CHAPTER 6

COMMUNITY CARE PROGRAMS

…significant reform is needed to Australia's community care system if it is to meet the expectation placed on it of assuming an increasingly significant role in the future of our care system and if it is to continue to provide high quality care services to older people.[1]

6.1 This chapter discusses the adequacy of community care programs in meeting the current and projected needs of the elderly. Community care programs are aimed at enabling frail older people and people with a disability to remain in their own homes for as long as possible. The flexibility of community care means that a well funded program can deliver a service that is tailored to individual needs and provides continuity of care as recipients' needs change.

6.2 The provision of high quality community care that helps people live in their own homes longer has several advantages:

- most people prefer to live in their own home rather than moving to a residential care facility;
- community care helps people retain their independence for longer;
- it is the sign of a healthy society to have more assistance provided to people living in the general community for as long as possible; and
- provision of high quality community care uses less health and aged care resources as it avoids costly admission to residential aged care and acute care.[2]

6.3 The demand for community care programs is expected to increase over coming decades. The Department of Health and Ageing (DoHA) estimated that based on current service use patterns, the number of people over 85 years who rely on community care programs will rise from 81 000 people in 2002 to 140 000 people in 2019. It is estimated that the number of people across all age groups who rely on community care programs will increase from approximately 650 000 people per annum in 2002 to approximately 970 000 people in the year 2019.[3]

Community care services

6.4 A number of community care programs provide a range of services including the Home and Community Care (HACC) Program, Community Aged Care Packages

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1 *Submission* 173, p.7 (ACSA).

2 *Submissions* 166, p.12 (CHA); 74, p.13 (ANHECA).

3 DoHA, *A New Strategy for Community Care: Consultation Paper*, March 2003, p.8.

(CACPs), the Extended Aged Care at Home (EACH) program and Veterans' Home Care (VHC). Other services include respite care, including the National Respite for Carers Program (NRCP) and support for carers. Of the total number of Australians aged 70 and over, 15.1 percent use HACC services, 7.8 percent are in residential care and 1.5 percent receive CACPs. [4]

6.5 The main differences between HACC, CACPs and EACH programs are summarised in table 6.1.

Table 6.1: Features of HACC, CACPs and EACH programs

	HACC	CACPs	EACH
Range of services	Wider range of services available	Narrower range of services available	Narrower range of services available
Relationship to residential care	Aims to prevent premature or inappropriate admission	Substitutes for a low care residential place	Substitutes for a high care residential place
Eligibility	ACAT assessment not mandatory	ACAT assessment mandatory	ACAT assessment mandatory
Funding	Cost shared by the Commonwealth, State and Territory governments and client contributions	Funded by the Commonwealth Government and client contributions	Funded by the Commonwealth Government and client contributions
Target client groups	Available to people with a greater range of care needs	Targets people with care needs similar to low level residential care	Targets people with care needs similar to high level residential care
Size of program	$1.2 billion funding in 2003-04	$307.9 million funding in 2003-04	$15.5 million funding in 2003-04
	Approximately 707 207 clients in 2003-04	28 921 operational places in 2003-04	858 operational places at 30 June 2004

Source: Productivity Commission, *Report on Government Services 2005*, Vol.2, p.12.18.

6.6 The HACC program, which provides the main community care program, is described in some detail below. CACPs provide an alternative home-based service for older people who Aged Care Assessment Teams (ACATs) assess as eligible for care equivalent to low level residential care. EACH provides a community alternative to high level residential aged care services. The program provides individually planned and coordinated packages of care designed to meet older people's daily care needs in

4 *Submission* 191, p.42 (DoHA).

the community. The EACH program differs from the CACP program in that it targets frail older people who would otherwise be eligible for high level residential aged care. An EACH package typically provides 15-20 hours of direct assistance each week. The services of the VHC program target veterans and war widows/widowers with low care needs. The program provides home support services, including domestic assistance, personal care, home and garden maintenance, and respite care. Other services, such as community transport and delivered meals are also available under Department of Veterans' Affairs arrangements with State governments.

Home and Community Care Program

6.7 The Home and Community Care (HACC) Program provides a range of services including:

- domestic assistance – help with cleaning, cooking, washing and ironing;
- personal care – bathing and dressing;
- food services – meals on wheels, centre based meals, help with shopping;
- community respite – to give carers a break or for frail older people living alone;
- transport – practical assistance with individual transport needs;
- home maintenance or modification – assistance to maintain a person's home, garden or yard to keep it safe; and
- home/community nursing – provided by trained nurses on a regular or one-off basis, in home or from a community centre.

Aids and appliances is one of the 'excluded services' for HACC funding because funding is already provided for these services through other government programs.

6.8 HACC is a jointly funded program. States and Territories are required to match the Australian Government annual offer of funding. The previous year's HACC funding for a State/Territory forms the basis of the next year's funding plus whatever growth is provided for in the Commonwealth Government Budget. The annual growth component has been set at cost indexation plus a real growth of 6 per cent for some years now.

6.9 The Commonwealth Government contributes approximately 60 per cent of Program funding and maintains a broad strategic policy role while State and Territory Governments funded the remainder. State and Territory Governments are responsible for the day-to-day management of the HACC Program. Total national expenditure on HACC was of $1.2 billion in 2003-04 consisting of $732.4 million from the Commonwealth Government and $471.3 million from State and Territory Governments.[5]

5 Productivity Commission, *Report on Government Services 2005*, Vol. 2, p.12.11.

6.10 Table 6.2 provides details of total Commonwealth and States' HACC expenditures from 1995-96 to 2003-04.

Table 6.2: Expenditure on the HACC Program, 1995-96 to 2003-04

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	C'wealth
	$m	$m	$m	$m	$m	$m	$m	$m	$m
1995-96	139.450	118.829	65.708	37.923	43.123	11.794	2.449	3.966	423.242
1996-97	143.780	126.635	73.506	41.734	45.687	12.720	2.691	4.467	451.220
1997-98	150.187	133.990	80.476	43.394	47.456	13.047	2.885	4.894	476.329
1998-99	155.862	141.226	87.705	44.751	48.960	13.322	3.070	5.304	500.200
1999-00	161.760	148.900	95.620	46.170	50.530	13.565	3.270	5.750	525.565
2000-01	174.129	157.230	104.765	50.047	54.587	14.630	3.642	6.424	565.454
2001-02	190.262	167.331	116.991	54.023	60.007	15.860	4.069	7.039	615.582
2002-03	209.522	178.703	131.375	58.556	66.289	17.303	4.559	7.779	674.086
2003-04	228.726	189.879	145.883	63.086	72.497	18.743	5.058	8.516	732.388

Source: Submission 191, p.43 (DoHA).

6.11 The number of clients accessing HACC services has increased from 375 000 in 1995-96 to 700 000 in 2002-03 – however this only represents 40 per cent of the HACC target population.[6] Client numbers increased to 707 200 in 2003-04. The HACC target population comprises people with moderate, severe and profound disabilities, as defined by the ABS Survey of Disability, Ageing and Carers. Identified special needs groups within the HACC target population include: people from culturally and linguistically diverse backgrounds, Indigenous Australians, people with dementia, financially disadvantaged people, and people living in remote or isolated areas. Carers of people in the HACC target group can also receive support through the HACC Program's respite care and counselling services.

6.12 Community and voluntary organisations, religious and charitable organisations, commercial organisations in some States, as well as State and Territory Government agencies and Local Government may provide HACC services.

Funding

6.13 Concerns were expressed at the adequacy of funding levels to meet the current and future demand for HACC services.[7] Submissions noted that demand for HACC services is likely to increase significantly in the medium to longer term as a result of:

- increasing numbers of older people due the ageing of the population and increased life expectancy;

6 *Submission* 191, p.50 (DoHA).

7 *Submissions* 166, p.12 (CHA); 173, pp.7-8 (ACSA); 174, p.14 (COTA National Seniors).

- increasing rates of 'core activity restriction' among older people as a result of people living longer with more long-term health conditions and frailties; and
- increasing preferences for community based services over residential care services as older people seek to remain in their own homes for as long as possible, resulting in demand for high level community care services.[8]

6.14 DoHA projections of the HACC target group, comprising people with moderate, severe and profound disabilities, over coming years based on ABS population projections indicate the numbers of persons involved will increase by about 2 per cent per year which is about twice the rate of the general population. The HACC client base continues to increase as the number of persons aged 70 and over increases relative to the general Australian population. DoHA stated that the current 6 per cent annual real growth in funding for HACC is considerably higher than the current projection that the HACC target population will increase by around 2 per cent per annum.[9]

6.15 Commonwealth Government funding for HACC has continued to increase. Over the nine years from 1995-96 to 2004-05, the Commonwealth has increased the funding available for HACC services by 87 per cent, or approximately $369 million. Total Commonwealth and State Governments HACC funding in 2003-04 was $1.2 billion.[10]

6.16 In relation to unmet need for HACC services, DoHA noted that the ABS Survey of Disability, Ageing and Carers 1998 identified a group of some 4 per cent of those people with a moderate, severe or profound disability (the definition of the HACC target population) who were in need of services but were not currently receiving any services. A further 32 per cent of this HACC target group indicated that though they were in receipt of services, they would like more services. These survey results have been taken as a broad measure of the unmet demand for community care services.[11]

6.17 DoHA noted that:

> …additional upwards pressure on demand for services is expected to continue. The ongoing increase in demand will result from the relative increase in the number of people who are 70 years of age and over, an increase in the care needs of the increasing number of older aged persons, and the continuing decline in the availability of informal care.[12]

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8 *Submissions* 202, p.18 (DADHC & NSW Health); 150, pp.19-20 (VAHEC).

9 *Submission* 191, pp.44,50 (DoHA).

10 *Submission* 191, p.45 (DoHA).

11 *Submission* 191, p.46 (DoHA).

12 *Submission* 191, p.47 (DoHA).

6.18 A number of groups argued that HACC funding needs to be increased by an initial 20 per cent and at least 6 per cent per annum (plus indexation) each year to ensure that a more appropriate level of care can be provided to existing clients and to ensure sufficient growth in funding to match future growth in demand.[13] Carers Australia argued that funding for HACC services should be increased by at least 30 per cent to meet unmet demand.[14]

6.19 Submissions also argued that the indexation method for the HACC programs, through the Commonwealth Own Purpose Outlays (COPO), is inadequate and fails to keep pace with the rising costs of providing community care.[15] Aged and Community Services Australia (ACSA) suggested that, in the longer term, community care providers should be funded to a level which supports the actual costs of providing care. This could be best be achieved by linking community care funding to an appropriate index of health sector wages.[16]

Recommendation 37

6.20 That, while welcoming the increases in Commonwealth and State and Territory funding for the Home and Community Care Program over recent years, the Commonwealth and State and Territory Governments increase funding for HACC services to ensure more comprehensive levels of care can be provided to existing clients and to ensure sufficient growth in funding to match growth in demand.

Recommendation 38

6.21 That the Commonwealth review the indexation arrangements for the Home and Community Care Program to reflect the real costs of providing care.

Special needs groups

6.22 Evidence indicated that within the HACC target population there are several groups that find it more difficult to access services. These groups include:

- people from culturally and linguistically diverse (CALD) backgrounds;
- Aboriginal and Torres Strait Islander people;
- people with dementia;
- financially disadvantaged people; and
- people living in remote and isolated areas.

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13 *Submissions* 170, p.17 (ACS of NSW & ACT); 125, p.10 (ACS SA& NT); 203, p.16 (NSW Aged Care Alliance); 209, p.2 (Community Care Coalition).

14 *Submission* 111, p.10 (Carers Australia).

15 *Submissions* 173, p.7 (ACSA); 170, p.17 (ACS of NSW & ACT); 111, p.10 (Carers Australia).

16 *Submission* 173, p.8 (ACSA). See also *Submission* 101, p.8 (MAV).

People from culturally and linguistically diverse backgrounds

6.23 Submissions noted that people from CALD backgrounds are relatively underrepresented in using core HACC services such as home care, delivered meals and personal care compared with people whose first language is English. Data indicate that approximately 25 per cent of HACC clients are people whose birthplace is outside Australia, with 9.2 per cent speaking a language other than English at home.[17] It was argued that it is essential that people from CALD communities have fair and equitable access to HACC services.

6.24 Groups representing CALD communities argued that there needs to be:

- increased flexibility in the design of HACC services to meet the particular needs of CALD communities;
- increased funding to support ethno-specific delivery of HACC services, especially social support programs;
- increased support and funding for the HACC in-home respite care program, the value of which is underated for CALD communities;
- the development of a uniform national framework to deliver culturally competent care;
- the creation of planning and funding allocation benchmarks and targets to improve CALD communities' access to services;
- cultural competence training across the HACC sector and evaluation of programs in relation to their cultural appropriateness; and
- improved data collection and reporting.[18]

6.25 Submissions also argued that CALD ageing communities require specialised intervention strategies such as the availability of bi-lingual assessment and care workers and extensive information initiatives to better inform particular communities of the availability of HACC services.

Aboriginal and Torres Strait Islander people

6.26 Submissions noted that there is a need to improve the accessibility and appropriateness of community care services for Aboriginal people. Some 2.4 per cent of all HACC clients are from an Indigenous background. It was noted that the low utilisation of residential aged care by Aboriginal people places an increased emphasis on the provision of culturally-appropriate community-based supports. It was also argued that funding for community care services needs to take account of the fact that

17 HACC Program Minimum Data Set, *2003-2004 Annual Bulletin*, DoHA, November 2004, pp.6,20.

18 *Submissions* 178, pp.17-20 (ECC of NSW); 82, p.3 (ECC of Victoria); 43, pp.2-4 (ECCFCSC). See also *Submission* 203, p.17 (NSW Aged Care Alliance); *Committee Hansard* 27.4.05, pp.38-41 (ECC of Victoria).

Indigenous people have a much poorer health status and die at a younger age than the general population.[19]

6.27 Submissions argued that there is a need to provide Aboriginal-specific services delivered by appropriately trained Aboriginal people – such services are at present inadequate and ad hoc. Submissions also noted the need to provide training to ensure that culturally appropriate staff are employed by mainstream services to ensure services cater for the particular needs of Aboriginal people.[20]

People with dementia

6.28 Submissions noted that with the ageing of the population, the number of people living with dementia will increase significantly. This increase in numbers will represent a significant driver in the growing demand for additional community care services. While some people with dementia will need support from specialist services, the bulk of the support will need to come from mainstream community care services.[21]

Homeless people

6.29 Submissions argued that many homeless people or people at risk of homelessness suffer from premature ageing and require the intensive care services appropriate to older people, such as HACC or CACP services, but they are often excluded from these services because they do not meet the age criterion. The Brotherhood of St Laurence (BSL) suggested that the HACC guidelines need to be amended so that homeless people are recognised as a special needs group so that these people would be eligible for HACC services due to premature ageing.[22]

People living in remote areas

6.30 Submissions noted that HACC services are more limited in many rural and remote areas. The distribution of HACC clients among remote and very remote areas is 1.6 per cent and 0.7 per cent respectively. While many people in these areas are eligible for HACC and other community care programs there are often long waiting lists. For those receiving services there is often difficulty moving through the various levels of care as their needs change. In rural and remote areas, with relatively more limited access to residential aged care, it is important to ensure people can access community care services.[23]

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19 *Submission* 173, Attachment 2 (ACSA).

20 *Submissions* 204, pp.18-20 (NCOSS); 203, p.17 (NSW Aged Care Alliance).

21 *Submission* 173, Attachment 2 (ACSA); 158, p.4 (Advocacy Tasmania).

22 *Submission* 52, p.5 (BSL). See also *Committee Hansard* 23.2.05, pp.28-29 (St Bartholomew's House).

23 *Submissions* 208, pp.8-9 (NRHA);165, pp.2-3 (TasCOSS).

6.31 Submissions noted that HACC providers in rural and remote areas are disadvantaged financially in operating services. For residential care providers a supplement to assist with viability is applied according to the geographical remoteness of the service. Extra costs associated with travel and operational costs are not taken into consideration in subsidy levels for HACC services. Aged Care Qld argued that the Commonwealth should extend the viability supplementation to the community care programs that it funds.[24]

Conclusion

6.32 Evidence indicates that additional resources need to be provided to special needs groups within the HACC target population to ensure equitable access to HACC services. The Committee also believes that the particular needs of homeless people need to be more adequately recognised under the HACC program. The Committee also considers that a funding supplement should be available for community care services operating in regional and rural areas.

Recommendation 39

6.33 That the Commonwealth and States and Territories substantially increase funding for identified special needs groups within the HACC target population including people from culturally and linguistically diverse backgrounds; Aboriginal and Torres Strait Islander people; people with dementia; financially disadvantaged people; and people living in remote or isolated areas.

Recommendation 40

6.34 That the HACC guidelines be amended to recognise homeless people or people at risk of homelessness as a special needs group.

Recommendation 41

6.35 That the Commonwealth introduce a funding supplement to reflect the additional costs of proving community care services in regional, rural and remote areas.

Other community care programs

Community Aged Care Packages

6.36 As noted above, the CACP program is a community alternative for older people with complex care needs who wish to remain living in their own homes with care and community support. The program provides individually tailored packages of care services that are planned and managed by an approved provider. The services

24 *Submission* 196, p.11 (Aged Care Qld).

provided as a part of a CACP are designed to meet people's daily care needs and may vary as an individual's care needs change.

6.37 The funding for the CACP program for 2004-05 is $327.4 million, with an additional $2.4 million for CACP Establishment Grants. A further 6635 Community Aged Care Places will be made available through Approvals Round over the next three years, including 2020 through the 2004 Aged Care Approvals Round.[25] DoHA stated that the CACP program will continue to receive increased funding to ensure the future needs of the elderly in the community are met.[26]

Extended Aged Care at Home

6.38 As discussed above, the Extended Aged Care at Home (EACH) program aims to provide an alternative to high level residential care for frail older people living in their homes, with the objective of improving the quality of life for the frail older people and reducing inappropriate access to both acute and residential care settings.

6.39 EACH packages are individually tailored, coordinated and planned packages of care, targeted at the frail aged whose care needs are assessed as equivalent to those who require high level residential care, but have expressed a preference to live at home.

6.40 The initial number of packages during the pilot stage was 290 packages. In the 2002 Aged Care Approvals Round (ACAR), a further 160 EACH packages were made available to provide for a moderate expansion of the EACH Program. This expansion aimed to build provider familiarity with the program and provide an Australian-wide base for program development. In the 2003 ACAR, an additional 474 new places were made available bringing the total places to 924.

6.41 EACH packages are currently funded at an average of $107 per day, which is equivalent to the Resident Classification Scale level 2 of high residential care. This is an average of $39 055 per annum per package. Expenditure for the EACH program in 2004-05 is estimated to be some $40 million.

6.42 DoHA stated that the EACH program continues to receive increased funding to ensure the future needs of the elderly in the community are met. To support continued strong growth in community care, 900 additional EACH places will be made available in 2004-05. In 2004-05 the number of EACH places will increase to 1824 places.[27]

25 *Submission* 191, pp.50-51 (DoHA).

26 *Submission* 191, p.51 (DoHA).

27 *Submission* 191, pp.51-52 (DoHA).

Views on programs

6.43 Generally, the evidence indicated that these community care programs provide valuable services but need further resources so that more services can be provided. The Committee received only limited evidence commenting on specific programs. One submission noted that while EACH is a laudable program the differences in level of care available under CACP funding and EACH packages creates problems in maintaining clients in their own homes because of the very different levels of care able to be provided under the different programs.[28] Another submission noted that CACPs and EACH packages are now seen as a way for HACC providers to 'offload' high user clients that in the past managed well with HACC supports.[29]

6.44 A recent House of Representatives report into ageing noted the growing demand for EACH places and the need for further resources to increase the number of these packages to enable people to have the chance of receiving high care at home.[30]

6.45 Many submissions argued that funding for these community care programs should be increased by 10 per cent to address past underfunding of these programs.[31]

6.46 In the 2004-05 Budget the Government changed the aged care planning ratio to increase the number of CACPs from 10 per 1000 over the age of 70 years to 20 per 1000 people over the age of 70. Submissions generally welcomed these changes.[32]

Recommendation 42

6.47 That, while welcoming the increases in Commonwealth funding for Community Aged Care Packages and Extended Aged Care at Home packages over recent years, the Commonwealth increase funding for these programs to meet demand for these programs and to provide viable alternatives to residential aged care.

Adequacy of community care programs

6.48 While there is widespread acknowledgement of the significant contribution community care programs make in enabling older people remain in their own homes, evidence indicated concerns about the adequacy of some aspects of current arrangements. The Victorian Association of Health & Extended Care noted:

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28 *Submission* 92, p.4 (Southern Cross Care).

29 *Submission* 100, p.4 (ACAS).

30 House of Representatives Standing Committee on Health & Ageing, *Future Ageing*, March 2005, p.129.

31 *Submissions* 203, p.16 (NSW Aged Care Alliance); 209, p.2 (Community Care Coalition); 170, p.17 (ACS).

32 *Submissions* 173, p.8 (ACSA); 170, pp.16-17 (ACS).

> Community Care as well as being preventative, is the most economically efficient and socially effective model of care. It improves people's lives and prevents admissions to residential care facilities. It literally is the way of the future.[33]

6.49 Evidence indicates that the community care system is not meeting all the needs of Australians who currently require it. Specific problems identified include the following:

- there are inadequate levels of service provision – 'For some years the Queensland Government has been concerned about the adequacy of community aged care, the multiplicity of Commonwealth Government programs and the absence of choice for frail older people'.[34]
- services are fragmented – currently there are 17 separate Commonwealth funded programs providing community based care services. In addition the States fund separate programs – in Victoria alone there are 42 different State and Commonwealth funded programs.[35]
- services are often difficult to access and they are unevenly distributed across the country;
- there is a complex mix of services that are difficult to access;
- there is evidence of considerable unmet need and there are waiting lists for many services;
- there is a lack of case management of clients to follow through with care plans.

6.50 Submissions commented on the complexity of community care programs:

> Community care is a complex matrix of services and funding streams that is difficult for the most experienced person to negotiate. At a time when we are encouraging our older people and people with disabilities to plan their own care, or remain in their own homes and communities it is becoming more difficult to do so. The system is confusing for people to access and is administratively inefficient for Governments and service providers. [36]

> The sheer complexity of the community care system and its plethora of programs can be defeating for people needing to access the system.…This complexity for consumers is a barrier in itself and creates unnecessary hardship, inequities and inconsistencies for consumers and families.[37]

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33 *Submission* 150, p.21 (VAHEC).

34 *Submission* 193, p.18 (Queensland Government). See also *Submissions* 101, p.5 (MAV); 241, p.1 (Legacy).

35 *Submission* 150, pp.20-21 (VAHEC).

36 *Submission* 201, p.25 (ANF).

37 *Submission* 203, p.16 (NSW Aged Care Alliance).

6.51 Submissions noted that average levels of service provision under HACC is very low. In 2002-03, individuals on average received 38 minutes of domestic service per week, 67 minutes of personal care, 108 minutes of respite care and 16 minutes of nursing care.[38] In terms of service intensity, data indicate that in 2002-03, 45 per cent of HACC clients received only one type of assistance; a further 24 per cent of clients received two assistance types and only 14 per cent received three assistance types.[39] Data for 2003-04 indicate no change with regard to service intensity compared with 2002-03 figures.[40]

6.52 These figures graphically illustrate the inability of the community care system to provide adequate support for those currently requiring assistance. Instead, the rationale appears to be to limit the time available to each client in order to provide as many people as possible with some service. Pensioner groups reported that many older people are either unable to access necessary services or have had their services cut back. COTA National Seniors stated that seniors report that they have difficulty in obtaining services, especially household support, community transport, gardening and home maintenance and essential home modification.[41]

6.53 Evidence indicated that HACC services are in danger of losing their preventative focus. One submission commented on 'the lack of capacity to provide preventative services for low care clients because of the necessity to attend to those with higher care needs who are unable or do not wish to access residential services'.[42] Another submission noted that HACC services are often now responding to crisis situations rather than responding to the ongoing needs of clients.[43]

6.54 Submissions noted that the level of services are inadequate for those with more complex needs.[44] The Aged Care Assessment Service Victoria commented that there has been 'a progressive reduction of flexibility in the provision of generic HACC services as provider agencies move towards setting limits on the number of hours of service clients can expect from the HACC system. This has meant there are now limits to HACC services for high need clients that prevent them from remaining at home'.[45]

6.55 Submissions also noted that many prospective clients in regional and rural areas in particular have limited or no knowledge of the range of HACC services that

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38 *Submission* 170, p.16 (ACS of NSW & ACT). See also *Submission* 173, p.7 (ACSA).

39 *Submission* 209, p.1 (Community Care Coalition).

40 HACC, *2003-2004 Annual Bulletin*, p.10.

41 *Submission* 174, p.15 (COTA National Seniors). See also *Submission* 240, p.3 (TPI Association).

42 *Submission* 174, p.15 (COTA National Seniors).

43 *Submission* 115, p.5 (Macarthur Aged & Disability Forum).

44 *Submission* 61, p.11 (Melbourne Citymission).

45 *Submission* 100, p.3 (ACAS).

are available.[46] Other potential clients are not receiving services. Carers Australia reported that many carers are missing out on services, along with the people that they support, in preference to people without carers – 'it appears, in an environment of resource constraint, people with no family support are being given greater priority for HACC services'. [47]

6.56 A significant concern for providers, especially smaller providers, is the onerous reporting requirements. ASCA noted that there is a growing array of community programs which have created separate reporting requirements. Often the same organisations provide a mix of community care programs and must complete multiple sets of essentially similar information. These different requirements are inhibiting the provision of quality care to individuals while adding to management overhead costs.[48] Submissions noted that some small organisations are reassessing their commitment to providing services due to the reporting requirements for grants.[49]

Community care review

6.57 Evidence to this inquiry as well as previous reviews of community care indicates that significant reform is needed to the community care system.[50] In 2002 the Commonwealth Government initiated a review of community care programs to identify strategies that would simplify and streamline current arrangements for the administration and delivery of community care services. The focus of the review is to ensure a community care system in which it is easier for people to access the care they need and within which community care programs are well aligned and interlinked, offering an appropriate continuum of care that is of high quality, affordable and accessible.

6.58 Following a review and consultation process, the Commonwealth Government released *A New Strategy for Community Care – The Way Forward* in August 2004, which outlines a series of steps for reshaping and improving community care. Four broad areas of action have been identified:

- addressing gaps and overlaps in service delivery – including the development of common arrangements for community care programs within a national framework; development of administrative arrangements for the allocation of HACC funds across a three-tiered community care system, based on different levels of care and support; improved alignment of CACP and EACH packages

46 *Submission* 165, p.2 (TasCOSS).

47 *Submission* 111, p.9 (Carers Australia).

48 *Submission* 173, Attachment 2 (ACSA).

49 *Submissions* 125, p.11 (ACS SA & NT); 57, p.13 (UnitingCare Australia).

50 Other reviews by the Myer Foundation, Catholic Health Australia and Aged Care Services Australia concluded that change is needed to reduce system fragmentation and complexity in community care programs.

with other services; and development of consistent eligibility criteria for community care programs.

- easier access to services – including the development of nationally consistent intake assessment for HACC and other community care services; and identification of entry points for easy access by consumers seeking community care services.
- enhanced service management – including the development of a standard financial reporting tool; implementing a quality assurance model for community care programs; and a nationally consistent approach to consumer fees.
- streamlining of Commonwealth Government funded programs – including the alignment of EACH within community care programs; development of a single national contract for dementia initiatives; better integration of initiatives under the Continence Management Strategy; merging the functions of the Aged Care Assessment Team and Dementia Support for Assessment Programs; and applying common arrangements to respite services funded under the National Respite for Carers Program.[51]

6.59 The *Way Forward* is based on the adoption of a common approach across all community care programs in key areas such as access, eligibility, common assessment, accountability and quality assurance. The *Way Forward* also involves the development of a new HACC Agreement with the State and Territory Governments, which will be underpinned by the principle of common arrangements. DoHA advised that discussions with the States are continuing in relation to the Agreement and that a draft Agreement is expected to go to Cabinet for consideration in July-August 2005.[52] State Governments argued that any new HACC Agreement needs to address certain issues such as the need to improve viability for service providers, reduce administrative burdens and provide sufficient funding to meet future demand for services.[53]

6.60 Evidence to the inquiry generally welcomed the Government's proposals for reform of community care programs arguing that they address many of the deficiencies identified in current programs. One submission noted that within the community care sector there exists:

> …in principle agreement with much of the shape of reform proposed…and an urgent need for reform which creates a sensible and flexible program structure to meet consumer needs, reduce consumer confusion and time wasted by services on reporting on, and managing multiple programs.[54]

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51 DoHA, *A New Strategy for Community Care: The Way Forward*, August 2004, pp.7-9.

52 DoHA, personal communication, 9.5.05.

53 *Submissions* 193, pp.20-21 (Queensland Government); 200, p.8 (Tasmanian Government); 180, pp.10-11 (Victorian Government).

54 *Submission* 111, p.10 (Carers Australia).

6.61 However, submissions pointed to the need for the Commonwealth to provide a detailed implementation plan and timetable for the reforms.[55] DoHA advised that major implementation of the reforms will begin in 2006, with some pilot programs and development work being implemented in 2005.[56] Evidence also pointed to the need for the Commonwealth and the States to work collaboratively in implementing the reforms.[57]

6.62 Evidence indicated that a particularly glaring omission in the *Way Forward* is that it fails to adequately address the need for effective interface between ageing and disability services. ACROD stated that:

> At present, bureaucratic and jurisdictional boundaries impede effective service delivery to people with disabilities. For some with long-term disabilities who are growing old, this is particularly so. Such people often search in vain for effective pathways between Commonwealth and State disability service systems, and between aged care and disability service systems.[58]

6.63 The implementation of *The Way Forward* has involved the establishment of compulsory competitive tendering for three respite care programs. Evidence was strongly critical of the process arguing that it was disruptive to services and counterproductive to the development of more integrated service provision. The BSL stated that it 'is causing quite a deal of distress amongst our service users and staff and, again, a lot of paperwork and extra work, taking people away from the direct care requirements'.[59]

6.64 Witnesses noted that competitive tendering does not actually support the client negotiating the myriad services currently available as providers who previously would have collaborated to serve that client are now in a competitive situation, so their desire to collaborate is diminished.[60] ACSA submitted that 'it certainly cannot in principle lead to better integrated services on the ground. They are already integrated. This is disintegrating them – or at least caries that risk. It is an expensive process'.[61] The Victorian Healthcare Association argued that 'it does not get us any closer to a system that is actually focussed on providing better care for the individual… Tendering…distracts from that'.[62]

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55 *Submissions* 166, pp.15-16 (CHA); 170, p.17 (ACS of NSW & ACT).

56 DoHA, personal communication, 9.5.05. See also *The Way Forward*, p.11.

57 *Submissions* 209, p.2 (Community Care Coalition); 170, p.17 (ACS of NSW & ACT).

58 *Submission* 26, p.2 (ACROD). See also *Committee Hansard* 11.2.05, pp.49-50 (ACROD).

59 *Committee Hansard* 27.4.05, p.6 (BSL).

60 *Committee Hansard* 28.4.05, p.35 (Southern Cross Care).

61 *Committee Hansard* 26.4.05, p.13 (ACSA).

62 *Committee Hansard* 26.4.05, p.13 (Victorian Healthcare Association).

Conclusion

6.65 Evidence to the inquiry indicated that community care programs provide a range of very valuable services to enable older people to live at home. It is, however, evident that significant reform of community care programs is required to achieve a system that better responds to the needs of consumers, care workers and service providers. Evidence indicated that the current system is not providing adequate levels of service; services are fragmented; and there is a complex mix of services that are often difficult to access.

6.66 The Committee notes that the community care review, *The Way Forward*, outlines, in very broad terms, a series of steps for reshaping and improving community care. The Committee supports the aims of the review in addressing gaps and overlaps in service delivery; providing for easier access to services; enhancing service management, including financial reporting; and streamlining of programs. The Committee considers, however, that the Commonwealth needs to provide a comprehensive implementation plan and timetable for the reforms. The Committee also believes that the *Way Forward* strategy needs to address the need for a more effective interface between ageing and disability services. The Committee also considers that the Commonwealth and States and Territories should assess the appropriateness of compulsory competitive tendering for future programs as part of *The Way Forward* strategy.

Recommendation 43

6.67 That the Commonwealth provide a clearly defined timetable for implementing all aspects of *A New Strategy for Community Care: The Way Forward*.

Recommendation 44

6.68 That, in supporting the approach in *The Way Forward* for implementing a more streamlined and coordinated community care system, the Commonwealth address the need for improved service linkages between aged care and disability services.

Recommendation 45

6.69 That the Commonwealth and State and Territory Governments assess the appropriateness of the compulsory competitive tendering process for future programs as part of the implementation of *The Way Forward* strategy.

Informal care

6.70 Evidence to the inquiry indicated that access to informal care plays a critical role in helping individuals who require assistance and support because they are frail, chronically ill or too disabled to remain living in their homes and communities. Most community care occurs in the home, making informal carers the backbone of the Australian community care system.

6.71 The ABS estimates that there are 2.3 million carers in Australia – of these some 450 900 are classed as 'primary carers'. A primary carer is a person of any age who provides the most informal assistance to a person with one or more disabilities.

6.72 The Commonwealth funds two community care programs specifically for carers – the National Respite for Carers Program (NRCP) and the Carer Information and Support Program (CISP).

6.73 Under the National Respite for Carers Program, the following services are provided:

- Commonwealth Carer Resource Centres – These provide information, support and advice to carers on a range of issues.
- Commonwealth Carer Respite Centres – These were originally established in each HACC region across Australia and have the capacity to arrange respite for carers through existing services. There are currently 61 Centres (with 89 outlets in all). These Centres have a pool of funds, called brokerage, to be used to purchase or subsidise short term or emergency respite care.
- Respite services – There are currently 432 community-based respite services delivered to carers and the people for whom they care in a variety of settings, including in-home, day centre, host family, residential overnight cottage-style accommodation and as holiday breaks. In 2003-04 the number of carers assisted by respite services was estimated to be 28 000.
- National Carer Counselling Program – The aim of the program is to address issues specific to carers such as carer stress, grief and loss, coping skills and transition issues. Counselling is provided on a sessional basis by qualified counsellors.

6.74 Overall, Commonwealth funding for the NRCP has increased more than five-fold from $19 million in 1996-97 to an estimated total of $104.9 million in 2004-05. The Commonwealth also funds CISP. This program provides carers with information and practical advice about services that can help them in their caring role. Funding for this program for 2004-05 is $2 million. [63]

6.75 In the 2005-06 Budget, the Commonwealth announced that it will provide $207.6 million over four years to support carers by improving access to respite care including increasing the number of respite care services available for carers in paid employment; paying an incentive to encourage residential aged care providers to provide high care residential respite; and increasing the level of respite services available to carers in rural and remote areas.[64] Support for carers is an essential component of the Commonwealth's community care policy which aims to give people the choice of remaining at home for as long as possible.

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63 *Submission* 191, pp.54-55 (DoHA).

64 *Portfolio Budget Statements 2005-06,* Health and Ageing Portfolio, p.82.

6.76 The NRCP complements other services funded by the Commonwealth, aimed at supporting the frail aged and people with disabilities to continue to live in the community, for example the HACC program. While carers are a focus of HACC, as noted above, the NRCP and the CISP are the only two community care programs for which the carer is identified as the main client.

Supporting carers

6.77 Submissions stated that the needs of carers need to be more fully recognised and addressed. The work that carers do in their caring role is constant and exhausting and without assistance carer burnout is likely to lead to increased numbers of older people relying on the formal care system. In particular, the Carers Australia noted that:

- Carer recognition and support needs to be central to *The Way Forward* strategy. Any community care strategy must address the needs of carers by ensuring that community care systems can respond to individual care situations. *The Way Forward* strategy also needs to address the needs of carers of workforce age – the bulk of the carer population.
- Carers have a dual role in the system – they have their own needs for support and assistance to sustain their caring role and they are also key providers of essential services in an unpaid capacity.
- Governments need to address the problem of fewer primary carers and greater numbers of people needing care over the next decades, due to the ageing of the population. This will lead to greater demand and reliance on formal community services to fill the gap in service provision.
- While the uptake of respite services has increased in recent years and resite is delivered in a more flexible manner some problems still exists, especially the need to book respite services often 12 months in advance in some States.[65]

6.78 Submissions noted that that the aged care system is dependent on carers to provide ongoing support for older people – without them the costs of providing care and support to older people would be substantially higher. NSW Health noted that lack of an informal carer, that is, a person living alone, is the single most common trigger for an older person moving into residential care – 'any changes to the balance of care for older people must therefore consider adequate carer supports, together with social changes (such as workforce participation) that impact on people's availability to fulfil the role of "carer"'.[66]

65 *Submission* 111, pp.10-11 (Carers Australia); *Committee Hansard* 11.2.05, pp.50-55 (Carers Australia).

66 *Submission* 202, p.19 (DADHC/NSW Health).

6.79 ACROD also noted that as well as increased support for formal services, a strategy to respond to demand growth for services should include increased support for unpaid carers, without whom demand would be much higher.[67]

Recommendation 46

6.80 That *The Way Forward* implementation strategy recognise the central role of carers in the community care system.

Recommendation 47

6.81 That, while welcoming the increases in Commonwealth funding for carer-specific programs over recent years, the Commonwealth increase funding for these programs through the National Respite for Carers Program and the Carer Information and Support Program.

67 *Submission* 26, p.2 (ACROD). See also *Submissions* 150, p.20 (VAHEC); 174, p.16 (COTA National Seniors); 62, pp.5-6 (Gippsland Carers Association).