Future care at home reform: Key insights from consultation

Overview

A public discussion paper on future care at home reform was available for consultation from 13 July to 21 August 2017. Some 318 written submissions were received from a range of stakeholders, including providers, consumers, carers, assessors, local and state governments, professional associations, advocacy groups, and peak bodies (see Attachment A). This report provides a summary of the key issues and feedback from the consultation, but is not intended to be an exhaustive compilation of the sector’s views. Key messages are outlined below.

Overall program design

- General support for the policy objectives identified in the discussion paper.
- Many providers want greater flexibility in program arrangements to respond to consumers’ needs, including those with diverse needs – but there were differing views on the most appropriate funding model/s.
- Broad support for an integrated assessment model, including a combined Aged Care Assessment Team (ACAT) and Regional Assessment Services (RAS) workforce.
- General agreement that the current approach to consumer contributions and fees is inequitable, both within and between programs. Needs to be addressed to ensure the system is fair and fiscally sustainable, and to address current disincentives for consumers to move from home support (Commonwealth Home Support Programme services (CHSP)) to home care packages.
- Strong support for a greater focus on short-term restorative care and reablement approaches, as well as ongoing services for those who require it. Some suggested there needs to be complete rethinking of the consumer pathway to ensure that program design allows for short-term restorative care and reablement interventions before the need for ongoing support is assessed.
- Broad agreement that improved supports for consumers and carers to navigate the system and access care are needed.
- Some stakeholders highlighted current gaps in service provision and funding, e.g. aids and equipment; palliative care; dementia services; respite services; carer support; consumers with diverse needs including older people with disability or mental illness; and access to health and aged care services in rural and remote areas.

Future reform and implementation

Many stakeholders commented on the approach to future reform and implementation. Common themes were:

- The pace of reform needs to slow down – as many providers and consumers are still ‘catching up’ with previous and current reforms.
- Need to bed-down, evaluate, and learn from outcomes of reforms to date before making major decisions about future reform.
- Reform must be co-designed with the sector.
- Implementation needs to be phased – not ‘big-bang’ reform at a single point in time.
- Must allow adequate time for communication and transition, including government advising the sector about timeframes well in advance of major changes taking effect.
- Ideally, major changes (especially to systems and funding models) should be piloted or trialled before national rollout.
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Objectives of an integrated care at home program

- Most stakeholders supported the policy objectives outlined in the discussion paper.
- Some additional objectives were also suggested, including:
  - Program arrangements should be flexible to meet consumer needs.
  - Equitable consumer contributions – those who can afford to pay should do so, with safeguards for those who cannot.
  - Recognise and support informal carers in their own right.
  - Recognise the importance of providers and support capacity building, including the workforce, in the sector.

An integrated assessment model

Single assessment workforce

- There was broad support for a single assessment workforce, combining the RAS and the ACATs. Many stakeholders felt that a single independent assessment process is a prerequisite to a future integrated aged care system.
  - It was suggested that a single assessment workforce could improve the consumer experience, in terms of minimising assessment time and the amount of information that needs to be provided by the consumer, more consistent processes, and more timely access to the appropriate level of care.
  - Most stakeholders emphasised the importance of having appropriately skilled assessors (e.g. multidisciplinary mix of skills and expertise) who are familiar with both local aged care and health services, and are independent of service provision.
  - Some highlighted the inconsistent performance of RAS, including variable knowledge of the local services available. Some stakeholders suggested that some RAS may be currently influencing consumers’ choice, e.g. towards RAS-affiliated service providers.

Streamlined assessment for entry level needs

- A common view was that the intensity of an assessment should be proportionate to a consumer’s needs.
  - Stakeholders suggested the need to streamline assessment for entry level needs, as the current assessment process to access basic services is regarded as overly complex. Some felt that the current assessment process is dissuading some consumers from seeking care.
  - Direct-to-service assessment/referrals by providers/health professionals (e.g. GPs) and self-assessment were suggested as alternative mechanisms for more timely access to basic services.

Duplicate assessments

- Duplication in the collection of consumer information was also highlighted as an issue.
  - Stakeholders felt that the current arrangements (where there can be multiple investigations by My Aged Care screening staff, assessors, service providers and health professionals) can be very frustrating for consumers and their families, particularly if they have to continually ‘repeat their story’.
  - CHSP providers said that there is often insufficient information about the consumer in the referral to inform service delivery (e.g. dietary or accessibility requirements). As such, the providers often needed to conduct a service level assessment, which they are no longer funded to undertake.
  - It was suggested that there should be greater ability in My Aged Care portals for assessors and providers to contribute to a central repository of information about a consumer that can be shared between them (with appropriate permission from the consumer).
Short-term restorative care and reablement

Short-term interventions before ongoing care

- Most stakeholders strongly supported short-term restorative care and reablement interventions prior to assessment for ongoing care (if the consumer has the potential to benefit from such interventions). It was noted this will not be easy or simple reform. Some suggested there needs to be complete rethinking of the consumer pathway to ensure that program design allows for short-term restorative care and reablement interventions before the need for ongoing support is assessed.
  - Such interventions should not be compulsory for all consumers, and assessment and referral for short-term support must not delay access to care and services where this is needed.
  - Some stakeholders noted that there may be instances where a consumer has the capacity to benefit from reablement services, but they may prefer ongoing services.

Supporting a wellness and reablement focus

- Many stakeholders emphasised the need for timely access to assessment and short-term interventions to ensure that a consumer’s condition does not decline beyond the point of reablement.
- Most felt that assessments need to have a greater focus on wellness and reablement. Assessors should shift the current focus from identifying a consumer’s deficits – to strengths and capacity and how best to support wellness and independence.
- Stakeholders noted that current arrangements do not support home care consumers in moving to a lower level package if their condition improves. It was suggested that a future program must allow for seamless movement between package levels (up and down).
- Some stakeholders noted the workforce implications of supporting a wellness and reablement focus, including the need for staff training, and the increased investment of time required.
- It was suggested that consumers should not be limited to accessing short-term high intensity interventions before receiving ongoing care – such interventions should be available on an as-needed basis, even when ongoing services have commenced.
- Continual monitoring and evaluation of outcomes of short-term interventions is essential in supporting a wellness and reablement focus. This will require more regular reviews and reassessment of consumers’ care needs. Some suggested that a large amount of unspent funds in a package could be a prompt to review the consumer’s care plan over time.

Changing the mix of home care packages

Higher level package

- There were mixed views about a new higher level home care package, but overall, most stakeholders did not support introduction of a ‘level 5’ package at this time.
  - Some stakeholders felt that, if sufficiently funded, a higher level package could enable some people with complex care needs to remain living at home for longer.
  - Other stakeholders expressed reservations about the safety and cost effectiveness of a new higher level package as an alternative to residential care (e.g. adequacy of staff qualifications, suitability of the home environment for high care needs, availability of suitable equipment, increased pressure on carers).
  - Some were concerned about the risks of future unmet demand for residential care if the new package level was funded through a reduction in residential care places.
  - Many suggested that it would be better to increase funding of the existing home care package levels (e.g. more packages or higher subsidies), rather than introducing an additional level at this time.
Lower level packages

- Most stakeholders felt that lower level home care packages, particularly level 1, lacked utility.
  - The funding for a level 1 package (around $8,000 p.a.) was generally considered to be insufficient to meet care needs, particularly once management/administrative fees are deducted. By comparison, the CHSP can often offer similar service levels with lower fees.
  - Some stakeholders suggested that funding for level 1 packages could be converted to higher level packages or redirected into the CHSP.

Review of home care packages

- Some stakeholders suggested that a review of home care packages should be undertaken before considering further changes.
  - It was suggested that a review could consider the number and mix of packages, and funding levels including ‘smoothing’ the subsidy amounts between levels.
  - Enabling greater flexibility in home care package funding (e.g. access to a pool of flexible funds for episodic care needs, time-limited supplements) to accommodate temporary increases in care needs was also suggested.
  - Some stakeholders suggested that additional supplements could be introduced to support consumers with higher care needs, such as nursing or palliative care.
  - Some suggested that allowing consumers to continually carry-forward large amounts of unspent funds should be reviewed.

Changing the mix of individualised and block funding

Individualised funding

- There were different views about the potential benefits afforded by individualised funding and potential changes to funding models.

- Overall, there was a consensus that there should be a mixed funding model (i.e. there is a role for both block funding and individualised funding), but no common view on what types of services and supports should be funded under one model or another, or how to transition towards more individualised funding (if that is the preferred funding model).

- Some stakeholders supported a shift towards individualised funding where the majority of funding ‘follows’ the consumer:
  - Some stakeholders felt that individualised funding would offer greater choice and control to a larger number of consumers, particularly those with capacity and/or support to make informed choices. It was suggested that consumers do not have the same level of choice in the CHSP, as they do in home care packages (although some challenged this view).
  - Individualised funding was suggested to be better suited for strong contestable markets that have predictable service needs and demand, and for services delivered in individual settings on an ongoing basis.
  - Suggested examples of services that could potentially be delivered on an individualised funding basis include, but are not limited to: nursing, personal care, domestic assistance, home maintenance, respite care, and allied health services.
• Others raised various concerns about the increased use of individualised funding for basic or entry level services, including:
  o reduced care and services for the consumer – as a relatively small budget is more likely to be eroded by administration costs, fees and other costs associated with operating in a competitive market (e.g. advertising and marketing).
  o risk of overwhelming and overburdening consumers (and their carers) with additional information and decision-making, particularly those without capacity or support, or those who require immediate access to basic services.
  o reduced efficiency of the system – with ‘disproportionate’ time and effort required for providers to administer small individualised budgets for a large volume of consumers.
  o inconsistent with an increased focus on short-term/episodic care and reablement focus – could encourage over-servicing.
  o could increase time to access entry level care.
  o risk of providers competing for consumers on the basis of price rather than quality of service.
  o could reduce knowledge sharing and collaboration among local providers due to the increased focus on competition.
  o could reduce opportunities for providers to trial innovative approaches to care delivery, due to the lack of pooled, flexible funds.
  o may lead to a shift towards a more casualised, less permanent workforce.
  o risk of losing small, local providers who become unviable without certainty of funding – if so, could lead to less competition in some areas.

Block funding
• Most stakeholders agreed that block funding should be retained where a competitive market cannot operate and to support specialised services. For example, block funding could be used:
  o in areas where there is sparse or fluctuating demand and variation in needs, e.g. rural and remote areas.
  o for specialised services supporting specific population groups, e.g. people who are homeless or at risk of homelessness, Aboriginal and Torres Strait Islander people, and people with dementia. Some also suggested that block funding is also the best way of supporting a range of other special needs groups, including those defined in the aged care legislation.
  o to support short-term restorative care services and people with episodic care needs.
• Many stakeholders valued the greater funding flexibility enabled by block funding. Stakeholders referred to the benefits of being able to plan ahead in how funding is used, e.g. workforce, inventory/stock levels.
• It was suggested that services with the following characteristics would require at least some block funding to continue operations:
  o significant capital/infrastructure costs, which are typically funded by lump sum (e.g. vehicle fleets).
  o services dependent on a volunteer workforce (e.g. meals).
  o delivery in group or centre based settings, where the needs of multiple consumers are simultaneously met.
  o delivery of low cost/high volume services (although there were mixed views on this).
• Some stakeholders suggested that block funding should be retained for all entry level services. While this was a common view among many CHSP providers, it was also suggested by other stakeholders and some peak bodies.
• Some suggested a hybrid funding model could be considered, e.g. where providers are funded through a combination of a fixed (block funding) component and a variable component through individualised funding.

Vouchers
• There was some support for the use of vouchers for specified, one-off or short-term entry level services.
  o Some stakeholders suggested that vouchers for discrete entry level services could give effect to greater consumer choice and control without the need to manage budgets.
  o Some suggested that the targeted and finite nature of vouchers could support the short-term, episodic and reablement focus of some services.
  o Others expressed concerns about the additional administrative burden posed by a new voucher system, particularly in combination with the current payment system.

Considerations for any major funding model changes
• Stakeholders emphasised that considerable work is required before any major changes to funding models are agreed and implemented. This could include:
  o substantial ongoing co-design with the sector on the detail to ensure that industry knowledge is considered.
  o detailed modelling and risk assessment to understand the impact of any changes.
  o piloting of funding model changes before national rollout.
• Some stakeholders suggested that a cost of care study also be undertaken to ensure the funding levels adequately reflect the cost of service provision. Some said that any consideration of changes to the mix and levels of funding should be predicated on an effective and responsive payment system.
• Stakeholders emphasised the need to allow transition to occur over several years to enable sufficient time for providers to build capacity, plan and make business decisions. If there is to be a shift from block funding to individualised funding, this would need to be progressively introduced.
• Local government CHSP providers said that ‘competitive neutrality’ principles would apply if there was a move towards an open market. This could mean that some local governments/councils would no longer be able to subsidise CHSP services with financial in-kind support as they do currently. As such, it may no longer be financially viable for some councils to continue as service providers.

Ensuring that services maximise independence

Greater focus on consumer outcomes
• Many stakeholders suggested removing the current restrictions which limit CHSP providers from delivering services outside of their funded service types. Greater flexibility in delivery across service types would enable providers to be more responsive to consumer needs.
• It was suggested that the current focus on reporting program outputs (e.g. volume) should shift towards individual consumer (and carer) outcomes. Some stakeholders suggested that government could consider offering incentives for providers to achieve desired policy outcomes.

Accessing services through both CHSP and home care packages
• Most stakeholders felt that some home care consumers should also be allowed to access CHSP services.
  o It was felt that most home care consumers access services through the CHSP either because their package funds are not sufficient to meet their clinical and service needs (e.g. they are on an ‘interim’ package), or due to a temporary increase in care needs.
  o Some CHSP providers also described the importance of ensuring community-based CHSP services, such as group social support and community transport, can be readily and affordably accessed by home care consumers. They emphasised these services provide important connections
with the community for all consumers, regardless of the programs they are accessing services through.

- Some CHSP providers said that there are increasing pressures on their service capacity as a result of unmet demand in home care. Suggestions for addressing this pressure included:
  - limits on the volume or timeframes for accessing CHSP services for home care consumers.
  - more consistent fee arrangements across the two programs.
  - clearer guidelines and more consistent application of the rules (by assessors and providers) for when a home care consumer can access CHSP services.
  - a mechanism to inform CHSP providers when a CHSP client has been allocated a home care package.

‘Wants’ versus ‘needs’

- Most stakeholders emphasised that government should continue to fund a wide range of services.
- However, some stakeholders suggested that consumers should only receive subsidised services that meet their assessed ‘needs’, rather than ‘wants’.
  - Some services might be the personal responsibility of the consumer, rather than funded by government.
  - Some suggested the need for clearer guidance on what can and cannot be purchased using package funds.

Consumers with diverse needs and in rural and remote areas

Higher costs of service delivery

- Many stakeholders highlighted the additional costs of providing services to consumers with diverse needs and to consumers in rural and remote areas.
  - For consumers with diverse needs, additional costs can relate to care and system navigation assistance, additional time required to build trusting relationships, case management or care coordination, and translation/interpretation costs.
  - For consumers in rural and remote areas, additional costs relate to the travel costs associated with long distances (e.g. travel time, petrol costs, vehicle maintenance).
  - It was suggested that government should provide additional funding to offset such costs – these costs should not be expected to be borne by CHSP providers or deducted from the consumer’s individualised budget.

Supporting access to care in rural and remote areas

- There was strong support for block funding of services delivered in rural and remote areas (see above). This could also be supported by funding supplements, building on the current viability supplements in home care packages.
  - It was suggested that the funding should be provided directly to small local providers operating in rural and remote communities, rather than larger providers (often located in regional centres or cities) who then broker to the local providers and retain a portion of the funds as profit.
- Other stakeholders identified access to an appropriately skilled workforce as a major issue in rural and remote areas. Suggestions for addressing this included:
  - encouraging a partnership approach with other organisations in the region to share resources (e.g. pool of local staff working across agencies, shared vehicles).
  - offering incentives to providers and staff to work and live in rural and remote areas.
  - providing training opportunities for local unemployed or underemployed people in the community or sub-contracting to informal carers.
Supporting access for consumers with diverse needs

- To make the system work better for consumers with diverse needs in accessing and receiving appropriate care, some stakeholders suggested the following:
  - block funding of specialised services that are targeted at consumers with diverse needs to ensure continued availability (see above).
  - investment in a diverse workforce (e.g. assessors, service staff) and training to recognise and accommodate the diverse needs of consumers.
  - ongoing translating and interpreting services – separately funded from a consumer’s home care package.
  - availability of consumer supports (discussed below).

Supporting informed consumer choice

- Stakeholders felt that many consumers are confused about the aged care system. In moving to a more consumer driven system, stakeholders emphasised the need to improve the system literacy of consumers so they better understand:
  - how the care at home system works.
  - how to access and move through assessment.
  - how to identify and negotiate services to help them meet their care needs, achieve their goals, and make informed choices.

- Face-to-face support (e.g. local information hubs, peer networks), rather than online or telephone, was frequently considered to work best for older people, including those with diverse and complex needs. Stakeholders also suggested that additional block funding should be allocated to:
  - independent system navigators and ‘wranglers’ to assist consumers in moving through the aged care system, as well as connecting with other support systems.
  - independent advocacy services to help uphold the rights of consumers and support them to receive care that meets their needs and preferences.
  - case management services to assist in care planning, service coordination, managing budgets, and reviewing care arrangements.

- Some stakeholders suggested the development of an overarching support model that brings together existing consumer support services, establishes linkages with supports and services outside the aged care system, and offers supports to ensure consumers are empowered to actively engage with the aged care system. Addressing the needs of and supporting vulnerable consumers is regarded as essential within the support model.

Consumer contributions

- While the discussion paper did not directly seek views on consumer contributions (as this was one of the matters being considered in the Aged Care Legislated Review), a number of stakeholders commented on the current approach to consumer contributions and fees.

- There was general agreement that the current approach to consumer contributions and fees is inequitable, both within and between programs. Most felt that this needs to be addressed to ensure the system is fair and fiscally sustainable, and to address existing disincentives for consumers to move from CHSP services to home care packages.

- Suggestions included:
  - tiered fees, including a basic daily fee, that are proportionate to package level.
o greater contributions from CHSP consumers based on capacity to pay – some suggested a mandatory fees policy be introduced to ensure equity and consistency, rather than the current principles-based framework.

o increased regulation of administration and exit fees in home care packages.

• Some also emphasised the importance of co-design with the aged care sector in the development of any new fees, charges or means testing arrangements.

**Supporting informal carers**

• Many stakeholders emphasised the vital contribution of informal carers (family and friends) in the aged care sector. Some felt that carers should be considered as consumers in their own right, with acknowledgement that carers have their own needs within and beyond the caring role. This will require complementary approaches across the aged care and disability sectors.

• Suggestions included:
  o carers own physical and emotional support needs should be considered as part of the aged care assessment for the person they are caring for.
  
  o separate or additional funding in the program for carers to access services such as respite, transport, social activities, education and supports that enable the caring role.
  
  o improving access to, and affordability of, planned and emergency respite services.

• Some felt that the aged care system needs to more effectively link with the Carer Gateway and the Integrated Plan for Carer Support Services being progressed by the Department of Social Services.

**Technology and innovation**

• There were a number of suggestions on how technology and innovation in the sector might be encouraged:
  o incentivising the use of innovation and technology (e.g. innovation grants, supporting the development of service partnerships with education institutions/IT companies) among providers.
  
  o establishing a ‘national aids and equipment scheme’ that better supports older people, including those with disability, to more consistently, easily and affordably access aids and equipment (including assistive technology).
  
  o improving the digital literacy of older people, including by removing barriers to internet access and information about assistive technology.

• The Aged Care Industry Information Technology Council Roadmap was identified as a pathway forward to deliver innovation and technology within the sector.

**Regulation**

• Reducing duplication and inconsistency of regulation for providers was considered to be an important objective of any future reforms. There are opportunities to reduce red tape in processes between Commonwealth and state governments; within and across health, aged care and disability sectors – including reporting across government systems and provider standards/accreditation.

• Many stakeholders also noted the need to ensure that the impact of any reductions in regulation is balanced with appropriate safeguards to protect older people, especially those who are vulnerable.

**Aged care and health systems**

• Stakeholders emphasised the need to break down silos between the health (including primary and acute care) and aged care systems. This could include pooling of funding for service delivery and capacity building, and stronger roles for Primary Health Networks.
Stakeholders highlighted the need for better coordination of care and information sharing between health, aged care and disability sectors (e.g. better integration of My Health Record and My Aged Care client record, allowing specialist health professionals to input into aged care assessment).

Some called for additional resources for aged care providers to deliver and/or support the delivery of palliative care services and end-of-life care.

**Major structural reform**

- There was a mix of views about longer term aged care reform, including the importance of new IT infrastructure in giving effect to consumer choice.
  - Some stakeholders supported the idea of payments being made directly to consumers to maximise choice and control over care, whereas others had concerns – citing risks of elder abuse, consumer and carer burden, and reduced accountability over the appropriate use of funds.
  - Some felt that government should not proceed with such major changes until the market has had ample opportunity to respond to consumer demands, and the outcomes and lessons from consumer-directed funding in the NDIS are more clearly understood.
  - Others noted that some organisations have already developed their own systems to distribute funding on behalf of a consumer to one or more service providers through brokerage models. It was suggested these types of innovative market-based solutions could be pursued further, rather than investing in large government-run systems.

- In implementing major structural reform, some stakeholders also emphasised that particular attention must be paid to the interfaces with other sectors, e.g. between the aged care, health and disability systems.

**Feedback on February 2017 (Increasing Choice) reforms**

- While the primary purpose of the discussion paper was to seek views about future care at home reform, stakeholders were also invited to provide feedback on the implementation of the February 2017 changes to home care. The following feedback relates to the early implementation period between February and August 2017.

- Overall, most stakeholders welcomed the greater ability for consumers to choose and change their provider, and the opportunities for new and existing providers to expand their business.

- However, a number of concerns were raised about the initial implementation of the reforms:
  - greater choice and control has resulted in confusion among some consumers about navigating the new arrangements, including the process to access and take up a home care package.
  - limited access to independent advice/support and information to enable comparisons between providers has posed challenges for informed decision making among consumers.
  - some consumers have been confused about the terminology and next steps in the notification letters. Some consumers have also received inconsistent information from the My Aged Care contact centre.
  - delays in obtaining an ACAT assessment and being assigned a package, and the lack of estimated wait time information as part of the prioritisation process.
  - concern from some providers about ‘poaching’ of consumers and provider marketing tactics, such as cold calling, door knocking or offering discounted basic daily fees.
  - impacts on providers’ business due to reduced referrals, delays with package take up, and ongoing issues with the aged care payment system.

A number of system and procedural changes have been made over the last 12 months to address feedback and concerns raised by consumers, providers and other stakeholders.
Profile of submissions, based on stakeholder category and location

The Department received 318 submissions from a wide range of stakeholders across jurisdictions. A break-down of the stakeholder categories and state/territory in which the stakeholders operate or reside is presented below.

Note: Stakeholders could select more than one category and state/territory.