up to 4 organisations to get services under CHSP to service their needs, eg a client has personal care from Dom Care, social support from Wesley Care , cleaning from the council, respite from ECH, dementia support from AASA."

Consumer confusion regarding the assessment, approval and allocation process was cited a number of times.

"The lack of information about waiting times is creating great unrest, particularly amongst older people and their carers. The lack of transparency in the process also is frustrating. Clients new to the system do not understand why they have to wait and why they can't be told where they are on the waiting list.

Respondents indicated that they need advice from the Department of Health particularly regarding the use of CHSP as a gap filling measure. A large number of clients were being advised to utilise CHSP services in the interim period between approval and allocation of a HCP. Service providers expressed concern at the impact on the long term CHSP capacity to fill these gaps.

On a positive note, the majority of respondents indicated that their organisation has the workforce capacity and flexibility to respond to market demand.

The majority of respondents indicated that they were dissatisfied with the number of HCP referrals they had received since 27th February with a number stating *"We have yet to receive one referral"*. Again there was acknowledgement that it is *"Still early days."*

Respondents provided a range of specific examples about service providers and consumer experience with Stage 1.
A number of examples demonstrated consumer confusion regarding the process and frustration with the length of time it takes to receive a service.

"Most of our clients are now so confused about who has called them, not knowing who to contact to get services and end up just giving up and going without any services, resulting in extreme carer stress and increased vulnerability of clients that don't have carers. I have been informed by QEH of carers who are presenting to outpatients exhausted and desperate."

Ongoing issues with MAC were cited in particular regarding inconsistency with initial screening and eligibility assessment.

Again there were examples of clients using CHSP to fill gaps whilst waiting for an allocation of a package, and also in preference to accepting a Package due to the cost.

"Many clients are not taking up HCP due to confusion, being overwhelmed and financial implications, instead CHSP is being accessed because affordable, and because volunteer supported, is flexible to client need rather than imposed for specific time periods."

Refer to page 6 of the discussion paper

Section 3. What type of care at home program do we want in the future?

3.1 Policy objectives

Question
Are there any other key policy objectives that should be considered in a future care at home program?

Refer to page 9 of the discussion paper

The role of informal carers in supporting and advocating for their person, needs to be recognised in the objectives.

The objectives need to recognise the entry point of the system as being short term or 'ad hoc' type services.

These 'ad-hoc' services can be:

- *the key to extending independence*
- *easy for clients to ask for especially when accessing help for the first time*
- *provide an opportunity for re-ablement*

Section 4. Reform options

4.2 An integrated assessment model

Question
What do you believe could be done to improve the current assessment arrangements, including addressing variations or different practices between programs or care types (e.g. residential care, home care and flexible care)?

Refer to page 12 of the discussion paper

Getting the assessment process right is integral to the success of the aged care system. It is the way all service providers and carers and family members understand what supports are needed and why they

are needed. There is support from service providers in the SCAP region for a single assessment service that combines both RAS and ACAT. A single service would likely be less confusing for consumers, be faster and ensure they enter the system at the right level. A skilled assessment workforce with access to multi-disciplinary professionals is essential to effectively assess the needs of consumers and avoid multiple assessments.

This need for better training also applies to MAC call centre staff as this is where the assessment process seems to be failing as MAC staff are not trained adequately to refer appropriately to RAS or ACAT.

As a single service would require a change to the Aged Care Act, and which may or may not not be necessary depending on other reforms, there was also support for the current dual service to continue on condition that there are sufficient resources available to ensure the two services work very closely together, which currently is not the case. Another key issue that needs to be addressed is improving transparency of the ITC system as currently RAS and ACAT assessors cannot access all of the information than MAC contact staff can access which is not conducive to effective assessment or service delivery.

The assessment services under the new integrated system need to focus on quality not outputs as it currently does. Also, the fee for service arrangement currently has assessments in regional and remote areas valued at the same price as for metropolitan areas, which is unrealistic and unviable for the obvious reason that it costs more to deliver any type of service in these areas due to distances that need to be travelled.

4.3.1 New higher level home care package │ 4.3.2 Changing the current mix of home care packages

Questions
Would you support the introduction of a new higher package level or other changes to the current package levels?
If so, how might these reforms be funded within the existing aged care funding envelope?

Refer to pages 12 – 14 of the discussion paper

There is a need for a level 5 package to prevent premature entry into residential care, and to enable more Australians to achieve their wish of dying at home rather than in hospital or in a nursing home.

However, it is questionable as to whether this could be achieved within the existing aged care funding envelope as it is quite apparent that the current aged care funding formula is not effective in predicting demand for aged care services. This is evidenced by the number of consumers assessed and waiting for higher level packages, and 'topping up' lower level packages with CHSP services while they wait. When even this level of service proves inadequate, consumers are prematurely entering residential care which contradicts the objectives of the system. A re-ablement focus, particularly at entry level, will likely have some impact on this, however it will not fully address the obvious current gap between supply and demand. There needs to be an anaylsis of why this is the case. Ideally the aged care system should be funded as is the NDIS and based on assessed need and uncapped supply. If this is not possible then a more effective formula for continued growth needs to be developed.

4.4.1 Changing the current mix of individualised and block funding

Question
Which types of services might be best suited to different funding models, and why?

Refer to pages 14 – 15 of the discussion paper

Service providers in the SCAP region strongly believe there is a need for a mixed funding model for the new integrated program. The following principles would dictate if a service type is to be block funded:

- *Short term and episodic services that have a focus on re-ablement.*
- *Services with significant infrastructure and/or capital elements and costs and /or social capital value, such as home maintenance and modifications, centre based services, including overnight respite accommodation and group social support, transport and volunteer services.*
- *Pilot stages of new and innovative services (reduces financial risk for providers).*
- *Service availability in areas (rural and remote) where there is little or no competition between service providers.*
- *Service availability for people with special needs (eg CALD, LGBTIQ, homeless, mental health, disability) where there is little or no competition between service providers.*

There was also support for ongoing block funded Sector Support and Development to assist with re-positioning of the CHSP sector to compete in a market-based environment.

Individualised funding should be made available for services that are based on the assessed needs and goals of the consumer and carer and could include: nursing, personal care, domestic assistance, home maintenance, respite care, meals and allied health services.

Question
What would be the impact on consumers and providers of moving to more individualised funding?

Refer to pages 14 – 15 of the discussion paper

HCP providers report that many consumers find confusing the various elements of individualised funding, namely exit fees, admin fees, hourly rates, etc therefore an extra 'support coordination' service will need to be available.

Individuals who require more than one service type should be able to purchase their services from as many service providers as they need/choose. This could lead to the creation of new business opportunities in regions as there would be no brokerage commission applied as there currently is with HCP's where the entire value of the package goes to only one provider who has to broker to another if they don't provide that service type.

Question
Are there other ways of funding particular services or assisting consumers with lower care or support needs, e.g. a combination of individualised funding and block funding, vouchers etc.?

Refer to pages 14 – 15 of the discussion paper

There should be multiple entry points for access to services depending on the type and length of service required.

To this end, there are a number of current CHSP service types that should not require an assessment and should be able to be accessed directly through a service provider, with an assessment only undertaken in the future if a consumer's needs change or they require ongoing services. These include:

- *Transport*
- *Some home maintenance services, eg gutter cleaning, window cleaning, 'spring' cleaning*
- *Group social support*

These 'entry level 'ad hoc' services can be:

- *the key to extending independence*
- *easy for clients to ask for especially when accessing help for the first time*
- *provide an opportunity for re-ablement*

Many CHSP consumers access only a single service for many years, eg once a year gutter clean or a social support group. These consumers do not comprehend the need for an invasive assessment and many are likely to reject it and therefore 'go without' which could result in negative outcomes for their well-being.

In the case of group social support, contacting MAC is a barrier to participation, and in the SCAP region this has been exacerbated by a number of consumers being rejected as ineligible for social support by the MAC contact centre as this is the only service type they are seeking and they are independent in other aspects of their lives. There is ample evidence that social isolation has significant negative health impacts, particularly on older people. Therefore there should be a focus at every opportunity of the aged care system to ensure that consumers have an opportunity to be socially connected or re-connected with their community. A consumer should be able to directly approach a group social support service provider and participate without an assessment in the first instance. Once connected with a service provider, they are more likely to seek or be referred to seek other service types should they need them in the future as their needs change.

4.5.1 Refocussing assessment and referral for services

Questions

Should consumers receive short-term intensive restorative/reablement interventions before the need for ongoing support is assessed?

If so, what considerations need to be taken into account with this approach?

Refer to page 16 of the discussion paper

Service providers in the SCAP region generally support the notion that consumers should receive short-term intensive restorative/reablement interventions before the need for ongoing support is assessed. However it also needs to be recognised that "some people will not get better" and there needs to be a way of identifying this before subjecting consumers to a program that will not achieve the desired restorative outcomes.

Question
How could a wellness and independence focus be better embedded throughout the various stages of the consumer journey (i.e. from initial contact with My Aged Care through to service delivery)?

Refer to page 16 of the discussion paper

Service providers in the SCAP region support the WA model that the assessment determines what a consumer can do rather than what they can't do. This reablement approach needs to be explained when a consumer first contacts MAC, and be reiterated by all parties so that consumers understand what they are committing themselves to when they seek subsidised support.

Once a relationship has been established with a RAS or ACAT assessor, phone or skype reviews would be possible in some cases to monitor how the plan is progressing, which would be more cost effective than a face-to-face review.

MAC call centre staff, RAS and ACAT assessors and service providers will need to receive appropriate training in this area as many service providers in the past have taken the approach of "what can we do for you?" rather than "what can you do for yourself?". Also, in the past, many consumers have developed unrealistic expectations of the services they are 'entitled' to receive as a result of inaccurate information received from the MAC call centre or RAS assessor.

Also, currently the ITC infrastructure does not have the capacity to provide all of the information that service providers need in order to deliver services that achieve a wellness and independence focus.

4.6.1 Ensuring that services are responsive to consumer needs and maximise independence

Questions
How do we ensure that funding is being used effectively to maximise a person's ability to live in the community and to delay entry to residential care for as long as possible?
For example, should funding be targeted to services or activities where there is a stronger connection with care and/or independent living? Are there examples of current services or activities that you believe should not be funded by government?

Refer to pages 16 - 17 of the discussion paper

A similar mandate as used by the NDIS, ie "the NDIS will pay for the reasonable and necessary supports that a participant needs to enjoy an ordinary life." Could be applied to aged care as "the Care at Home Program will pay for the reasonable and necessary supports that a participant needs to maintain independence as they age."

The definition of 'reasonable and necessary' should be developed in consultation with consumers and service providers.

There should be a focus on wellness. A person with good mental health will likely have better all round health.

Question
How do we maximise the flexibility of care and support so that the diverse needs of older people, including those with disability, are met?

Refer to pages 16 - 17 of the discussion paper

Service providers are funded to deliver outputs against clearly defined service types. These funded outputs may not necessarily match local consumer demand nor be relevant to a consumer's support plan.

Service providers need to have more flexibility to offer genuine choice to consumers to better meet their goals. Freeing up of CHSP service type funding restrictions will enable this.

Short term case management should be a service type that is available for CHSP consumers.

4.6.2 Accessing services under different programs

Question
Under the current program arrangements, does allowing some consumers to access both programs promote inequity, particularly if other consumers have to wait for a home care package?

Refer to page 17 of the discussion paper

When a HCP consumer also utilises CHSP they are using services that could otherwise be provided to an entry level consumer who may only need that service to maintain independence. This is inequitable as CHSP is designed for entry level needs.

If a service provider has the capacity to provide services for a HCP recipient it should only be for a short term basis.

Episodic supports should be included in the package as they are likely to be predictable.

Questions
Until an integrated care at home program is introduced, is there a need to more clearly define or limit the circumstances in which a person receiving services through a home care package can access additional support through the CHSP? If so, how might this be achieved?

Refer to page 17 of the discussion paper

The survey of 100 South Australian service providers regarding Stage 1 that was conducted in April-May 2017 by the SA Collaborative Projects found that significant proportion of respondents (70.37%) indicated that "My organisation needs more advice from DoH about the protocols for providing CHSP services to clients who are waiting for HCP's."

This demonstrates that more consultation with the sector is required to more clearly define or limit the circumstances in which a person receiving services through a home care package can access additional support through the CHSP.

4.8.1 Supporting specific population groups

Question
How can we make the care at home system work better for specific population groups, particularly those whose needs are not best met through current CDC models and administrative arrangements?

Refer to page 19 of the discussion paper

Block funded programs are likely to be the most effective way of delivering services to some population groups, eg some ATSI and CALD communities, remote communities, and people wo are homeless or at risk of homelessness.

4.8.2 Supporting informed choice for consumers who may require additional support

Question
What additional supports could be considered to ensure that people with diverse needs can access services and make informed choices and exercise control over their care?

Refer to page 19 of the discussion paper

To better support people with diverse needs, the SCAP region support ACSA's concept of providing additional supports such as:

- *Independent advocacy services*
- *Peer networks*
- *'System navigators' to support goal development and to identify suitable providers*
- *'System wranglers' to work across systems and services*
- *Short term case management should be available for CHSP consumers*

4.10 Other suggestions for reform

Question
Do you have other suggestions for care at home reform, or views on how changes might be progressively introduced or sequenced?

Refer to page 20 of the discussion paper

There needs to be more support for service providers and assessors to learn how to use the system. It has been up to providers and RAS to work it out for themselves in SA. Also any system updates have been interpreted differently by different providers. The sector in SA has used the Collaborative Projects (funded through Sector Support and Development) to facilitate information exchange and problem solving at a regional level.

Further consultation with the sector needs to be undertaken regarding sequencing. The NDIS roll out involving staged piloting and implementation appears to have been effective, especially as it has allowed for a number of changes and improvements to take place prior to full scheme roll out.

The NDIS roll out will have an impact on the aged care system. There is confusion about the Continuity of Care program amongst consumers and service providers which also needs to be considere

Section 5. Major structural reform

5.2 What would be needed to give effect to these structural reforms?

Question
Are there other structural reforms that could be pursued in the longer-term?

Refer to page 21 of the discussion paper

A single integrated system comprising Aged Care, NDIS and Carer Support working effectively with the health system.

Section 6. Broader aged care reform

6.1.1 Informal carers

Question
How might we better recognise and support informal carers of older people through future care at home reforms?

Refer to page 22 of the discussion paper

Carers have been forgotten in the current system. They need to be more of a focus in the new integrated system.

Currently a carer cannot register with MAC if they are under 65.

RAS assessors do not have the skill set to consider the role of the carer or to include the carer in the assessment process, and assessors need to give consideration to how much is expected of each carer when conducting assessments or making recommendations.

Currently there is confusion about the process for accessing emergency respite for both CHSP and HCP consumers.

Both CHSP and Home Care Packages are programs that focus on the client (>65 in need of support) and not the carer. Carers need a program that focuses on their own needs. As such, flexible respite, which is for the carer and not the client, should be taken out of CHSP and packages and put in a stand-alone Carer Support Program.

Carers should be recognised for their role in supporting or advocating for their family member or friend. There should be formal recognition of this role in the new integrated program that ensures they are able to participate in the relationship with MAC, assessments, determining level of package required, delivery decisions, etc. Decisions that will impact on the person they care for, the carer and the rest of the family.

An holistic family approach to support has been proven to have greater success then when either the client or the carer are excluded.

6.1.2 Technology and innovation

Question
How can we best encourage innovation and technology in supporting older Australians to remain living at home?

Refer to page 22 of the discussion paper

Introduce Government incentives to provide opportunities for the marketplace to respond to need.

Question
What are the existing barriers, and how could they be overcome?

Refer to page 22 of the discussion paper

Whilst a large number of older people are open to the use of information technology, many of the older cohort have not been convinced of the benefits having not experienced it in their working lives and therefore would need to be convinced otherwise through a public education campaign and increased availability and access to training at a local level. Cost would be another barrier with many unable to afford ITC devices. Whilst some could use funding from their package to cover this, it would likely be at the expense of another support or service which could be detrimental to their well-being.

6.1.3 Rural and Remote areas

Question
How can we address the unique challenges associated with service delivery in rural and remote areas?

Refer to page 22 of the discussion paper

Question
What other service delivery and funding models could we consider for providing care at home services to consumers living in rural and remote areas, including examples of innovative local community models?

Refer to page 22 of the discussion paper

The NDIS model which allows self-managed participants to purchase services from whomever they choose rather than an approved or registered provider may address this, however this model does come with risks.

Technology and Innovation has a role to play in better servicing rural and remote areas.

6.1.4 Regulation

Question
How can we further reduce regulation to allow for innovation while ensuring that essential safeguards remain in place?

Refer to page 23 of the discussion paper

Consultation with the sector required to address this

6.1.5 Aged care and health systems

Question
What are some examples of current gaps or duplication across the aged care and health systems, and how could these be addressed?

Refer to page 23 of the discussion paper

The issue of the aged care and health systems not working together needs to be addressed through a strategic review and planning process involving both sectors and supported by training and development for the existing workforce in both. It also needs to be addressed during education and training at entry level for both sectors so that new entrants to the work force understand how the sectors best work together for the benefit of consumers and to maximise resources.

Any further comments?

Other comments

Do you have any general comments or feedback?

Co-payments

Service providers in the SCAP region support the view that consumers should contribute towards the cost of a service if they can afford to.

However means testing arrangements should not be extended to entry level consumers requiring small amounts of services, as the cost of doing this would likely far outweigh the small amount of revenue that would be collected. The level of co-payment for CHSP services needs to be determined through implementation of a fair and transparent process. If fees are considered too high by consumers they will either attempt to do it themselves or go without a service to the detriment of their well-being.

Means testing for residential care and home care package recipients includes both income and assets, however in farming areas consideration needs to be given to the wider ramifications of including assets such as farms in the assessment process where they are jointly owned by a number of family members or held in trust.