Victorian Community Care Coalition

MOVING TO CENTRE STAGE

Community care for the aged over the next ten years

August 2006

Community Care Coalition

Helen MACPHERSON SMITH Trust
SERVING VICTORIA

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Final Report

Moving to Centre Stage:
Community Care for the Aged Over the Next 10 Years

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Helen MACPHERSON SMITH Trust
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1 Foreword

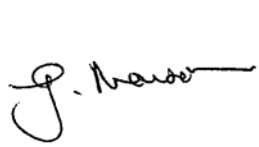
The capacity of community care services in Victoria to meet growing demand and changing consumer expectations over the next decade is the focus of this report. Victoria faces major challenges in responding to growing demand, increasing acuity and the need for more flexible, responsive and efficient community care services. This report examines the drivers of change and discusses options for improving the capacities of the community care system in Victoria over the next decade.

This report was commissioned and funded by the Helen Macpherson Smith Trust who had the foresight to recognise the significance of this issue. It has been undertaken by the Nous Group for the Community Care Coalition. Aged and Community Care Victoria (formerly VAHEC) have been responsible for the management of the project. Representatives of the Council on the Ageing Victoria (COTA Vic), the Royal District Nursing Service (RDNS), the Municipal Association of Victoria (MAV) and Carers Victoria provided information to the consultants in the preparation of their report and facilitated consultations across the sector. A broader reference group, chaired by Rob Knowles also offered input and feedback to the authors of this Report. Details of the reference group membership are detailed in the report.

The focus of this report is on people aged 65 years and above. There are also a growing number of people with a disability who are ageing. Addressing their particular needs and a more integrated response across the HACC and disability service systems has not been possible within the scope of this report. The commissioners of this report acknowledge this as a priority issue for future research, policy development and Government action.

It is hoped that this report will stimulate discussion and debate about needed reforms to the community care system in Victoria. The Victorian and Commonwealth Governments have demonstrated a genuine commitment in working collaboratively with the sector in building community care. Such collaboration needs to be a key element of future planning and reform processes if the challenges outlined in this report are to be adequately addressed.

Aged and Community Care Victoria and the Victorian Community Care Coalition (VCCC) wishes to acknowledge and thank the directors and staff of the Helen Macpherson Smith Trust for their vision in funding this project. They wish to thank the Nous Group for this contribution to the debate about how to improve the community care system in Victoria.



Gerard Mansour

Chief Executive

Aged and Community Care Victoria (formerly VAHEC)

2 Executive Summary

2.1 Background to the report

The community care sector provides vital services to a diverse range of Australians. The sector helps maintain the independence of older people; assists those with health and other vulnerabilities; contributes to the independent living capacity of people with disabilities and supports the families and informal carers on which these people depend.

Over the coming decade, the sector will be transformed. Demographic changes, health service arrangements and community preference for care in the community rather than residential aged care will generate sustained growth. How this happens, and how satisfactory the outcomes will be for service users and their carers, service providers and government, is a critical question.

The Victorian Community Care Coalition (VCCC), a coalition of community care providers and representatives of service users, and the Helen Macpherson Smith Trust, commissioned this report to inform and influence the sector's development in the decade ahead.

Moving to Centre Stage follows and expands upon a series of earlier reports that have addressed the care of the aged. These include the Myer Foundation's reports on aged care, the Australian Department of Health and Ageing's *The Way Forward*, and the Victorian Department of Human Services' ambulatory care strategy, *Care in Your Community,* which addressed care for the aged and other groups.

Moving to Centre Stage is an important report that covers significant new territory. It deserves careful consideration by government, providers and service users for three reasons. First, in this report the community care sector receives serious and rigorous attention as a critical element of the system of services providing for the care of older people in Victoria. Second, the report is an in-depth, analytical report which identifies the need for and recommends substantive change. Third, the report was commissioned by the service system itself-representatives of users and the coordinating and leading providers in the sector-with the will to implement the recommended changes if they receive appropriate support, in particular from the Federal and Victorian Governments.

2.2 Project objectives and scope

The Nous Group, an independent, national public policy consulting firm, was engaged to prepare a report which:

1. Provides a strategic overview of the current operation of the community care system
2. Identifies the current and likely future pressures that service users and the care system face in the next 10 years
3. Recommends a range of actions that will respond effectively to these pressures and that together will substantially contribute to a capable, responsive and sustainable system
4. Identifies a range of options that need to be considered to contribute to a more capable, responsive and sustainable community care system.

The report focuses upon care for the aged.[1] However, community care is also provided to a range of other groups including a major component of services to people with a disability and their families. While the needs of these groups have not been considered in detail in this report, further attention should be given to implementing reforms which will ensure that the sector continues to effectively meet their needs. The report focuses on Victoria, but its findings and recommendations are broadly relevant for community care for the aged across Australia.

2.3 Key findings

2.3.1 Drivers of change in community care

The drivers of change outlined in the report coalesce into six key messages which need to inform the development of the community care sector over the next decade. They are:

1. Community care must be understood as an amalgam of family, informal and formal service provision. This is a strength of the sector which must be preserved. There are real risks (community, demographic and policy-related) to the capacity and willingness of informal carers which must be carefully managed. Careful management will preserve the strengths and may enhance the capacity of informal carers.
2. The foundations on which formal community care services are built are strong and capable of evolving to meet new challenges.
3. Sustained growth in demand for services and changing expectations among older people and their families will be powerful drivers of change in the sector and will place pressure on services and provision arrangements. Australia is just at the beginning of a powerful generational shift in community expectations which will demand a more comprehensive and responsive community care service and a refined response from health and residential care providers.
4. The complexity of the needs of service users and their carers and their cultural and linguistic diversity will increase over the coming decade.
5. International trends, relevant to Australia, are establishing a more integrated and flexible approach with more market-driven service provision arrangements.
6. Community care, if effectively refined and positioned, can facilitate reforms to residential care and health care provision that are necessary to meet government policy.

The preconditions from which to launch the next decade of reform are not well developed. There are important barriers and issues which need to be addressed. Critical among them are:

- policy disjunctions and gaps which limit older people's access to a flexible continuum of care
- inadequate articulation of the outcomes to be achieved and consequent failure to link policy, funding and accountability to clear outcomes
- program arrangements that are fragmented and create planning and operational difficulties and inefficiencies
- adequate resources to meet future demand

[1] In this report 'aged' is defined as 70 years of age or older. However some data sets focus on the group 65 and older, and where this is the case, the report's analysis uses this age group.

- underdevelopment of the industry/sector structure exacerbating the difficulty in advancing reform.

For community care to contribute effectively to care and support of older people over the longer term, these issues urgently need to be addressed.

2.3.2 Investments required

Relative to the size of the recurrent spending on residential aged care and hospital services for people aged 70 plus, the investment in home and community care services today is modest. Total State and Commonwealth investment in home and community care services for the aged in Victoria was approximately $400 million in 2003-04, which was around 31 per cent of the recurrent investment in residential aged care and 24 per cent of the recurrent investment in acute care for the aged in Victoria.[2]

It is recommended that the Victorian and Federal Governments' plan for annual funding increases in the decade to 2015. Nous Group forecasts indicate that:

- 6.5 per cent real funding growth per year is required due to demographic change, weaknesses in system infrastructure, rising labour costs, greater client complexity and a marginally higher disability rate. These factors mean that an additional $350 million per year will need to be invested in community care for older people in Victoria in 2015.
- Real HACC funding in Victoria increased by an average of 4 percent per year over the 5 years from 2000-01 to 2004-05.[3] Therefore the increase in funding for the overall community care system which this report argues is required over the next decade is not vastly higher than the recent historical growth rate for the largest community care program, HACC.
- The ratio of Commonwealth Aged Care Package (CACP) places funded per 1000 Victorians aged 70 or over needs to be increased from 20 to 30 over the next 10 years to respond to the continuing shift in older people's preferences away from low level residential care towards care in the community. In 2015, an additional $137 million in real funding for CACP or equivalent places will be required relative to 2005 funding levels.
- $20m per year in additional funding will be required over the decade to 2015 to support an increased focus on and greater investment in supporting independence, health promotion and disease prevention.
- $105 million in additional funding will be required over the decade to 2015 due to changes in practices in the acute care sector resulting in more care in the community.

2.3.3 Reforming policy and programs

This project has found that current policy and program arrangements do not provide nor enable an effective fabric of care for all. Over time, governments have responded to particular

[2] The estimate of $400m in total Commonwealth and State funding for community care services for the aged in Victoria is based on the assumption that 30% of the HACC budget (around $100m) is spent on services for people aged under 70. This assumption derives from data on the ages of HACC service recipients in sources such as *Who Gets HACC?* (Department of Human Services Victoria, 2004, page 3). It should be noted that the ratio of 30% under 70 does not apply in all HACC service categories. It is an average across the various HACC-funded services.

[3] National Institute of Economic and Industry Research, *Expenditure on HACC and CACP 1993-94 to 2003-04,* Unpublished report for the Victorian Community Care Coalition, November 2005. Page 9.

needs by introducing new programs, ranging from large initiatives such as Community Aged Care Packages (CACP) to a plethora of small, specific programs. These 30-plus programs, each of which appear sensible individually, have collectively created a jumble of overlapping and uncoordinated care arrangements rather than a sensible patchwork quilt of care. Instead of facilitating effective care, the policy and program arrangements require that providers become expert in shuffling and blending services across programs to meet the needs of their service users.

While significant improvements could be made by merely simplifying the plethora of programs, this report recommends a fundamental redesign of policy settings and program arrangements. The redesign should start with a new policy framework which sets the objectives for the system as:

1. 'Ageing in place' (encompassing community care, acute and primary health care, and residential care)
2. A smooth 'continuum of care' over time as needs change
3. Support for the 'care unit'-services should focus on supporting users and their carers.

Reorganising the current array of programs into a set of three complementary programs is also recommended. The programs would be:

1. Early intervention and independence support
2. Chronic/complex health care and disability maintenance
3. Hospital and community transitions.

This function-driven approach contrasts with the Commonwealth's *The Way Forward* report, which envisages a three-tier program structure based on levels of assessed need. The *Moving to Centre Stage* report argues that distributing funds through programs focusing on the functional outcomes being sought is more coherent, efficient and effective. Within each of these programs, it is proposed that allocations be made to each level of need.

The principles against which these policy reforms should be assessed are:

1. focus on outcomes
2. balancing investment across levels of need and service types
3. aligning services with the health and residential care sectors
4. maximising flexibility and responsiveness for users and carers
5. ensuring the sustainability and efficiency of the service system.

Moving to Centre Stage recognises that any change to policy and program settings requires careful consideration of the funding arrangements. This is essential in order to create appropriate motivations for users and providers, a capacity to change in response to changing circumstances, and expenditure control for government. The report explores a range of options and recommends further consideration of two:

Option One - A minimalist position of a 'clean–up' of current funding arrangements and a simplification of programs

Option Two - A move to a new approach termed 'service pool reviews', which provides greater choice to service users, certainty to service providers, capacity to move funds over time as the needs of service users change, and budget control.

2.3.4 A capable, responsive and sustainable sector

Community care for the aged is a partnership between informal carers-service users' families and friends-and the formal care sector. The current formal care sector in Victoria has two large providers in any region: the Royal District Nursing Service (RDNS), or a local nursing service that provides nursing and personal care, and local governments (or its agents) which provide personal care and home support. These are complemented by a large array of other smaller care providers.

Over the last decade additional providers have entered the sector, initially through the Australian Government's CACP arrangements. More recently, a number of small private providers appear to be emerging on the margins of the sector, responding to the demands of an increasingly affluent clientele (if not the service users themselves, then commonly their adult children).

The next decade's rapid growth in demand is very likely to accelerate an increase in the diversity of new providers, both not-for-profit and for profit. That is, the community care sector is likely to become a more heterogeneous, or mixed, system of public, not-for-profit and private providers. For service users to fully benefit from this diversity, a number of changes will need to be made to the arrangements supporting the sector.

1. *Navigation*: Service users will need greater assistance to utilise available services. There are three aspects to the navigation arrangements which require attention. Service users and carers will require better information regarding their service options to enable them to navigate their way through the sector so that they can make the arrangements that best suit their needs. The report also recommends enhancement of the current assessment arrangements. Currently, assessment is performed by service providers primarily for their specific services, with the result being that assessment lacks standardisation. The report proposes that:
    a. a common assessment tool be finalised quickly
    b. a national framework for assessment be agreed
    c. above a defined level of need and complexity, assessment be undertaken independent of service delivery
    d. additional funds be invested in supporting assessment.
2. *Quality assurance and standards*: Community care currently lacks sector-specific and consistent quality assurance strategies, tools and mechanisms. Services variously access existing quality assurance and/or accreditation arrangements. States and territories have developed jurisdiction-specific service excellence or quality assurance approaches. Whilst these programs individually assist services to develop and maintain quality assurance practices and standards, the sector lacks, and consumers do not have access to, a benchmark system that ensures consistency of standards across the sector.
3. *Data system development*: The sector has generally inadequate data systems and infrastructure, and a consequent lack of reliable data. This means that it is difficult to readily draw conclusions about the adequacy of existing service delivery, relative funding or outcomes in the absence of major projects such as this report. As a result, it is impossible for the sector or governments to plan adequately for the future. As the sector moves to centre stage, governments and service providers will need to make major investments in data systems and processes to enable the sector as a whole to manage itself more professionally in the interests of service users.
4. *Workforce*: With a sector growing in the order of 6.5% per annum, and the overall Victorian workforce unlikely to grow in size at all, there is a looming crisis in availability of staff for the formal care system. With new service provider entrants recruiting heavily, this crisis will

be exacerbated by potentially higher churn rates in employment. There are three parts to the solution:

   a. encourage greater independence by people needing to access care services, particularly through support for carers, so that demand on the formal care system grows more slowly than is projected
   b. expand the pool of available staff, probably from people who are currently not working
   c. encourage greater flexibility in working arrangements to enable greater productivity over time.

5. *Future financing arrangements*: Over the next decade, community care for the aged will slowly move from being, effectively, entirely publicly funded, to arrangements where a small but increasing proportion of financing will be provided privately, mainly by users. Further work needs to be undertaken to recommend how best to accommodate these private financing streams to help meet growth in demand and to complement publicly funded service provision without diminishing older peoples' capacity to live in the community with dignity and independence. These streams are likely to be direct payment by service users, as they choose more or different services from those that are publicly funded, and private insurance. No providers currently offer community care insurance, although it is understood that several insurers have considered the opportunity.

2.3.5 Leadership opportunities

Putting the changes recommended in *Moving to Centre Stage* into effect will require leadership from all sector participants.

1. *National*: The Australian Government will need to lead the reform of the policy and program arrangements.
2. *State*: The Victorian Government will need to work together with the Australian Government to put the recommended reforms into effect. In addition, the Victorian Government will need to plan how best to support and sustain the public providers through the significant changes presaged in this report.
3. *Regional*: Delivering a seamless service system across the range of providers that any service user may need will require effective planning of service delivery on a regional scale. This will require that existing community care providers, health providers and the Victorian Government work together to understand how their services should interact in the best interests of their user population.
4. *Formal care system*: Service providers must continue to invest in their capacity to meet the needs of individual service users by creating more flexible care models and to better coordinate the provision of care between different organisations.

3 Introduction

3.1 This report

Moving to Centre Stage: Community Care for the Aged Over the Next 10 Years was commissioned by the Victorian Community Care Coalition, a coalition of aged care providers and representatives of service users, and funded by the Helen Macpherson Smith Trust.

The report is presented in two formats designed to meet the needs of different readers: this full length final report and a short executive summary.

The report:

1. provides a strategic overview of the current operation of the community care system
2. identifies the current and likely future pressures that service users and the care system face in the next 10 years
3. recommends a range of actions that will respond effectively to these pressures and that together will substantially contribute to a capable, responsive and sustainable system
4. identifies a range of options that need to be considered to contribute to a more capable, responsive and sustainable community care system.

Moving to Centre Stage follows and expands upon a series of earlier reports that have addressed the care of the aged. These include *The Myer Report*, the Australian Department of Health and Ageing's *The Way Forward*, and the Victorian Department of Human Services' ambulatory care strategy, *Care in Your Community,* which addressed care for the aged and other groups.

Moving to Centre Stage is an important report that covers significant new territory. It deserves careful consideration by government, providers and service users for three reasons. First, in this report the community care sector receives serious and rigorous attention as a critical element of the system of services providing for the care of older people in Victoria. Second, the report is an in-depth, analytical report which identifies the need for and recommends substantive change. Third, the report was commissioned by the service system itself-representatives of users and the coordinating and leading providers in the sector-with the will to implement the recommended changes if they receive appropriate support, in particular from the Federal and Victorian Governments.

3.1.1 Scope

The report focuses upon care for the aged.[4] However, community care is also provided to a range of other groups including a major component of services to people with a disability and their families. While the needs of these groups have not been considered in detail in this report, further attention should be given to implementing reforms which will ensure that the sector continues to effectively meet their needs. While the report focuses on Victoria, its findings and recommendations are broadly relevant for community care for the aged across Australia.

[4] In this report 'aged' is defined as 70 years of age or older. However some data sets focus on the group 65 and older, and where this is the case, the report's analysis uses this age group.

3.1.2 Methodology

The report was prepared by the Nous Group (www.nousgroup.com.au), an independent, national public policy consulting firm. The Nous project team undertook a comprehensive review and analysis of available Victorian and Australian data, and conducted a series of consultation forums and interviews with service users, service providers, representative bodies and policy makers from the Victorian community care system. Frontier Economics provided input and advice on the report's financial modelling (www.frontier-economics.com). The project was managed by a steering committee comprised of members of the Victorian Community Care Coalition.

3.1.3 Report structure

The report is divided into five main sections. Section 2 'Community care today', provides a detailed profile of the service users, informal carers, programs and service providers which together comprise the Victorian community care system. Section 3, 'Drivers of change', examines the forces which will reshape the community care system in the next decade. In Section 4, 'The Future: Growth and opportunity', we analyse the funding and policy responses required. Section 5, 'A capable, responsive and sustainable sector', addresses the changes needed at the operating level, in and among service providers. Section 6, 'Leadership opportunities', discusses the areas where specific pro-active responses are needed from governments and providers.

3.2 Understanding the community care sector

The community care sector provides vital services to a diverse range of Australians. The sector helps maintain the independence of older people; assists those with health and other vulnerabilities; contributes to the independent living capacity of people with disabilities and supports the families and informal carers on which these people depend.

The character of community care has and will continue to change over time. It also has different meanings for different stakeholders. These are good things given the context in which community care operates and the diverse range of service users and carers that depend upon community care.

There are two central elements of community care which provide the touchstone against which changes over the coming decade can be assessed:

1. Community care is the provision of health and community services required to support living at home where a disability, frailty or health condition diminishes/compromises an individual's capacity to live independently.
2. Community care represents a philosophy of care that focuses on maintaining and enhancing the health, wellbeing and ability to live in the community of service users, rather than responding only to the onset or existence of illness or disability. It should be pro-active management of health, activity and independence.

Community care should have a particular focus on service interventions which promote client and carer independence, rather than encouraging dependency. For this reason there is a firm aspiration towards enabling users and their carers to have significant agency as they interact with the system. Also integral to the nature of community care are the overlapping contributions of support which come from informal carers and formal service providers. Care from family members is the dominant type of care and the formal care system's role is both to

provide support to family carers and to provide care to those clients who have limited or no access to family carers or who have specialised care needs. The linkage between the formal system and informal carers is fluid and varied.

While the two core principles outlined above are the touchstones, other particular characteristics of community care include:

- a range of services, ranging from personal activity and home support through to nursing, including medical support
- the array of providers that typically provide the service, ranging from the large RDNS and local government providers through to quite small providers
- the range of programs that currently constitute community care and represent the funding streams that finance the provision of services.

This report will argue that the two central elements highlighted at the top of this section must be preserved, while the other meanings cited here are changing now or should change over the next decade.

3.3 An overshadowed and undervalued sector

The sector can be characterised as overshadowed and undervalued. Overshadowed by the more heroic, critical and high profile health, residential care and community service sectors with which community care interacts. Undervalued because it lacks the high visibility buildings, industrial strength and media power generated by large and sensitive queues.

The characterisation of the sector as overshadowed and undervalued does not imply weakness or inadequacy. The sector has many strengths and delivers highly valued services to older Australians; many of them frail and vulnerable. The sector has achieved significant reform and development despite its position. Should the preconditions and context surrounding the sector be changed, major gains can be achieved from the platform which has already been built.

The sector also suffers as a result of the policy and program structures imposed by government. These structures, having evolved over time, have the benefit of ensuring that government outlays are controlled and focused on broad priorities. However, the arrangements have costs because they limit service provider efficiency and restrict the choice and flexibility of service users and their carers.

3.4 The next decade: ‘Moving to Centre Stage’

The coming decade will bring significant change to bear on community care for older people. Key factors driving this change will be demand, community expectations, and the limitations of current policy and programs. The impact of this change will move the community care sector from the ‘wings’ of aged-care services to ‘centre stage’. How this happens, and how satisfactory the outcomes will be for service users and their carers, service providers and government, is a critical question. Proactive leadership by existing providers in conjunction with governments would maximise the benefits of change. Conversely, passivity by providers over the next decade-with or without government action-can be expected to restrict potential benefits and to potentially contribute to raising costs and longer-term disruption of support for older Australians, particularly for those in marginal groups and categories of need.

The preconditions for proactive leadership are already partially in place, although more needs to be done. Current and future service users (and their families) are increasingly conscious of the possible need for support. The drive to receive that support in their local area, and not be defined as 'ill' or 'dying' before receiving support, is growing. Community expectations are rising and lead towards community-based rather than health-based institutional care as the service of choice. The significance of carers and the need to deliver a package of services which sustain the 'care unit' is growing. Community care cannot be sustained as a service model or as an economic investment without the partnership of primary carers, family and community carers and the formal community care service system.

Service providers, sensitive to these changes and the demographic profile, are also contemplating and planning for change. Effective and acceptable services will be based upon collaborative arrangements which recognise that:

- the needs of service users and their circumstances change over time
- coordinated or integrated care is most effective in terms of quality of care, efficiency of resource use and cost
- there are many ways to deliver the outcomes needed by older people.

Multiple providers with differing skills and capacity, but with a commitment to collaborative delivery, will be needed. The planning, assessment and funding arrangements required will be built on, but differ from, existing structures. The will and resources required to make these changes is limited and will need to be supplemented and complemented by government action.

Governments have a renewed interest in the sector, and not only because the expectations of their voters require it. Increasingly, in their drive to manage continuously increasing demand for residential care and acute health care, they are turning to the community care sector as a powerful mechanism to drive and facilitate needed and emerging changes in residential care and health service provision. For example, both the Victorian Government's recently updated social policy strategy *A Fairer Victoria* and its *Care in Your Community* ambulatory care strategy deepen the commitment to community based rehabilitation for the aged.[5]

There is good policy and pragmatic economic benefit in strategically investing in community care. The needs and circumstances of older people dictate that government involvement in funding, quality control and engagement in public provision will remain a high priority for the next decade and beyond. However, for the community care sector there is a strong possibility that this investment will be fragmented, delayed or driven through a health or residential care paradigm that is not consistent with the central principles of community care.

The sector currently consumes a considerable government investment. Outlays on community care by the federal and all state and territory governments are estimated to be in the order of $2 billion.[6] This amount is supplemented by user payments and the contributions of service providers. In Victoria, local government contributes $70 million specifically to the HACC program.[7]

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[5] *A Fairer Victoria – Progress and Next Steps,* Department of Premier and Cabinet, 1 June 2006. *Care in Your Community – A Planning Framework for Integrated Ambulatory Health Care,* Department of Human Services, 2006

[6] Nous Group estimate based on published reports and budget papers from Commonwealth and State governments.

[7] Municipal Association of Victoria estimate.

Further growth can be anticipated, given that the forward estimates of governments assume both cost-driven and demand-driven increases. Planned and anticipated changes to both health care practice and residential aged care provide likely pools of funds which could be invested in additional services. While government forward estimates assume limited growth, they will not be adequate to meet the projected level of demand.

In the lead up to the February 2006 Council of Australian Governments (COAG) meeting, there was serious consideration within state and Commonwealth governments given to major structural reform of community care. A split of programs for aged from those for disabled people, with the Commonwealth taking full responsibility for the funding and management of services for the aged and states taking responsibility for disability services, was examined thoroughly. In the end it was concluded that at this time this approach was not feasible. In light of this, it would be sensible to assume there will be limited opportunities for significant structural reform in the near future.

4 Community care today

4.1 Programs

Almost 85 per cent of the funding for community care services in Victoria comes from two programs: the Home and Community Care program (HACC), a jointly funded Commonwealth, state and territory agreement, and Community Aged Care Packages (CACPs) funded within the Commonwealth residential aged care program. The other 15 per cent of funding comes from over 30 smaller state and Commonwealth programs. These programs have been introduced by successive governments, usually in response to priorities emerging at particular times and in the context of the then contemporary political philosophies or considerations. The diversity of programs includes equally diverse entry criteria, accountability arrangements, terms and conditions, user fees policies and evaluation mechanisms as a consequence of this incremental, indeed piecemeal, evolution in services.

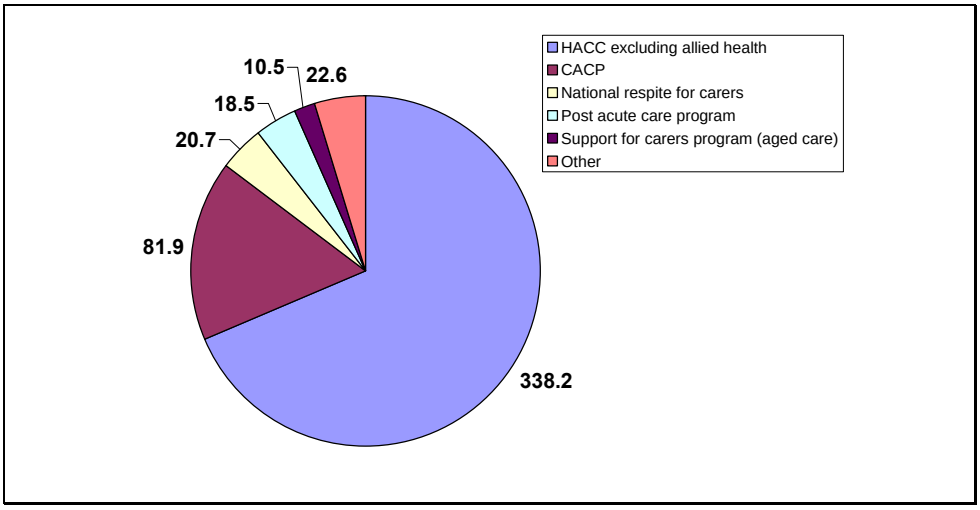

Figure 1: Major community care funding programs in $ million (Victoria 2003-04)[8]

Relative to the size of the recurrent spending on residential aged care and hospital services for people aged 70 plus, the investment in home and community care services is modest. Total State and Commonwealth investment in home and community care services for the aged in Victoria was approximately $400 million in 2003-04, which is around 31 per cent of the recurrent investment in residential aged care and 24 per cent of the recurrent investment in acute care for the aged in Victoria.[9]

[8] "Response to issues raised by the Commonwealth's Community Care Review", Victorian Departmental Advisory Committee on the Home and Community Care Program, October 2003. Note: These programs do not exclusively serve those aged 70 plus or caring for those aged 70 plus. Younger persons with a disability are also supported through these programs.

[9] The estimate of $400m in total Commonwealth and State funding for community care services for the aged in Victoria is based on the assumption that 30% of the HACC budget ($100m) is spent on services for people aged under 70. This assumption derives from data on the ages of HACC service recipients in sources such as *Who Gets HACC?* (Department of Human Service Victoria,

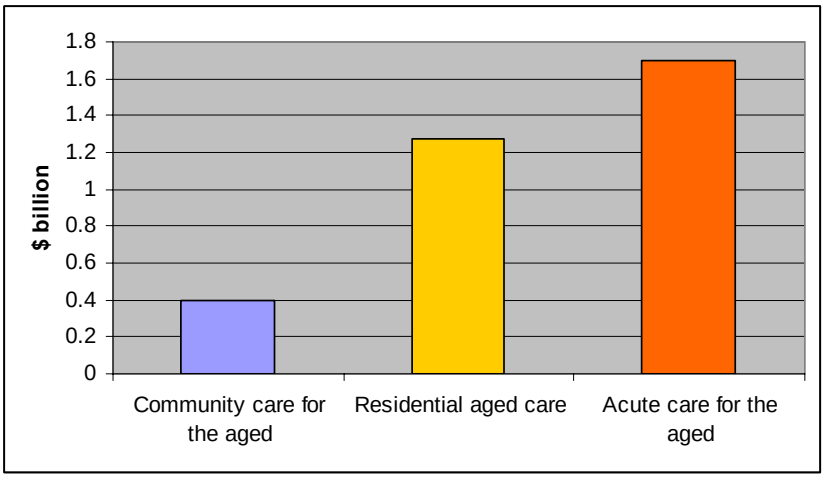

Figure 2: Expenditure levels per annum on community care, residential aged care and acute care for those aged 70+ (Victoria 2003-04)[10]

A profile of the two largest community care programs is outlined below.

4.1.1 Home and Community Care (HACC)

Funding to the HACC program represents about 70 per cent of the total state and Commonwealth investment in home and community care in Victoria. The program's objective is to provide a range of support services to enable the frail aged and people below 70 with functional disabilities to live at home independently. Thirty-two per cent of HACC funds are spent on the two largest categories-home care and nursing. Other major service categories are personal activity groups, personal care, meals, respite, allied health and property maintenance. The funding allocations by service type are outlined in the pie chart below.

2004, page 3). It should be noted that the ratio of 30% under 70 does not apply in all HACC service categories. It is an average across the various HACC-funded services.

[10] 2004-05 Victorian government spending on admitted services at hospitals was $3.9 billion (Department of Treasury (Victoria), Budget Paper 3, Service Delivery, 2004-05). 46% of multi-day stays in hospitals were from the 70 plus age group so hospital services this group cost around $1.79 billion. The cost of bed days does decline over the length of the stay so this may be a slight over-estimate.

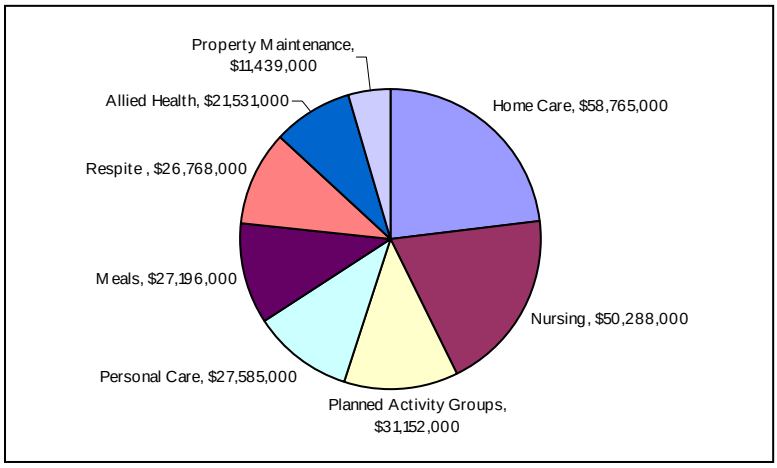

Figure 3: HACC Program – Estimated Cost of Services Provided in Victoria (2002-03)[11]

Around 70 per cent of funding goes to services for those over 65, with 30 per cent of funding providing services for those under 65. The Victorian Government contributes approximately 45 per cent of HACC program funds, with the Commonwealth contributing around 55 per cent. Local governments also supplement HACC with additional funding from their own rate base. The Municipal Association of Victoria estimates the total local government supplement to the HACC program is $70m per annum. Means-tested user charges are levied on HACC users and these generate around $35m per year.[12]

4.1.2 Community Aged Care Packages (CACP)

The CACP program is fully funded by the Commonwealth and was established to enable a package of care and support services, equivalent to the care component of lower tiers of the residential aged care system, to be provided to people living at home. Australia-wide there were 28,921 operational places in 2003-04. Approximately 25 per cent of these were in Victoria. CACP packages are allocated in quotas to local areas with reference to a target ratio of 10 packages per 1000 people over the age of 70.

An average CACP package is valued at $11,900 per annum. It covers a range of services including case management, carer support, personal care, meals, home cleaning and maintenance, and can be tailored to the specific circumstances of the CACP recipient. The program is supplemented by user charges which generate approximately 17 per cent of the program budget.[13]

4.1.3 Other programs

The 30 plus other programs providing community care funding address:

- system infrastructure–e.g. Commonwealth Day Therapy Care Centre and Care Package Establishment Grants, Commonwealth Carelink Program

[11] Nous Group estimate based on data in *Who Gets HACC?,* Department of Human Services (Victoria), 2004.

[12] Allen Consulting Group, *Financial Implications of Caring for the Aged,* Report to the Myer Foundation, 2002, page 40.

[13] Ibid.

- specific niche categories of service need-e.g. the Commonwealth Extended Aged Care at Home (EACH), the Victorian Post Acute Care Program and Personal Alert Victoria
- support for carers-e.g. the Victorian Support for Carers program, National Respite for Carers.
- health-related services-e.g. state based Community Health Centres.

4.2 Service users

Of the total number of Australians aged 70 and over, 15.1% use HACC services, 7.8% live in residential care and 1.5% receive CACPs.[14] Just over 150,000 people aged 65+ received a service under the HACC program and 7,250 received CACP packages in Victoria in 2003-04. As figure 4 below illustrates, the majority of users of the HACC and CACP programs are between 70 and 90 years of age.

Age group	0-60	60-70	70-80	80-90	90+
HACC recipients (2003)	20%	13%	30%	30%	7%
CACP recipients (2003)	13%		29%	44%	14%

Figure 4: Age group distribution among users of HACC and CACP programs[15]

The service users in community care is quite diverse in two ways: (1) complexity of care need; and (2) length of care need-episodic or ongoing. Users range from those who are largely independent but who need a small amount of support infrequently, to those with severe disability needing frequent and complex support services. The user pool of the two major programs-HACC and CACP programs-is very diverse as the figures following illustrate.

HACC	Clients	Dollars spent
Low cost (<$10k per year)	99%	$186m
Medium cost ($10k-$39k)	1%	$35.5m
High cost ($40k-$120k)	0.1%	$12.2m

Figure 5: Level of service usage[16]

[14] Source: *Quality and Equity in Aged Care,* Senate Community Affairs Committee report, Commonwealth of Australia, 2005 http://www.aph.gov.au/Senate/committee/clac_ctte/aged_care04/report/c06.htm

[15] *Who Gets HACC?,* Department of Human Services (Victoria), 2004 & *Community Aged Care Packages in Australia 2002-03,* AIHW, 2004.

[16] *Who Gets HACC?,* Department of Human Services (Victoria), 2004.

CACP Length of service	Clients
Short (less than 6 months)	31%
Medium (6 months-1 year)	20%
Ongoing (1 year or more)	49%

Figure 6: Length of time on CACP package[17]

The following table compares the Resident Classification Scale (RCS) rating levels used in the residential aged-care system with the service funding allocated to groups of users within the major community care programs. Extended Aged Care at Home (EACH) is a small program which allocates around 200 packages a year in Victoria to enable frail aged people with very high care needs to stay at home.

$ Value[18]	Residential care	EACH	HACC to people 70+	CACP recipients
$44,402	RCS 1	$10m 250 clients	$3.7m 100 clients	
$40,234	RCS 2			
$34,653	RCS 3		$24.5m 17,000 clients	
$24,510	RCS 4			
$14,775	RCS 5			$81m 7,200 clients
$12,245	RCS 6			
$9,399	RCS 7		$185m 135,000 clients	
$7,500				
Up to $7,500				

Figure 7: Relative expenditure by client in EACH, HACC, CACP and residential aged care[19]

4.3 Providers

Care provision to frail elderly people living at home comes from two critical sources. The *formal care system*, which is comprised of government agencies, not-for-profit and for-profit organisations engaged in the business of care provision, and the *informal care system*, which is comprised of care and support provided by spouses, family members and friends. These two systems together combine to support frail elderly people to live at home.

4.3.1 Informal carers

It is estimated that in 2006 there will be around 215,000 primary carers of the frail aged in Australia and around 54,000 in Victoria.[20] The number of elderly Victorians currently accessing

[17] *Community Aged Care Packages in Australia 2002-03,* AIHW, 2004.

[18] Department of Health and Ageing, 'Residential Care Subsidies', 1 July 2005.

[19] HACC client numbers are estimates based on information provided to authors by Department of Human Services (VIC). The source for EACH and CACP client numbers is the Department of Health and Ageing (Australia).

some form of formal support service is approximately 150,000. Over the next decade carer numbers are forecast to grow by 21 per cent[21], with the over 65 population expected to grow by 35 per cent. The two largest categories of informal carer are spouses and daughters. An estimated three-quarters of all carers of people over 65 are female, approximately 60 per cent of carers are aged under 65 years, and over 60 per cent live with the person for whom they providing care.

Some carers receive payments from the Commonwealth Government in the form of Carers' Payment and the Carers Allowance programs to fund some or all of their living costs.

Unpaid Carers	Carers Payment	Carers Allowance
At least 27,500 primary carers do not receive government funding	21,000 recipients	73,500 recipients
	$230m per year	$241m per year
	$10,700 per recipient/year	$3,280 per recipient/year

Figure 8: Funding of informal carers by the Commonwealth Government Victoria-wide 2005 (both younger disabled and frail aged 65+)[22]

There is also a range of programs delivering services which provide training, advice and support to informal carers in their role.

Programs in Victoria	Funding 2003/04
National Respite for Carers (C'wealth)	$20.7 million
Support for Carers program (State)	$10.5 million
Carers Information and Support Program (C'wealth)	$0.3 million

Figure 9: Support programs in Victoria for informal carers[23]

4.3.2 The formal care system

The following charts show the mix of HACC funding levels across types of provider.

[20] Estimate from NATSEM, *Who's Going to Care?,* Report for Carers Australia, 2004.

[21] Ibid.

[22] Nous estimates based on Australian statistics cited in *Economic Implications of an Ageing Australia,* Productivity Commission, March 2005, Chapter 7; and Carers Victoria - Fact Sheet, 2005.

[23] Source: Victorian Departmental Advisory Committee on the HACC Program, *Response to the Issues Raised by the Commonwealth's Community Care Review,* October 2003.

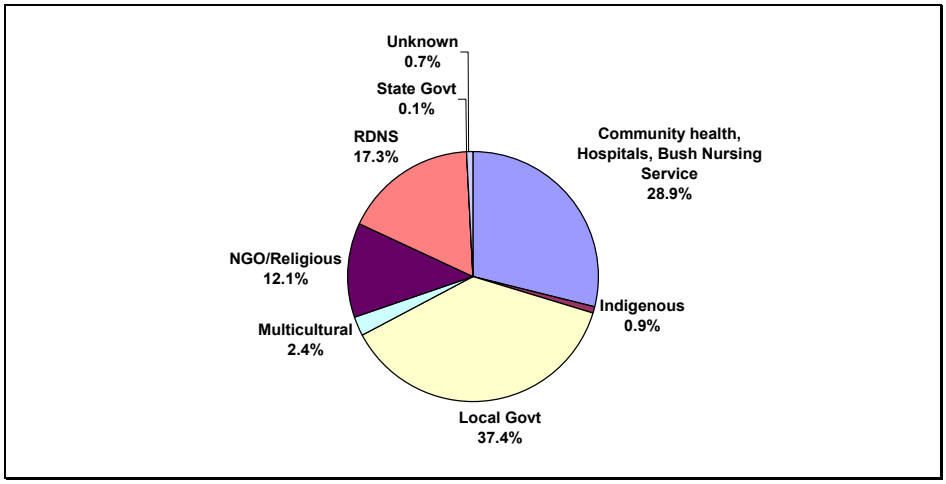

Figure 10: 2001-02 HACC funding levels by service provider type[24]

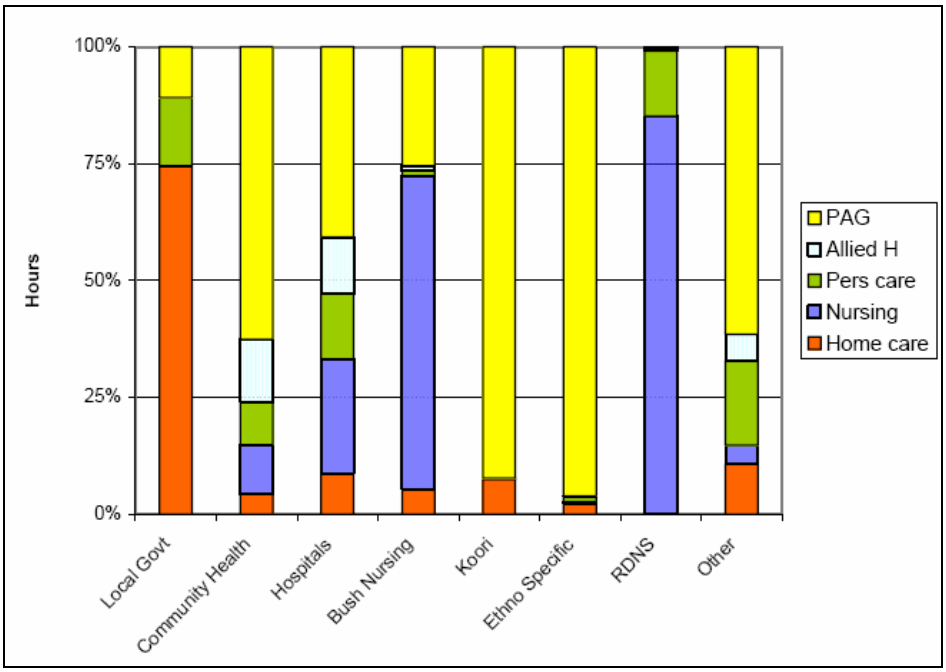

Figure 11: Hours by service type by agency category[25]

A salient feature of the provider landscape in community care in Victoria is that in each geographic region, the two largest categories of service (nursing and home care) are provided by a single provider: nursing by the Royal District Nursing Service or district nursing service, and home care by the local council or its agent.

Apart from these two major providers, where there is significant funding scale, the provider landscape in general is quite fragmented with many smaller agencies. The funding allocation

[24] *Home Care in Victoria,* Department of Human Services, 2001.

[25] Ibid.

approach in the CACP program further fragments service provision. In Victoria there are a total of 63 providers of CACP packages and 53 of these providers also receive funding from the HACC program to deliver services. It has been an explicit policy of the Commonwealth Government to limit the number of CACP packages allocated to individual providers. Most CACP providers have under 50 packages to deliver in total.

In the last decade there has been considerable anecdotal evidence of growth in the number of commercial operators moving into the provision of consumer purchased home care services for the elderly. One indicator of this trend has been the 160 per cent growth in the number of listings in the Yellow Pages in this category from 2000 to 2005. Some private providers also participate in early discharge or post-acute recovery services that are purchased by third party purchasers, including public and private hospitals, for specific patients.

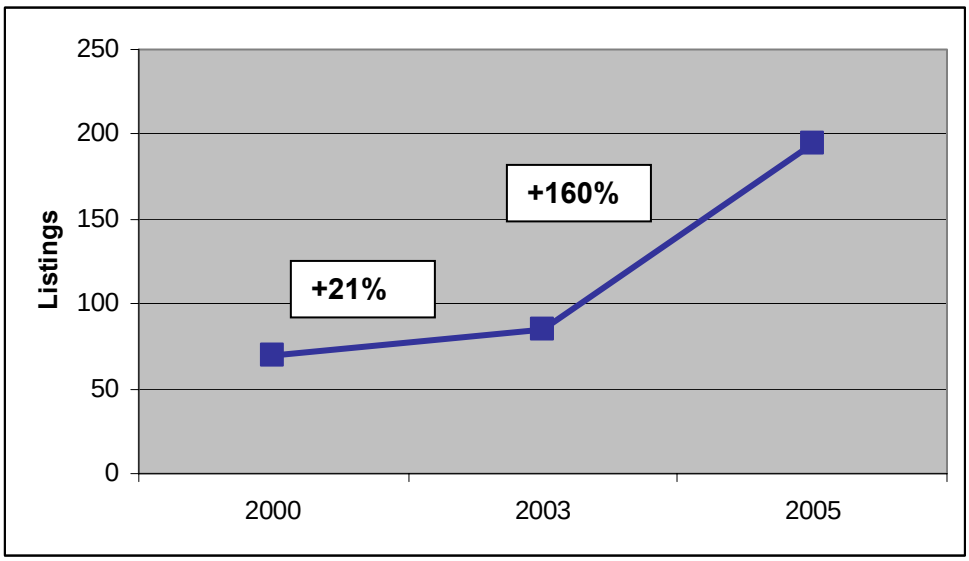

Figure 12: Melbourne Yellow Pages Listings-'Aged care services' category

5 Drivers of change

The community care sector meets the needs of many older people effectively. However, the service sector is not without limitations and pressures; nor in its current form is it likely to be able to meet the needs which will emerge over the next decade. There are several major factors currently driving or inhibiting change in community care that need to be considered in shaping policy and service responses.

The report identifies four major groups of influences. They are:

1. the evolution of community care
2. service-user needs and scale of demand
3. policy and program limits
4. sector development and capacity.

5.1 The evolution of community care

Internationally and nationally, governments and communities have long recognised the importance of community care for older people. The international focus is increasingly upon changes to meet rapidly increasing demand. This section identifies the key features of the Victorian and Australian community care system which will shape the future capacity and scope of services and the potential opportunities which could be drawn from international experience.

5.1.1 The sector's changing face

The community care sector has a long history of delivering services to vulnerable older people. It has also demonstrated ongoing ability to lead and respond to change. The sector powerfully reflects its history and the state and local circumstances in which it is provided. Its capacity for change will influence the shape, scope and pace of change.

Families have always been the cornerstone on which community care rests. While changes in family configuration, mobility and workforce have been and will continue to be significant in their impact on social organisation, families will remain at the heart of the community care system. The formal system of community organisations and local government has, for many years, been engaged in supporting and substituting for family and informal carers.

The following chart summarises the major stages of development of the formal community care service system from the late 19th century.

The Charitable Era	Building Local Responses	Government Engagement	The Program Stage	The Future
1880 - 1950	1950 - 1970	1970 – 1980s	1980s – 2000s	2006 and beyond
Charitable and other community agencies develop specific service responses	Progressive expansion of initiatives responding to local need and circumstances Pressure on government as demand grew	Introduction of targeted programs and expansion of residential care Creation of the HACC program in 1985 to integrate existing programs and provide national system of care at home	Expansion of Commonwealth targeted programs to complement HACC Emergent private sector contributors	National effort to review existing programs and arrangements Changing demand expectations

Figure 13: Major stages in the development of community care in Victoria

The foundations of the formal community care system were established many years ago. Some of the charitable and non-profit bodies which continue to provide community care in all jurisdictions were established in the late 1800s. The Royal District Nursing Services (RDNS) and its equivalents have evolved from the 1880s from a charity service for the poor into a comprehensive home health service. Other agencies, such as bush nursing services and many community health centres in Victoria, have also developed their service responses over a long period. Meals on Wheels Inc., a voluntary organisation, has been providing meals across South Australia for over 50 years.

Local government's long engagement in this area, most particularly in Victoria, is important in understanding the history of this sector and is relevant to contemporary policy discussion. Individual local government authorities, responding to the needs of their communities, began providing services from their own resources before state and Commonwealth subsidies and programs began. Local governments have also led the development of new services and approaches, invested resources and co-ordinated planning and service provision. In Victoria, local government's influence and major financial contribution has been fundamental to the capacity of the community care service system.

Into this context have come a range of government responses. Following World War II, a range of tightly defined programs funded by both Commonwealth and State Governments were established. These programs responded to claims by community and local government agencies that they were unable to meet demand.

Aged residential care has developed in parallel with the evolution of community care. This sector enjoyed rapid expansion in the 1970s and '80s in response to community demand. Aged Care Assessment Teams were established which continue to provide an important information, gate keeping and review function for residential care and, to some extent, to community care as well. While the sector continues to grow, concerns regarding both the desirability of existing approaches and the sustainability of the sector have been current for some years.

These concerns were, in part, responsible for the establishment of the Home and Community Care (HACC) Program in 1985/86. The HACC Program was designed to make more coherent the diverse range of small scale and tightly targeted community care programs for older people identified above. The legislation establishing the program provides for basic support and maintenance to people living at home whose capacity for independent living is at risk, or who are at risk of premature or inappropriate admission to long-term residential care. The HACC program also provides services to younger disabled people where their support needs are similar.

In the last 15 years, national aged-care policy and funding has bridged the separation of community care from residential care for older people through the development of a range of new and targeted programs. Key examples include Community Aged Care Packages (CACP), Extended Aged Care in the Home (EACH) and respite care programs. There are now some 30 different community care programs operating in Victoria.

The operation of the community care system has also been affected by the changing priorities and approach of the health care system. Long-term trends involving reducing hospital bed days, new technology and the use of primary care will continue to influence community care. State governments have begun to invest in early discharge and hospital care in the community with the Post Acute Care program in Victoria providing additional funding for short-term transitional services provided by consortia of health and community care providers. These new programs, including Victoria's Hospital Admission Risk Program (HARP), have only partially met the changed community service needs resulting from changes to health care practice.

In recent times a range of further developments have begun to shift and broaden the system's 'reason for being':

- continuing increases in demand due to demographic trends
- increasing recognition from users and policy-makers of the stand-alone importance of the community care system in its own right, rather than just an adjunct to the residential care system
- the emergence of concrete direction statements, such as the Ambulatory Care Framework, which orient the health sector squarely towards community-based responses to health needs wherever possible
- changing community expectations regarding care for older people which are likely to increase demand at the complex end of services, as people become less accepting of residential care services and exhibit a higher level of expectation regarding quality and service responsiveness
- small but growing interest from private providers interested in the sector in its own right and as part of a strategy to create opportunities for their residential care services (vertical integration). Private sector interest is built upon interest in accessing publicly funded service delivery and in meeting demand for privately funded service provision.

Community care is now poised to 'move to centre stage'. The forces for change described above position the sector for a new status as the lynchpin at the centre of the aged-care system and heighten the urgency of policy reform. This is recognised nationally through the attention being paid to community care specifically, and to aged-care policy in general. *The Way Forward: A New Strategy for Community Care* has articulated the need for change and canvassed options. The previous Federal Minister for Ageing Julie Bishop has been quoted:

- highlighting changing community demand for 'customised care'
- anticipating increased demand for consumer-directed care
- as proposing that funding follow the person (private and public)
- anticipating service provision by diverse providers.[26]

[26] Summary of Grattan, M, 'New System of Old Boomers, *The Age*, November 2, 2005 quoting from an article written by Minister Bishop in *The Party Room*.

5.1.2 International trends

Community care developments in other countries do not necessarily influence the shape or direction of the sector in Australia. However, opportunities for learning from the evolving approaches being adopted elsewhere should be captured. International approaches may have attractions for some stakeholders and are therefore likely to be influential.

As in Australia, there is broad interest in community care in developed countries.

> *'… the challenge facing long-term care services is "to reorganise and rationalise programs that have evolved in bits and pieces in order to support, both cost-effectively and qualitatively, the needs of growing numbers of older people, worldwide, who will live long lives with chronic illness or disability."*[27]

There are several key themes which deserve commentary and consideration as part of the development of community care in Australia over the next decade. These themes seem to cross cultural and structural differences internationally and are therefore likely to have implications in Australia. The themes are:

5.1.2.1 Expectations and demand

Community care is increasingly attractive to consumers and governments because it is a flexible approach, capable of adaptation to diverse needs, and has economic and social benefits when compared to long-stay hospital or residential care services.

Focus upon clear high-level outcomes and use these to drive service development and delivery.[28]

5.1.2.2 Policy settings

Capturing the benefits requires a focussed policy approach given the competing demands and imperatives of parallel service systems. This is particularly the case in Australia given the strong focus on institutional provision. The benefits of aged-care services are likely to be maximised if an integrated policy and service framework comprises:

- *Ageing in place* - This principle applies to the whole service system and not just to the management of residential aged care. The primary goal is for older people to remain in independent or supported accommodation for as long as possible while support and care services are progressively provided
- *A social model* - Aged care is a service which focuses upon supporting and assisting people to live independently and effectively in their community. It should not be conceptualised as a health service or an institutional response
- *An integrated service system* - This principle would involve the development of 'continuous care' arrangements supported by policy, program, funding and service system arrangements.[29]

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[27] Kane, R.A., Kane, R. L., & Ladd, R.C. (1998). *The Heart of Long-term Care*. New York: Oxford University Press, quoted in Supplement 2, September 2001 pp. 5- 4.

[28] *Independence, Well-being and Choice. Our Vision for the Future of Social Care for Adults in England,* Department of Health (UK) March 2005.

[29] See McCallum, J; Calder, R; Walsh, J; Moy, S; Adamzcuk, S,; Bye, R; and Nakamura, T 'Australian Aged Care & the New International Paradigm', *Australasian Journal on Ageing*, Volume 20.3 Supplement 2, September 2001 pp 5 -14.

Separation of care from accommodation in policy and practical terms. This structural shift would facilitate clearer choices regarding the most appropriate approach to supporting particular individuals.

5.1.2.3 Service systems

Service arrangements need to reflect:

- strong information systems which enable potential and current service users to maximise their knowledge and thus ability to express their priorities and maximise their independence
- cross-program planning at local level to ensure that a range of service options is available and that processes of meeting changing needs are in place
- consistent and accessible entry points which screen, assess and guide service users across service systems
- co-ordinated service level assessment and care needs planning.

Quality assurance systems which are:

- independent
- accessible
- capable of contributing to ongoing service improvement.[30]

Funding arrangements which:

- reflect the social compact that governments have a major role in supporting those in the community who need care as a result of illness or disability
- increasing expectations that older people continue to contribute to their housing-related costs
- attach funding entitlements to individuals rather than particular institutional types.

5.2 Demand and the requirements of different service user groups

The aged care and community care sectors exist to meet the needs of service users and carers. Ensuring that service users and carers are at the centre of both policy and service provision arrangements is critical. The next decade will bring with it major changes in the profile and expectations of users to which the service system will have to respond.

This report uses the words ‘service users’ sometimes alone and sometimes linked to carers. We do this as this is the common parlance. We believe, however, that it is important that in the future the common understanding is that the service user can include the individual with support needs and his or her informal carers-‘the care unit’. In order to ensure that this

[30] See for example *Home and Community-Based Services for Older People and Younger Adults with Physical Disabilities in Wisconsin – Final Report* prepared for the US Department of Health and Human Services Health Care Financing Administration, J Weiner; S Lutzky 2001

definition is given sufficient prominence this section deals with carers' needs both specifically and in general.

It is anticipated that existing capacity, policy and service responsiveness issues will become more problematic and new issues arising from the changing expectation will also become prominent over the next decade.

The changes anticipated in this section of the report will generate exciting opportunities and obligations which will reshape service provision and resourcing arrangements.

This section of the report provides an overview of:

- the likely trends in service user and carer expectations and needs
- demographic and other demand trends.

5.2.1 Changing expectations

There is clear national and international evidence of generational shifts in expectations. Authors and social researchers such as Hugh Mackay have chronicled the changing styles and expectations of the so called 'lucky generation', the 'baby boomers' and the 'options generation'.[31] The baby boomers have aged conscious of the fact that life expectancies continue to rise. Their lives are longer and different than previous generations. Also, their lifestyles, expectations and economic circumstances are significantly different.

While there are risks of over simplification, the baby boomers will expect more choice, autonomy and flexibility and have higher expectations regarding the quality of services provided. These expectations will inform their engagement in the following issues both for their parents and for themselves:

- planning for older age and declining health and functional ability
- decisions regarding service requirements and arrangements, including the range and type of services provided
- issues relating to the quality of service provided.

Baby boomers will become increasingly influential as they engage with their parents' needs and circumstances.

At the highest level of generality it can be anticipated that older people and their families will expect to 'age in place', although they may choose to change their place. The common goal will be to avoid institutional options for as long as possible and where institutional care is necessary to expect it to be as much like community living as possible.

The trend towards community care rather than low care residential care has been noted in various publications, as has the likelihood that this trend will continue.[32] Some commentaries see limitations in the longevity and scope of this trend. Apparent limits on the capacity of informal care and the increasing number of older people living alone would provide a natural limit to the growth in demand for community care.

It is unlikely that these limitations will be significant over the next decade. Furthermore, it is likely that the proactive adoption of responsibility to support the 'care unit' will significantly sustain the informal care capacity which may diminish under current program settings. This

[31] Mackay, H., *Generations: Baby Boomers, their parents & their children*. Macmillan 1997.

[32] *Economic Implications of an Ageing Australia*, Productivity Commission Research Report 2005, p. 179.

report is therefore highly optimistic that community care can grow considerably if supported with an effective policy, resource and service infrastructure.

Service user expectations will not be satisfied only by an extension of existing arrangements. Emerging users are likely to be more vigorous and assertive in articulating and guiding their service requirements. They are also likely to identify a more diverse range of services and service delivery arrangements than are commonly available under current arrangements. As with the rest of their lives, there will be an expectation of power and control rather than a recipient mentality. This will have profound effects on governments, program infrastructure and service providers.

5.2.2 Changing needs

Changing expectations will be accompanied by changing needs. This section of the report provides an overview of the needs-profile changes and identifies particular user groups whose needs deserve specific attention.

5.2.2.1 Increasing complexity

In the next ten years, increasing proportions of community care users will have complex and chronic health conditions. The drivers of this shift toward complexity include:

- Medical treatments and technology advances. Changing medical practices will contribute to longevity, survival after serious illness and with chronic conditions, and treatment in the community rather than hospital.
- Demographic trends with increasing numbers and proportions of very old people. The 'baby boom' in association with improved nutrition, changing work practices and significant advances in health care, contribute to a more complex demand pattern in the future. The increases in longevity are contributing to increasing numbers of older people with dementia. Many people with dementia have high and complex support needs.

It is likely that these trends will grow and align with community expectations, as outlined in Section 5.2.1 above, and with government policy.

An increasingly complex service-user profile will contribute to changes in the service system and in service provision. Key areas of impact will be upon:

- *Planning.* A greater proportion of older people with complex needs will generate a need to enhance planning, particularly at the local area level. Service providers within the aged-care sector will need more collaborative arrangements, capacity to adapt to changing requirements and ability to engage with a diverse range of health and other community service providers.
- *Assessment and care co-ordination*. More detailed assessment and ongoing care co-ordination will be required to ensure that services effectively meet the needs of service users and their carers with complex health and care needs. The increased demands on assessment will arise at the point of eligibility and throughout the period of care, as there will be an increased likelihood of change to which services will have to respond.
- *Adaptability.* Service users and carers with complex conditions are likely to need community care services able to respond rapidly to changing circumstances. This can mean rapid response to particular events and more frequent changes in service configuration and mix.
- *Workforce demands*. Staff involved in provision of community care to an increasingly complex service user group will need higher and more complex skills.

5.2.3 Issues for culturally and linguistically diverse (CALD) users

Australia celebrates its multicultural status and enjoys the benefits which immigration has brought. An increasing number of people who contribute to the strength of our multicultural community will be moving into older age over the next decade.

Australian Institute of Health and Welfare (AIHW) projections suggest that by 2011, 30.8 per cent of all older people will be from CALD backgrounds, up from 23.1 per cent in 1996.[33] In Melbourne, the proportion will be 38 per cent in 2011.[34] People of Italian, Greek and German descent will be the largest groups in this cohort.

There is evidence that people from these backgrounds have a stronger than average preference for community care above residential care.[35] English language proficiency is a issue in older people's capacity to access and manage support services. As the Victorian Government's submission to the Productivity Commission's report on the economic implications of an ageing Australia, explains:

> *"Linguistic and cultural barriers may reduce the access of people from diverse backgrounds to government programs and services, including health and aged care services, life-long learning, public transport and cultural activities.*
>
> *"Linguistic barriers are particularly challenging as CALD seniors may never become fluent in English, or may revert back to their first language as they age. The risk of isolation is compounded for those CALD seniors separated from their families overseas and with limited community networks to meet their care needs and support their ongoing involvement in the community.*
>
> *"Responding to these challenges and providing effective access to services for these communities as they age will require the provision of information and service delivery models sensitive and appropriate to the language and cultural backgrounds of various groups. It may be necessary, for example, to use bilingual employees in key service delivery activities such as health and aged care. Support of this nature will increase the average unit cost of providing a given service and place further fiscal pressure on government as the CALD population ages."*[36]

Significant investments by government and community organisations have been made in recent years to ensure that cultural issues are dealt with effectively in community care service provision.[37] There are a considerable number of culturally-specific services funded through the HACC program and service provider agencies have worked hard to recruit multilingual staff. This provides a base upon which continuing efforts can be made to ensure responsiveness to the needs of older people from diverse backgrounds.

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[33] Gibson, D et al,. *Projections of Older Immigrants,* Australian Institute of Health and Welfare, 2001.

[34] Victorian Government submission to the Productivity Commission's report, *The Economic Implications of an Ageing Australia,* November 2004, Page 6

[35] Gibson, D. & Griew, R. *New Approaches and Models of Care,* Myer Foundation—A Vision for Aged Care 2020, 2002.

[36] Victorian Government submission to the Productivity Commission's report, *The Economic Implications of an Ageing Australia,* November 2004, Page 27

[37] Home and Community Care Program Culturally Equitable Gateways Strategy DHS 2004.

Community care, like many social programs, faces the challenge of ensuring that so-called mainstream programs are culturally appropriate and responsive, and that there are an appropriate number and range of culturally specific services.

5.2.4 Issues for indigenous users

The age structure in the indigenous population is very different to the non-indigenous population, with significantly smaller cohorts of people over 65 due to shorter average life span. In 2001, only 2.8 per cent of the indigenous population was over 65. Aboriginal people experience the onset of chronic and complex conditions requiring care at earlier ages than the average for the community. They also utilise residential aged care and CACP packages at a higher rate than the community average.

Many older indigenous people face barriers to accessing community, aged and other health care services. Notwithstanding investments by all jurisdictions in recent years indigenous-specific services face high levels of demand and limited resources. In some areas mainstream service providers lack the level of cultural sensitivity and responsiveness required to ensure that indigenous people are comfortable. These limitations in the formal service system place increased pressure on family and community carers often when these carers face significant challenges in daily life.

5.2.5 Issues for rural users

Rural communities are diverse and differ from area to area. While overall population levels remain relatively stable, there are changes both in demographic profile and locational choices which are important in the development of community care over the next decade.

Some 28 per cent of Victorians live in rural areas. Overall population trends in regional Victoria are upwards, with a one per cent growth rate in 2004-05 which is similar to that in metropolitan Melbourne.[38] However, with this overall growth many regions are experiencing a steady build-up of population in regional centres and coastal areas and a movement away from smaller towns and rural districts. A high proportion of the population remaining in smaller towns and rural districts is often aged over 65, with care needs now or highly likely to emerge over the next decade.

For the most part these users share the same concerns regarding the problems of the system as their counterparts in cities. For users in some rural areas, the issues regarding navigation difficulties and lack of choice and flexibility in care arrangements are especially marked because of remoteness. Adjusting funding formulas to ensure the higher cost of transport in rural areas is covered was frequently raised in consultations of stakeholders conducted for this project. There are also likely to be greater pressures on the availability and capacity of informal carers in some rural areas.

The changing profile of rural areas is likely to pose different challenges in different areas. Areas where population growth is occurring, particularly where that growth includes a substantial proportion of older people (e.g. coastal areas), will face demand and capacity questions. Areas where there is population decline or concentration in provincial cities will face issues regarding service models and costs which derive from diseconomies of scale and distance.

[38] Brook, C, 'Policy and Pragmatism in Action: Victoria's Primary Care Partnerships', *Spotlight on Spring Street Paper*, Institute of Public Administration Australia in Victoria, October 2005.

Options being explored in these areas include the collaborative management of community care services across a group of smaller rural councils in order to pool resources and achieve operating scale efficiencies.

5.2.6 Issues for users with mental illness

Many elderly people with mental illnesses, who in the past lived in institutions with care services on site, now reside in the community. As they age, their support needs must now be met by the community care system. Because of the nature of their conditions they often have very difficult relationships with their families and so are less likely to have access to support from informal carers as they age. This means they have a particular need for the support from formal care providers. It is critical that the community care system develops the processes and skills required to be prepared to assist and support the mentally ill as they age.

5.2.7 Issues in relation to palliative care

The community care system will also need to play its part in ensuring that older people who are dying do so with minimum pain and with support for the dying person and their family and friends. At any one time 60,000 people in Australia are living with a life threatening illness that will shorten and reduce their quality of life.[39] Palliative care is "an approach that improves quality of life of patients and their families facing problems associated with life threatening illness through the prevention of suffering, by early identification and impeccable assessment and treatment of pain and other problems, physical, psychological and spiritual."[40]

50 percent of all deaths in Victoria (16,684 in 2003) had a palliative care diagnosis. Of these, 32 percent had an admission to a community palliative care service. It is projected that the demand for palliative care services will grow by an average rate of three percent per annum until 2016.[41]

As the demand for palliative care services increases over the next 10 years, the need for linkages between the health care, community care, and aged care sectors is becoming increasingly important in ensuring an adequate response to people who are dying.

In the area of primary health care, there are three areas which require attention over the next decade:

1. the provision of psycho-emotional social and family support and care;
2. appropriate assessment and control of pain and symptoms
3. assessment and referral to specialist services when need exceeds capacity of primary care services.

In residential aged care facilities, the need for a palliative care approach increasingly needs to be recognised.

The palliative care education and training of generalist health care and aged care staff will become paramount if the needs of the aging population are to be properly met. The specialist palliative care sector will need to be expanded to ensure it has the capacity to develop and provide a specialist liaison service including education and training in palliative care and the palliative care approach.

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[39] Palliative Care Victoria

[40] World Health Organisation definition (www.who.int)

[41] Department of Human Services (Victoria) 2006. www.health.vic.gov.au/palliativecare

5.2.8 Issues for older people with a disability

People who have life long or acquired intellectual, physical, sensory or psychiatric disability and who are ageing are another group that requires major policy attention. The particular needs of this group requires a more integrated approach between disability and aged service programs. Collaboration and service planning across the two service streams and recognition of the special needs of this group are required. There are a unique set of clinical, service delivery and funding challenges that need to be addressed.

The focus of this report is on people aged 65 years and above. There are a growing number of people with a disability who are ageing and face issues which are distinct to those whose disabilities occur after they are 65. A thorough examination of the issues faced by these groups and the policy options for addressing them is a major issue that needs to be addressed in a more comprehensive manner. While not within the scope of this report, a focus on these issues should be a priority for future research, policy development and Government attention.

Appendix 2 summarises some of the issues that need to be addressed. This material is extracted from a report prepared by Dr Chris Fyffe for VICRAID, the peak agency representing disability accommodation support organisations, and ACROD, the national industry association for disability services. This report reflects the views of VICRAID and ACROD about the issues the Victorian Government needs to consider in addressing this policy area. There are a number of major policy issues that need to be addressed in regard to the policy framework that should be adopted in regard to people with a disability who are aging.

The Victorian Community Care Coalition recognises this as a matter of high priority which requires further research and policy discussion.

5.2.9 Carers' issues

This report gives high priority to the issue of carers' capacity and support needs. It does so because of the centrality of carers to the outcomes for the frail aged and to the nature of the formal community care system that is required. If community care is to continue to play a vital role in older people's lives, the support needs of carers will need to be addressed.

A number of reports addressing the economic and social implications of an ageing demographic profile in Australia have addressed the issue of informal carers. In overview, the summary seems to be:

> *'… there is unlikely to be a significant shortage in the number of informal carers in the period 2003 to 2013 … However, Australia's population will 'age' significantly after 2013, and the supply of carers may not keep pace with increasing numbers of the elderly.'*[42]

This raises a number of questions for the community care sector over the next decade. In the first instance, it is important to be confident that the short-term analysis is accurate and, because of its generality, does not disguise important issues.

The Australian Institute of Health and Welfare analysis recognises that there will be growth in the number of carers in coming years, but also identifies that the growth in persons over 65 years of age with a severe or profound disability will be much greater. The following graph demonstrates the shifting balance.

[42] *Economic Implications of an Ageing Australia*, Productivity Commission Research Report 2005, p 180.

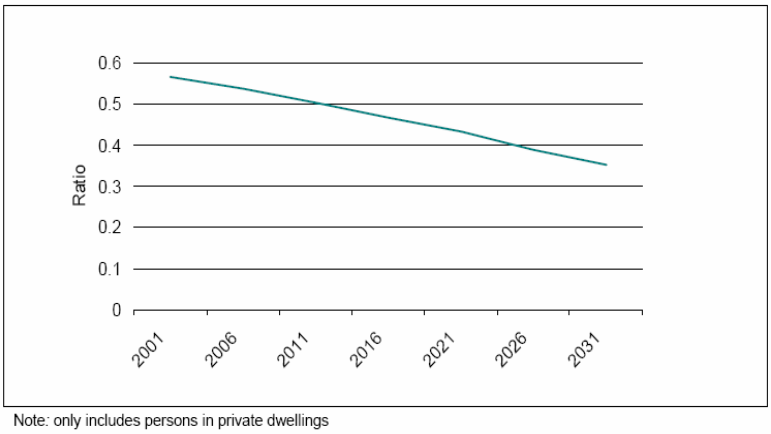


Figure 14: Projected ratio of carers to persons aged 65 and over with a severe or profound disability and living in private dwellings, Australia 2001-2031[43]

While the overall analysis suggesting no care shortage in the next decade may be sound, the decline in the carer ratio illustrated in figure 14 above is a signal, or an early warning. This warning is compounded by analysis which highlights a shift in the circumstances of older people with a profound or severe disability. There is a steady shift in the mix of people living in private dwellings with a primary carer and those without, as outlined below in figure 15.

	2001	2006	2011	2016	2021	2026	2031
	%	%	%	%	%	%	%
In community with a primary carer	57	54	50	47	43	39	35
In community without a primary carer	43	46	50	53	57	61	65

Figure 15: Projected caring circumstances of persons aged 65 and over with a profound or severe disability, Australia 2001-2031-private dwellings[44]

The above analyses are, necessarily, done on a 'policy neutral' basis. Policy and service delivery responses are, however, possible and necessary. They should focus upon:

- actions which might slow the decline in the carer ratio
- actions which are designed to ensure that both carer support services and service user services are increasingly capable of meeting the needs of older people living in the community without a primary carer.

If the growth in the supply of carers were to fall at a more rapid rate than expected, there would be significant financial consequences for government. Figure 16 presents the expected growth in the next decade.

[43] NATSEM, *Who's Going to Care?* Report for Carers Australia, 2004.

[44] Ibid.

2001	2006	2011	2016
198,000	215,000	235,000	260,000

Figure 16: Projected growth in the number of primary carers of people 65 and over-Australia-wide (2001-2016)[45]

A range of factors may reduce the growth in the supply of informal care over the next decade:

1. slowing of the growth of the primary care giving age group (women aged 50-64)
2. increased rates of relationship breakdown-more people living alone as they age
3. increased female labour force participation rates-less capacity to provide care
4. smaller families and increased childlessness-less children to provide care
5. greater mobility and dispersal of families-less capacity for family members to provide care
6. inter-generational propensities to care-less inclination to provide care from younger age groups
7. higher prevalence of chronic illness and associated disability among older age groups-less capacity to provide care.

However, there are reasons for caution regarding projections of a fall in the supply of informal care over the next decade:

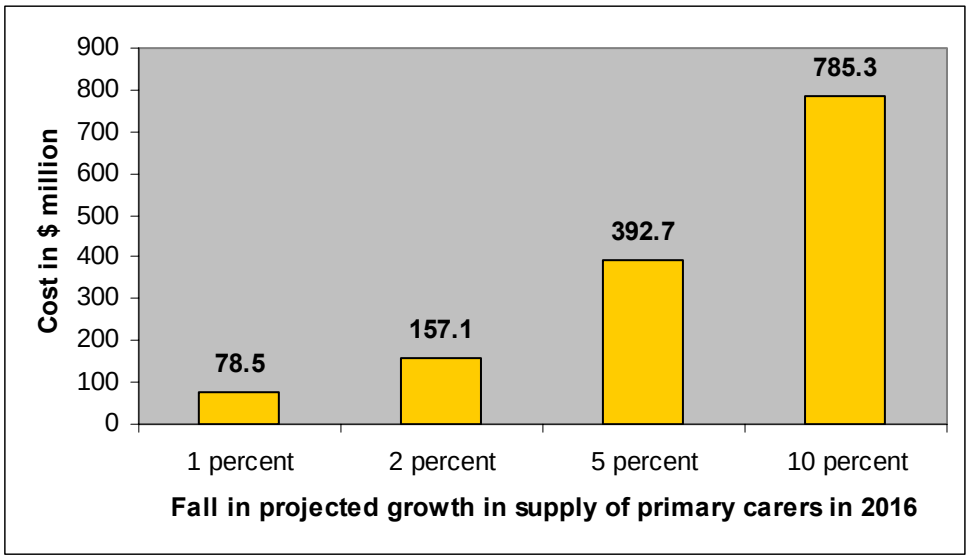
1. The absence of evidence of a reduction in the growth of supply of informal carers during past decade, when many of the factors outlined above have been prevalent
2. Uncertainty over the extent to which the impact of the relative decline in the number of the traditional carer groups (e.g. daughters aged 50-64 and spouses) will be neutralised by other categories of people taking on carers' responsibilities. For example, the Australian Institute of Health and Welfare has reported that the retirement of the baby boomer generation over the next decade may provide a boost to numbers of informal carers.[46]
3. The view from sources such as the Productivity Commission that the greatest impact of the demographic factors outlined above will be in the period after 2016.

For these reasons, chart 1 below illustrates the cost-impact of relatively small reductions in the growth of informal care over the coming decade: 1, 2, 5 and 10 per cent falls over the total period.

[45] Source: NATSEM, Who's Going to Care? Report for Carers Australia, 2004

[46] AIHW, *Carers in Australia,* Canberra, 1999. Page xiii-xiv

Chart 1: Additional cost burden on the formal care system Australia-wide if the supply of primary carers for the over-65s is 1, 2, 5 or 10% lower than projected in 2016[47]



The key assumptions underlying the estimates above are:

1. Access Economics' methodology for costing the replacement value of informal care is used.[48]
   a. $25.01 per hour is the cost to replace an hour of informal care with an hour from the formal care system
   b. 49 per cent of primary carers care for clients with mild/moderate disability and average 10 hours of care per week
   c. 35 per cent of primary carers care for clients with severe disability and average 29.5 hours of care per week
   d. 16 per cent of primary carers care for clients with profound disability and average 50 hours of care per week
2. Care needs are met by the community care system rather than the residential care system.

As figure 17 below illustrates, these relatively small reductions in the supply of carers are clearly very significant when compared to the overall funding level of the community care system in a decade's time.

[47] Nous Group estimates based on NATSEM and Access Economic costing of the replacement value of informal care.

[48] *The Economic Value of Informal Care,* Report by Access Economics for Carers Australia, 2005.The replacement value of $25.01 per hour includes a base wage of $18.05 per hour plus loadings for capital costs, supervision and administration, and on-costs such as superannuation and payroll tax.

	1 % fall	2 % fall	5 % fall	10 % fall
Fall as a percentage of national HACC and CACP budgets in 2016[49]	**2.6 %**	**5.2 %**	**13.1 %**	**26.2 %**

Figure 17: Replacement cost of reductions in number of informal carers in 2016

5.2.10 Unmet demand

There is a strong and widely held view among service providers and local government that there is significant unmet demand for community care in Victoria. This view is supported by anecdotal accounts describing:

- individual clients in certain areas who are unable to access adequate levels of services
- high stress levels among informal carers who are unable to access sufficient support services
- the inadequate coverage and restrictive terms of certain types of care packages which are argued to be insufficiently funded to cover the cost of services sufficient to meet clients' assessed need.

While there is clear anecdotal evidence supporting the view that there is currently significant unmet demand, there is also some indirect evidence to the contrary. In human service systems, which are akin to community care, the stretching of service capacity typically leads to the emergence of indicators of institutional stress. Examples might include tragic cases of client or patient neglect as a result of insufficient resourcing at a hospital, or a breakdown in the communications infrastructure at an ambulance service due to insufficient investment over time.

In reviewing developments in the community care sector in the last five years it is difficult to identify any pattern of sustained institutional stress reflecting the service system's inability to meet demand. It should be recognised that this relative lack of any systemic pattern of stress may also reflect the fact that the bulk of community care provision is intended to sustain service users' independence. For such service users, an alternative systemic pattern of stress might instead emerge as earlier entry into higher-need services. However, no data exists currently upon which to base an objective and quantifiable assessment of existing unmet demand.

Service providers consulted on this project use a range of techniques to manage demand, including:

- rationing services to give something to every eligible person
- establishing waiting lists
- excluding low-needs service users in favour of high-needs service users

[49] *The forecast combined national HACC and CACP budget in 2016 for the purposes of this table is $3 billion. For more detailed analysis on this forecast see Section 4.4 below.

- referring potential service users to other providers/program.

Queuing is a normal and, up to a point, effective manner to ration scarce goods where price mechanisms are inadequate and or inappropriate. Market pricing mechanisms are not appropriate in this system and queuing is therefore a key feature of service system management. The presence of queues in this service system is not of itself a demonstration of unmet demand.

In sum, the absence of systemic data on this issue means that this report cannot make a precise calculation of the extent of current unmet demand for community care services in Victoria.

5.2.11 Funding growth

Multiple factors will impact upon the growth in funding required for community care for older people. The most powerful driver will be the growth in the 65-plus age group, which will generate an estimated increase in demand of 3.2 per cent per year for the next ten years.[50]

Five other factors are also likely to be influential. They are:

1. disability rate changes, potentially upwards given increasing chronic disease and obesity related disorders
2. increasing complexity of care as the proportion of older old people grows
3. rising labour costs
4. changes in health care practice
5. changing residential care demand.

Overall, this report forecasts that the annual community care budget in 2015 will be 143% higher than in 2005. (See Section 4 for more detail.)

5.3 Policy and program limits

Service users and carers able to make and fully fund their own arrangements are rare in the system at present. The age pension or equivalent is the principal source of income for around 75% of people over 65.[51] Compulsory superannuation contributions were first introduced in 1992 so few retirees in the next decade will have significant retirement savings accumulated. Although the strong economic conditions of the past decade are likely to mean that a greater number of older people, their families and possibly their health insurers will have a capacity and inclination to meet care costs, most older people and their carers will continue to depend upon a publicly authorised and supported service system. Ensuring the design and implementation arrangements appropriately meet the needs of older people and their carers is a central focus of this report.

Existing arrangements deliver in a satisfactory way to many people. However, changes are now required and many of these will become more critical over the next decade. This section highlights issues in four critical aspects of the service system. The elements are:

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[50] Nous projection based on ABS Population Projections; 2002-2101, (2003).

[51] Department of Family and Community Services, Fact Sheet No.3, *Income Support Recipients June 1998*, 1999

1. program complexity, rigidity and inflexibility
2. funding levels
3. planning
4. shifting ground–program linkages.

5.3.1 Program complexity, rigidity and inflexibility

Because each of the current programs have been developed individually to address specific needs, in total they are complex, rigid and inflexible. The complexity, rigidity and inflexibility of community care program structures is highlighted by:

- the Australian government in *The Way Forward: A New Strategy for Community Care*, which lists 17 discrete community care programs which it funds[52]
- the Victorian Departmental Advisory Committee on the Home and Community Care Program which in a recent document listed some 30 programs (funded by various levels of government) that are designed to meet the needs of people with functional disabilities (community care, equivalents and support programs)[53]
- most documents relating to the HACC program identifying between 13 and 21 different types of service. Commonly, each service type attracts its own funding and performance requirements. Services funded through HACC (e.g. respite) are also funded through other programs and services
- service providers being held accountable through various unit cost and service activity arrangements rather than outcomes.

These program arrangements:

- do not reflect diverse policy intentions. Most of the programs seek to contribute to the achievement of the same high-level goals, although some have very wide ranging mandates (HACC) while others are very specific (National Continence Management Strategy)
- have not been created to reflect a balanced investment across the outcomes sought or the interventions likely to achieve those policy outcomes. The investment mix:
  - results from an incremental reform process, introduces specific requirements and cannot be articulated with the development of the HACC Program to generate an optimal investment mix
  - inadequately addresses the health promotion and early intervention opportunities that exist and which can be tackled, in part, through community care related interventions and which would avoid or delay movement to more expensive service options
- have limited capacity to provide flexibility and choice to service users-there are few choices possible in the system and little information on which service users can rely
- do not reflect a commitment to creating a market of providers, although that appears to be one of the consequences. The market being created, however, appears neither robust nor well targeted as there are examples of providers in a local area not knowing who is funded through another program and therefore having no collaborative or referral capacity.

[52] *The Way Forward: A New Strategy for Community Care*, Australian Government, 2004. p. 45.

[53] Response to issues raised by the Commonwealth's Community Care Review. Victorian Departmental Advisory Committee on the Home and Community Care Program October 2003, p. 42.

These program arrangements have emerged over a period of years and reflect incremental reform rather than coherent and strategic approaches. The arrangements reflect:

- progressive efforts by the Australian government to broaden its investments, largely to divert older people from residential care.
- an apparent lack of confidence in the capacity of the HACC program, which was originally created as an integrated platform to overcome the problems created by a diverse range of specific programs. Whether this lack of confidence stems from problems in joint Commonwealth/state initiatives or the nature of the legislation underpinning HACC (or both) is not clear. The creation of aged-care specific programs avoids the risk that funds will be used/diverted to meet the broader HACC goals relating to younger disabled people. The creation of Commonwealth-only programs also avoids tensions with states and territories regarding targeting and accountability processes, and enables the Commonwealth to engage with service providers of choice.
- a structure which enables program-related rationing rather than a broad platform which risks broadening and deepening demand.

Packaged care arrangements, comprising Linkages or Community Options Packages in HACC and CACP and EACH as residential care alternatives funded by the Australian governments, have been introduced, in part, in order to increase flexibility and responsiveness. However, some advocates argue that for the most part users feel they hold relatively little control over their community care arrangements. This relative lack of control is driven by:

- low funding received by the sector, making it difficult to respond to individual requirements
- lack of capacity and/or willingness from service providers to provide flexibility
- program complexity and gaps.
- Initiatives such as the creation of the Carers' Information and Support Program and respite services have provided much needed services and given profile and momentum to these service types. Specifically targeted programs play an important role in these circumstances. The question for the long term is whether specific programs become a limiting rather than driving force on the development of the service system.

Commonwealth-State-Local government relationships

As identified above, one of the program difficulties which confronts the community care sector relates to the roles of the Australian government and the states and territories in policy, program management and funding. Community care, like a range of other health, community service and welfare programs, suffers from structural and priority differences between jurisdictions.

In the case of community care, the intergovernmental issues relate to:

- overlapping but differing priorities regarding services for older people
- inconsistencies between programs for the aged and for people with disabilities
- differing priorities regarding establishment of integrated arrangements for older people and younger disabled individuals
- duplicating involvement in program management

These differences were considered by Heads of Government through the work of the Council of Australian Governments.

5.3.2 Funding arrangements

The funding decisions facing policymakers in the Federal and State governments fall into three categories:

1. *Overall funding level* - Quantum and benchmarks for determining adequacy
2. *Allocation mechanism* for that funding to states and to local areas, and to different levels of need
3. *Payment mechanism* for that allocation to service providers, including accountability arrangements.

Issues in relation to 'Category 1 - Overall funding level' are discussed in section 6. Categories 2 and 3 are discussed here.

Allocation mechanism

At present, the prevailing structure for determining the allocation and payment mechanism in community care in Victoria is the program. Funds are currently allocated into programs and then, in most cases, across regional areas according to a range of different criteria and objectives. Some program allocations in Victoria are managed by the federal government (e.g. CACPs) and others are managed by the State Government (e.g. HACC). All allocations are capped to ensure government budget control.

The range of allocation approaches across different programs leads to considerable difficulties in applying consistent eligibility criteria and being able to focus investment on particular types of need. For example, local governments and RDNS receive considerable funding allocations from the HACC program and have significant leeway in the way they invest these funds in services and for whom they deliver services. But they are required to make their decisions without precise information about the federal government's allocations of CACP packages in the areas in which they operate. The lack of a coordinated approach to the allocation of funds for community care services means that the outcomes for different users with similar needs are not necessarily consistent.

From the service users' perspective, the varying allocation mechanisms means there can be confusion and discontinuities when their needs change and they move from services funded by one program to services funded by another.

Payment mechanism

Across different programs, different payment mechanisms for providers prevail. In the CACP program, providers bid for specific quantities of packages in particular areas. CACP providers are then accountable to the federal government for delivering on the service outputs in the service plan agreed for the clients they are allocated. Under HACC, there are a variety of approaches to provider payments. Approximately 40 per cent of the program's funds are allocated to local governments, which then take responsibility for delivering an agreed amount of service outputs (i.e. number of hours of home care or meals provided). Some local governments manage all service provision internally. Others tender out various service types to third parties. Other HACC funds are paid to RDNS and Bush Nursing Services which then

report to the state government on performance in delivering an agreed volume of hours of nursing to clients in their target areas.

The smaller programs incorporate other payment structures but, in general, most funds are paid directly to providers who then report on their performance in terms of the volume of outputs they delivered with their funding.

While these payment approaches do result in highly satisfactory services for many users, there are an array of problems with them:

1. **Value of packages not keeping-up with provider costs**
   Feedback from service providers suggests that the current arrangements in the packaged programs (CACP, EACH, Linkages) do not adequately keep track of rising costs for providers. There are also problems flowing from the lack of provision for funding of case management, a critical service for some users.
2. **Imprecise targeting outcomes**
   Feedback from service providers suggests that the HACC program is being used to top-up the service level of users whose needs cannot be fully met under other programs. Providers funded under the HACC program provide services to the level of around $1,100 per year to the average user. However, HACC also funds services to a small number of single users above $40,000 per year. There are no clear criteria defining which users are eligible for high values of HACC services. Judgements need to be made by local government and other service providers. These outcomes illustrate how the current payment arrangements, especially in regard to HACC, make precise targeting of funding to need level difficult.
3. **Lack of benchmarking of providers to encourage continuous improvement in operating efficiency**
   The current funding arrangements do not feature a systematic means by which providers' performance can be assessed relative to their peers in different jurisdictions.
4. **Accountability is tied to activities rather than outcomes**
   Current accountability arrangements for funded agencies mainly focus on activities they have *performed* rather than outcomes they have *achieved*. This approach means that providers face an incentive to manage their operations to deliver a target level of outputs (i.e. number of hours/meals/services provided) at a particular cost, rather than doing whatever is required in the specific circumstances of particular users and their carers, given the resources available, to ensure that the target outcomes are achieved (i.e. improved well being and independence for clients). If service providers were made accountable for the outcomes their services achieved, they would focus more clearly on responding to user and carer needs. This new outcomes-focus would create an incentive for greater innovation in service design and ideally facilitate more flexibility in service planning.
5. **Inadequate alignment with the acute system**
   Present funding arrangements mean that client transitions between hospitals and the community care system are not optimal. Some specific programs, such as the Post Acute Care program, directly address the problems which arise here. But the different funding and payment approaches between the two systems make the client experience and provider relationships harder than they should be.

5.3.3 Planning

Planning is a process which needs to be closely linked to the purposes for which it is being done. Central planning is desirable in some domains. Local planning is fundamental in others. Current planning arrangements for community care are duplicated and centralised and this mismatches with the requirements of service users.

Effective planning arrangements contribute to:

- mechanisms for providing and sharing critical data about the community and service needs
- decisions regarding resource allocation and management
- clarity regarding the scope and opportunities for service providers
- development of robust and well connected service systems
- organised mechanisms for reform and redevelopment
- development of means to address system failure.

Current community-care planning arrangements reflect the history of the sector and the approach common to many health and community service domains. Existing planning arrangements are inadequate because:

- Government planning focuses upon programs and outputs. Boundaries are created by program definition rather than population need. This fragmentation of planning limits the capacity of stakeholders to address the needs of older people in a consistent and integrated manner. This matters a lot when there are numerous community care programs and even more when there are a much larger number of residential care, ambulatory care, primary care and other health services needing to operate as part of a service system but planned for separately and largely centrally.
- Large programs also generate multiple levels of planning. While largely necessary there are complexities and a relatively high level of central prescription which limits the scope, content and connection of service system development.
- There is insufficient cross-jurisdictional collaboration and a misalignment of roles. There is too much reliance upon relatively closed processes which are also program-centric, rather than need- and community-capacity focused.
- Planning has been heavily focused upon system requirements and service provider needs, with limited, if any, substantive input from current or potential service users and carers. There has been little intersection between government and individual planning processes.
- Insufficient attention is paid to planning at an area level. Most planning occurs at central levels in the federal, state and territory governments. Such planning makes important but inadequate contributions to converting policy into practice. It cannot access or respond to the diverse range of information and influence available at lower levels directly connected to communities and service systems.
- The structural arrangements established by governments have also discouraged development of open and engaged planning between service providers. While there are numerous examples of strong and well-planned joint work, protocols for referral and service provision are not as well developed or as comprehensive as is desirable because the incentives do not encourage this style of management.

The problems with planning arising from government's involvement in aged and community care will be compounded over time by other factors. Changing community expectations regarding personal engagement in decisions regarding service provision choices will also influence the way that service providers and governments plan.

There is increasing recognition that the 'silos' of government programs are problematic. Community concerns regarding the rigidity and lack of responsiveness of many services are increasingly influential, as are the claims of providers that centrally driven and prescriptive program outputs diminish their capacity to deliver effectively and efficiently. The effectiveness of new approaches will depend upon government leadership and sectoral advocacy for change.

5.3.4 Shifting ground-program linkages

Community care sits at the centre of multiple service systems. People, particularly older people, have always been discharged from hospital with the need for care and support during their rehabilitation. Increasingly, individuals and the health system are finding ways to avoid admission in the first place, although this can increase the care and support burden for people with illnesses who remain in the community. Many older people strive long and hard to delay or avoid admission to a residential care facility. For some older people, housing options rather than health or functional disability are critical to their decisions regarding service provision. These roles are central to the reason that community care exists.

Consequently, community care has the capacity to leverage, integrate and strengthen the impact of these services and the policies which drive them. Planned and anticipated changes in the health, community services and aged care programs have widespread implications for the ongoing development of community care. Moving community care to 'centre stage' is important in its own right and fundamental to broader social and policy goals.

Residential aged care

Residential aged care has been the focus of considerable government and external scrutiny in recent years.[54] Much of the attention has been informed by, if not driven by, the view that existing arrangements are not financially sustainable in the long term. Options for managing this situation (accepting that it is an accurate assessment) focus upon:

- shifting the cost burden to service users
- generating productivity improvements
- shifting policy in ways which will contribute to cost reductions.

Shifting costs to service users of residential care will, in the longer term, make a difference to the public costs as will any productivity improvements that can be achieved. The major implication for community care is in policy shifts at the interface between residential and community care.

[54] Key examples include: the Hogan, W., *Review of Pricing Arrangements in Residential Aged Care*, Department of Health and Ageing, 2004 and *A Vision for Aged Care in Australia 2020* commissioned by the Myer Foundation in 2003.

The residential and community care interface has been changing in recent years as a result of progressive reduction in residential care ratios and the introduction of community care alternatives and substitutes. This has seen the benchmark ratio drop from 110 places per 1000 people aged 70-plus to 83 places per 1000 people aged 70-plus. Australia's demographic profile and the associated impacts of dementia will ensure that aged residential care remains a vital service system over the next decade. These factors will offset declining community demand.

Government policy is likely to focus upon reducing demand and capacity at the low care end of the residential aged-care system. This focus will be consistent with community expectations. It is also anticipated that many families with complex needs will seek to use community care and to delay, as long as possible, admission to a residential care placement. Residential care providers are also discussing possible changes which would see this service used more extensively for respite and short-term care.

Health care

Changes in health care practice continue to be major factors in the development of community care. Increased provision of acute care in community settings will be one of the most important drivers of community care demand and service provision over the next decade.

Older people make up approximately 46 per cent of hospital bed days (but only 9 per cent of the population) and are substantial users of general practice and allied health services. Changes in this sector have major implications for family and formal community care arrangements.[55]

In broad terms, constraints on the number of general practitioners have important impacts upon particular geographic areas where recruitment is difficult, rather than affecting all older people. There are, however, significant numbers of older people in rural and remote areas where there are far fewer GPs per capita compared to urban areas.

Significant overall reductions in average length of stay in public hospitals (average stays have dropped from 6.9 days in 1985-86 to 3.8 days in 2001-02)[56] have impacted upon older people, whose typical multiple, chronic conditions and slower recovery rates are not well suited to the style of operation now essential in hospitals. Additional factors driving change are:

- the realisation that hospitals are not good places for older people to be. Functional decline in older people's ability commences rapidly because of the circumstances which surround hospitalisation
- the knowledge that there are a significant number of unnecessary and avoidable hospital admissions for older people. A study which overviewed the Australian research on this issue suggests that: 'people 65 and older are about 12 per cent of the population and account for 44 per cent of avoidable admissions'[57]
- medical and pharmaceutical technology is changing the way health care is provided. Much more can be achieved through day procedures or very short hospital stays.

[55] Victorian data quoted in *Improving Care For Older People: A policy for Health Services* DHS 2003 P1. Likely to broadly reflect national patterns of bed usage.

[56] Reported in *Governments Working Together: A better future for all Australians*, The Allen Consulting Group 2004, p. 52.

[57] Unpublished report—data provided by the authors.

Notwithstanding this analysis, many older people remain for longer than necessary in hospitals because alternative services are unavailable.

While jurisdictional strategies and approaches vary, the face of health service provision is being transformed by these and other factors. The scope for and benefits from these changes will be affected by the quality of the linkages made with community care providers.

The Victorian Government is investing considerable resources and effort in supporting development of non-hospital health service strategies. Key strategies or frameworks include the:

- *Post Acute Care (PAC) Program*. PAC provides short-term community-based services to assist people to recuperate following a hospital episode (acute, sub-acute and emergency department). People receive individually tailored packages of service.[58] While this program is available to all age groups, the vast majority or people supported are 60 years old or more.
- *Sub-Acute Ambulatory Care Framework*. This framework supports the provision of community rehabilitation (centre-based, home-based and specialist assessment and management, including geriatric evaluation and management clinics.[59])
- *Primary Care Partnerships Strategy (PCP)*. The (PCP) has been developed as a key vehicle for change and aims to have a service system which connects public health providers, private health service providers with hospitals and the community sector.[60]
- *Care in Your Community: A Planning Framework for Integrated Ambulatory Health Care*. This framework was launched in April 2006 and articulates the way that health and associated service provision arrangements need to be configured to capture the health and economic benefits of a more community-based health care system. It represents a considerable reframing of the health care sector's approach and relationships with the community and the network of service providers on whom they will increasingly rely. Trials of integrated area-based planning using the 'Care in Your Community' framework will be conducted in 2006-07 in Eastern metropolitan region, Southern metropolitan region and Gippsland Region.

Provision of health care services in the community requires the individual, family and carers to continue with their normal roles and routines, but it commonly adds to the range and complexity of tasks involved. Without their ongoing and possibly expanded care and support, the health outcomes may be jeopardised. At the most basic level, provision of transport to and from day procedures can be a major and sometimes insurmountable burden on some individuals and families. Processes to assess and respond to these needs (often for practical, day-to-day support) will need to be established and integrated into the practice of health providers. It will also be important that health care providers do not, unwittingly, establish services which duplicate existing community care services.

As outlined above, the Victorian Government is supporting a number of strategies designed to facilitate and drive changing health care service delivery. Much of this reform has merit, but it also has risks.

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[58] *Post Acute Care Program, Report on 2003-2004*, Department of Human Services (Victoria).

[59] *Sub-Acute Ambulatory Care – An Integrated Service Framework* Department of Human Services (Victoria), 2004.

[60] Presentation by Dr Chris Brook Executive Director, Rural and Regional Health and Aged Care Services Department of Human Services to an Institute of Public Administration Australia forum October 2005.

The Department of Human Services (DHS) has sought to use PCPs to create a flexible platform for reform. The future vision for PCPs is that they are the 'building blocks' for a system where:

- investment in health services is better aligned with earlier service provision at community rather than tertiary or institutional level care
- preventable acute admissions do not occur
- there is a strong focus on health promotion, early intervention, integrated disease management and restorative approaches
- flexible, innovative and responsive models of care are provided in community settings.

Currently, the effectiveness of this strategy is mixed. Some PCPs are working effectively in planning, service co-ordination and integration. Departmental investments in information systems and flexible service requirements are only beginning to generate change. Some PCP are not working well and have, as yet, not won the support and engagement of many of the available partners. It is not clear whether, with their current mandate, PCPs can provide the systemic integrating force needed to reform and rebalance investment mix and service provision arrangements. There are arguments that, in the near future, more powerful mandates may be required in order to facilitate and drive planning, service co-ordination and investments in early intervention and prevention activities.

Sub-acute and ambulatory care programs are valuable efforts to reform and rebalance effort. However, dilemmas arise in managing these reforms and linking them to existing service systems on which they can and perhaps should rely. There is a sustained risk that parallel systems with duplicating functions are, or will be, established. Managing this risk is the responsibility of health sector managers and the existing providers of community care, and involves building relationships and a vigorous dialogue. This dialogue must focus upon determining what is required to meet the needs of older people in the health system and defining and delivering the most efficient service response to those needs. The existing service system needs to be challenged to respond to these requirements.

The relative size of the budget of the acute care system means even a small shift into services delivered in community settings will have significant implications for the existing community care sector. Just one per cent of the Victorian Government's current spending on acute care is $52 million.[61]

[61] Budget allocation to public hospitals in Victoria in 2004-05 is $5.2 billion. *Your Hospitals—July to December 2004*, Dept of Human Services.

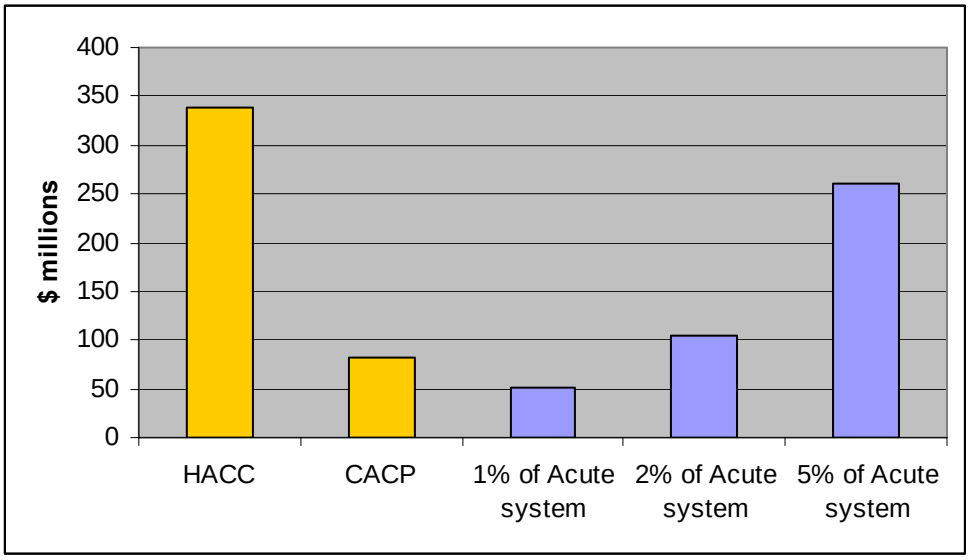

Figure 18: Relative funding levels of major community care programs and the acute system in Victoria (2003-04)[62]

The diversion or transfer of services from the acute to the community setting also represents a potential diversion or transfer of costs from the acute to the community care system. The Victorian Association of Health and Extended Care (VAHEC) submission to DHS in response to the *Ambulatory Care Framework* argued that:

> *'Residential and community care providers feel that early discharges can and do achieve savings for acute public hospitals, and in many cases are also the preference of the patient. However, as a result of an acute episode the overall care needs of a person may increase markedly in the short and/or long term. Once discharged from hospital the person's usual care service generally does not receive additional funding to increase the care and support during this period. The cost of providing care arising from a person's acute health state are often cost-shifted to non-hospital services.'*[63]

Funding for ambulatory care services in the future will probably be directed by government largely through the acute care system in order to ensure that accountability for medical/health outcomes is not diluted. The sector is also likely to retain control in order to reinvest any savings generated through the change in meeting the ongoing and increasing demand for health services. A key challenge is to achieve reform, continue to enhance the capacity of the health system and to strengthen the overall capacity of community care, rather than distort or diminish its capacity to meet the needs of a wide range of older people.

Housing services

[62] Sources: Victorian HACC Departmental Advisory Committee *Response to Issues Raised by the Commonwealth's Community Care Review*, October 2003, p42, and *Your Hospitals—July to December 2004*, Dept. of Human Services.

[63] Victorian Association of Health & Extended Care (VAHEC), "Response to the Victorian Government's Department of Human Services *Ambulatory Care Framework"*, September 2005, p. 7.

Availability of informal carers is not the only possible constraint on the achievement of future users' expectations regarding community care. A key issue for many older people in making choices regarding lifestyle and care arrangements is housing. For many people, remaining in their own home will continue to be the housing option of choice. Others will downsize but remain effectively independent in a housing sense. For a significant and perhaps increasing number of older people, appropriate housing will be a critical determinant of their choices.

For the increasing number likely to be living alone, or where both partners are experiencing diminishing capacity or those (primarily private) renters in unstable situations, housing becomes critical. Supported housing is the mechanism which would enable them to continue to live independently, albeit with community care services.

For some of these people, the market will provide an appropriate response. For others, government and community action to provide supported and public housing options will be required. This will require a national reframing of public housing priorities and exploration of new models of supported housing. This is not a minor or marginal issue. Some community care programs already face very high costs in supporting those with high needs in the community. As demand for this kind of care grows, the diseconomies of continuing care, when compared to residential care, will become more obvious and the pressures to diminish costs greater. New social housing models are a part of the response to this situation.

The authors note that significant work is being done on adaptable housing and universal design issues at Commonwealth and state levels. The design and accessibility of housing stock is a crucial factor in supporting older people and disabled people to live in the community. Greater focus and attention will need to be given to implementing adaptable housing and design codes into planning and building codes over the next 10 years.

5.4 Sector capacity

This paper posits that the service system will be subject to continuing change over the coming decade, driven primarily by the growth in demand for community care services. These changes include:

- growth in demand for community care due to growth in the number of older people, increase in the complexity of their needs, and their preference
- potential reduction in workforce availability and the number of informal carers
- growth in care that will occur in the community substituting for care in acute settings, flowing from policies such as Victoria's 'Care in Your Community' Framework
- changes in government policies and programs in response to the rising importance of community care as a mode of care for older people.

The service provider arrangements and the network of service providers required in the future are likely to build upon and refine existing arrangements. The future demands on the sector will highlight some existing deficiencies and raise new issues which need to be addressed through early planning.

5.4.1 Provider diversity

There are over 500 providers involved in the community care sector in Victoria although, as in many sectors, there are a small number of large providers, and a large number of smaller providers. This structure has evolved over the last two decades. The current structure of the sector is the result of pre-HACC arrangements, supplemented by submission-based evolution,

with further elements grafted on through largely unrelated tender processes. Providers have responded to efficiency pressures that have been brought to bear through the introduction of unit pricing or capping of expenditures for individuals through packaging.

Figures 19 and 20 below, based on 2001-02 data, display the distribution of funds by provider type for HACC services, and the types of services the providers provide.

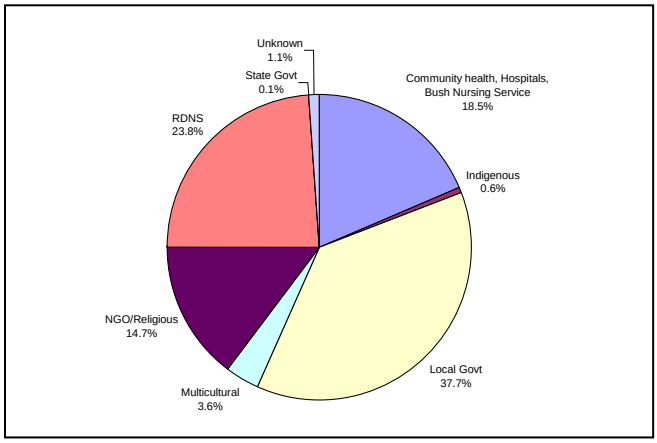

Figure 19: HACC funding levels by service provider type 2001-02 (Metropolitan Victoria)[64]

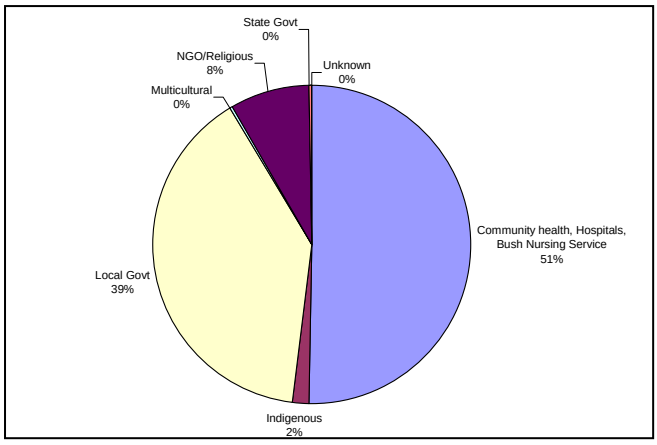

Figure 20: HACC funding levels by service provider type 2001-02 (Regional Victoria)[65]

Figures 19 and 20 indicate that there are four general groups of providers which relate to service type, as highlighted in figure 21.

[64] Nous Group estimate based on data in *Home Care in Victoria,* Department of Human Services, 2001.

[65] Nous Group estimate based on *Home Care in Victoria,* Department of Human Services, 2001.

Provider type	Service type
1. RDNS (metro) / Bush nursing services, hospitals (rural)	Nursing / health care
2. Community health, hospitals	Allied health, planned activity groups
3. Local government	Home care and personal care
4. Cultural groups (Koori, Ethno specific, Community health, Other)	Planned activity groups

Figure 21: Four major categories of provider by service type

This arrangement of providers demonstrates limited overlap within areas in the services of nursing / health care, allied health, and home and personal care. There may well be significant overlap between groups providing planned activities. However, given the nature of this particular service, duplication is unlikely to be a major problem.

There does appear to be significant overlap between the providers of these HACC services and the services provided by CACP and EACH providers. Such providers do sub-contract to the large providers at times (e.g. to RDNS for nursing services), so there is an active market for service provision. However, a challenge does exist in terms of the relative coherence of care between the CACP and EACH packages and HACC.

To encourage greater coherence, providers have chosen to pursue collaboration in a variety of arrangements, particularly where they are well established. However, relatively few incentives have been provided for collaboration, either in service provision of through shared back-of-house systems.

It is likely that more users-pays approaches or co-pay arrangements which exist now but generate modest revenue will be expanded in the community care sector over the coming decade. There is a natural progression from policy frameworks oriented towards the development of a ‘person-centred’ and ‘family-centred’ system to policy designs where signals of need, capacity to pay, and preference for service delivery, come from the bottom up rather than from the top down. The strong economic conditions of the last decade also suggest that it is likely that older people, their families and possibly their insurers will have a greater capacity and inclination to meet care costs. Governments are likely to both recognise this and use the principles of consumer choice and consumer control to constrain demand for funded services to those assessed as unable to self-fund.

If these changes occur, a greater share of the revenues of the sector will be directed by users, their carers and brokers acting on their behalf. This will have consequences for the structure of the sector, as providers best able to respond to the needs, expectations and preferences of purchasing users, their carers and their brokers can be expected to increase their role in the community care sector (their market share) and those not able or willing to respond will struggle.

As has occurred in other government-funded and regulated service sectors, when demand for services grows rapidly, as is likely to be the case over the coming years in community care, two phenomena happen:

1. Governments become concerned about their capacity to fund the demand, and begin to ask how they can encourage / mandate a larger proportion of service users to user pays arrangements and how they can drive greater choice in the service provision.
2. Both in response to demand and to changing government policy, more providers from a diversity of backgrounds-for-profit and not-for-profit-develop to service that demand, and in particular to service the user-funded demand.

It appears very likely that community care will experience a similar change in service provision over the next decade. As noted earlier, private providers are already expressing interest in community care. One indicator of this trend has been the 160 per cent growth in the number of listings in the Yellow Pages in this category from 2000 to 2005. (See Figure 12 on page 23.)

The sector is likely to experience further growth in the market of service providers in the decade to 2015, from both new for-profit and not-for-profit providers. It is likely that funders and policy makers will use evidence of operational efficiency as one of, if not the, most critical factor/s in determining future funding investments. The identification of the 'lowest-cost, most efficient' provider is already a focus in government and acute care sector decision making. In an environment of fast expanding need for community care services, this can be expected to be the guiding principle in future growth in taxpayer-funded services.

For service users and carers to fully benefit from this diversity, a number of changes will need to be made to the arrangements supporting the sector, and these are discussed below.

5.4.2 Access and assessment

For users and their carers, access pathways to and within community care services are not easy enough at present. These difficulties stem in part from the program structure outlined in Section 4.1 of this report. There are informational, process management and structural factors which make it difficult for some service users and carers to navigate their way through the community care service system. These difficulties compound the complexity which arises from the diverse needs of service users and their carers.

The factors which make navigation difficult include:

Information

There has been limited investment in information services for users and carers. The reasons for this under investment are numerous. Key factors include:

- historical expectations that consumers will use few services and should be responsible for their own decisions
- expectations that GP's and service providers will act as information providers (and that they will be sufficiently well informed to perform this role)
- limited interest from service providers in consolidating information using their existing resources to produce and sustain collaborative information systems
- For the last four years the Commonwealth has funded a national network of Carelink Centres to provide information and advice about community care. The effectiveness of these centres has not been formally evaluated and some stakeholders consulted for this project are critical of their performance.

Assessment and care management

The process by which clients use the community care system varies widely. Some people need only one service or at least one service at a time and for relatively stable periods of time. Some people enter the formal care system early and have long engagement with one provider organisation which comes to know them and can adapt the response to their changing needs. Others have multiple and changing needs. The processes and mechanisms for ensuring that these needs are met are different.

The stakeholders in community care also have different needs which are met through the assessment process. These are summarised in the figure 23 below.

Stakeholder	Needs
Service users and carers	Assessment from the service user's perspective is the key mechanism by which they gain access to service and influence the mix and range of services provided.
Service providers	Assessment from the provider perspective involves decisions regarding client mix and choices.
Assessment staff	Assessment staff need to receive professional satisfaction from doing their job and assisting service users to find and sustain appropriate support and care services.
Governments	Governments need assessment service to provide quality gate-keeping and navigation services which meet the needs of service users, ensure that people with higher needs gain access to the right mix of services and contribute to the task of overall budget management.

Figure 22: Needs of various community care system stakeholders

Assessment is a function which can serve many purposes. In this report, assessment is defined as encompassing a broad range of purposes. These are outlined in the figure 24 below.

Purpose	Description
Information dissemination	Clients, families and carers need information on how the aged-care system works and the services that are available in order to be able to plan for current or future care needs. Provision of information provides access to first line self-assessment or screening into the aged-care system, or can forestall entry to it for a time.
Screening	Involves a brief assessment, which may take the form of a self-administered questionnaire, in order to identify people who need or would benefit from a more in-depth assessment.
Comprehensive needs assessment	Involves evaluation and cataloguing of client, carer and family needs, strengths, resources and disabilities, risks and quality of life. Outcomes often result in major decisions regarding long-term care.
Specialist assessment	Involves assessment for specific disorders, medical or other therapeutic interventions and aids.
Eligibility assessment/ gate-keeping	Approves access to individual services to ensure that services are provided to people in most need and that criteria for targeting are applied consistently.
Planning integrated packages of care	Not technically 'assessment', but a process of matching appropriate services to clients' identified needs.
Assessment of levels of resource allocation and priorities	Once eligibility has been authorised, determines the amount of service that can be offered and the prioritisation of clients to receive services.
Monitoring and review	Necessary to maintain appropriate levels and type of care.

Figure 23: Purposes of assessment[66]

This complex definition is needed to ensure understanding of the breadth and significance of the assessment function. For many purposes, assessment is defined as 'needs assessment' or 'service planning'.

Service providers have, for the most part, managed the assessment function well. The task has progressively become more complex and demanding. Key factors in driving this change have been:

- Growth in the service system
- The task of assessment has grown with the population of people receiving services. The HACC service user group has grown by over 5 per cent per year for the last five years. Other programs have also grown in similar proportions.

[66] Butler, A., Dickens, E., Humphries, S., Otis, N. and Russell H. 'Emerging issues for Australia in assessment of older people: A review of recent international literature', *Lincoln Papers in Gerontology,* no. 38, 1998.

- Increasing diversity and complexity of service users
- The community care service system has also taken responsibility for a changing service user population as it has grown. Assessments at eligibility, service planning and review for a care unit with complex needs are necessarily more complex and time consuming.
- Number and range of programs
- The growth in the range of programs generates more options which need to be considered in determining the most appropriate way to meet a care unit's needs. Proliferation of programs each with their own eligibility requirements, access processes and service provision arrangements add complexity and cost to the assessment process. This is particularly problematic when many staff involved in assessment work 'within a particular program' rather than 'within the service system'. It is difficult to know all the eligibility and other requirements even when you have a system wide role. It is extremely difficult when you work in a particular service system and your role focuses upon service assessment.
- Disconnection between residential care and community care
- Aged Care Assessment Services (ACAS) have broad assessment responsibilities across the residential care sector. This role has formally broadened to assessment of needs for community-based care as a result of the development of CACP and EACH programs. ACAS does not have similar engagement with other programs, although in some areas strong working relationships with other providers have been established. There are increasing risks for duplication and navigational difficulties for potential service users trying to move through the system.

The dilemmas outlined above have been compounded by a lack of investment in assessment. Community care programs systemically face high levels of demand, commonly exceeding capacity. In this environment, governments and service providers have under-invested in assessment capacity. This under-investment has driven pressures of demand, delayed development of agreed systemic approaches to assessment, and meant there is inadequate training and support for staff involved in providing assessment services.

Existing difficulties will become more critical over the next decade. Key reasons for this relate to:

- **Ongoing expansion in demand and growth in complexity**
  The problems generated by overall growth and increasing complexity will become much more significant over the next decade.
- **The changed expectations of older people**
  As noted earlier in this report, future service users and their families will expect more involvement in decisions regarding their care. Assessment, at all its levels, will be a key point at which this requirement for involvement, flexibility and choice will be felt.
- **The need to broaden the focus to the care unit**
  As outlined earlier, the service system will have to increase its focus upon the needs of carers as a fundamental part of the care unit which has to be supported. Assessment tools and processes will have to be broadened to ensure that the full range of carer support needs are assessed and the service responses identified and delivered.
- **The ongoing emergence of the health sector as a driver of community care**
  Over the next decade changes in the health care sector will become significantly more important for the community care sector. It is anticipated that the complexity of service users emerging through changes in the health sector will be relatively high as will the

urgency of decision making and rapidity of change in clients and needs. The health system will increase overall demand and the 'speed' of the service system. The health system is also likely to seek more specialist assessment given the medical and related conditions and this is likely to require different skills and knowledge than have traditionally been found in community care provider or aged care provider assessment systems.

Governments have begun to pay increasing attention to assessment. Critical steps taken include:

- **Funding for assessment in the HACC program in Victoria has increased**
  Over recent years funding for assessment and care management has increased from $5.5m to $15m and further investments are planned.
- **Victorian government commissioned work on assessment**
  A detailed analysis of assessment within the HACC program has been developed by the Department of Human Services and is expected to lead to a strategic framework which it is understood will be introduced over the next three years.[67]
- **Federal government commissioned work on assessment**
  The Department of Health and Aged Care has also commissioned independent work on the arrangements for eligibility assessment across the community care programs funded by the federal government.
- **$18m in additional Federal government funding over the next four years (2006-07 to 2010-2011) to improve assessment of the frail aged**
  At the February 2006 Council of Australian Governments' meeting, the Commonwealth agreed to boost funding for the assessment of the frail aged to ensure such assessments are more timely and consistent.

Related work is also underway across a number of health programs which reflects growing focus on this area but also increasing risk of duplication and overlap.

A system requirement, closely aligned to assessment is care co-ordination. Care co-ordination involves an ongoing process of ensuring that the contributions of multiple service providers to a care unit are effective and complementary. Care co-ordination also involves making sure that changes in the needs of the care unit are responded to by appropriate movements in the mix, range and level of service provision.

Service users and carers with multiple needs commonly require assistance with care co-ordination. Agreements and protocols between service providers can be effective ways to provide this service. It is, however, clear that as part of the overall development of assessment attention will have to be paid to care management over the next decade.

Assessment and care management are a cost which must be born in services of this kind. They are also an investment which generates returns. Skilled and adequately supported assessment processes assist in managing public risk regarding ineffective and poorly targeted service provision. Well designed assessment processes help minimise service users' risk of receiving poor quality or inappropriate services.

[67] *Strategic Directions in Assessment: Victorian Home and Community Care Program Final Report,* Department of Human Services, Victoria, 2005.

5.4.3 Quality assurance and standards

To date, community care has largely been self-regulated. That is, it self-assures that the care it is providing is of an appropriate standard for the service user. Service providers do account to their funders for the use of the funds provided at a quantitative level: how many service users, of what type, etc. Quality assurance, however, is undertaken by the providers themselves. This would appear to be appropriate where the services provided are to service users who have a relatively low level of need, and where the service providers are well established self-governing organisations.

Indeed, providers today do not complain of the level of regulation and reporting for any particular program. Rather, they complain about the reporting requirements arising from the diversity of programs which make up community care. This issue is discussed in detail in section 4.3.

The character of regulation is also shaped by the program structure in which services sit. So, HACC services are subject to one regulatory regime, while CACP and EACH services are subject to Commonwealth Aged Care Act regulation. Given that HACC clients can range across a wide range of need from low to high to the level of EACH, there is little consistency in regulation for service users of similar need.

Self-regulation is likely to become a more difficult issue where there is a greater diversity of providers (including more for-profit services) and a greater proportion of service users that have a higher level of need. In such a situation, governments will be more likely to choose to effect quality based regulation as well as quantity based regulation, more akin to the residential care sector. This will be particularly the case should there be well publicised cases of poor service provision. Such regulation should establish a consistent minimum standards of service and make a single level of government responsible for monitoring these standards.

Two other related issues are likely to increase in prominence in the next decade:

- *Occupational health and safety*. Community care involves a range of relatively high-risk activities in a diverse range of locations which are to a significant degree outside the control of employers. These are long-term structural risks which will gain increased importance as the scope of activity within the sector changes and as the expectations of service users and carers change. Service providers are likely to change their requirements and processes to take increased care with regard to staff wellbeing. The publication of the Victorian Home Care Industry Occupational Health and Safety Guide in 2005 is a good foundation resource going forward.
- *Legal exposure*. The growth in demand, diversity and service user expectations is also likely to increase the risk exposure of service providers in what is anticipated to be a more litigious society. This factor will also drive more caution into the service arrangements, offerings and requirements imposed on service users. Management of this risk is likely to drive more conservative practice and may be a barrier to small and new providers seeking to move into the sector or for existing providers to develop innovative programs.

In summary, the current regulatory arrangements provide comfort to governments that funds are being allocated to the specifications of their programs. However, the diverse set of arrangements are onerous and expensive from a service provider perspective, and add only limited value to future policy and strategy and offer limited protection to service users.

5.5 Sector sustainability

In order to sustain sector capacity in a changing environment, investments in the following areas are important.

5.5.1 Workforce planning and development

The sector currently faces significant workforce issues and these will become more important over the decade as full employment and an ageing workforce stress existing provision and make expansion to respond to growing demand very difficult.

There is growing evidence, both nationally and internationally, of increasing pressures on, and shortages in, nursing and aged-care staff in the coming decade. In 2004, *The Hogan Report* found that the aged-care workforce would need to increase by 35 per cent in the next decade. In contrast, the expectation for the growth in the overall Australian workforce is only 8 per cent during this time. Growth in demand for care from members of CALD communities will require providers in some areas to bolster their staff's capacity to provide appropriate services to these communities.

A major factor that can be expected to contribute to the future structure of the community sector will be which service providers and system/s can do the best job of attracting and retaining staff. Those service systems and organisations which are able to offer incentive based and flexible working conditions, and to demonstrate to government their capacity to attract and retain scarce skilled staff, can be expected to be key providers in the forthcoming decade.

A separate but related issue is the supply of informal carers. Due to trends such as the rise in single person households among the aged and greater female workforce participation, some forecasters expect a relative shortage of informal carers over the decade to 2015. Feedback from Carers Victoria suggests that there is strong unmet demand for carer training and support. Investment in programs to address these needs will likely be critical to attracting more carers to take on the caring role.

5.5.2 ICT capacity

There is substantial evidence that existing information systems are not as developed as is needed and that another generation of information systems are required for the next decade. Over the last ten years, many sectors with mobile workforces have invested substantially in ICT that increases the service capacity, quality and productivity of their workforces. As a relatively less well-funded sector, community care providers have been unable to invest less in such improvements. The limitations on performance of this under-investment will become more pressing over the coming decade.

Information systems developments are required for:

- consumer and community information at local, state and national levels
- assessment and care management systems which connect with associated service systems
- service provision and system data and accountability reporting
- service provision management for such tasks as rostering and route management
- back-of-house administrative systems.

5.5.3 Knowledge leadership and R & D

Mature industries and sectors have well developed mechanisms for innovating and sharing knowledge and practice reform. Community care has received relatively less attention than other sectors, leading to poorer information and knowledge regarding the operation of the sector and opportunities to improve its service capacity and performance. As the sector becomes more critical to Victoria's care for the aged, this lack of knowledge will become more pressing over time.

In areas such as education and health care, sector-specific research and development institutes play an important role in assessing the effectiveness of prevailing techniques and approaches, developing more efficient and effective practices, and developing innovative responses to emerging challenges.[68] These institutes and centres often sit within universities and TAFE colleges, but assiduously maintain their links with practitioners to ensure the relevance and utility of their research programs.

There is an urgent need for the establishment of an institute of this kind in community care. Community care is a multidisciplinary sector but most of the relevant research work that is currently done typically focuses on a single discipline and often assumes a residential care context. In order to build links and share knowledge across regions, such a centre would ideally be based upon a national 'hub and spoke' model. The Australian Primary Health Care Research Institute provides a good example of this structure.[69]

5.6 Conclusion

The drivers of change outlined in this section coalesce into six key messages which need to inform the development of the community care sector over the next decade. They are:

1. Community care is an amalgam of family, informal and formal service provision and this is a strength which must be preserved. There are community, demographic and policy-related risks to the capacity and willingness of informal carers which must be carefully managed. Careful management will preserve the strengths and may enhance the capacity of informal carers.
2. The service foundations on which community care is built are strong and capable of evolving to meet new challenges. Each jurisdiction has differing characteristics which can be a great strength, particularly if there are structural mechanisms which inform and drive cross-jurisdictional learning about what works most effectively and cost-efficiently. This will be vital given the changing context in Australia. Clear articulation of the strengths which need to be preserved and the features which have to change will be required.
3. Demand growth, changing expectations and community capacity will be significant in driving change in the sector and in its service offerings and arrangements. Australia is just at the beginning of a powerful generational shift in community expectations which will demand a more comprehensive and responsive community care service and a refined response from health and residential care providers.
4. The complexity of the needs of service users and their carers and their cultural and linguistic diversity will increase over the coming decade.

[68] Examples include the Australian Primary Health Care Research Institute (www.anu.edu.au/aphcri/), the National Centre for Vocational Education Research (www.ncrer.edu.au), and Australian Institute for Teaching and School Leadership (www.teachingaustralia.edu.au)

[69] Information on the APHCRI 'hub and spoke' model is available here: http://www.anu.edu.au/aphcri/Structure/aphcri_structure.php

5. International trends, relevant to Australia, are establishing a more integrated and flexible approach with more market-driven service provision arrangements.
6. Community care, if effectively refined and positioned, will leverage reforms to residential care and the rebalancing of health care provision that are necessary to meet government policy.

The preconditions from which to launch the next decade of reform are not well developed. There are important barriers and issues which need to be addressed. Critical among them are:

- policy disjunctions and gaps which limit older people's access to a flexible continuum of care
- inadequate articulation of the outcomes to be achieved and consequent failure to link policy, funding and accountability to clear outcomes
- program arrangements that are fragmented and create planning and operational difficulties and inefficiencies
- adequate resources to meet future demand
- underdevelopment of the industry/sector structure exacerbating the difficulty in advancing reform.

For community care to contribute effectively to care and support of older people over the longer term, these issues need to be redressed. Options for change are discussed through later sections of this report.

6 The future – growth and opportunity

Remarkable growth and change will affect the community care sector and associated sectors over the next decade. Government investments, from various sources, will be required to respond to the demand growth and changing expectations of service users, and to support a new emphasis on strengthening independence.

Real outlays on community care for the aged need to grow by 6.5 per cent annually, according to Nous Group forecasts presented in Section 4.4 below. This means that the sector, in Victoria, needs to grow from a Commonwealth and state government budget of $400 million today to $750 million in 2015 at 2004 prices.[70] A range of factors underpin this forecast, including increased demand for services due to projected population changes and the need for additional investment in a more robust program and service infrastructure.

Changes in health care practices over the coming decade (which are likely to reduce hospital based care and increase care in the community), and the continuation of the shift in older peoples' preferences away from residential aged care towards community care, are forecast to require further increases in funding for community care.

A new program and program framework is required in order to generate the most value from the additional funding and to give greater emphasis to independence. This is discussed in Section 6.1 'Policy Directions' and Section 6.2 'Strengthening Independence'. The focus on independence will generate costs in the early years. However significant dividends will be generated in later years, not only in community care but across the health and aged care sectors.

Section 6.3 will address the revisions needed in regard to the interfaces between community care and health and residential care.

Section 6.4 will detail the sustained funding growth which will drive the development of the sector and in so doing require changes in approach and emphasis.

New funding and payment arrangements will also be required, and the options are outlined in Section 6.5.

6.1 Policy directions

Section 5 of this report points to key themes and messages which inform and frame the thinking regarding the directions of reform for community care. Appropriate action on these themes, and the issues which underpin them, will 'move community care to centre stage' and, more importantly, equip it to perform well while there. As noted earlier, proactive management by service providers and governments will be required if community care is to take its rightful place in the service systems which support older people.

The earlier sections of the report show that current arrangements are inadequate to meet future demand and consumer choice. The lack of integration in policy and the proliferation of funding programs diminish the achievement of outcomes and represent significant barriers to responding flexibly to the needs of older people. The existing arrangements do, however, provide effective control over government expenditure through the capping of programs and the varying eligibility and entitlement arrangements.

[70] The $400 million figure used for the current budget for community care for the aged in Victoria does not include the share of the HACC program budget spent on people aged under 65 (around $92 million).

This report outlines more flexible and responsive arrangements which could better meet the needs of the next generation of older people. The introduction of improved policy, consolidated programs and different planning and service delivery arrangements will also need to be accompanied by different funding, targeting and expenditure management measures. Existing arrangements and the difficulties they present are, in part, a result of incremental changes. The arrangements required for the next decade and beyond need to have a high degree of consistency and coherence if they are to effectively support a high-quality service system.

Government decisions are fundamental to the operation of the community care sector. Governments remain the primary funder and therefore have the power to set the parameters of service provision. Given the evidence for the extensive and continuing commitment to community care that will be required from governments over the next decade, this report proposes that a new policy framework is required. The proposed policy framework has three components:

1. *Core policy elements*-the fundamental objectives of the system
2. *Policy principles*-the principles by which community care should be managed and delivered
3. *Program streams*-the three streams of services which together comprise best practice in community care.

6.1.1 Core policy elements

As outlined above, community care experiences policy and program fragmentation which is compounded by inadequate connection to residential aged-care policy and healthcare arrangements for older people.

Continuation of a national policy regime in which residential care and community care are defined and managed distinctly is clearly an option which can be pursued. This option will ensure that policy attention is focussed upon the specific issues raised in each service system. It also has the potential to compromise the ability of services to meet service users' needs as they change, and as a consequence may generate sub-optimal outcomes for all stakeholders. This option may not deliver equitably to differing users and may also limit the responsiveness of service delivery. From a government perspective, long-term separation of policy making may also reduce efficiency and thus increase the overall cost of the system. Such structural inefficiencies would arise where service users and providers are unable to make cost-effective choices because of programmatic separations which arise from distinct policy structures.

While recognising the complexity of creating an integrated aged-care policy, the evidence from our current situation and the international trends suggests that this is an option with significant benefits. An integrated policy framework would recognise the inter-relationships of levels of care within different aged-care service programs, and provide for flexibility of service provision and choice for consumers, across the service programs.

A policy framework for the next decade and beyond should include three key elements which will underpin program and service design. These elements were identified earlier as key features of leading edge policies internationally and can be integrated into a range of policy frameworks. They are:

1. **Ageing in place**

Program and service objectives should be designed to enable support and care for older people in their chosen place of residence; to maximise responsiveness; and to emphasise prevention and early intervention. Given the high costs of providing community care support for people with very high needs, particular provisions will need to be developed to manage care choices and the safety, quality and cost effectiveness of care for this small proportion of service users.

2. **Continuum of care**

Service systems should be organised to provide for progressive change in service provision in place and between settings of care as older people's needs change, both episodically and over time. Program arrangements should not create artificial barriers or disjunctions in care and support options.

3. **Support for the 'care unit'**

Services should have an explicit focus on the needs of the service user and the carer to provide support in place and between settings of care through strengthening of the care capacity of family and other carers.

6.1.2 Policy principles

The five principles which should underpin the new policy framework are:

1. Focus upon care outcomes.
   Development of the community care sector will be most effective if shaped by agreement regarding the outcomes which it is designed to achieve. A focus on outcomes:
   - gives clarity to service users' preferences regarding entitlements and opportunities
   - enables service providers to deliver services best designed to achieve outcomes rather than to meet program- or activity-level requirements
   - clarifies accountability requirements.

   In broad terms, the overarching outcome sought by the program should be:

   'Maximising the independence and quality of life of service users and carers.'

   It should also seek to achieve outcomes in the following four core areas:

   - *Community engagement and active services*-There are clear health and wellbeing benefits which derive from ensuring that older people remain active in their community, make valued contributions and have engagement with neighbours and community organisations and have appropriate opportunities for physical activity, maintenance of healthy diet and support to avoid injury.[71]
   - *Independence support and development*-The outcome is that older people and their carers are supported to maintain a socially acceptable and meaningful lifestyle.
   - *Health*-The outcome is that older people enjoy good health and have access to healthcare services in order to maintain age-appropriate health.
   - *Maintaining dignity*-The outcome is that older people are supported and cared for directly and indirectly in ways which maintain their dignity and protect them from abuse, exploitation and accidental injury.
2. Balancing investment across levels of need and service types.

[71] Clark, H, Dyer,S and Horwood, J (1998) *That little bit of help: the high value of low-level preventative services for older people*, The Policy Press: London.

The long-term effectiveness of the service system will require careful judgement regarding the level of effort required. Under-investment in some needs and circumstances is likely to lead to long-term cost increases.

3. Aligning services with the health and residential aged care services.

   Alignment, or where appropriate integration, between community care and acute and residential care will facilitate flexible, responsive and effective service provision.

4. Maximising flexibility and responsiveness for users and carers.

   Program boundaries and rules should not restrict the choices of service or provider beyond the limitations set by policy, eligibility and budget.

5. Ensuring the sustainability and efficiency of the sector.

   Complex and substantially government-funded service systems typically lack the capital and other resources to invest in training, system development and research. This needs to be addressed in policy and program design.

6.1.3 Program streams

The array of services delivered to older people by community care and residential care services, supported by acute healthcare systems, are best understood as three major streams of care. Reforms to program arrangements within community care and across associated programs must ensure a balance of investment across the three streams.

1. Early intervention and independence support.
   This stream should be a focus of significant investment over the next decade to provide a wide range of home- and community-based activities that prevent, delay and minimise the need for in-home health and capacity maintenance services.
2. Chronic/complex health care and maintenance.
   This stream provides for the continued development of existing capacity albeit with increasing complexity as the alignment of community and residential care becomes more extensive.
3. Hospital and community transitions.
   This stream represents a significant growth area as health care practices change. The community care system will be involved in:
   - admission prevention
   - early discharge from acute facilities
   - rehabilitation, palliative and sub-acute care support services.

Implementation of a program structure which better integrates existing arrangements and establishes alignment with residential care services will raise a number of issues, some of them critical to its acceptance. Major concerns and the response are outlined in the following table.

Concern	Nature of risk	Protective mechanism proposed
Loss of expenditure control for government	Existing arrangements provide reliable program-specific expenditure control mechanisms. An integrated program will require new mechanisms for expenditure control.	Expenditure control across the integrated program will be protected by the new planning, benchmarking and service purchasing arrangements which will operated within the budget parameters decided by government.
The risk of funding being drawn up the hierarchy towards higher-needs clients	Flexible programs, of the kind proposed, can enable increasing demand for complex care where specific programs limit this risk and can focus on particular kinds or levels of care.	Central to the risk management strategy will be the implementation of the planning arrangements proposed in section 6.3 of this report. The planning requirements would involve national and jurisdictional level benchmarks across the levels and area based planning (with prescribed flexibility) using those benchmarks as a starting point.
The risk of focus being lost on key areas of work, particularly the investment in carer support and servicing	Specific programs have the benefit of ensuring that funds will be spent upon particular issues. Creation of larger and broader pools of funds can lead to movement of effort to the largest and most vocal claimants rather than achieve a balanced programmatic investment.	The overall risk of loss of focus could be protected by national benchmarking arrangements. These could be complemented by guidelines for area based planning which require: • area plans to specify arrangements regarding carer support for the first five years. This would not involve quarantining these funds but would create a planning and accountability requirement which would drive practice. • Introduction of a broader assessment process advocated in section 7.2 which would focus upon delivering services to the carer as an integral part of the assessment, service planning and review functions

Figure 24: Concerns regarding a better integrated aged care sector and responses

6.1.4 Enabling legislation

Community care services to the aged are currently provided under two overarching pieces of legislation, the Aged Care Act (1997) and the Home and Community Care Act (1985).

Adopting the new policy and program framework proposed above will require substantial revision of the way the community care system is managed and resourced. Change of this magnitude to fundamental objectives, policy principles, and funding programs can best be enabled by new legislation. New legislation would have the practical function of authoritatively defining the operational detail of the new framework. Adopting new legislation would also have symbolic power, sending a clear signal to the sector that historical structures and practices are now in the past and that a new era with a fresh approach has begun.

Recommendations for action:

- **An aged-care policy framework be developed, through collaboration between the federal government and state and territory governments, to provide for:**
  - **'ageing in place' (encompassing community care, acute and primary health care and residential care)**
  - **'continuum of care'**
  - **support for the 'care unit' (service users and their carers).**
- **That action be taken, through collaboration between the federal government and state and territory governments, to establish a coherent community-care program framework and integrate existing community-care services within the following streams of care:**
  - **early intervention and support for independence**
  - **chronic/complex healthcare and disability maintenance**
  - **hospital and community transition services.**

6.2 Strengthening independence

The second major force for change which should shape and guide development of community care in the next decade is 'strengthening independence'. The proposed policy and program framework makes this explicit at the level of outcomes and across the program streams.

This is not a new idea, as older people and community care providers have always sought to retain or support independence. It is also one of the goals of many existing community care programs. However, this is a significant challenge to current policy and program arrangements as the aspirations of service users and providers are not being achieved under current arrangements.

Focusing upon strengthening independence has several elements:

- support for carers
- health promotion and early intervention
- refocusing service provision.

6.2.1 Support for carers

Community care depends on family and other informal carers. Informal care is often all that is available or needed. In many other situations both informal care and formal care are provided. Most community care programs and interventions focus upon the service user. In recent years, carers have received increased support, typically in the form of respite care.

Public policy discussions, in recent years, have identified the risk that changes in demographic profile, family formation and mobility and workforce changes will lead to a decline in availability of family and informal care. The potential cost to governments of such a decline has been discussed in section 5.2.9 above.

Over the next decade, the partnership between informal and formal care arrangements should be reframed. The quality of life of both service user and carer will be enhanced through changes which make the care unit the focus of service. A reframing of the focus of service onto the care unit and investment in direct carer support will:

- enable existing carers to sustain their effort
- encourage new carers to undertake the role.

A focus upon direct support for carers will deliver benefits to all parties and contribute to the capacity to provide for ageing in place and to meet growth in demand. It should not represent a shift in the burden of care to carers nor a cost saving to government. A focus upon supporting carers needs to be included in:

- future community care policy, program and funding arrangements
- workforce, employment and family support policy
- community strengthening and neighbourhood development strategies.

The policy and program changes that are required to enable direct support to carers will include:

- systemic investment in family and local area education strategies which empower families in the planning and early stages of care provision
- revised assessment tools and processes which broaden the focus to more comprehensively assess the carer's needs as part of the care unit
- more flexible provision of supplementary support services which are responsive to the needs and choices of the care unit
- provision of practical individual and carer support and training services which leave the carer with capacity to continue caring.

6.2.2 Health promotion and early intervention

There is evidence that well designed, implemented and supported health promotion and early interventions work.[72] Promoting healthy lifestyle and early interventions which address emerging issues are critical ways to promote and sustain the independence of older people.

Governments are actively searching for ways to strengthen and expand existing investments in health promotion. The recent Council of Australian Governments' (COAG) decision to invest $1.1 billion in a 'Better Health for All Australians' package is the most recent and possibly most important initiative in this direction.[73] The package establishes "a new approach to promotion, prevention and early intervention" and a range of other initiatives in relation to older Australians.

Many existing investments in health promotion for older people are project- or locality-focused and are not of a scale or level of sustainability to have population-wide impacts. Giving health promotion and early intervention services and strategies scale and sustainability will require attention at many levels and various approaches. The community care sector is well placed to systemically contribute to health promotion and early intervention with older people. The sector in Victoria:

- operates across the state
- has local, regional and state-wide infrastructure capable of contacting older people and managing appropriate interventions
- engages with many vulnerable older people at an early stage
- has broadly and relevantly skilled staff
- has strong recognition and credibility with older people and local communities.

Detailed design work is occurring and will need to continue in order to develop and implement health promotion and early interventions which work in the context of community care. Given the health status of older people and the evidence regarding effectiveness the sector has substantial capacity to drive efforts regarding:

- healthy diet
- physical activity
- mental wellbeing
- dental care
- injury prevention
- chronic disease management.

The literature also suggests that prevention and early intervention strategies have an impact upon dementia. This is significant given that a two-year delay in onset is predicted to reduce the prevalence of people with dementia by 20 per cent over 50 years.[74]

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[72] Clark H, Dyer S and Horwood, J (1998). That little bit of help: the high value of low level preventative services for older people, The Policy Press: London.

[73] Council of Australian Governments' Meeting, Communiqué, 10 February 2006, p10

[74] *Dementia Framework for Victoria, 2005 and Beyond Consultation Paper*, Victorian Dementia Reference Group, Aged Care Branch, Department of Human Services, Victoria, 2004. Also *New research reveals lifestyle habits linked to getting Alzheimer's*, Report of the Alzheimer's Association International Conference on Prevention of Dementia, 2005.

Health promotion and early intervention initiatives in these fields can be developed for implementation across the older population in a community and can be integrated into service provision for those assessed as eligible for service provision.

6.2.3 Refocus service provision

Refocusing upon independence throughout the range of community care services will have important repercussions for the service system, not just for a small number of people.

For those eligible for direct services within the proposed community care program structure, the goals would be to offer information, advice and assistance to reorganise personal and home care tasks, introduction of aids and technologies to assist or reduce risk and development of tailored diet, exercise and disease management programs.

Recommendations for action:

- **The reformed program arrangements in community care give increased priority to:**
  - **strategies designed to sustain and expand the range of community, family and other informal care providers**
  - **interventions and actions which prevent or delay the occurrence of preventable disability and illness**
  - **early interventions which maintain optimal independence, social engagement and health with disability and chronic illness.**

6.3 Better continuity across sectors

Introduction of the more aligned aged care sector advocated in the policy and program framework described above creates the preconditions for improved working relations across the community care and residential care systems. The focus upon strengthening independence will also provide greater opportunities and obligations for collaborative work.

Over the next decade, a major challenge will be the development of effective working interfaces with the various elements of the health sector. As identified earlier, changing health sector practices will drive increasing demand for community care. The demand will commonly be for urgent, relatively short-term and intensive service provision.

In order to implement the reforms anticipated in documents such as Victoria's Ambulatory Care Framework, the acute care system will need to further develop its capacity for delivering services outside hospitals.[75] To achieve this it has a range of options:

1. expand operations beyond hospitals through usage of in-house capacity.
2. contract with existing community care agencies to deliver some or all care services.
3. look beyond existing providers and seek to engage new providers from other sectors including both an emerging private sector capacity and the residential aged care system which has the necessary skills and resources.

It is likely that, across the nation, all three options will be used with varying results. Achieving health sector reform in ways that meet health goals, deliver responsive support services and maximises the efficient investment of public monies will be important.

6.3.1 Options for the future

This report has focused upon two overarching concerns. They are (1) achievement of care outcomes for service users and carers; and (2) efficiency outcomes which maximise the benefits of public spending. The substantial expansion of health care-related community care and the options for development generate a significant risk that the achievement of neither of these outcomes will be maximised.

Development of parallel policy, purchasing and service delivery arrangements creates risk of duplication and creation of complexity for service users and carers. Minimising these risks will require collaboration and change from health service providers and the community care sector.

The community care sector should further develop partnership relations with providers of acute health care in order to deepen understanding of their quality, effectiveness and efficiency. The goal would be to become 'provider of choice' in what is likely to become a more competitive market. The community care sector is well-placed to lead the development of these partnerships because it best understands the defining elements and characteristics of community care and what they mean in practice. It can also provide the intellectual and practical support for the policy elements of 'ageing in place', 'a social model' and an 'integrated service system'.

The sector has a substantial body of expertise and knowledge about the needs of older people and the services which meet those needs. If the general reforms to planning, assessment, case management and co-ordination outlined in this report are implemented, the sector would, in the longer term, be well placed to be the driver of community service provision. This would involve the sector in having an integrating and linking responsibility for the long-term health of older people in partnership with GPs. The option of becoming the service driver would be very demanding and would require considerable sophistication in the areas where it was adopted. It also involves the community care sector in accepting a level of risk which current resourcing arrangements would not encourage.

Positioning the existing community care sector in this way provides a platform for sectoral change which should give health service providers confidence that the needs of patients can be met effectively and efficiently.

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[75] Department of Human Services, *Care in your community: A planning framework for integrated ambulatory health care,* January 2006

6.4 More funds

Over the next decade, growth in funding required for community care will be driven by the cumulative forces of:

- increases in demands and costs within the existing service system
- promoting independence
- changes in health care practices which result in more care being delivered in community settings rather than hospitals
- increases in demand for community care from older people eligible for a residential aged care bed.

6.4.1 Existing service system

Five key factors will driver the need for funding increases for the existing community care sector. The largest, most obvious and easily quantified contributor will be demographic factors. Population ageing is a long established topic for discussion in policy forums and the community. The advent and impact of the baby boomer generation and the subsequent fall in the birth rate have been thoroughly explored. The economic consequences of a higher dependency ratio and higher use of health care resulting from these demographic changes have received considerable attention. Reference is also regularly made to the implications for aged care, although the details of the impact are less well explored.

1. **Demography-driven growth: ↑ 3.2 percent per year**

The number of Australians aged over 65 will grow by an average of 3.2 percent per year for the next decade, according to ABS projections.[76] Therefore, assuming the average cost of community care services per capita for the age group over 65 stays constant at 2004 levels, to maintain the current levels of service to this growing population will require funding to increase by an average of 3.2 percent per year for the next decade.

2. **Investment in sector sustainability: ↑ 2.5 percent per year**

As the analysis in Section 3.5 above makes clear, there has been insufficient investment in system infrastructure and R & D in the community care sector over recent decades. As a result of under-investment in information systems, there is a marked scarcity of data on many aspects of the community care system's operations and performance. Feedback from stakeholders consulted in this project indicates that this lack of data hinders effective and efficient planning and management in the sector. The absence of strong shared information systems means that transitions for clients between providers are less smooth and involve greater than necessary staff costs as a result of duplication of effort.

The low levels of investment which have occurred historically in R & D relating to community care systems, processes and service models also needs to be addressed. R & D investments lead to more vigorous innovation and more rapid sharing of ideas for practice improvement. Ultimately, the result of such investment in R & D is improved outcomes for service users and their carers, and more efficient and effective use of public resources by service providers. Boosting R & D investment is especially critical in light of the substantial demand growth which

[76] Projection based on ABS Population Projections; 2002-2101, (2003) holding the average cost of community care services per capita for the age group over 65 constant at 2004 levels.

will occur over the next decade and the resultant overall expansion in the amount of services provided each year.

The Nous Group's assessment is that funding for community care should be increased by an additional 2.5 percent per year over the next decade to fund greater investment in information systems and community care practice R & D. This recommendation is based on an assessment of the extent of the gaps in the sector's information infrastructure and the annual investment in R & D in other comparable human service systems.

3. **More complex needs in the aged population: ↑ 0.2 percent per year**

Increasing life spans are increasing the proportion of the older age group that is over 85. This group, because of dementia and other factors, is likely to have more complex needs. The more complex profile of those needing care is likely to add 0.2 per cent per annum to the cost of the sector.[77]

4. **Labour costs increases: ↑ 0.5 percent per year**

Known pressures in health workforce recruitment and retention will impact on community care and are likely to add to costs in the next decade. In 2004, *The Hogan Report* found that the aged-care workforce would need to increase by 35 per cent in the next decade. In contrast, the expectation for the growth in the overall Australian workforce is only 8 per cent during this time. Community care is a labour intensive sector, with staff costs comprising upwards of 60 per cent of all costs for most providers. The Nous Group estimate is that the cost-impact of rising staff costs (above inflation) will be in the order of 0.5 per cent per year.

Medical and home-based technologies are predicted to contribute to reducing costs although there is evidence that medical technologies which extend life and reduce morbidity actually contribute to increased costs. For the purpose of this report, technology will be regarded as a factor for which no reliable predictions can be made.

Productivity improvements can also be anticipated during the course of the next decade. However, savings generated should not be applied to savings but should be reinvested in addressing long-term inadequacies in cost indexation (see section 4.1.4 below) and under-provision of service.

5. **Obesity impacts on disability rates: ↑ 0.1 percent**

Australia's disability rates have been increasing slightly while international trends have been slightly downwards.[78] There is now concern that changes in lifestyle and particularly the rise in overweight and obesity will sustain Australia's rising disability rate. There is no consensus forecast in the literature on this. The Nous Group forecast is that these factors will contribute to a further 0.1 per cent increase in the cost of the community care sector.[79]

Total funding increase required: ↑ 6.5 percent per year

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[77] This forecast was calculated by using the ABS projections for growth of the 65+ age group over the period 2005-15 and then applying an assumption that the per capita cost of community care services for the cohort aged 85 and over was 50% higher than the age cohort 65-85.

[78] ABS surveys in 1987, 1993 and 1998 reported a moderate increase in the disability rate for Australians aged 65+ (Madge, A., *Long term aged care,* Productivity Commission, 1999) Most other industrialised countries have had steady or moderately decreasing disability rates during this period. Only the UK and the Netherlands have experienced a moderate increase like Australia.

[79] *The Hogan report in 2004 allowed for a slight fall in disability rates (0.25% per annum) in its costs projections for aged care services. Since Hogan, a range of US studies have begun to model the impact of growing obesity rates on overall rates of disability. Sturm et al. ("Increasing Obesity Rates And Disability Trends", Health Affairs, 2004; 23: 199-205) have completed empirical analysis which concluded that, if current US obesity trends continue, disability in those Americans aged 50-69 years would increase by approximately 1% per year compared to no further weight gains. Australia has similar obesity rates to the US, so it is reasonable to expect similar impacts here.*

Overall, the five factors described above together mean that funding to the existing community care system will need to increase by 6.5 percent per year on top of inflation for the next decade.

2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
$400.0	$426.0	$453.7	$483.2	$514.6	$548.0	$583.7	$621.6	$662.0	$705.0	$750.9

Figure: 25: Forecast real funding ($m) required for community care for the aged in Victoria 2005-15[80]

Real HACC funding in Victoria increased by an average of 4 percent per year over the 5 years from 2000-01 to 2004-05.[81] Therefore the increase in funding for the overall community care system which this report argues is required over the next decade is not vastly higher than the recent historical growth rate for the largest community care program, HACC.

6.4.2 Promoting independence

The policy and program framework outlined earlier emphasises the importance of a more integrated health promotion strategy across community care. In the long term, this approach will generate savings through sustained improvements in health status and reductions in chronic disease levels. In the short term, increased investments as signalled by COAG in February 2006, are required.[82]

A minimum additional investment in Victoria through the proposed new program structure outlined in the sections above of $20m per year over the course of the next decade will be required. This amount, combined with existing health promotion efforts relating to older people living in the community, will contribute to long term health improvements. Benchmarking activities proposed in Section 4.5 below should be used as the means to adjust funding allocations over time as changes in population health status indicate that these new investments are having the anticipated effect.

This amounts to an additional investment in community care services for the aged in Victoria of $200m over the ten years to 2015.

6.4.3 Changes in health care practices

Health care practice will continue to change and will become a major force in the size, shape and capacity of the community care sector. Reduced hospital admissions, fewer inappropriate admissions, shorter bed stays and day procedures all shift or leave 'patients' in the community. Many will have community care needs directly attributable to changing health care practice.

In the Victorian context, government policy and strategy focussing upon post acute care, stronger primary care and ambulatory care suggest that progressive shifts in the investment of the health budget will require and enable community care expansion.

[80] The $400 million figure used for the current budget for community care for the aged in Victoria does not include the share of the HACC program budget spent on people aged under 65 (around $92 million).

[81] National Institute of Economic and Industry Research, *Expenditure on HACC and CACP 1993-94 to 2003-04,* Unpublished report for the Victorian Community Care Coalition, November 2005. Page 9.

[82] Council of Australian Governments, Communique, 10 February 2006.

The Nous Group estimates that the size of these shifts will be around three per cent of the current acute health investment in the 70+ age group per year or some $54m per year based on the 2004-05 Victorian acute health care budget.[83] This estimate draws on feedback from stakeholders in both sectors gathered during the project and the Nous Group's knowledge of the acute care system. It is anticipated that the reallocation would have three components, namely:

1. funding for alternative community-based health services
2. funding for the consequent community care services required
3. a dividend recognising the different cost structures in community settings.

While recognising the diversity of situations that will result from health care system change, the Nous Group assessment is that a minimum of 15 per cent of the reinvested funds will be committed to community care.

This would amount to a reallocation of funds to community care services for the aged in Victoria of $105 million over the ten years to 2015.[84]

6.4.4 Changes in the preferences of older people away from low level aged residential care towards community care

Community preferences will continue to shift demand from 'low level' residential aged care to community care over the next decade. This process is already occurring in Australia with the growth of the CACP program and mirrors similar changes occurring internationally. This change will be beneficial to consumers if the community care sector is capable of meeting their needs (their preferences may change if the sector does not or cannot respond appropriately). It will also result in enlargement of the overall funding of community care services.

At present the Commonwealth's funding benchmarks per 1000 people aged 70 or over are as follows:

- 40 places in high level residential aged care
- 48 places in low level residential aged care
- 20 CACPs

Feedback from residential aged care operators and VAHEC gathered during this project suggests that in many areas there is insufficient demand for low care places to warrant the 48 places funded per 1000 aged 70 or over. However operators also report that the 40 high care places funded is not adequate. There are considerable waiting lists for many high care facilities. Clearly, further adjustment and careful monitoring of these population benchmark ratios will be needed over the coming decade.

As the chart below illustrates, there has already has been significant growth in the number of CACPs funded in the last eight years, with 30% average annual growth in places funded.

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[83] 2004-05 Victorian government spending on admitted services at hospitals was $3.9 billion (Department of Treasury, *Budget Paper 3, Service Delivery,* 2004-05). 46% of multi-day stays in hospitals were from the 70 plus age group so hospital services to this group cost around $1.79 billion. The cost of bed days does decline over the length of the stay so this may be a slight over estimate. 2% of this budget is $54 million.

[84] The forecast assumes 4% per year real growth in the funding for acute care system and 0.5% cost increases above inflation due to workforce shortages.

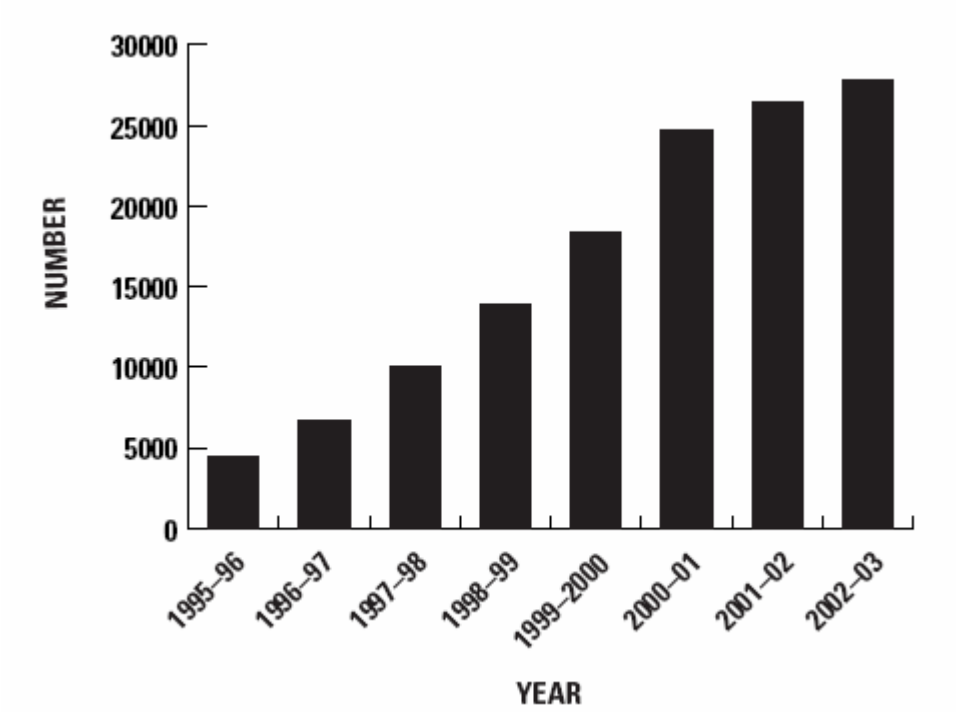

Figure 26: Number of Community Aged Care Packages, 1995-96 to 2002-03[85]

Since 1996, the Commonwealth's population benchmark for CACPs has lifted from 10 to 20 packages per 1000 people aged 70 plus. There are now 28,000 older Australians receiving support under a CACP. As older people's preferences continue to shift away from low care residential to community care, we can expect that this ratio will grow further.

There is insufficient data to enable a precise forecast of the size of this preference shift over the next decade. However the Nous Group's forecast based on the last decade's trends and feedback from stakeholders in the sector, is for an increase in the CACP benchmark each year until 2015 of one additional place per 1000 people aged 70 or over. This means that by 2015 there will need to be 30 CACPs funded per 1000 people aged 70 or over.

The ABS projects that there will be 2.5 million Australians aged 70 or over in 2015. Therefore, under the Nous Group forecast, there will need to be a total of 75,000 CACPs funded in that year (around 18,750 in Victoria).

This reallocation of funds from low care residential programs to community care packages will enlarge the overall funding for the community care system in Victoria in 2015 by an estimated $137 million. Reallocated funding per year under this forecast starts at around $10.5 million in 2006 and rises to around $16.2 million in 2015.

6.4.5 Inadequate indexation

The sector's capacity to absorb and effectively invest the anticipated growth will be affected by many factors outlined throughout this report. A further factor not substantially addressed elsewhere is the financial pressure under which the sector currently operates. Recent

[85] Department of Health and Ageing, *The Way Forward: A New Strategy for Community Care*, 2004, page 17

research by the National Institute of Economic and Industry Research (NIEIR) has highlighted the deleterious effects of inadequate indexation of the funding base on which the sector operates.[86]

The NIEIR analysis indicates that the index used to calculate indexation for the HACC Program has apparently under estimated cost movements in wages and other costs. Use of a balanced index using ABS data indicates that the sector has lost 16 per cent of capacity over the last eight years. Provision of funding to redress this situation would provide capacity to deal with existing gaps and service deficiencies and development of some of the infrastructure required by a more effective and robust sector for the future.

6.4.6 Benchmarking

Growth in the sector in the past has been somewhat ad hoc and debate regarding the adequacy of existing provision continues. The figures outlined in this report are predictions based on existing provision and reasonable estimates of growth. A more rigorous approach is desirable and should be the result of a systematic assessment of service adequacy undertaken by the sector and government. This issue is discussed in more detail in section 6.5.1.

[86] National Institute of Economic and Industry Research, *Expenditure on HACC and CACP 1993-94 to 2003-04,* Unpublished report for the Victorian Community Care Coalition, November 2005

Recommendations for action:

- **It is recommended that the Victorian and Federal Governments' plan for significant annual funding increases in the decade to 2015. Nous Group forecasts indicate that:**
  - **6.5 per cent real funding growth per year is required due to demographic change, weaknesses in system infrastructure, rising labour costs, greater client complexity and a marginally higher disability rate. These factors mean that an additional $350 million per year will need to be invested in community care for older people in Victoria in 2015.**
  - **$200m in additional funding will be required over the decade to 2015 to support an increased focus on and greater investment in supporting independence, health promotion and disease prevention**
  - **$105 million in reallocated funding will be required over the decade to 2015 due to changes in practices in the acute care sector resulting in more care in the community.**
  - **The ratio of CACP places funded per 1000 Victorians aged 70 or over needs to be increased from 20 to 30 over the next ten years to respond to the continuing shift in older people's preferences away from low level residential care towards care in the community. This reallocation of funds from low care residential programs to community care packages will enlarge the overall funding of the community care system in Victoria by $137 million 2015.**
- **It is recommended that the needs of people with a disability who are aging and the interface between aged and disability services in Victoria be recognised as a priority for further research and policy development. It is recommended that the Department of Human Services and philanthropic trusts provide resources to support this research and policy development.**

6.5 Improved funding mechanisms

This aspect of policy is one of the most crucial for stakeholders in the community care system:

- *For service users and their carers* the funding and accountability arrangements determine the type and level of services they receive, and impact upon the quality of services they access too.
- *For service providers* the funding and accountability arrangements are important because they: (1) determine the level of resources they have to deploy in their operations; and (2) set the terms and conditions governing their access to these resources.
- *For governments* the funding and accountability arrangements are the practical expressions of policy in a service sector where delivery is undertaken primarily by external entities. They are critical tools for ensuring services provided meet their policy objectives and for ensuring the sector's costs remain within budget constraints.

Section 6.4 above highlights the need for additional funding to support growth and to respond to changes in demand. The figures derive from existing effort and projections. What cannot be quantified with any confidence is any capacity deficiency which currently exists.

Reforms to funding arrangements are discussed below in three parts. They are:

1. *Funding level benchmark*-the means by which service adequacy can be monitored and maintained
2. *Allocation mechanism*-the means by which funds are allocated to particular areas and need types
3. *Payment mechanism*-the means by which care providers are funded.

6.5.1 Funding-level benchmark

An important element missing in the current approach to community care funding is an overarching mechanism by which the adequacy of funding provided to service a given number of clients with an assessed level of need can be measured. Without such a mechanism it is not possible to identify the extent of unmet need at a point in time, the types and numbers of client receiving inadequate levels of service, and to effectively plan for future service needs.

A solution is to introduce a benchmark for service adequacy. A number of models for benchmarking already exist. One approach is to set a target level of service provision at a range of need levels for a given population size (e.g. for every 1000 people aged 65+), taking account of other factors which impact on disability rates, such as cohorts of CALD or indigenous people and socio-economic conditions. For example:

Age group	CALD, indigenous share of population, socio-economic conditions	Care services: low need	Care services: medium need	Care services: high need	Care services: very high need
65-70	+/-X%	$X,000s	$X,000s	$X,000s	$X,000s
70-75	+/-X%	$X,000s	$X,000s	$X,000s	$X,000s
↓					
90+	+/-X%	$X,000s	$X,000s	$X,000s	$X,000s

Figure 27: Setting a funding benchmark

The analytical process required to define the cost at each level would involve:

- an independent, case-level assessment of desirable service levels and mixes across a carefully constructed sample
- analysis of available data on queuing, waiting list management and substitution of services
- sampling of existing service recipients to ascertain satisfaction and adequacy.

6.5.2 Allocation mechanism

At present, funding allocations to areas and levels of need are made on a program-by-program basis. Levels of government (state or federal) responsible for managing each program apply separate allocation formulae to distribute funds to different areas. The objectives and eligibility criteria of specific programs determines the funding of different need levels within each area.

This approach is problematic because it is uncoordinated and not sufficiently responsive to variations in need. Allocation decisions in one program are made without knowledge of decisions being made in another. This results in under-funding and/or misallocation of funding to particular need categories in particular areas. Programs with very flexible eligibility criteria, such as HACC, are being used to fund 'top-up' services to users whose needs cannot be met under centrally determined funding allocations.

A better approach would be to use a common mechanism for all community care funding allocations to each area. The mechanism should include benchmarks for funding allocations within each area to:

- Level of need-'low', 'medium', 'high' and 'very high' need categories
- Type of service-using the program streams proposed earlier.

Figure 28 below provides an example of how this would work. (The percentages in each box are indicative only.)

Area Allocation				
	Low need	**Medium need**	**High need**	**Very High need**
Total: 100%	Benchmark: 65% Range: +/- 5%	Benchmark: 25% Range: +/- 5%	Benchmark: 8% Range: +/- 5%	Benchmark: 2% Range: +/- 5%
	Allocation within each need level			
Early intervention and independence support	Benchmark: 30% Range: +/-10%	Benchmark: 20% Range: +/-10%	Benchmark: 15% Range: +/-10%	Benchmark: 10% Range: +/-10%
Chronic/complex health care and maintenance	Benchmark: 65% Range: +/-10%	Benchmark: 60% Range: +/-10%	Benchmark: 60% Range: +/-10%	Benchmark: 60% Range: +/-10%
Hospital and community transitions	Benchmark: 5% Range: +/-10%	Benchmark: 20% Range: +/-10%	Benchmark: 25% Range: +/-10%	Benchmark: 30% Range: +/-10%
Total	100%	100%	100%	100%

Figure 28: Example allocation mechanism

6.5.3 Payment mechanism options

The current approach to provider payments is to fund via program structures with output-based funding. However, the current program structure is fragmented. The fragmentation reduces service system responsiveness to user needs, works against optimal collaboration between providers, creates few incentives for more efficient practice and results in under-investment in system infrastructure. Program capping does give government control of overall expenditure, but it does not provide control over spending on particular need types due to the HACC program's very flexible eligibility criteria and management guidelines.

There are a range of alternative payment mechanisms:

- **Vouchers**
  In this model, vouchers with a designated dollar value of service would be allocated to users with an assessed level of need. Users would purchase services from providers with vouchers. Providers' funding would be tied to the value of the vouchers they can secure.
- **User choice**
  Under this approach, a provider's funding within each area would be tied to the number of users with each assessed need level who select them from the list of eligible providers in that area. This approach is somewhat like the current approach in residential care where a certain number of providers with a set service delivery capacity are 'licensed' or registered in each area and individuals with assessed care needs can select among those providers with capacity to meet their needs in their area.
- **Competitive tendering**
  A competitive tendering process would be conducted every three years within each planning area. A common structure for the services to be tendered would be agreed across all areas. Area planning bodies would determine the precise quantum and mix of services needed in their area, taking account of national benchmarks. Providers would enter bids to deliver specific types of services in each area and would be assessed on price and other criteria.
- **Service pool reviews**
  Under this mechanism, the allocation of funds in the overall pool for each planning area would be reviewed every three years. Twenty-five per cent of the funding base of existing providers plus the growth funding allocated to the area would be up for potential redistribution to different service types or service providers. Providers would submit proposals at this review process indicating the type and volume of service they have the capacity to provide over the next three years. These proposals would be assessed against objectives of the area planning body and re-allocations made in order to optimise the service mix in the area for the next three years.
- **Rationalised program structures**
  An option is to retain the output-based funding arrangements for providers but substantially reform the program structures. This would involve combining smaller programs, eliminating gaps and overlaps, and establishing more consistent eligibility and reporting rules. Greater responsiveness to service user needs could be built into output definitions and efficiency from providers could be driven via annual reviews of prices paid for particular outputs.

Figure 29 below classifies the various models according their position on the spectrum between 'market-based' and 'government managed', and between 'provider-driven' and 'user-driven'.

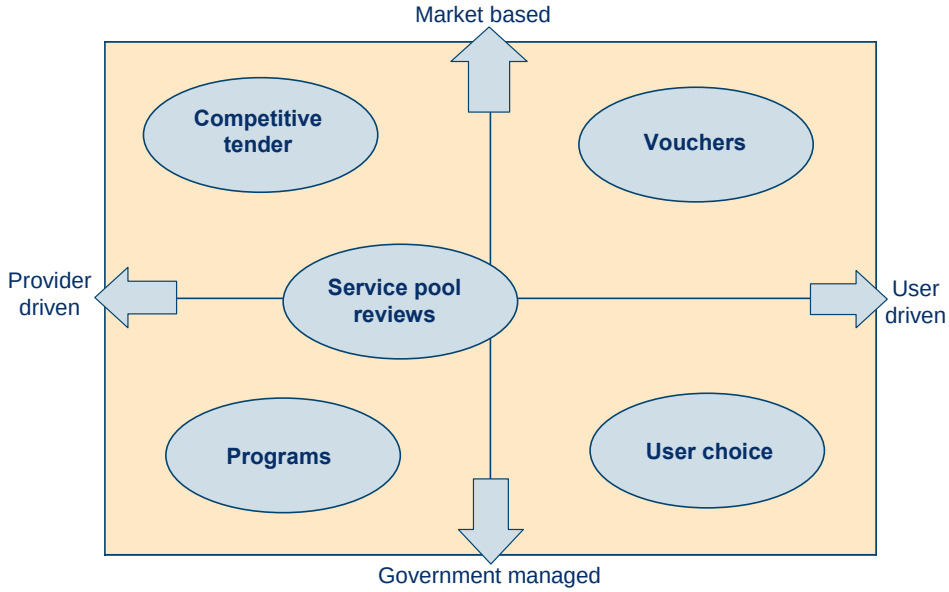

Figure 29: Classifying the funding mechanism options

6.5.3.1 Assessment: 'User choice' and 'Vouchers' models

Both the 'user choice' and 'vouchers' models seek to introduce a more user-driven, market-like mechanism to payments in order to promote greater responsiveness to user needs and greater efficiency from service providers through competitive pressure from peers. Both mechanisms allow users to choose their provider and express their preferences in regard to location, timing and personnel. Choice, though, would be limited to registered providers with capacity and in some areas at some times there may not be a large range of choices.

Coupled with a precise allocation mechanism, these mechanisms would enable governments to balance investment across areas and need types. However, entitlement-based schemes can be politically risky for governments. Allocating fixed-value vouchers to particular need levels could expose government to a big upswing in claims from the many frail aged people currently having their care needs met from family or informal carers. Vouchers may be likely to introduce unhelpful inter-organisation competition which would be counterproductive in a service system which is dependent upon cooperation and collaboration at the local service level.

Furthermore, approaches of this kind only work well in contexts with the following conditions in place:

1. There is a mature market of well-established, competing providers.
2. Purchasers are well-informed and there are minimal constraints and costs on switching between providers.
3. A comprehensive and independent regulation regime around the market exists to enforce standards.
4. The scheme does not create a new entitlement of indeterminate cost to government and is therefore not politically risky.

None of these conditions presently exist in the community care sector:

1. Previous funding approaches have created monopolies and/or set in place barriers against the development of a range of mature providers.
2. Many service users in community care have difficulties accessing information and face particular burdens in switching providers (i.e. new person to explain care needs to).
3. Providers in this sector generally self-regulate.

Introduction of a 'vouchers' or 'user choice' based scheme would, be problematic in this sector. However, given that this option is being actively considered by the current Federal Government and supported by the senior members of the Opposition more detailed consideration of this option by the community care sector is required.[87]

6.5.3.2 Assessment: Competitive tendering

This mechanism would introduce a regular competitive process to heighten pressures on providers to achieve efficiency and responsiveness, but may also undermine a range of the other target principles as a result of the wholesale changes to relationships and responsibilities at every round of tendering.

Criteria in regard to responsiveness could be built into the tender specification and into the payment structure for successful tenderers. However, a tender process that resulted in a frequent turnover of providers would diminish responsiveness in another aspect if institutional knowledge about clients' particular circumstances and needs was not effectively transferred. Frequent turnover would also harm alignment with the health and residential aged care sectors, and could diminish collaboration between providers and their commitment to building and maintaining shared infrastructure.

Regular competitive tendering would expose the cost positioning of providers to regular scrutiny and create strong incentives for costs management. However, the process itself would have its own costs in terms of administration and in terms of the cost to providers of responding to tenders. These costs would typically be added into the pricing of winning bidders.

6.5.3.3 Assessment: Service pool review

This model has many of the strengths of the competitive tendering mechanism (outlined above) but limits the percentage of each area's funding which is subject to re-allocation to 25 per cent of the previous round's allocations to providers, plus growth funds. A service pool review every three years or so would ensure that a significant share of the service system would be subject to competitive pressure and would create opportunities for new and existing providers with innovative operating approaches to deploy these approaches at scale. It would also give existing providers a degree of certainty about future revenue streams while introducing new incentives for them to refine their service suite to better meet users' needs and improve efficiency. Criteria in regard to responsiveness could be built into the service pool review process and into the payment structure for providers seeking to expand their funding allocation.

[87] Speech by the ALP's Dr Craig Emerson MP reported on Tuesday March 14, 2006: http://www.abc.net.au/news/newsitems/200603/s1591552.htm

In regard to ensuring a balance of investment across areas and needs, the 'service pool review' process every three years would enable the service mix to be adjusted to ensure services are delivered in a balanced manner across the range of needs in each area. This model also creates a regular opportunity for providers to collaborate in putting forward proposals for service delivery over the next three years. Such approaches may involve joint proposals for additional funding to deliver for new service models. Collaborative approaches could be specifically designated as a priority during the service pool review process.

6.5.3.4 Assessment: Rationalised program structures

A major overhaul of program arrangements would go a significant way to overcoming the key problems with the current payment approach. Combining smaller programs, eliminating gaps and overlaps, and establishing more consistent eligibility and reporting rules would improve the system greatly. Such reforms would need to adequately cater for sufficient investment in the three service streams outlined above. Output and activity-based funding arrangements for providers would need to be maintained to ensure financial control. However, this approach offers limited leverage to promote responsiveness from providers to user need and greater service innovation.

6.5.3.5 Overall assessment

Each of these options need to be carefully considered and evaluated. While service pool reviews and rationalised program structures appear to be the acceptable transitional options, the efficacy and consumer responsiveness of all options needs to be carefully considered.

Recommendations for action

- **The community services sector, in conjunction with the Victorian and Commonwealth Government agencies, develop community-care service benchmarks for specific levels of disability and chronic illness needs, and identify appropriate funding benchmarks for each defined level of need to guide ongoing resource development. Such work requires funding by government.**
- **Funds be allocated to jurisdictions and regional areas on the basis of an agreed equity formula and through a high-level allocational tool.**

Recommendation for consideration

- **A detailed assessment of the full range of options for reforming funding arrangements should be undertaken. The assessment should compare options on the basis of their contribution to:**
  - **focus on outcomes**
  - **balancing investment across levels of need and service types**
  - **aligning services with the health care and residential care sectors**
  - **maximising flexibility and responsiveness for users and carers**
  - **ensuring the sustainability and efficiency of the service system**

7 A capable, responsive and sustainable sector

In order to ensure that the community care sector is able to meet service user needs and government policy requirements over the coming decade, a range of responses need to be considered. Given the significance of the challenges and growth outlined, funding will be required to support the proposed development of the sector.

7.1 Mixed service system for responsiveness

Until recently, the provider landscape in community care has been reasonably stable and homogenous with the two largest categories of service (nursing and home care) being provided by a single provider in each area: nursing by the Royal District Nursing Service or Bush Nursing Service, and home care by the local council. Other service categories tend to be delivered by different smaller providers in different localities, most of whom are not-for-profit.

In the last five years there has been considerable anecdotal evidence of growth in the number of new commercial operators moving into the provision of home care services for the elderly. One indicator of this trend has been the 160 per cent growth in the number of listings in the Yellow Pages for Victoria in this category from 2000 to 2005. The sector is likely to experience further growth in the range of service providers in the decade to 2015, from both new for-profit and not-for-profit providers. Feedback from VAHEC members and other current providers of residential care suggest that they see the following in community care:

1. Clear synergies between residential aged care and community care given the similarity of client needs, and of workforce requirements and staffing
2. Prospects of future funding growth and greater consumer appetite for ‘services to the home’
3. Opportunities to build relationships with older people who may need residential care in the future.

Additionally, it can be anticipated that state and federal governments will be willing to facilitate greater competition in community care service provision through program design and funding choices which attract new entrants.

In most circumstances it has become standard public administration practice to explore avenues by which government funded services can be exposed to competitive processes to promote efficiency and process improvements. If there are efficiency gains to be achieved from structural changes in the sector (i.e. to leverage economies of scale) then governments may pressure for such structural changes.

It is important to note that there will be a limit to the extent to which the provider landscape changes in the next ten years because of how critical continuity of service provider is to clients in this sector. A wholesale shift to a completely new set of providers would have a real cost in terms of quality of outcome for clients.

The change in the provider landscape with the arrival of new entrants will create challenges of two types that will require a response:

1. *Competitive pressures and challenges for existing providers*
   These pressures will create incentives for service innovation and may lead some existing providers to cease provision of some service types and commence provision of others.

2. *System performance challenges*
   Policy and program management of changes in the provider landscape must ensure:
   - Service coherence – that clients receive high quality services that achieve program goals and meet community expectations
   - Quality assurance and regulation – that service quality and the quality of care outcomes and client well being are maintained.

7.2 Access and assessment

For frail and disabled older people and their carers, the fragmentation of the current program arrangements can make it difficult to understand what supports are available and to access them. Reforms to program arrangements should be undertaken with a focus on making it easier for users to navigate through the system.

7.2.1 Information

The service system is already difficult for consumers to navigate and is likely to become more so as more providers enter the sector. The provision of good quality, easy-to-access information about the services available has a range of benefits. It assists elderly people and their families to plan ahead and to anticipate the services they might need to access in order to maintain their independence as their frailty grows. It also enables users and carers to understand the terms of the services they are currently receiving and to monitor their adequacy as their needs change.

Early and significant work is required in order to establish better navigation aids for service users. The work required includes both paper and ICT-based systems, and local information providers and well informed service staff who can more actively assist people with information and some direct assistance. This will require additional effort which builds upon the existing strategies of state and federal governments and additional resourcing at the local level. Improving the coherence of program arrangements will also make it significantly easier for users and carers to understand the service system.

7.2.2 Assessment

High quality and responsive assessment is in everyone's interests. Service users and their carers want services that meet their needs in a flexible and responsive manner. Service providers want to deliver services appropriately. Governments want to be assured that their funds are being invested to most effectively and efficiently meet the needs of the target population. Assessment is one of the key decision-making tools which can ensure that these requirements are met.

Assessment is a complex and multifaceted process. Assessment involves judgements regarding potential service users' needs and circumstances (eligibility) and the responses which will best meet those needs (service planning). Development of enhanced assessment arrangements, protocols and processes is underway through collaborative work between governments and the sector. This is important developmental work which should continue and attract greater support in order to more quickly establish the assessment arrangements required to support the changing service system over the next decade.

Section 5.4.2 reviewed the key drivers that are likely to influence the development of the assessment function over the next decade. They can be summarised as:

- increasing expectations of service users and their carers

- the need to establish assessment tools and processes which focus upon the overall needs of the care unit
- need for a more systematic process as the result of a more integrated policy and program structure
- need for more extensive capacity to respond to more diverse demand resulting from changes in health care practice
- the need to redress past under-investment in capacity.

The aged-care sector will become both larger and more complex over the next decade. The community care component will be dealing with both relatively simple care needs and highly complex care and health needs. The residential care system will be dealing with complex needs and there will be frequent requirements for judgements by assessment staff, service users and their carers about the appropriateness of community or residential care.

The reforms to assessment arrangements that need to be considered include:

1. Progressive introduction of standardised tools supported by training for assessment at eligibility, service planning and review stages.
2. Support for increased assessment expertise within service delivery organisations dealing with low and medium need service users and carers. This includes training to enable provision of assessment as the 'public face' of the service system.
3. Introduction of independent assessment capacity for all potential and actual service users likely to require in excess of an agreed service value. To implement this step, proposals would need to be sought from organisations capable of meeting specified assessment standards and processes.
4. Development of a pilot common care-planning tool across state and federal government-funded aged care services. This could be an adaptation of the Victorian SCTT tool.
5. Development of comprehensive assessment mechanisms for service users and carers. Comprehensive assessment requires relatively high levels of skill and broad system and cross-system knowledge. Comprehensive assessment will increasingly be the point at which service users express their expectations regarding customised and divergent service requirements. Critical expectations will include:
    a. *Independence*. Independence will be increasingly expected by service users and required as the range of services and providers continues to diversify. Independence can have a number of variations, can be achieved in a number of ways and should be accompanied by the introduction of transparent reporting requirements. Major options include:
        i. assessment undertaken by an organisation not involved in service delivery
        ii. assessment undertaken by a unit or division of a service delivery organisation which is structurally separated from and has different accountability requirements from the service delivery function.
    b. *Technical skills*. The range of service needs that will be being addressed, the requirement for whole of care unit assessment and the broadened service system will all contribute to the requirement that staff and the systems which support them are seen to be increasingly technically competent.
    c. *System knowledge*. As above, a broader more complex service system with new contributors and service users needing to move between service systems will mean

that assessment services will need to manage and access knowledge about, and have relationships with, a broader system.

d. *Creativity.* The future system and future service users and their carers will demand access to a much wider, customised and innovative range of services than the standard suite currently available under existing program constraints.

As identified in section 5.2, care coordination/management will be an increasingly important function in the aged-care service system of the next decade. As the level of complexity rises and the significance of cross sectoral service provision increases, care coordination too will grow in importance.

Care coordination is a complex and intensive activity which will need to be resourced. Ongoing discussion regarding the circumstances when care management represents an effective way to guide and support service provision and where the cost is justified is required. These discussions should focus upon clarifying:

- the circumstances of the service user
- the variety of service providers and systems
- the capacity of informal carers.

These factors influence the need for this additional service element.

Recommendations for action:

- **New information systems, both electronic and local, be established to support service planning, service provision and management.**
- **The sector, with support from the Victorian and Federal Governments, expedite collaborative work on a consistent assessment policy and strategy including development of a pilot care assessment and coordination tool.**
- **Increased attention be given to the provision of system-wide assessment through:**
  - **progressive introduction of standardised tools supported by training for assessment at eligibility, service planning and review stages**
  - **support for increased assessment expertise within service delivery organisations dealing with low and medium need service users and carers**
  - **introduction of independent assessment capacity available to all potential and actual service users likely to require in excess of an annual benchmark to be determined**
  - **development of a pilot common care planning tool for use across State and Commonwealth funded aged care services**

- **development of comprehensive service user and carer assessment mechanisms.**

- **Further review of the means of establishing and resourcing independent assessment arrangements should be undertaken. Options include:**

  - **inviting proposals from organisations capable of meeting specified assessment standards and process and with effective separation from service provision where they are involved in service provision**

  - **further consideration be given to the development of care co-ordination arrangements to support changing service user needs and circumstances.**

7.3 Quality assurance and standards

7.3.1 Quality assurance

There are several elements to a quality assurance framework for community care. In broad terms the key elements are:

- Consumer-focused
  The quality of community care services is in general terms quite high. In the face of the anticipated demographic, market and service system changes discussed, specific initiatives to give service users, carers and families confidence that this will continue to be the case will be required. Consumer-focused quality assurance requires:
  - Service providers to establish, publicise and maintain consumer complaint mechanisms which are seen to be fair and accessible
  - Independent complaint mechanisms which facilitate service-user complaints and feedback. Given the size of the community care sector and the sensitivity of the services provided, careful thought will be required in order to focus these mechanisms to enable and facilitate both individual concerns and issues, and to manage and respond to service significant and systemic concerns and issues.
- Service provision-focused
  Community care providers are involved in a range of quality assurance programs. Most are designed for generic purposes or in relation to other sectors. Service standards which relate directly and in an integrated quality assurance framework for community care have not been established. Services variously access existing quality assurance and/or accreditation arrangements including:
  - the Australian Council on Healthcare Standards (ACHS), EQuIP and POS programs
    - the Evaluation and Quality Improvement Program (EQuIP) is generically designed to provide for all types of organisations which provide health care
    - the Performance and Outcomes Service (POS)provides a range of information to all healthcare organisations, e.g. to develop clinical indicators/ performance measures for health care organisations and assist health care
  - Australian and New Zealand Standards ISO 9000 series: international standards designed to help organisations establish quality management systems

- Australian Quality Improvement Council Standards modules including:
  - The Health and Community Services Core Module
  - Community and Primary Health Care (CPH) Services Standards Module
  - Home Based Care (HBC) Services Standards Module
  - Integrated Health Services (IHS) Standards Module.

States and territories have also developed jurisdiction-specific service excellence or quality assurance approaches.

Whilst these programs individually assist services to develop and maintain quality assurance practices and standards, the sector lacks, and consumers do not have access to, a benchmark system that ensures consistency of standards across the sector.

There is a strong case for a national accreditation system for community care providers. A national investment should be made in the development of accreditation and quality assurance standards that measurably define best practice in community care and address effectiveness and efficiency.

Performance benchmarks are also needed at the access points to the system. For example, VAHEC have proposed that there should be more thorough tracking of the time that people wait to receive a service after their eligibility has been confirmed. If detailed information was gathered and regularly published regarding waiting times, there would be greater pressure on service providers and governments to address demand issues. Financial incentives could be put in place to encourage the attainment of a benchmark level of responsiveness by service providers.

7.3.2 Regulation

The current regulatory arrangements, with a relatively light touch for any particular program, represent a good base from which the care sector should move with caution. However, the current program base does create problems in terms of maintaining consistent regulation for users with common needs. Two anticipated changes over the next decade will also create pressure for more comprehensive regulation. The first change is the expected increase in the number of service users with complex needs. Any service system serving higher complexity, higher risk clients is likely to be subject to greater regulatory checks. The second change is the likely entry of many new service providers. New providers will have less of a track record than established providers and so there may be pressure to introduce more extensive regulatory checks to maintain standards.

Any changes in regulatory mechanisms should provide for:

- consistency for users with common needs, which will in turn require changes to program structuring
- service provider accountability which focuses upon outcomes and establishes system-wide and service provider benchmarks
- regulatory mechanisms which are protective of service users and drive ongoing improvement in performance
- minimisation of the reporting burden for providers.

Recommendations for action:

- **A scoping study be commissioned to identify:**
  - **existing standards which could be integrated into national accreditation standards for community care**
  - **national benchmarks which measurably define best practice in delivery of community care**
  - **a process by which independent assessment of service providers' performance could be introduced to draw on the new standards and benchmarks.**

7.4 Data system development (client management and reporting)

Good information is a cornerstone of quality service provision and has been limited in this sector. Service users need information to make informed decisions about their usage of the service system. Service providers need information to manage their services on a day-to-day basis and for longer-term planning. Governments need information for planning, accountability and sector development purposes. Information and communication technology plays an increasingly central role in information management.

Several kinds of information and data are required in order to manage the service system in the next decade. Urgent developments are needed in:

1. **Consumer and community information at local state and national level**
   As outlined in the earlier analysis, the service system is already difficult for consumers to navigate and is likely to become more so as more providers enter the sector. Early and significant work is required in order to establish better navigation aids. The work required includes both paper- and ICT-based systems but also local information providers and well informed service staff who can more actively assist people with information and some direct assistance. This will require additional effort which builds upon the existing strategies of the federal and state governments and additional resourcing at the local level.
2. **Assessment and care management systems which connect with residential aged care and health systems**
   Assessment is a vital element of this sector and will become more so as the service-user profile changes. Improved assessment information systems will improve the quality of service and contribute to efficiencies particularly where cross-sectoral systems are developed.
3. **Service provision and system data, and accountability reporting**
   A range of developments are desirable in this area. Important gains have been made on the development of a common minimum data set and further developments are required in order to provide governments, service users, service providers and other stakeholders with the level and kinds of information required to guide and develop the service system.

4. **Service provision management for such tasks as rostering and route management**
   In other industries substantial investment in ICT-based management systems have improved efficiency in rostering, route management and staff allocation and are likely to contribute to improving efficiency for many community care providers.
5. **Back-of-house administrative systems.**
   Many organisations, large and small, are developing shared service systems which provide scale efficiencies and specialist skills not available in individual organisations. Many community care providers could benefit from the collaborative provision of organisational management systems.

While these are important examples of information system development, they are neither comprehensive nor definitive. The community care sector should develop a national information standard and system development strategy in partnership with government. The sector should seek to develop proposals and support for work on a common approach to access and assessment, for benchmarking of quality standards, and to advocate for implementation of a national accreditation system and a national data collection standard and system that maximises information for planning, quality and demand management and minimizes the reporting burden.

Recommendations for action:

- **National standards for community care data collection be developed in partnership between governments and the sector**
- **An information and communication system development strategy be implemented to bring the sector's capacity and efficiency up-to-date.**

7.5 Workforce

Community care faces important workforce development challenges over the next decade. Demand will be increasing rapidly while training and other structural barriers are likely to be limiting capacity. Discussions regarding the workforce should reflect the differential impacts likely to be felt in different parts of the country. Small oversupply is possible in some geographic areas and job types, while rural and remote areas are expected to suffer from dramatic undersupply.

The Productivity Commission report, *Australia's Health Workforce*, identifies a number of measures which will be required to ensure that demand for services across the health sector can be met.[88] While the community care sector has some specific requirements, the general measures proposed in the report are likely to have some impact. Critical options for generating the necessary workforce development are likely to include:

1. training more health workers
2. utilisation of skilled overseas trained workers

[88] *Australia's Health Workforce,* Productivity Commission, Canberra, 29 September, 2005.

3. increasing focus on health promotion
4. increasing rates of retention and re-entry
5. increasing the efficiency and effectiveness and responsiveness of the current workforce
6. job redesign.

In light of the skills shortages looming in community care, the sector needs to prepare a long term workforce development strategy which builds on the work currently underway.[89] The strategy should focus on:

- the commonly held positive and negative perceptions about working in community care
- workplace issues where greater focus from providers is required
- barriers to workforce development in the sector.

Recommendations for action:

- **A sector workforce development strategy be prepared as part of national health workforce planning. The strategy should focus upon recruitment and retention in order to pre-empt expected skills shortages over the coming decade. It should draw on work currently underway in the sector. This process should identify:**
  - **the commonly held positive and negative perceptions about working in community care**
  - **workplace issues where greater focus from providers is required**
  - **any barriers to workforce development in the sector.**

7.6 Research and development

Managing the changes which will occur in the community care sector and implementing the proposals outlined in this report will not be easy. In some cases, further analytical and practice development work will be required. In part, the sector is where it is because of a lack of investment in systemic research and development. If the sector is to meet the requirements of service users and governments, this will need to change.

Creating a research and practice development momentum requires three things. They are:

1. **An agreed agenda**
   Many of the elements of a research and development agenda are embedded in this report.

[89] Victoria's Department of Human Services launched a HACC Workforce Development Strategy in 2001. (http://www.health.vic.gov.au/hacc/projects/workforcestrat.htm) Under the strategy, a range of initiatives have been pursued including a project focused on how to attract new entrants to the HACC workforce.

A more systematic assessment of possible priorities should be undertaken before confirming specific initiatives.

2. **A defined and adequate resource base**
   Research and practice development are commonly under-resourced because it is hard to attract funds in a competition with direct service provision. The decision to allocate funding to R&D must be made at a high level and, when necessary, defended against claims for investment in service provision. The community care sector also needs to increase its access to existing research funds from government, academia and philanthropic sources.
3. **A leadership function**
   Drawing together the agenda and the resource base requires a leadership function. Leadership involves developing and championing the research and development agenda and leading (but not totally controlling) the research program. The leadership function also involves a heavy obligation to facilitate dissemination and uptake of the learnings from the research program. Other countries have tackled this issue through the creation of specialist centres of excellence. This model is likely to have application in Australia provided that it operates on a 'hub and spoke' model. This model is necessary to engage with and be relevant to the differing needs of our many jurisdictions and service delivery environments.

Recommendations for action:

- **Funding be provided for an Australian community care research and development institute. The institute would undertake research and development of improvements in the delivery and management of community care. It would be based upon a national hub and spoke model.**

7.7 Future financing arrangements

Users-pays approaches or co-payment arrangements exist now in the community care system but generate modest revenue. The age pension or equivalent is the principal source of income for around 75% of the population aged over 65, so most older people pay minimal or no user fees for their community care services.[90] However the strong economic conditions of the last decade suggest that it is likely that more older people, their families and possibly their health insurers will have a greater capacity and inclination to meet care costs. Governments are likely to both recognise this and use the principles of consumer choice and consumer control to constrain demand for funded services to those assessed as unable to self-fund.

Given the considerable growth in demand for community care expected in the next decade, there is a strong case for commissioning work to better understand the legitimacy, scope for and effectiveness of contributions from service users through mechanisms such as reverse mortgages and health insurance policies. There are important equity considerations as well. Accommodation bonds are used in the residential aged-care sector, so there is a precedent for tapping the equity in people's homes to contribute to the cost of their care. However, a wide range of complex and interrelated factors must be considered in designing policies in this area.

[90] Department of Family and Community Services, Fact Sheet No.3, *Income Support Recipients June 1998*, 1999

A poorly designed user fee system could create perverse incentives which could work to discourage family members and friends from providing informal care and/or in some circumstances to discourage older people from seeking support with adverse consequences for their long-term well being.

Recommendations for consideration:

- **Further analysis should be undertaken on the feasibility, scope for and effectiveness of contributions from service users, including options such as private health insurance, higher fees and home equity draw down.**

8 Leadership opportunities

Evaluating and responding to the changes outlined in this report will require leadership from the formal care system, from government, from consumer organisations, and in planning and implementation.

8.1 Formal care system

Service providers have a significant leadership task to ensure that they sustain the provision of high quality and responsive services to older people through the increases in demand and changes in services which are ahead. This is a challenging and changing mission. Proposals made throughout this report are designed to assist and support providers in this task.

The VCCC has undertaken such a leadership role through its support for and participation in this project. Service providers also have sector-wide leadership opportunities, many of which are outlined in this report. The key opportunities identified include:

- facilitating and expediting existing and proposed work on assessment
- development of benchmarking proposals
- organising standards and performance assessment models for community care
- advocacy for implementation of new data collection standards.

Sectoral advocacy for, and support of, the proposals made in this report will also be a leadership function.

Recommendation for action:

- **The community care sector should establish and support strategic leadership mechanisms to take forward the proposals made in this report and to lead towards the implementation of other recommendations, particularly:**
  - **proposed work on assessment**
  - **quality assurance standards and accreditation for community care**
  - **new data collection standards.**

8.2 Governments

Government decision making has shaped and driven the operation of the community care sector. Over the decade to 2015, governments-federal, state and local-will continue to be the primary funders and will therefore determine the parameters of service provision.

All levels of government in Australia have established interests in community care. Older people's wellbeing is a primary national interest and also an important economic policy issue. The federal government's predominant interest in aged residential care funding and policy gives focus to its interests.

State governments also have strong policy interests and major roles in service system management. The interface with health care policy is also a primary concern. Local government in Victoria, as one of the initiating forces and funders of community care, retains a strong interest in ensuring that the needs of residents are met.

Over the next decade, development of improved community care delivery will depend, in part, on improvements in the ways that the federal and state and territory governments engage with the issue and with each other. This proposition was effectively recognised when, at the Council of Australian Governments (COAG) meeting in February 2006, Australia's political leaders agreed to major reform package for Australia's health system.[91]

The locus of responsibility for leadership in this context means various things to different stakeholders. Responsibility is commonly used to include policy, funding and purchasing. These functions are to some degree divisible.

Three broad options appear to be available in this domain as with many others. They are:

1. federal government leadership
2. state and territory leadership
3. shared engagement.

In the context of this report, a comprehensive assessment of future government responsibility is difficult and likely to be overtaken rapidly by the considerations of COAG. Given the uncertainties, this report simply proposes that the debate about the roles and levels of government engagement in this sector be focused upon ensuring:

- policy consistency and integration across aged care and health
- that the level of government engaged in purchasing services is responsive and accessible
- resource adequacy
- minimising administrative duplication.

In the case of local government there are multiple and largely complementary roles. As the level of government with the capacity to represent local perspectives and the scope to provide a broad governance role at the local level, there are significant benefits in local government continuing to play a key role. Local government, especially in Victoria is also a core provider of services in this sector and invests some of its own revenue to supplement program funding. It is important that the representative and governance capacity is both recognised and separated from the service provider functions in future. Choices by local government, other providers and service users may see important changes in the level of direct service provision by municipalities over the next decade, and decisions of this kind should be made as part of local and area-based planning in light of organisational priorities. Local government's representative and governance role should, however, be strongly supported and enhanced.

[91] Council of Australian Governments, *Communiqué*, 10 February, 2006

Recommendation for consideration:

- **Decisions regarding the roles and levels of government engagement in the comprehensive aged-care policy framework and the community care program should be focused upon ensuring:**
  - **policy consistency and integration across all service sectors, including acute and primary health**
  - **that the level of government engaged in purchasing services is responsive and accessible**
  - **resource adequacy**
  - **minimising administrative duplication.**

8.3 Planning

Planning arrangements are a vital tool in transforming policy prescriptions on one hand and personal aspirations or expectations on the other, into productive action. Individuals plan informally and, on big decisions, formally. Governments need planning arrangements in order to ensure that their policy goals are effectively achieved.

As outlined in section 5.3.1 above, governments are concerned about the flexibility and responsiveness to local need of many services. These general concerns about the effective operation of government are a driver of change for community care.

International trends, both in health care and aged care, focus upon planning processes which are:

- multilayered
- area linked and population oriented
- broadly focussed (cross-program)
- involve providers in collaborative arrangements.

These arrangements are now evident in primary health care in the USA and the UK in particular. In the USA, Evercare and Kaiser Permanente are independent, non-government organisations providing integrated health and community care for area-based populations. More detail on Evercare is provided in Appendix 3.

In Australia over the next decade, planning processes will need to change to:

- respond to community expectations
- facilitate further refinement of service partnerships

- link and integrate the requirements of the policy and program approach outlined in this report.

Planning to support the development of community care over the next decade should:

- *Be comprehensive*: Program or service-specific planning will become increasingly dysfunctional and counterproductive. Planning processes will need to create the framework for interdependent and comprehensive service provision.
- *Involve key stakeholders*: Over the next decade planning arrangements will increasingly need to involve stakeholders from within the community care service system, the residential care service system and the health service system if the outcomes proposed are to be achieved. The services provided by each sector are complementary and or substitutable. Responsiveness, choice and efficiency will depend upon cross-sectoral
- planning and collaborative delivery.

Effective delivery of quality aged-care services which meet the needs of service users and carers over the next decade will require planning at multiple levels. The key challenge is to have the right tasks and functions undertaken at the right level and with the appropriate stakeholders effectively involved. The following chart outlines four levels at which planning commonly occurs. Each level is likely to be required in order to develop and deliver community care effectively over the next decade.

Level	Core Role
National	Determining a broad strategic framework for achieving agreed national policy goals Developing and refining an integrated set of high-level outcomes to be achieved through aged-care service provision Establishing a framework for determining investment mix across the range of interventions and outcome groups Defining equitable formulae for distribution of funds to jurisdictions Development of benchmarks for services Managing interface issues with other Commonwealth programs Agreeing area planning boundaries and developing accountability arrangements for jurisdictions and areas Supporting quality assurance, information and research and development capacity
Jurisdictional	Linking national policy goals to jurisdictional priorities Determining equitable formulae for distribution of funds to areas Managing interface issues with other jurisdictional programs Linking community care to intersecting service systems Agreeing area planning boundaries and developing accountability arrangements for jurisdictions and areas Supporting quality assurance, information and research and development capacity
Area	Identification of the needs of older people within the area consistent with the national policy goals and jurisdictional priorities Determining the investment mix which will best meet the long-term needs of older people in the area Defining the most effective way to organise services
Provider	Establishing corporate and business plans to deliver agreed services.

Figure 30: The four common levels at which planning commonly occurs[92]

[92] Nous Group chart based on literature reviews and input from project stakeholders.

This articulation of planning roles represents a significant upgrading of the role of area level planning with associated change in the role of central planning at national and jurisdictional levels. It leaves both Commonwealth and state and territory governments to focus upon:

- policy leadership functions
- goals and priorities
- budget and resource allocation
- quality assurance and accountability requirements.

Further details on the proposed planning role at area level are provided below in this section of the report.

The power of the change proposed will be maximised if made in concert with other reforms outlined in this report. International and local experience indicates that revised planning arrangements which include local area planning, in concert with high-level policy and outcomes being defined by governments, are effective in supporting delivery of health and community services. In the health sector these changes are being introduced internationally and there is emerging evidence of benefit, particularly in improving health outcomes and reducing cost.[93]

There are powerful and sensible reasons to link health, aged care and community care planning given the increasing connections and overlaps between the service systems. There are also significant risks which arise given the resource, status and capacity differences between the systems. The movement of community care to centre stage will be impeded if it is subsumed into a health planning paradigm. The development of a responsive aged care service system will be made more difficult if residential care remains the starting point. Appropriate planning linkages can be made if governance, focus and resourcing arrangements are effectively structured.

In presenting new planning arrangements for aged care, this report proposes that:

- reform of aged-care planning should proceed regardless of the broader and more complex issues affecting decisions on health care planning
- aged care would require specific consideration and processes within the broader health care arrangements.

As noted earlier, the evidence indicates that responsive services, capable of meeting complex needs, benefit from an area-based planning process which aligns to the scale and focus of service provision. This level of planning is complementary to, and relies upon, planning at national and state level. It also depends in part on more local planning, some of which occurs at municipal level and some at neighbourhood level.

The key features of an effective area-based planning capacity would include:

1. **Area scale**
   For planning purposes an area needs to be:

- large enough to span most of the services that would typically be utilised by most service users but small enough for effective partnership arrangements to operate

[93] *Governments Working Together*, Allen Consulting Group May 2004 p 195 referring to the Australian Institute for Primary Care 2004, *General Practice and Medicare: Options for Reform*, Draft for the Victorian Department of Premier and Cabinet.

- aligned to the maximum extent possible with planning arrangements for intersecting sectors
- align with local government boundaries and jurisdictional regions where they exist.

2. **Governance**
   Area-planning mechanisms of the kind envisaged require a level of authority and independence. Area plans have to be more than advice to a level of government or aspirational statements. They need to have formally agreed authority to develop a plan which is the framework for action. The mechanism should not, however, become another level of bureaucracy. It is proposed that the following elements form the template for developing area planning mechanisms:
   a. The authorised entity for each area would operate through a formal memorandum of understanding (MOU) with relevant governments. The MOU would define the roles and responsibilities and operating arrangements.
   b. An authorised entity would have to demonstrate that its decision-making mechanisms involved balanced input from service users and their representatives, provider organisations, local government and community interests.
   c. An authorised entity would have access to planning information and resources already in existence as the basis for the new approach. New resources may be required, however the base of the area capacity should be drawn from existing investments in all levels of government and service providers.

3. **Participation**
   Area planning mechanisms need to engage a wide range of stakeholders in order to have access to the information required and work through area-based consultation processes to build legitimacy for their decisions. Careful, area-specific consideration needs to be given to the mix of government, service provider, service user and associated interest stakeholders who are formally involved as participants in the area-planning mechanism.

4. **Funds management**
   A number of options for funds management are available to support an authoritative area-planning mechanism. The goal of each option would be to support implementation of the agreed plan. Options include:
   a. funds pooling and purchasing at the area level
   b. regional purchasing according to the area plan.

Recommendation for action:

- **The Federal Government should introduce comprehensive, cross-sectoral planning mechanisms, with clarified roles for government and consultative processes to engage the community care and other service sectors to inform and guide:**
  - **future development of community care services**
  - **detailed consideration of the initiatives and developments proposed in these recommendations**
  - **planning and service co-ordination mechanisms involving all service providers and stakeholders in geographically defined communities.**

8.4 Implementation

Leadership will also be required in establishing the processes and priorities for reform. This report has considered a number of high level and far reaching proposals. After a short period of assessment and reflection on the proposals and their implications an implementation action plan should be developed. Priority should be given to:

1. Confirmation of the level and timing of funding increases for the sector for the next five years. The provision of additional resources is an important motivating tool to encourage stakeholders to speedily and comprehensively make the changes required of them.
2. Implementation of the policy and program arrangements proposed and of the proposed funding mechanisms. In this domain, early attention should be given to:

- developing the program details to support the proposed prevention and early intervention stream and the analysis of operational and practice shifts required to increase attention to self-sufficiency across the new program
- developing a timetable and strategy to establish the community care service framework incorporating existing community care programs into the three proposed streams of care
- development of new budget, equity, allocational and purchasing mechanisms.

3. Introduction of service system changes, including:

- expediting existing work regarding assessment tools, arrangements and processes and broaden this to provide a greater focus upon the care unit
- enhanced resourcing and development of multi-level information support services
- development of national data standards.

4. Developing new protocols, planning mechanisms and funding arrangements which ensure consistent delivery of community care whether funded from a community care, health or residential care source.
5. Facilitating development of the Victorian sector through:

- rapid completion of the scoping study on relevant standards and development of new standards and benchmarks for community care.

9 Conclusion

Community care is a vital resource in our community: a resource to individuals, families and the government, and it is a resource which faces major challenges over the next decade.

Over the next 10 years the sector will be transformed. Demographic changes, health service arrangements and community preference for community rather than residential aged care will generate sustained growth in the sector and will challenge existing systems and settings.

A revised paradigm is required to deliver maximum benefit to service users and carers, achieve efficient and effective services and control overall expenditures, particularly public outlays. A renewed and broadened focus on strengthening independence is the core of the new paradigm. Independence-focused community care will be more involved in health promotion and community wellbeing, while at the same time providing critical services to individuals with high support needs. Independence-focused community care will proactively support carers as well as service users. In so doing, it will diminish emerging cost pressures resulting from the probable reduction in caregiver availability.

New policy, program and funding arrangements focused upon outcomes and consolidated streams of service will be required. A more robust and heterogenous service system which more effectively plans for the service needs of the community and helps older people and carers navigate the system will be required. Changes proposed in the report are designed to improve and simplify the community care interface with the health care and aged residential care sectors.

To give government, taxpayers and service users greater confidence in the system, new quality assurance and data systems will be required. All stakeholders will have to be engaged in tackling the problems of maintaining and growing the workforce required.

All of this change will require leadership. Leadership from all levels of government, service providers and consumer interests. This leadership will have to be delivered through better allocation of responsibilities and the establishment of new planning processes and structures to enable the system to work effectively in the interests of older people.

10 Report recommendations

Throughout the preceding sections, this report has recommended actions to support future growth and development; to enable the community care sector to provide leadership in the planning and delivery of health, community and residential services for the aged; and to develop system capacity, sustainability and responsiveness. There are two types of recommendations:

Recommendations for action are addressed to the Victorian community care sector, the Victorian State Government and, where applicable, the federal government.

Recommendations for consideration address strategic issues on which further work or debate is relevant and warranted.

The full list of recommendations is presented below.

Meeting future growth and managing development

Recommendations for action

Policy and program frameworks

1. An aged-care policy framework be developed, through collaboration between the federal government and state and territory governments, to provide for:

- 'ageing in place' (encompassing community care, acute and primary health care and residential care)
- 'continuum of care'
- support for the 'care unit' (service users and their carers).

2. That action be taken, through collaboration between the federal government and state and territory governments, to establish a coherent community care program framework and integrate existing community care services within the following streams of care:

- early intervention and support for independence
- chronic/complex health care and disability maintenance
- hospital and community transition services.

Focus on strengthening independence

3. That reformed program arrangements in community care give increased priority to:

- strategies designed to sustain and expand the range of community, family and other informal care providers
- interventions and actions which prevent or delay the occurrence of preventable disability and illness
- early interventions which maintain optimal independence, social engagement and health with disability and chronic illness.

Resourcing future growth

4. It is recommended that the Victorian and Federal Governments' plan for significant annual funding increases in the decade to 2015. Nous Group forecasts indicate that:
   - 6.5 percent real funding growth per year is required due to demographic change, weaknesses in system infrastructure, rising labour costs, greater client complexity and a marginally higher disability rate. These factors mean that an additional $350 million per year will need to be invested in community care for older people in Victoria in 2015.
   - $200m in additional funding will be required over the decade to 2015 to support an increased focus on and greater investment in supporting independence, health promotion and disease prevention.
   - $105 million in reallocated funding will be required over the decade to 2015 due to changes in practices in the acute care sector resulting in more care in the community.
   - The ratio of CACP places funded per 1000 Victorians aged 70 or over needs to be increased from 20 to 30 over the next ten years to respond to the continuing shift in older people's preferences away from low level residential care towards care in the community. This reallocation of funds from low care residential programs to community care packages will enlarge the overall funding of the community care system in Victoria by $137 million 2015.

5. It is recommended that the needs of people with a disability who are aging and the interface between aged and disability services in Victoria be recognised as a priority for further research and policy development. It is recommended that the Department of Human Services and philanthropic trusts provide resources to support this research and policy development.

Funding mechanisms

6. That the community services sector, in conjunction with the Victorian and Federal Government agencies, develop community care service benchmarks for specific levels of disability and chronic illness needs and identify appropriate funding benchmarks for each defined level of need to guide ongoing resource development. Such work requires funding by government.
7. Funds be allocated to jurisdictions and regional areas on the basis of an agreed equity formula and through a high-level allocational tool.

Recommendations for consideration

8. A detailed assessment of the full range of options for reforming funding arrangements should be undertaken. The assessment should compare options on the basis of their contribution to:
   - focus on outcomes
   - balancing investment across levels of need and service types
   - aligning services with the health care and residential care sectors
   - maximising flexibility and responsiveness for users and carers
   - ensuring the sustainability and efficiency of the service system.

9. Further analysis should be undertaken on the feasibility, scope for and effectiveness of contributions from service users, including options such as private health insurance, higher fees and home equity draw-down.

Enhancing capacity, responsiveness and sustainability

Recommendations for action

Access and information

10. New information systems, both electronic and local, be established to support service planning, service provision and management.
11. The sector, with support from the Victorian and Federal Governments, expedite collaborative work on a consistent assessment policy and strategy, including development of a pilot care assessment and coordination tool (i.e. adaptation of the Victorian SCOT tool).
12. Increased attention be given to the provision of system-wide assessment through:
    - progressive introduction of standardised tools supported by training for assessment at eligibility, service planning and review stages
    - support for increased assessment expertise within service delivery organisations dealing with low and medium need service users and carers
    - introduction of independent assessment capacity available to all potential and actual service users likely to require in excess of an annual benchmark to be determined
    - development of a pilot common care-planning tool for use across State and Commonwealth funded aged-care services
    - development of comprehensive service user and carer assessment mechanisms.

13. Further review of the means of establishing and resourcing independent assessment arrangements should be undertaken. Options include:
    - inviting proposals from organisations capable of meeting specified assessment standards and process and with effective separation from service provision (where they are involved in service provision)
    - further consideration be given to the development of care co-ordination arrangements to support changing service-user needs and circumstances.

Quality assurance and standards

14. A scoping study be commissioned to identify:
    - existing standards which could be integrated into national accreditation standards for community care
    - national benchmarks which measurably define best practice in delivery of community care
    - a process by which independent assessment of service providers' performance could be introduced to draw on the new standards and benchmarks.

Data system development

15. National standards for community care data collection be developed in partnership between governments and the sector.
16. An information and communication system development strategy be implemented to bring the sector's capacity and efficiency up to date.

Workforce development

17. A sector workforce development strategy be prepared as part of national health workforce planning. The strategy should focus upon recruitment and retention in order to pre-empt expected skill shortages over the coming decade. This process should identify:
    - the commonly held positive and negative perceptions about working in community care
    - workplace issues where greater focus from providers is required
    - any barriers to workforce development in the sector.

Research and development

18. Funding be provided for an Australian community care research and development institute. The institute would undertake research and development of improvements in the delivery and management of community care. The institute would be based upon a national hub and spoke model.

Leadership opportunities

Recommendations for action

Formal care system

19. The community care sector should establish and support strategic leadership mechanisms to take forward the proposals made in this report and to lead towards the implementation of other recommendations, particularly:
    - proposed work on assessment
    - quality assurance standards and accreditation for community care
    - new data collection standards.

Planning

20. The Federal Government should introduce comprehensive, cross-sectoral planning mechanisms, with clarified roles for government and consultative processes to engage the community care and other service sectors to inform and guide:
    - future development of community care services
    - implementation of the initiatives and developments proposed in these recommendations
    - planning and service co-ordination mechanisms involving all service providers and stakeholders in geographically defined communities.

Recommendation for consideration

Government engagement

21. Decisions regarding the roles and levels of government engagement in the comprehensive aged-care policy framework and the community care program should be focused upon ensuring:
    - policy consistency and integration across all service sectors, including acute and primary health
    - that the level of government engaged in purchasing services is responsive and accessible
    - resource adequacy
    - minimising administrative duplication.

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Appendix A: Project Steering Committee members, Project Reference Group members, and Members of the Victorian Community Care Coalition

Members of the Project Steering Committee

Clare Hargreaves, Municipal Association of Victoria

Lindy Spurr, Royal District Nursing Service

Gerry Naughtin, Council on the Ageing Victoria

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Members of the Victorian Community Care Coalition

ACROD Victoria

Alzheimer's Australia VIC

Australian Association of Gerontology VIC

Australian Medical Association VIC

Australian Society for Geriatric Medicine

Carers Victoria

COTA VIC

Ethnic Community Council of Victoria

Municipal Association of Victoria
Office of the Public Advocate
Royal District Nursing Service
Victorian Association of Health & Extended Care
Victorian Healthcare Association
Victorian Council of Social Service
VICRAID
VICSERV
Catholic Health Australia

Appendix B: People Ageing With a Disability

The following document has been contributed by ACROD Victoria and VICRAID.[94]

People who have life long or acquired intellectual, physical, sensory or psychiatric disability and who are ageing are a particular population group that require significant policy attention. The concept that people with a disability are transferred to the aged care service systems when they reach 65 is not appropriate. However, there are a unique set of clinical, service delivery and funding challenges that need to be addressed. This section summarises these challenges.. This appendix summarises some of the issues that need to be addressed as part of policy work in this area.

The following section is an extract from a report prepared by Dr Chris Fyffe for VICRAID and ACROD titled "Towards a Positive Third Age for People with Disabilities".

This report reflects the views of VICRAID and ACROD about the directions of the Victorian Government should take on this vital issue. There are a number of major policy issues that need to be addressed in regard to the policy framework that should be adopted in regard to people with a disability who are aging. The sponsors of this report recognise as a matter of high priority. This issue requires further research and policy discussion.

Not all older people with disabilities have dramatically increasing support needs. There is a danger that failures of the service system to respond to people's changing needs go unrecognised and are described in terms of the assumed deficits of all older people. Some of what is described as older people wanting a change or a choice could be as reasonably applied to younger people. Rigidity of the service system boundaries and the lack of positive ageing policy limits the service options for older people with a disability.

It is also relevant that the general community has stereotypes and restricted views about older age which do not reflect the reality of people's diverse lives – the same stereotypes could be expected (and have been found) more generally amongst service providers for people with disabilities. These attitudes and expectations have a profound impact when staff have a major role in planning an individual's lifestyle. Lack of attention – or capacity – from disability services to respond to older people's health, skill maintenance and sense of self have been reported. Conversely, the Aged Care system has knowledge of older age and illness but not in the context of younger old people with longstanding disabilities where individualised planning and choice have been core service principles.

The service responses to positive ageing are part of the continuum of strategies required to respond to people experiencing additional ageing-related disability and illness. The following initiatives consider the current group of older people including those where service providers are reporting difficulties, and those people with disabilities who are currently middle aged and younger. Many of these initiatives rely on partnerships between different service types, in particular day support and the individual's accommodation arrangements. Many of the initiatives have the potential to be incorporated within existing service delivery options and processes.

Actions required by service providers and planners in disability and aged care sectors for people commence with defining the meaning of "ageing in place" and "positive ageing" within the disability sector, and the links with Aged Care and HACC. Specific initiatives are required from some older people who are inadequately supported now, within the context of the overall policy of healthy ageing. Some of these initiatives may be less critical in time if earlier

[94] The assistance of Phillipa Aspley and Murray Dawson Smith in the preparation of this appendix is acknowledged.

planning and responses to issues of older age are implemented. The extent to which early and intensive home based support can and should offset the demands for shared accommodation for people with developmental disabilities requires exploration. This ultimately will lead to better definition of services and support for people in the third and fourth ages of life who have long-term life experience with a disability.

As most older people with disabilities will be living with family members or in supported accommodation, (and most will have an intellectual or cognitive disability), it is the interface between home and external services and supports which must receive the most attention in the context of exploring relevant services and supports for the third age. This will mean differing initiatives for people in shared accommodation compared with those living with elderly carers.

Towards a Positive Third Age for People with Disabilities (Extract)

By Dr Chris Fyffe

Commissioned by ACROD and VICRAID

2004

A policy framework for positive and active ageing

An articulation of Victorian disability policy is required from which non-government organisations can establish an operating framework. In general terms, despite initiatives from individual agencies, the current group of older people with disabilities are experiencing the impact of very negative or uninformed stereotypes about ageing in the disability sector, combined with a lack of support from positive ageing –related health and well being strategies. These latter services and supports are provided by the HACC program for people who are not in the state disability system or are without these long standing disabilities. The result has been support for people with intellectual disability in the context of that disability, but not attuned to their older age.

A Victorian DisAbility policy on ageing with a longstanding disability

Goal

To have a Victorian DisAbility policy statement on ageing with a longstanding disability in the context of the State Plan for Disability Services which would:

- Be based on the principles of individualised planning, healthy and active ageing, and ageing in place.
- Identify the third age as a life stage transition point within disability services (compared with school to work) and the characteristics of services and support for the third age.
- Remove the actual or implied upper age limit for disability services making it clear individuals will typically continue to remain supported in their third age by the disability sector. This would include access for people who approach the disability system for the first time for support in the third age and describe the transition from full time supported employment to services supporting the third age.

- Emphasise the importance of people remaining in their own homes, be that shared accommodation or private home.
- Describe the parameters and support issues inherent in ageing in place policies for people living with older carers.
- Describe the nature of ageing-related disabilities and who has the mandate for response, particularly in relation to promoting physical and sensory access and nursing.
- Describe the relationship with Aged Care for the frail aged population, that is, for example, under what circumstances could someone not be supported in their long standing (shared) accommodation arrangements and seek nursing home support.
- Describe the circumstances when an individual may be required to move house within the disability sector. This would include when development of shared accommodation for people with additional ageing related specialist support needs may be desirable and viable, such as specialist nursing, aids and equipment, additional staffing.

A partnership between sectors

While the State DisAbility Program can define its own policy framework within current resources, there are significant cross-sectorial issues to be resolved. While these don't need to precede disability policy, the program boundary issues will ultimately moderate the effectiveness of the state disability initiatives. Most particularly, the relationship with disability shared accommodation and HACC services for health support and aids and equipment for people who develop additional ageing-related disabilities and who require additional assistance to stay in their own homes, albeit shared accommodation. What is the role of the Commonwealth in "top up" in relation to ageing related issues such as physical access, aids and equipment, nursing, or access to supports and packages such as HACC, CACPs and Linkages? There may be a Commonwealth funding role in minimising the likelihood of nursing home care being needed. The precedent whereby HACC services support people in Supported Residential Services is relevant here.

Goal

To develop a continuum of service responses in partnership between DisAbility, HACC and Aged Care.

Initiatives

Table D describes a relationship between the service sectors for people with disabilities with varying support needs, and as they become older. A new service response for people living in shared accommodation with high disability support needs and high ageing related support needs is proposed. This is level 4 on Table D. This response requires a partnership with disability and HACC services, similar to that which occurs in people's private homes already.

Service and support needs	Increasing support needs of person with a disability	Provider
1. Individual needs assistance within own home, but not personal support Entry point – people with low support needs due to age or disability that is, any age	Provision of aids, equipment, adaptation, home help, home maintenance, social support, transport. Employment, day and leisure activities determined by individual. Transport may be available. Carer- In home and facility respite, carer support in their own right as an older person.	HACC
2. Individual needs staff personal support in home Entry point: People who require personal care at critical times. Variations for people who are older or with disabilities, older only (CACPs) and disability only with higher support needs.	Provision of hours of staff time at pertinent times. Employment, day and leisure activities determined by individual. Transport may be available. Home renovations and adaptations. Carer- In home and facility respite, carer support in their own right as an older person.	CACPs Linkages or State disability eg Home First, IHAS which have higher hours. Making a difference
3. Individual requires 24 hour staff support Entry point: People who cannot be left alone – may be nature of disability or increasing need where levels 1 and 2 no longer enough. Mainly people with developmental disabilities.	Shared accommodation (higher staff costs necessitates group living). There is limited/ no shared accommodation for other groups, especially those with later onset. Typically requirement for full time day support.	State disability
4. Individual requires 24 hour staff support and is experiencing higher support needs of ageing Entry point: People with high support needs due to a lifelong disability who experience additional impacts from ageing (especially increased need for supervision, medical support, home/ equipment adjustment)	Shared accommodation with capacity for staffed house during the day, in home nursing; aids and equipment; more flexible transport for day activities. There is no mechanism for ageing-related input. Requires a precedent as for HACC services with SRSs.	State disability and HACC
5. Nursing home Entry point: People who are frail aged in their last year of life with no alternative informal supports.	For frail aged – typically for people in their last 6-12 months of life	Residential aged care

Table D: A proposed continuum of support across the aged and disability sectors

When older people do have additional ageing-related support needs

The preceding continuum of service responses acknowledges the range of support needs of older people who have lifelong disabilities. Most of the following proposals focus on the overall group of older people many of whom will not have significant ageing-related disabilities. However, some older people will have significant additional ill health and disability related issues. Currently, it is this group who are causing great concern to service providers who feel unable and under resourced to respond to these new support needs. While nursing homes may be an option at this stage, they will not be the sole solution, or necessarily available (see levels 4 and 5, Table D). There are immediate and longer-term support issues if an older person does deteriorate, particularly if this occurs rapidly.

Goal

To develop service responses for people who experience significant and at times rapid ageing related disabilities.

Initiatives

- Develop a "top up" capacity for shared accommodation to provide additional staffing or specialist medical responses, including while individuals are waiting for a nursing home.
- Development of shared accommodation for older people with ageing related disabilities/ illness (for example in clusters.) This requires resolution of policy issues in relation to when people would be asked to move from their own (shared) housing.

Towards services and support for the third age in disability services

Within an overarching policy on ageing with a longstanding disability, responses to the different support needs of older people in the third age can be developed. The focus for such service development is likely to be people's homes- either family home or shared accommodation and partnerships to promote flexibility with others services and supports. The capacity to respond to and support any changing ageing related health and disability needs is fundamental. However, no one-service structure is proposed as there is no one solution for all situations, but rather there are common principles, which can be applied.

It has been stressed that the majority of older people with long standing disabilities are in the younger old group that is not the target for Aged Care. Within this group, there are people with additional ageing –related disabilities. It is therefore possible to articulate the additional capacity the disability system requires, noting that this system does have little experience with older people. In general, there are several additional service responses required:

- Staff having a positive and diverse view about getting older which will then underpin their expectations and relationships with older people and the subsequent program planning.
- The service's capacity to respond to increasing support needs. This has implications for individual funding and review processes and service design and interface issues.

- Some health-related issues that may be new to the disability system, or at least new to the present provider/ staff group. For example, reduced physical stamina, reduced physical mobility and pain due to arthritis, confusion and memory loss, incontinence.
- Planning for older age and emphasising health and healthy lifestyles, maintaining their skills and assisting people to understand about being older. That is, planning for active older age.

Develop training strategies for all staff and management

Goal

By training and recruitment, increase the skills and knowledge of staff in the disability sector about ageing with a disability

Initiatives

- Recruit people familiar with positive ageing, grief, dementia etc to create a pool of staff skilled and interested in working with older people with lifelong disabilities.
- Identify within existing staff pools those with skills or interest in working with older people.
- Ensure issues for supporting older people are included in work force competencies and training plans.
- Ensure information and support strategies to staff and other residents in relation to the death of an individual or their family members.

Reviewing agency and funding policies and practices for their impact on older age

Any shared accommodation arrangements would consider the known impact of people living in the one home for decades. Issues to be planned in advance would be housing design, physical access and capacity for renovation. The rationale for house groupings would also consider older age and the capacity to establish and maintain social groupings.

Goal

To ensure that policies and practices of the disability sector aim to minimise known difficulties associated with older age.

Initiatives

- Ensure that all house groupings, included those due to vacancy management practices, are cognisant of the longer-term issues for each house grouping.
- Ensure that standards for housing are established which are sensitive to physical, visual, and auditory access and the potential for renovation.
- Remove the upper age limit for all disability services (for example IHAS, Flexible options) to ensure people can remain in familiar surroundings.

Individualised planning for older age

There is evidence that there is not systemic, agency-based or individualised planning for people with disabilities before they reach older age. Such planning would assist making ageing in place more of a reality. Such planning and information is relevant for individuals in their younger and middle years; how people are grouped; physical access; and information for parents and carers.

Individualised planning at regular times and following specific events remain the cornerstone of planning for older age. There is an ongoing need for individualised and early planning for third age activities and ageing, as part of lifelong planning for support. This would include the capacity for reviewing changing support needs. This planning would be educative for carers and the individual, as well as staff, about issues for the future.

Establish age appropriate assessment and review

Goal

An age appropriate assessment and review process to be incorporated with individual planning (GSP as relevant) processes. This process would be part of annual reviews and in response to key life changes and events.

Initiatives

- Trial an appropriate assessment and review process, which includes lifestyle planning across programs/ services and annual review of functional abilities (for example, broad screen checklist (MINDA) or FIM (Spastic Society NSW). Identify age and event triggers for broader implementation.
- Review health ageing planning for all older people to include health screening for all people annually at least from 55 years of age.

Determine how to respond to changing, individual support needs of older people

Goal

A process to respond to an older person's increasing age-related disability or ill health.

Initiatives

- Establish specialist case managers with flexible brokerage funds and monitoring capacity for older people, particularly those with an intellectual disability as this group are under represented in case management. These could be assigned as a percentage of existing case management resources within disability services.
- Maximise the numbers of older people living with older carers receiving Linkages and CACPs.
- Include State trustees where relevant in planning and review to establish individual resources to achieve preferred lifestyles.
- Develop a specific focus in screening and planning for people with Down's syndrome, who have a higher and earlier prevalence of dementia.

Funding packages for the whole person

Goal

To have the capacity to plan for an individual's total support needs as those needs may change. This would reduce the rigidity between current state program boundaries, particularly shared accommodation and day support.

Initiative

Establish individualised funding packages for older people across all support needs, consistent with other initiatives incorporating individual funding.

Involving carers in developing services for the third age

People living with older carers are increasingly going to out live their parents. Ideally, preparation and support would be to maximise the likelihood that the person with the longstanding disability can stay in their local area or home or have a planned transition to shared accommodation. This requires planning the support to the older carer and the person with a longstanding disability who is now older. The aim is to minimise occasions whereby the death or incapacity of an older carer precipitates sudden and disruptive accommodation options for the individual with a disability.

Planning with older parents and carers

Goal

To involve parents and carers in the planning processes for services and supports for their older family member.

Initiatives

- Involvement of carers in regular individualised planning processes (see above).
- Nominated staff to work consistently with older carers about options.

New directions in day support

For many older carers, day support is expected to be away from home and five days a week. This has been their experience over many years and household patterns have developed as a consequence.

Goal

To develop new service responses to maintain support for older carers and move to third age activities for older people with disabilities.

Initiatives

- Develop options for day support whereby older people are not required to be away from their homes and the needs of older carers are satisfied. In some instances, individuals will be able to stay at home, in others, in home support may be required.
- Maximise access to HACC, Linkages and CACPs for older people with disabilities and their carers.
- Encourage regular respite for the older carer and experience for the individual in different in home or out of home settings.
- Establish options for emergency respite for older carers.
- Allocate a percentage of Flexible Care Packages (MaD) for people with disabilities over 65 years.

Develop shared accommodation arrangements relevant to people in their third age

It is typical of people in their third age that more of life is based around and from home. Models of shared accommodation have been developed assuming people will not spend major portions of the weekdays at home.

The option of more time at home

Goal

Ensure older people are not forced to leave their home all day because of program boundaries and restrictions.

Initiative

- Identify the additional funds required to have additional daytime staffing for the target people in shared accommodation. This could include changing the rosters in supported accommodation to include a later start in the mornings, to viable options for staffing available throughout the day.
- As an alternative to any increased funds to day services, fund the increased time in residential settings for older people to be more home-based. This would necessarily create spaces in day support.
- Explore how older people's day support funds could be translated into more flexible arrangements.
- Develop incentives for agency- network plans for responding to progressive changing needs, particularly between day support and community accommodation. Negotiate at a local for increased flexibility for the individual in or between service boundaries.

Aim that older people do not have to move from their homes

Goal

To identify ways the current service configurations can be more flexible and responsive to the issues for older people and their carers.

Initiatives

Audit all new and existing houses for suitability for older age regarding access (physical, visual, hearing) so that there are no major obstacles to individuals continuing to live in these houses over many years.

Appendix C: Profile of Evercare Health Care

Evercare was established in 1987 as a pilot programme for the US Federal Government and today is a national programme serving over 60,000 individuals. Evercare is regarded as one of the most successful US Federal demonstration projects implemented during the last decade. The core principles of Evercare are:

- apply an individualised, whole-person approach to health and long-term care of older persons, with all interventions focused on promoting maximal function, independence, comfort, and quality of life
- use primary care as the central organising force for health care across the continuum
- provide care in the least invasive manner, in the least intensive setting
- avoid adverse effects of medications and polypharmacy
- use data to strengthen decision-making.

Studies on the Evercare approach in the US have shown that Evercare:

- has demonstrated a 50 per cent reduction in the hospitalisation rate of its enrollees in care facilities while achieving the same mortality results as compared to a control group (Kane 2002)
- significantly reduces the number of prescription drugs a Medicare person takes while maintaining health, which achieves cost savings for beneficiaries and lowers side effects
- has a 97 per cent satisfaction rating among families, as well as an extremely high physician satisfaction rating
- contributes cost savings to the Medicaid and Medicare programmes-estimates are that the programme has resulted in federal budget savings of 7 per cent for the population it serves.

A programme based on the Evercare approach is currently being established by the UK National Health Service in conjunction with nine Primary Care Trusts to implement managed care for vulnerable elderly.