national
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COMMONWEALTH HOME SUPPORT PROGRAM (HSP) DESIGN

This paper provides advice on the development and design of the Commonwealth Home Support Program (HSP) announced as part of the *Living Longer Living Better* (LLLB) aged care reforms. The HSP is to commence operation from 1 July 2015 and will combine the existing Home and Community Care (HACC) Program, National Respite for Carers Program (NRCP), Assistance for Care and Housing for the Aged (ACHA) and the Day Therapy Centre (DTC) Program.

The National Aged Care Alliance (the Alliance) believes this provides an opportunity to create a program that will serve the longer term needs of Australia's ageing population. With this in mind, along with the current system requirements and operation, the Alliance has designed an outline of the Home Support Program as well as a longer term vision to support people living at home. What is done in the short to medium term must support a longer term vision to deliver quality services to all older Australians who need them.

A Long Term Vision

The aim of the HSP should be to support an older person to live as independently as possible, in their own home and community, for as long as they can and wish to do so.[1] Where the older person has a carer the HSP should also support the care relationship to enable both the consumer and carer to live independently.

This is best achieved by creating a single, coherent home care and support system, amalgamating the HSP and packaged care programs within the broader aged care system and legislative arrangements. The removal of the current artificial program barriers will enhance continuity of care and improve access to services.

Access to services would be further enhanced by ending the current system of aged care rationing and adopting the entitlement, based on assessed need, system recommended by the Productivity Commission in its seminal *Caring for Older Australians* report.

The Alliance also recommends replacing the current output-based funding model with a mixed funding approach which includes:

- Individualised funding, based on assessed need, for services and support that assist the older person to identify and achieve their goals and enable them to live as independently as possible.

Alliance members have differing views on the management of individualised funding. Some members are comfortable with the current packaged care approach with funding provided to organisations who deliver the care. Others believe that to be transparent and enable full consumer direction funding should be cashed out and provided directly to the consumer to purchase the services and support they need. The form individualised funding takes needs to be further explored before its introduction.

[1] There are practical limits to what can be provided to individuals through Government subsidised services and private and family supports. People will not always be able to get the level of service they are assessed as needing. A variety of factors need to be taken into account in deciding whether the person can remain at home including the level of support required and able to be provided, as well as the availability of alternative care options. Ultimately the older person, and/or their carer, will make this decision.

Trials of options (including cashing out) could be undertaken to inform this decision.

- Block funding for:
    - services with substantial infrastructure and/or capital elements and costs, such as home maintenance and modifications, centre based services (including overnight accommodation), transport and volunteer services;
    - the creation of new and innovative services; and
    - service availability in areas (such as remote Australia) or for people (such as those with special needs) where there is limited or no competition between services and smaller populations.

This programmatic change will require a significant level of service system development and repurposing of existing funding. A transition and implementation plan should guide such a significant change.

The LLLB aged care reform legislation sets out the process and parameters for a five year review and the reforms. Consideration of the move to entitlement is included in this review. The Alliance recommends that the review also consider the creation of the single home support and care program operating with a combination of individualised and block funding, including the legislative amendments required as a result.

Recommendation 1: The creation of a single home care system (incorporating HSP and packaged care) should be considered as part of the 5-year review of the reforms.

Recommendation 2: A combination of individualised and block funding should be adopted in the single home care system. As much as possible should be funded on an individualised basis with continuation of block funding for services that are best funded in this way.

In the Short to Medium Term - Creation of the Home Support Program

In the short to medium term the creation of the HSP is a sound initiative which will move the system in the direction of the Alliance's long term vision (refer page 1). There are many considerations in the development of a new funding program. This paper sets out, and makes recommendations about, the various elements required for an effective support program to commence operation from 1/7/2015.

Program Goal

The HSP should support the older person, and their carer, to live at home and in their community, as well and independently as possible for as long as they can and wish to do so.[2]

Program Target Population/Eligibility

The Alliance recommends the HSP provides services to people aged 65 years and over and Aboriginal Peoples and Torres Strait Islanders from the age of 50 who:

- Need assistance with daily living to remain living independently at home; and
- The carers of the above.

[2] Refer to footnore 1.

This includes special needs groups (as defined under the Aged Care Act 1997 as amended) and people with specific needs.[3]

The target population should apply from 1/7/2015 when the HSP is introduced.

The arrangements in place between Commonwealth and State Governments should see people under the age of 65 years, including younger people with disabilities and people with younger onset dementia receive services from State funded programs and National Disability Insurance Scheme (NDIS). However, until such time as NDIS is fully operational in 2019 and eligibility issues are resolved, people under the age of sixty five should be able to continue to access HSP services. Depending upon decisions made about eligibility for NDIS, the proposed target population for the HSP may need to be reviewed to ensure that all consumers who need services are able to receive them from either NDIS or HSP.

Older people with disabilities acquired over the age of 65 including those with vision impairment, will be ineligible for services from NDIS. The funding and provision of services for these people needs to be clarified overall but within this the HSP must be able to support older people with disabilities to remain living independently at home.

This is a large target population. HSP funded services should be focussed on providing timely low level support to people to assist them to continue to live independently in their own home and community.

Expenditure in HSP should generally equate to less expenditure on an individual basis than for people receiving a Level 2 package.[4] People receiving more expenditure than this at the time the HSP commences should either be grandparented or transferred to packaged care. This should enable the HSP to target its resources to those with lower level needs. The introduction of this limit should be trialled to ensure there are no unintended consequences for consumers.

[3]This describes those people living with cognitive impairment and dementia, people with a mental health issue, and the special needs groups as defined in the Aged Care Act 1997 Principles (as amended), which include:

- People from Aboriginal and Torres Strait Island communities;
- People from culturally and linguistically diverse backgrounds;
- People who live in rural and remote areas;
- People who are financially or socially disadvantaged;
- Veterans;
- People who are homeless, or at risk of becoming homeless;
- Care leavers;*
- Parents separated from their children by forced adoption or removal;
- Lesbian, gay, bisexual, transgender and intersex (LGBTI) people; and
- People of a kind (if any) specified in the Allocation Principles..

In addition this encompasses individuals who have specific cultural, spiritual, ethical and privacy requirements that need to be recognised and supported to ensure quality care provision.

* Care-leaver means a person who was in institutional care or other form of out-of-home care, including foster care, as a child or youth (or both) at some time during the 20th century.

[4]The expenditure limit set would need to be averaged on a per annum basis. In its *Provision of Respite in the Commonwealth Home Support Program* Discussion Paper the Alliance has recommended residential respite care be funded as a HSP community service. This would not be included in an individualised funding cap.

Program Philosophy

The LLLB aged care reform package identifies and supports two philosophies and approaches to the delivery of aged care services:

- Wellness; and
- Consumer direction.

The Alliance supports application of these philosophies and approaches across all aged care services, including HSP. This recognises best practice in home care and ageing services within Australia and internationally.

Wellness

Wellness is a philosophy that focuses on whole of system support to maximise clients' independence and autonomy. It is based on the premise that even with frailty, chronic illness or disability, people generally have the desire and capacity to make gains in their physical, social and emotional wellbeing and to live autonomously and independently. It emphasises prevention, optimising physical function and active participation. It focuses on finding the service solutions to best support each individual's aspirations to maintain and strengthen their capacity to continue with their activities of daily living, social and community connections.

The provision of reablement services is a part of this philosophy. Reablement is the use of timely assessment and targeted interventions to:

- assist people to maximise their independence, choice and quality of life;
- appropriately minimise support required and reliance on future and/or alternate support;
- maximise the cost effectiveness of programs; and
- support people to continue to participate and remain engaged in their local communities as they wish.

The basis of the approach is to help people regain and/or maintain their physical and cognitive function and independence (after an illness, disability or crisis or to halt any decline in capabilities) enabling the person to continue to look after themselves. An assessment is undertaken which identifies the individual's goal in attaining, retaining or enhancing a particular function.

An example would be to walk a certain distance after a hip replacement or undertake meal preparation after shoulder surgery. Services would then be provided to support the person reach that goal.

Another example would be a person who is having difficulty getting up and down to go to the toilet and in standing in the shower. Provision of a home based strength and balance program initially moving to participation in an exercise program would be an effective way to maintain that person's independence at home. Once the goal is reached a lower level of service can be provided and in many instances no further service is required. Reablement services may only be needed for a short time or intermittent periods which ultimately assist with program sustainability.

For a person who is blind or vision impaired this may include a mobility program to enable them to travel independently after a further loss of vision or death of a partner.

Reablement has positive and evidence-based outcomes for older people. However, it needs to be acknowledged that some people will need ongoing care and support as they will not be able to regain or maintain function. Such people should still be eligible to receive HSP services.

Reablement has been used extensively in England and New Zealand. In Australia some individual providers and the Victorian and West Australian Governments have introduced a reablement approach to service provision. This provides the opportunity to learn from their experience and apply the learnings to support the broader adoption of this philosophy.

Consumer Direction

The current implementation of CDC Home Care Packages has given the term 'consumer directed care' a set and specific policy meaning in Australia. However, the term consumer direction has a broader meaning and application both internationally and in Australia.

The Alliance supports the following 'working' definition of consumer direction:

CDC empowers the consumer to have more control over their own life. It focuses on the person's life goals and strengths, and provides services and support (including aged care, disability and health services) to achieve them. The person makes choices and/or manages the services they access, to the extent they can and wish to do so, including who will deliver the services and when. Where there is a carer, their needs are also acknowledged and considered. CDC incorporates many of the principles of person-centred care, while putting the consumer in charge of decisions about their care.

Applying CDC in the HSP would be relatively simple. For example it would mean that rather than a worker going in each week (or time of service) and doing exactly the same thing there is a discussion with the client about what they want or need at each service occasion. So rather than the standard weekly housecleaning service (dust, vacuum and cleaning the bathroom) they might clean the fridge or the pantry or some other household requirement that deviates from the standard service on the direction of the consumer. Or it might be that person needs assistance to prepare some meals or to do the shopping because they have been unwell and unable to get to the supermarket. Or it might be that some social interaction or activity is the most important thing for that week. There are myriad things a consumer might want assistance with and there should be flexibility for such assistance to be provided at the consumer's direction.

This is a very basic example to show how consumer direction can be actioned within services which provide lower levels of support.

Given that a number of older people will transition from the HSP to packaged care it will be important to have consistency with elements of the consumer direction model in both programs. This would include features of the home care package program including transparent budget arrangements and goal setting. The approach is outlined in detail in the new Home Care Package Guidelines. Application of this now will also streamline the consolidation of the two programs in the longer term.

Program Design Principles

These principles also apply to any carer of an older person receiving home support.

- *Consumer Rights* - Older people have the same human, legal and consumer rights as the population generally.

- *Consumer Participation* - Older people have the right to participate fully, or to the level the individual aspires, in their community.
- *Consumer Direction*[5] - Older people are supported to continue managing their own life, as they have throughout their lifetime.
- *Wellness and Reablement* - Older people are supported to maintain and improve their health, cognition, wellbeing and independence both after periods of illness and in an ongoing way.
- *Accessibility* - Home Support services are accessible to all people who need them without discrimination.
- *Equity* - Every effort is made to ensure equity of access and positive outcomes for all older people regardless of where they live and/or their specific or special needs.[6]
- *Affordability* - Services are affordable for the older people who need them, taking into account their capacity to contribute to the cost.
- *Sustainability* - Funding for aged care service enables the provision of quality services while being sustainable for the taxpayer.
- *Quality* - Older people receive quality, evidence based services which strive for continuous improvement and innovation, (including the use of assistive technologies).
- *A Skilled Workforce* – Older people receive services from a skilled workforce who are paid fair and competitive wages.
- *Locally Responsive* - Services are nationally consistent (in the interests of accessibility and equity), but are also able to respond to local conditions and demands.
- *Flexibility* - Services are provided flexibly to meet the assessed needs of the older person and any care relationship in place. These needs change over time and may include access to different services, across existing program boundaries and at different levels of intensity.
- *Certainty* – Older people receive services from stable services which support continuity of care.
- *Partnerships* – Services are delivered in partnerships between the older person, carers and/or service/s to achieve efficiencies and effectiveness.
- *Privacy* – Older people can identify and manage access to their information.

Recommendation 3: The above program goal, target population, philosophies and principles be adopted for the HSP.

Recommendation 4: Trial the introduction of an expenditure based individual limit (up to Level 2 packaged care, plus access to residential respite care) to enable HSP to provide low levels of support across its full target population.

[5] As defined above

[6] Refer to footnote 3

Service Streams

The HSP needs a program structure for development, management of funding and accountability purposes. The Alliance recommends adoption of service streams which:

- Focus on the consumer outcome and the primary purpose the service is provided to achieve/meet;
- Streamline and remove as much system complexity as possible; and
- Enable a change to individualised entitlement-based funding (for relevant services) in the future.

Table 1 outlines service streams which meet the above criteria. This table has been developed to highlight how existing HACC and other program service types would map to the streams. This should not be seen as an indication that these are the only services that can, or should, be provided within these streams.

Table 1 Outcome Based Service Streams

Service/ Outcome Stream	Existing Service Types within the new streams
Social Participation and Access	Social Support, Centre Based Day Care, Community Visitors Scheme,[7] and Transport.[8]
Health and Wellness	Allied Heath services, Home Modifications,[9] Goods and Equipment,[10] Reablement, Massage, Nursing Services, Personal Care, Personal Services, (hygiene), Meals, other Meal and food Services[11] and Day Therapy Centres.
Carer Support	HACC Respite, In-Home day Respite, In-home Overnight Respite, Community Access-Individual, Community Access-Group, Host Family[12] Day/Overnight Respite, HACC Counselling (for carers), Overnight Community Respite, Mobile Respite, Other Respite, and Residential Respite.
Household Maintenance	Domestic Assistance, Home Maintenance[13], Gardening and Linen.[14]
Service Innovation and System Resourcing	Service innovation and system resourcing not covered in the above streams including management of contracted/brokered services, system supports (e.g. training and development roles, aged services workers), etc.

Wellness and CDC philosophies applied across all service provision.

Program management expenses (such as a case co-ordination , service level assessment & review, management) need to be factored into each of these streams.

[7]Incorporation of the CVS was not recommended in the LLLB reforms. The Alliance considers that all social support programs should be combined within the HSP.

[8]This service type is subject to an individual review. Its placement and development will be considered more fully when the review is complete, notionally at the end of the 2013 calendar year.

[9]This includes currently funded allied health services such as Occupational Therapy, Speech Therapy, Physiotherapy, Podiatry, Diversional Therapy and other therapy but also be expanded to include dietitians, exercise physiologists and others.

[10]This service type is subject to an individual review. Its placement and development will be considered more fully when the review is complete, notionally at the end of the 2013 calendar year.

[11]As above.

[12]Family needs to be defined based on the older person's own designation of family, which may or may not include biological relatives.

[13]This service type is subject to an individual review. Its placement and development will be considered more fully when the review is complete, notionally at the end of the 2013 calendar year.

[14]As above

These streams may be overlaid with a matrix that would determine the most effective funding mechanism for each stream and/or activity type (i.e. block funding, individualised funding or some form of unit cost).

Initially the current service types will continue to be defined within each stream. Due to changes in access for people with a disability acquired over the age of 65, some other services will need to be funded and available within the HSP. This will include services such as access to specialist rehabilitation services for blind or vision impaired people as well as specialist equipment (such as magnifiers, talking phones, specialist software and braille equipment).

Over time the specificity within the streams will be phased out and be replaced by a more flexible and individualised approach. Consumers and services will determine what needs to be provided to meet the goal and assessed need of the individual. This approach will increase innovation and flexibility.

When this point is reached, Government guidelines would only need to identify any service responses that are not able to be provided with HSP funding (for example Government could specify that funds are not able to be spent on illegal activities) for accountability purposes. As far as possible, this should mirror the approach taken to exclusions in the Home Care Package program.

Some services that are currently funded under HACC would continue to be funded but may be better placed with other programs/services. These services are largely those which support the consumer access, make the most of and address any individual issues and concerns with available services:

- *Assessment* – primarily this function would move to the *My Aged Care Gateway*. It is recognised that individual service providers will continue to have an ongoing role in assessment (including WHS assessment, specialist assessment for disabilities, reassessment, service specific requirements (e.g. nutrition, reablement) and liaison with the *My Aged Care Gateway*). Work is occurring now to determine the relationship between HACC Service Group 2 assessment functions and the *My Aged Care Gateway*. This will inform how the assessment functions and funding are allocated between HSP services and the *My Aged Care Gateway.*
- *Client Care Co-ordination, Case Management* – in an individualised funding system this function would be assigned to people who have a higher level of need within a package (or resource level based on assessed need). However, sometimes all people need is a case manager who can assist them to keep managing their own life. These services need to connect with the proposed *My Aged Care Gateway* linking service. Further consideration is required about the placement of these services until such time as the individualised funding approach is adopted.
- *Counselling* – there is limited information about this service type and a survey is currently underway to find out more about it. Counselling is an important service within home care and can currently be the first point which identifies when a person has mental health issues, such as depression. There may be links to client co-ordination/case management to be explored once the survey is complete.
- *Client Information* – this function will primarily sit within the *My Aged Care Gateway*. Individual service providers will also continue a role on providing information to consumers about their own services and related issues.[15]

[15]This relates primarily to information about services rather than information about the client. Appropriate privacy and access arrangements need to be put in place for the Client Record at the *My Aged Care* Gateway.

- Advocacy[16] – A survey is currently being undertaken to understand how advocacy works within HACC Service Group 2. However, the Alliance supports the creation of a new advocacy program which brings together advocacy services and functions from a range of different sources, including HACC Service Group 2 and the National Aged Care Advocacy Program. There is a need for a cohesive and consistent system wide approach to advocacy. Advocates must be able to stand with and for the consumer (including through issues and complaints with services), which requires independence from those who deliver the services.

Programs Being Incorporated within the HSP

- *Assistance for Care and Housing for the Aged (ACHA)* - ACHA is an extremely effective and valuable program so its placement in the reformed system must ensure its ongoing p provision and success. Preliminary discussions about ACHA and the program streams has identified that the relationship with the *My Aged Care Gateway* linking service for people who are vulnerable requires further exploration. It is therefore recommended that a workshop be held to specifically explore this issue and make recommendations to the Alliance on the optimum approach on the ACHA Program.

- *Day Therapy Centres (DTC)* - the Alliance supports this move as DTCs can play an integral role in a structured HSP reablement service. However, their patchy geographic distribution will limit the number of consumers who can access this form of support. DTCs have traditionally also supported low care residents[17] in aged care homes. There should not be an artificial barrier erected which prevents residents from accessing DTCs, while recognising their placement in HSP means the main focus will be on people living in the community. DTCs (as with other centre-based HSP services) will require access to a modest capital funding stream, both for current centre upgrades and construction of new services. Funding should allow creative models such as links with community services including gyms and hydrotherapy pools.

New Services and Programs

The streaming approach should, over time, support the creation of new services and responses to meet people's needs and changing preferences. It is impossible, and would be inappropriate, to determine what such services could and will be at any given point in time. However the Alliance supports reablement being incorporated as a response within HSP from its commencement.

Dependent on the goal set a structured reablement service may only need to be offered for a 6 – 12 week period. For some people there may be a need for some ongoing support to maintain function which would otherwise be lost. Services provided could include allied health, home modifications, assistive technology or equipment.

Access and referral to reablement services should be triggered by an assessment at the *My Aged Care Gateway* or where appropriate by a consumer or service provider request. People receiving a home care package should also be able to access a reablement service, either prior to the package being provided or throughout the time of the service delivery.

[16]This service type is subject to an individual review. Its placement and development will be considered more fully when the review is complete, notionally at the end of the 2013 calendar year.

[17]The distinction between low and high level residents is set to be removed from 1/7/2014. Access to DTCs needs to be considered in this context.

Reablement services must be developed and delivered in a way that is appropriate for all HSP clients, including people with disability or dementia (who evidence shows can continue to benefit from such an approach) and must also take into account the needs of carers. The reablement services should be linked to transition care and state based post acute care services while acknowledging that not all people who will benefit from reablement will come through such services.

The Alliance has also considered the newly introduced level 1 home care packages. There is a view that the funding of these packages is too low to be overly effective as a standard package within the current program and funding structure. This will not be an issue if packaged care and HSP are merged as recommended by the Alliance's long term vision, which would allow for a more graduated approach to individualised funding. In the interim Level 1 packages could be effectively utilised as a reablement service to enable time limited interventions for eligible individuals.

Accountability Framework

These changes would require a new approach to accountability for funding which would move away from output-based funding, which results in perverse incentives in the current system. Measurement of the outcomes of service provision should occur from a consumer and system perspective. Development of the accountability framework should include:

- links with the development of home care quality indicators over the next 2-3 years;
- review of the HACC Minimum Data Set (which is very output focussed), including the relationship with the electronic client record;
- reconsideration of the restrictive and time consuming approach to financial acquittals, with a more explicit link to rewarding providers for achieving contracted client outcomes; and
- clarification of the relationship with quality review processes and the Home Care Standards, (to be implemented by the Aged Care Quality Agency), including use of consumer satisfaction measures as part of this system.

The Alliance recognises this is an area that will need further development.

Recommendation 5: The HSP should operate with five service streams – Social Participation and Access; Health and Wellness, Household Maintenance, Carer Support and Service Innovation and System Resourcing – which focus on consumer outcomes and the primary purpose of provision.

Recommendation 6: To assist with transition, current funded service types will initially be identified within the service streams. To encourage flexibility and innovation, this listing will be replaced over time by a clear statement of exclusions or what funding can't be used to provide.

Recommendation 7: Consideration is given to the placement of assessment, client care co-ordination, case management, counselling and client information within the reformed aged care system (not just within the HSP).

Recommendation 8: A new advocacy funding program is developed incorporating advocacy currently funded in a variety of programs including the existing HACC services. The new program should be developed now and be ready for implementation from 1/7/2015.

Recommendation 9: A workshop is held for the ACHA Program to determine how it can best be integrated in the new aged care system.

Recommendation 10: Work should commence on developing reablement services so they can be incorporated and offered to consumers from the launch of the HSP on 1/7/2015.

Recommendation 11: A new approach to accountability, which moves the system to an outcomes rather than an output-based funding approach, be developed.

Service Delivery

There are a range of specific service delivery issues that need to be built into the HSP Program design. This section of the paper identifies and recommends action on these areas.

Assessment and Prioritisation

The *My Aged Care Gateway* commenced operation on 1/7/2013 as an information service.[18] It is scheduled to undertake assessments, using a nationally consistent tool and framework,[19] for aged care services from 1/7/2014. The existing assessment processes will continue in parallel over the next 2 to 3 years which means that people will able to be assessed either at the Gateway or by an individual service provider. Over time this will change with more people going through the Gateway.

Over time the *My Aged Care Gateway* will introduce and keep a client record which will improve the links between service providers and ultimately the service experience for consumers. Ideally, from its inception the HSP should use the same assessment tool and framework as the Gateway. Use of the same tool and framework will enable a system wide prioritisation process to enable consistency of approach for all consumers. Specialist assessments, such as those needed by blind or vision impaired people must be incorporated into the new framework so that appropriate referral occurs.

The prioritisation process needs to ensure those with the highest needs receive support but also provide early intervention, access to specialist assessment services and low levels of service provision to those who will benefit and be able to remain independent as a result. This is in line with the longer term vision of a combined home support and care service providing individualised funding to meet consumer goals and assessed needs.

Further work needs to occur to ensure the framework and tool deliver quality assessments and outcomes for all older people and their carers as well as operating effectively within the aged care service system.

Recommendation 12: HSP services should use the same assessment tool and framework as the My Aged Care Gateway.

Recommendation 13: The aged care assessment tool and framework must enable and support a wellness and reablement approach and consumer direction philosophy.

[18]The information provided is at present limited to Commonwealth funded services. To realise the full potential of the Gateway information must be expanded to include all other services an older person may want or need to access.

[19]A trial of the proposed assessment framework and tool has been undertaken. It should be noted that the Alliance has reservations about the extent to which the tool which is currently being trialled supports wellness, reablement and consumer direction. It is hoped that the tool will be amended following the trial to ensure that aged care assessments support these approaches and philosophies which are at the heart of the aged care reforms.

Access and Equity

The HSP needs to be accessible to all people who need support. The program should also deliver equitable outcomes for all people, including those who have specific and/or special needs.[20] The introduction of an entitlement, based on assessed need, coupled with an individualised funding approach should ultimately overcome equity issues.

However, in the current supply constrained environment, there needs to be equitable resource allocation across geographic locations and between individual consumers. Equity should take into account the level and urgency of assessed need of both the carer and the person receiving care. The following strategies to achieve equity could be adopted for the HSP from 1/7/2015:

- Allocation of global resources using an equity formula, which takes into account local demographic data and regional attributes;
- Capping the amount of resources for individuals to the equivalence of a Level 2 Home Care package (refer page 3, footnote 4 and recommendation 4); and
- Provision of viability supplements to Individual eligible service providers.

There are a number of precedents in both home and residential care that shows acknowledgement of, and action on, these additional costs. Packaged and residential care both have rural and remote supplements and LLLB has introduced supplements for veterans, dementia/cognitive impairment and homeless people. The Alliance recommends that these viability supplements be extended across HSP services. Consideration to how the viability supplements would be applied is required as the HSP will initially be block funded as opposed to packaged and residential care which is funded on the basis of individual client needs/levels.

Recommendation 14: In the short term access and equity is addressed through the application of a resource equity formula at the global program level and viability supplements are made available to individual, eligible services.

In the longer term the Alliance recommends adoption of a funding model which meets the costs of service delivery and reflects that there are differing costs of provision based on location of delivery (rural and remote areas) and/or for special needs groups. This approach was recommended by the Productivity Commission in its *Caring for Older Australians* report.

Current funding provided does not meet the costs of service provision in any location. Not only should funding match the real costs of delivery but planning should ensure that funding continues to meet the costs as they increase over time. There is very little information available on the costs of service delivery including the additional costs of delivering services to special needs groups. It is recommended that a costing study be undertaken so that the funding provided meets the cost of delivery.

Recommendation 15: HSP funding is variable reflecting the different costs of service delivery experienced as a result of location (e.g. rural and remote) or special needs (e.g. homelessness).

Recommendation 16: Undertake a cost of care study so that funding provided meets the cost of service provision, including for services where the location or clientele increases the overall cost.

[20] Refer to footnote 3

Workforce and Staffing

The workforce is the key to being able to meet the needs of consumers. This includes staff understanding and being able to deliver services that implement the recommended HSP philosophies of consumer direction and wellness.

At a program and policy level the HSP should ensure that there is training and support available so that all services can meet the needs of the increasingly diverse consumers requiring HSP services. Training and support should be available across the sector on:

- Consumer direction;
- Wellness and reablement;
- Cultural awareness;
- LGBTI awareness and sensitivity; and
- The needs of consumers with disability or cognitive impairment and dementia.

Additionally, those services that have completed special needs sensitivity and awareness training, as well as services which choose to identify as 'specialist' providers should be easily identifiable in information systems and this information should be made available on the *My Aged Care* website.

Strategies can also be adopted by individual service providers to ensure staff are able to meet the needs of their target population and the demands of the location in which the service is being provided. Strategies include:

- Giving priority to recruiting personnel whose background and knowledge meet the cultural mix of the local community;
- Recruiting bi-lingual and culturally competent staff; and
- Ensuring staff receive appropriate ongoing training, supervision and support.

Volunteers

Volunteers play an important role in the provision of home support services in varied roles including friendly visitors, meals delivery, members of Board of Management, transport, social support and (in some areas) home maintenance provision. The involvement of volunteers, reduces the cost of service delivery and make them more sustainable.

The importance of acknowledging and supporting volunteers, as well as ensuring there is adequate funding for their recruitment (including the cost of police checks), training, induction and management is a crucial issue and should be structured into HSP design. Additionally, the extra importance of volunteers in the CALD, LGBTI or Aboriginal peoples and Torres Strait Islander specific services and disability peer support services should be noted and supported.

Recent research on the current level of engagement and volunteer views would provide useful information to support their valued ongoing contribution and to identify new opportunities for involvement. Research into the baby boomer generation views on volunteering highlighted that they want to volunteer but generally not in the traditional way and with traditional models.[21]

[21]City of Holdfast Bay 2012

Paying Informal Carers

The Alliance members have differing views about paying for the provision of services by informal carers (family, friends or neighbours). However there is general agreement that for special needs groups, or in locations where there is a lack of appropriate or available service options and workforce, this may already occur and should continue to do so where there is no other workable alternative. However, a number of issues must be considered and addressed where such arrangements are in place including:

- Elder abuse safeguards;
- Provider responsibility for service quality, including the need to include the informal carer in their employee/volunteer/sub-contractor systems;
- Legal responsibilities;
- Industrial implications;
- Insurance requirements;
- Workplace health and safety; and
- Qualifications and training required to provide certain types of care.

Fees and Charges

The creation of the HSP provides an opportunity to address a number of inconsistencies and financial disincentives inherent in the existing fees and charges for services provided to people in their own homes. The LLLB reforms introduce a new fee structure and means testing approach for home care packages and residential care from 1/7/2014. In its recent economic statement the Rudd Government announced it would introduce a nationally consistent fees policy for the HACC Program which would raise fee revenue from its current level of 5% of overall program funding to 15% by 2016/17.

The Alliance recognises the importance of a consistent national fees policy and therefore recommends in principle that the HSP be subject to the same means testing approach as that being adopted for packaged care.[22]

Such an approach will minimise or remove the current disincentives to move from HACC to packaged care. The approach will need to be adapted as the nature of the HSP services (such as meals, domestic assistance) provided will have to dictate the actual fee charged for example an hourly or product (meals, bus trip) rate will be more appropriate than a weekly/fortnightly fee.

Fees must be commensurate with the costs of service delivery and set in conjunction with funding levels provided. The fees policy developed and adopted must also ensure that people who need services receive them regardless of any inability to pay the set fee. Strong hardship provisions must be put in place.

There are some services for which it is inappropriate to charge a fee including ACHA, short term reablement services, advocacy, information and some social support services (such as friendly visiting) delivered by volunteers. The Alliance's service/outcome stream approach would move advocacy, information and potentially the ACHA services out of the HSP which would address the fee issue.

[22]The Alliance notes that as a result of the Senate Inquiry of the aged care reform bills the fees and charges will be closely monitored and adjusted based on the impacts the proposed regime has on ongoing access to services for people on low to middle income. The Alliance fully supports this occurring.

Fee policy development should be informed by:

- Close review of fee schedules for HACC services already operating In Victoria and Western Australia;
- Research on service costing and government subsidies; and
- Policies adopted in similar programs, such as NDIS.

There will need to be a staged transition to the new fee arrangements which may include grandparenting for existing consumers.

Recommendation 17: That a national fees policy, consistent with the means testing approach for home care packages and residential care be developed.

Transition and Implementation

The HSP is to commence operation from 1/7/2015. To meet this time frame Government needs to:

Sept 2013 – March 2014.

1. *Determine HSP Design and communicate that with the sector.*

In this paper, the Alliance has recommended a particular design for Government consideration. the Alliance understands that while its Advisory Group is representative of the sector broadly, Government may want to undertake further consultation. To provide certainty to service providers, consultation and subsequent decision should be finalised by 31 March 2014. Communication about the program design can then commence.

2. *Finalise the individual service type reviews and determine how they will operate within the new service design.*

Reviews are underway of Meals services, Community Transport, Home Maintenance and Modification and Service Group 2. These are due to be completed by the end of the 2013 calendar year. There is considerable anxiety within the sector about this process with concern that funding for services will cease as a result of the reviews. Clearly communicated decisions about the service types, within the context of the program design, are needed as quickly as possible.

3. *ACHA Workshop and decisions*

Once the ACHA workshop (outlined on page 9) is held, a decision can be made on the relationship of the ACHA Program to the HSP program streams and the *My Aged Care Gateway* linking service for vulnerable people. To fit with the overall time frame the workshop should be held this calendar year and decisions made, within the context of the program and broader system design, by March 2014.

4. *Communicate decisions with the sector and outline implications.*

Service providers need surety of funding. With the exception of assessment services, a guarantee of funding should be provided to all as the existing service types are valued and required to support older people. Where a service review has indicated changes are required to service models, providers should be given the option of moving to the new model within a specified time frame (for example by 30/6/2016). Where the provider elects not to adapt to the new model, that service can

be tendered. This keeps the HSP in line with the packaged care program where funding is provided in an ongoing way and only new funding is subject to a competitive process.

March – December 2014

5. *Translate existing service types to new service/outcome streams*

Work with individual providers to translate the services they provide to the new service/outcome streams. Maintain the identification of the old to new services for the first twelve months of operation. From 1/7/2016 cease that identification and clearly state anything that cant be provided with HSP funding. This will enable greater flexibility of service provision within the service/outcome streams. Identify anything that is to be excluded from provision in line with the Home Care Packages program.

6. *Assess viability and implications of the expenditure limit.*

The implications of an expenditure limit needs to be tested. Service providers would be able to identify existing clients who are above or below the proposed limit to gain an understanding of the numbers of consumers involved. Once identified a system examination can occur to determine the appropriateness of grandfathering and capacity to transfer to packaged care. Based on the data from this exercise, and future projections, a decision can be made as to whether the limit is feasible and can be applied. HACC in WA have applied this approach and their advice on this should be sought.

7. *Develop a structured reablement service response.*

Within the Health and Wellness stream the Alliance has recommended a structured reablement service be developed and provided from 1/7/2015. This could start with the existing DTC's and HACC programs, including having reablement services as a priority for the 2014-15 HACC funding round.

8. *Revised and streamlined accountability framework.*

The accountability requirements, including the minimum data set, will need to be overhauled. This provides an opportunity to reduce unnecessary red tape, report on program and service outcomes and gather data which can be used to improve service delivery. It will be important to determine data requirements prior to HSP commencement to enable systems to be established.

9. Determine assessment and case management provision within the HSP.

This needs to occur on the basis of the nationally consistent assessment tool and framework which has just been trialled and include consideration of the need for specialist assessment. Until this is resolved there can't be funding surety for either those HACC funded services or the *My Aged Care Gateway*. The Alliance's Assessment Working Group will make further recommendations on this issue.

10. *Create the national advocacy program.*

The need for this Program is outlined on page 9. Consultation and discussion to develop the Program should proceed to enable it to be in place and operational from 1/7/2015.

11. *Design and implement a resource equity formula/introduce viability supplements.*

A process to develop a resource equity formula should be developed. Extending the existing viability supplements could be done in the context of growth funding over the next two years.

In The Longer Term

12. Undertake a costing study.

The need for a costing study is outlined on page 12. A plan should be put in place for this to proceed and should include consideration of the role of the Aged Care Financing Authority (ACFA).

13. Develop a fees policy

The fees policy needs to be developed and communicated with consumers and providers and should be in place from 2016/17 to meet the 15% revenue target set.

Further Work Needed

The above timeframe and implementation considerations are provided as a guide for how this could proceed. Further work and consideration is needed between Government and the sector once final decisions about the HSP have been reached.

Recommendations

Design of the HSP must ensure quality services are provided to older people from 1/7/2015 and that ongoing evolution of the aged care system is supported. In addition, design should provide certainty for service providers to support strategic planning and development. While some of the Alliance's recommendations require further work or fleshing out they are provided to set the direction and enable Government and the service system to prepare for introduction of the HSP and for longer term reform. This will include developing a clear transition plan for all funded services.

Recommendation 1: The creation of a single home care system (incorporating HSP and packaged care) should be considered as part of the 5-year review of the reforms.

Recommendation 2: A combination of individualised and block funding should be adopted in the single home care system. As much as possible should be funded on an individualised basis with continuation of block funding for services that are best funded in this way.

Recommendation 3: The program goal, target population, philosophies and principles (as outlined on pages 2 to 6) are adopted for the HSP.

Recommendation 4: Trial the introduction of an expenditure based individual limit (up to Level 2 packaged care, plus access to residential respite care) to enable HSP to provide low levels of support across its full target population.

Recommendation 5: The HSP should operate with five service streams – Social Participation and Access; Health and Wellness, Household Maintenance, Carer Support and Service Innovation and System Resourcing – which focus on consumer outcomes and the primary purpose of provision.

Recommendation 6: To assist with transition, current funded service types will initially be identified within the service streams. To encourage flexibility and innovation, this listing will be replaced over time by a clear statement of exclusions or what funding can't be used to provide.

Recommendation 7: Consideration is given to the placement of assessment, client care co-ordination, case management, counselling and client information within the reformed aged care system (not just within the HSP).

Recommendation 8: A new advocacy funding program is developed incorporating advocacy currently funded in a variety of programs including the existing HACC services. The new program should be developed now and be ready for implementation from 1/7/2015.

Recommendation 9: A workshop is held for the ACHA Program to determine how it can best be integrated in the new aged care system.

Recommendation 10: Work should commence on developing reablement services so they can be incorporated and offered to consumers from the launch of the HSP on 1/7/2015.

Recommendation 11: A new approach to accountability, which moves the system to an outcomes rather than an output-based funding approach, be developed.

Recommendation 12: HSP services should use the same assessment tool and framework as the My Aged Care Gateway.

Recommendation 13: The aged care assessment tool and framework must enable and support a wellness and reablement approach and consumer direction philosophy.

Recommendation 14: In the short term access and equity is addressed through the application of a resource equity formula at the global program level and viability supplements are made available to individual, eligible services.

Recommendation 15: HSP funding is variable reflecting the different costs of service delivery experienced as a result of location (e.g. rural and remote) or special needs (e.g. homelessness).

Recommendation 16: Undertake a cost of care study so that funding provided meets the cost of service provision, including for services where the location or clientele increases the overall cost.

Recommendation 17: That a national fees policy, consistent with the means testing approach for home care packages and residential care be developed.

The National Aged Care Alliance is the representative body of peak national organisations in aged care including consumer groups, providers, unions and professionals.