Aged & Community
Services • Australia

CONSUMER DIRECTED CARE IN COMMUNITY CARE

DISCUSSION PAPER FOR ACSA POLICY DEVELOPMENT

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Purpose

Consumer Directed Care (CDC) programs, also known as Direct Funding, or Individual Budget programs, have been available in the disability sector since the early 1990s and have considerable support from user groups, both in Australia and overseas. CDC has its advocates in the aged care sector as well.

The Australian Government has expressed its interest in exploring the introduction of consumer directed care models in aged and community care.

The main purpose of this paper is to assist in the development of an industry position on the use of consumer directed care in the service delivery system. This discussion paper:

- explores the benefits and deficits of the various models that have been tested to date, primarily in the disability sector;
- explores options for the development of consumer directed models of care in Australia; and
- highlights issues for discussion in determining an industry position.

Introduction

In most Western countries dramatic growth in the cost of aged care is projected for well into the 21st century. At the same time, the number of informal carers for each dependent aged person is projected to decrease, just as dramatically. According to the World Health Organisation,

> *The rising future financial burden of care for older people requires the optimum use of resources with care settings tailored and customised to both individuals and communities. The projected decline in the supply of informal care will require investment in home-based self-care and increased caregiver support in the home environment. The projected increase in the utilization and cost of institutionally-based care can be partly offset by investment in formal home-care and home-environment alternatives'.*
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> *Consumer directed payments, in which older people may be offered the option of receiving a cash payment or individual budget in lieu of formal care so that they can choose, manage and pay for their own social care, perhaps from an evidence-informed long-term care menu tailored to their unique circumstances, are an option here (Coyte and others, World Health Organization/ European Observatory on Health Systems and Policies, 2008: key messages).*

Consumer Directed Care, its proponents argue, is about consumer choice and control, but it has also been proposed as a cost-effective option for expanding home-based care provision.

CDC models range from direct payment or 'cashed out' programs that give actual dollars or vouchers directly to the 'consumer' and their family (or other nominee), enabling the direct purchase in the public market of care services (which may include purchases from existing aged care providers), to models that direct funds through existing community packaged care providers, offering consumers both a choice of provider and a choice of services from the chosen community care provider. The emphasis in each case is on consumer choice. Experience to date, internationally and in the disability sector, indicates that many consumers, when offered the choice, exercise that option by choosing an established provider to manage their care.

CDC emerged in the 1990s, out of the disability self-advocacy and empowerment movement, and to date has been primarily instituted for the care of younger people with disabilities. Direct payments for the purchase of home care help, activities and other services and supports has been available in the UK to disabled community care clients since 1996 and to aged care clients since 2000 (Allen Group: 49, n.84). As late as 2003, the Howard Government's *A New Strategy* *for Community Care* still associated Consumer Directed Care with ‘packaged care for younger people with disabilities’. The very successful Attendant Care Program has strong elements of CDC. Community Options, (a consumer directed HACC program) has also been helpful in extending the range of services available in the HACC program (NCOSS: 13). Howe (2003:4) considers that the Carers Allowance, Carer Payment and the Domiciliary Nursing Care Benefit can also be seen as pioneers in consumer direction in Australia.

The Victorian Transport Accident Commission has an Individual Funding Agreement self-purchasing program for clients with severe injuries. Funds can be provided directly to self-managing clients or be directed through brokers, in accordance with agreed individual care plans that support lifestyle choices and care needs. Clients’ funds can also be vested in guardians or administrators. An extensive suite of services can be purchased under the scheme including attendant care, child care, chiropractic, community programs, domestic services, allied health services, gym and swimming programs, post acute support, respite and a wide range of other services (TAC Self Purchasing website). Amongst the benefits of self-purchasing noted by TAC are client empowerment and ‘cost stabilisation’. An evaluation of the pilot program found that the initial set-up process is labour intensive and that there was some initial lack of clarity between brokerage and case management functions. It found also that all clients operated within their budgets and there was an increase in measured client satisfaction rates. Client responses ranged from ‘sceptical and pessimistic as to the benefits’ at the beginning, to a sense that ‘it’s changed my life’. Lessons from the pilot included the finding that small changes in a person’s life can make a big difference, especially in regard to the added flexibility enabled by the program, and that ‘ability to administer self-purchasing must not affect eligibility’, i.e. systems can and should be put in place to enable people (and/or their families) who cannot administer the scheme themselves to participate regardless, if they wish.

In 2000 the Western Australian government instituted the Intensive Family Support (IFS) funding program to provide case managed individual funding to two groups of families:

- families who are seeking respite to continue caring for a family member with high support needs, at home; and
- families with a child under 18 with a disability who may be deemed ‘at risk’ in regard to child protection and who may have complex support needs.

This combination of aims and clienteles was deemed to be a shortcoming by evaluators who were quite critical of aspects of the scheme. In 2005-6 the average allocation was around $30, 000. The evaluation found the IFS to be effective in providing respite to families in crisis but less effective in its other designated role of providing preventative, early intervention mechanisms for supporting families to maintain and build on their strengths. A lack of flexibility in the IFS program due to the requirement that services be selected from ‘fixed menus’ was identified as a shortcoming in the initial iteration of the program, as was the allocation of self-managed funding to families already under stress. The evaluation called for more clarity as to the mutual responsibilities and roles of families and administering bodies, and the need for the IFS to have a client outcomes focus rather than an outputs and funding accountability focus. Some service agencies declined to administer the scheme and ‘the evaluation … identified that the quality of activities for people with disabilities provided through IFS is not always consistent with Disability Services Standards’. Workforce shortages also presented a significant challenge (Gatter 2007: Executive Summary).

Recently CDC has been flagged in Australia as a mode for delivering community care to those we might designate as ‘mainstream’ aged care consumers.

The Netherlands, England, France, Denmark, Austria, Germany and Japan initiated CDC programs in the 1990s (Coyte and others 2008). In 1995 the Netherlands instituted a program based on social insurance in which people had a choice to receive a personal budget rather than services.

Fiscal agents assisted people to make best use of their budgets, which usually required a co-payment from consumers. A European Court ruling directed the Netherlands to move to an open-ended entitlement system, leading to cost blowouts (Weiner 2007). Around 10 per cent of home care beneficiaries in the Netherlands were personal budget holders in 2001 (Weiner 2007).

Consumer Directed Care in Germany is also based on social insurance. Allocations are 'cashed out' at '40-50 per cent of the cost of the maximum service benefit' (Weiner 2007). 'While these funds may be used to purchase services, they primarily provide financial support for informal caregivers' (Weiner 2007). In 2003 almost one million people, or 76 per cent of eligible home and community beneficiaries, chose the cash benefit. Another 16 per cent chose a combination of cash and services (Weiner 2007). This means that CDC is the choice of the vast majority of home care recipients in Germany. 'While about 60 percent of all long-term care insurance beneficiaries chose the cash option or the combination of cash and services, these benefits account for only about 31 percent of total program expenditure' (Weiner 2007). This means that the 'cashed out' options provide substantial savings to social insurers.

The US *Cash and Counselling* Demonstration Project, conducted in Arkansas, Florida and New Jersey, included elderly clients of Medicaid in both a 'treatment' group and a control group. Vouchers were given to recipients, rather than cash. The projects were evaluated in 2006-7. According to Weiner (2007) each state 'controlled the range of services and equipment that could be purchased, which was consistent with government fears of fraud and abuse'. One finding was that in Florida, 'among the elderly, *Cash and Counselling* had little effect on [care] outcomes because so few treatment group members actually received the allowance' because the administrative burden was too onerous for many older folk (Carlson and others 2007). Knickman and Stone (2007) found that the US Demonstration Projects left 'several unresolved issues', including 'how the program gets operationalised within each state, how case management is addressed … (and) how quality is assured'. The issue of trust when consumers have public cash in hand is a recurrent one in CDC programs (Burgess and Stephens 2004).

A major evaluation of Individual Budget programs has been underway in the UK since May 2006. The Individual Budgets Evaluation Network (The IBSEN Project) has evaluated 13 pilot programs, including Individual Budgets (IB) programs for older people in receipt of community care. Three university-based research units have been involved in this comprehensive evaluation, including a team from the London School of Economics. A draft report was submitted to the UK Department of Health in April 2008 for peer review. A response from the minister is expected by mid-2008. According to the IBSEN newsletter of May 2006, 'Individual budgets sit at the heart of government policy for improving choice and control for individual social care service users'.

Significantly, 'Individual Budgets' (with oversight by not-for profit and private agencies) represent a step back from experimental consumer-managed 'Direct Payment' programs that expressed the extreme end of the self-directed care spectrum and proved unpopular with consumers (IBSEN *A Summary of Early Findings*: 4). The preliminary report from the UK IBSEN project does not discuss specific models in any detail.

The CDC Debate in Australia

In November 2005, the then Minister for Ageing, Julie Bishop, called for the exploration of consumer directed care to meet the needs of 'the new old' of the baby boomer generation, whose relative wealth and consumer savvy has opened a market for 'diverse, more specialised and more innovative … customised care' (Bishop: "Consumer-driven aged care": *The Party Room*, Spring 2005: 25). According to Bishop, consumer directed care would open up 'a broad array of options for people to choose how, when, where, and notably by whom, they will receive care'. She envisaged that demand for such an aged care option is likely to expand rapidly, and described CDC as an option ‘where public and private dollars follow the person rather than the provider’: where

> *a person needing care could, with advice from families and professionals, decide how to spend the dollars ear-marked for their long term care. Care could be purchased from the sources they choose. For example, a spouse, relative or friend could be employed as a personal care assistant (Bishop: 25).*

She noted schemes in Austria and Germany, the latter entailing individual funding to the consumer through a voucher system. Bishop qualified her enthusiastic support for CDC by noting that ‘such options would need to include adequate safeguards to ensure that personal choice is enhanced and quality care delivered’. She argued that ‘in situations where older people or their families will not, or can not, take greater control over the exercise of that choice, there *could* still be a role for intermediaries or case managers’ (emphasis added). Such a system, she noted, relies on ‘active consumers’ and would have complex ‘implications for employment and fiscal sustainability … [and] issues of quality assurance’ (Bishop: 25). Bishop’s contribution was quoted at length and with approval by Vern Hughes who argued strongly for ‘demand-side, person-centred’ care to be extended to aged care, based on a voucher system (Hughes 2006: 5, 18).[1]

Beyond choice, as Coyte and others make clear, is the association of CDC with aged care cost control and minimisation. So envisaged, CDC may be positioned as an ‘incentive’ payment or support system to encourage informal carers to remain *at their post*, despite the finding that ‘increased public funding for in-home and residential care in Europe [and the USA] reduces the likelihood of receiving informal care from [mostly female] family members or friends who do not reside with the care recipient’ (Coyte: 3, citing Viitanen 2007), but also *decreases* the likelihood of entry into very high cost residential care.[2]

CDC, therefore presents as the ‘best hope’ option for a number of intersecting agenda of:

- aged care consumers and their families for individualised services that enhance choice;
- informal carers for recognition of services rendered; and
- Governments for cost control around the provision of aged care.

The evidence suggests that some of these hopes have not been realised.

CDC has, in general, received qualified philosophical support from within the Australian community or not-for-profit (NFP) sector, although there are some strong advocates of CDC in the sector. Uniting*Care* Australia is a particularly strong proponent of CDC and has called on the Rudd Government to institute ‘a series of contained demonstration projects around consumer directed care and evaluate the costs and benefits of this approach’ (Uniting Care, NSW: *Aged Care and Older People;* 2007 Federal Election Issues paper, October 07).

Enthusiastic support for CDC – or CDC influenced or oriented programming – also comes from *Alzheimer’s Australia*. Jane Tilly (Alzheimer’s Association, USA) and Glenn Rees (Alzheimer’s Australia) argue that CDC will enable older Australians to stay at home longer, an outcome that is clearly viewed positively by consumers of aged care services and their families. Rees and Tilly have called for the piloting of a range of models of community care with higher levels of consumer control than is currently offered, to test the interest of consumers in exerting more control over their care regimes. ‘The key question now’, they argue, ‘is whether consumers and service providers see advantage in exploring the notion of increasing consumer choice through

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[1] Hughes also argued that governments should cease funding peak bodies and advocacy groups ‘and direct those savings to consumers and their intermediaries’ (the latter of whom, he argued, should include private market service brokers) (Hughes: 5).

[2] As Coyte puts it, ‘the financial impact of substituting formal care for informal care depends on the setting in which formal care is provided – wider admission to institutional care, for example, is claimed to have more significant financial consequences than a wider application of home-based care’ (Coyte 2008: 4).

the provision of cash, vouchers or budgets in place of agency services' (Tilly and Rees, May 2007: Introduction).

Tilly and Rees argue that, despite "challenges", with the right support aged persons, including those with dementia, and their carers, can benefit from the ability to make decisions for themselves. They argue that such programs also provide opportunities to respond to carers' needs for support (Tilly and Rees: Exec Sum). They argue that CACPs and EACH packages already represent government responses to the CDC movement and form a solid base for further development of CDC in community care delivery (Tilly and Rees, May 2007: 3).

They report a range of international research that suggests that 'elderly and non-elderly program participants and their family carers, across a wide range of incomes, have better outcomes related to quality of life, independence, and satisfaction with care than those who rely on agencies'. They also report no evidence of systematic abuse and neglect (Tilly and Rees:p.4-5). Tilly and Rees found that CDC can facilitate seemingly minor changes in care programs that can have major positive impacts (e.g. paying a nominated carer to attend at a time nominated by the recipient and their carer rather than having to fit in with an agency schedule, so that preferred routines can be maintained.)

Rationale for CDC

The Allen Group, in a report commissioned by the Community Care Coalition in March 2007, identified four rationales for CDC. In addition to the claim that it brings health and wellbeing benefits to clients, and the belief that clients are best placed to identify their own needs and preferences, there is also 'the promise for government that if a client plays a greater role in their own care provision, this will reduce the cost of delivering some service types' (a proposition challenged by the report). The report also expressed 'the belief that allowing clients to enlist the support of relatives or other informal caregivers will help overcome the problems in the community care sector to attract and retain community care workers' (Allen Group: 50).

Much of the debate on the applicability of CDC to aged care, be it residential or community care, turns on the question of whether aged persons are capable of, or are interested in, taking on the tasks and responsibilities of directing their own care. Australian researcher Anna Howe, who surveyed findings from programs in Australia, Europe and the US, found that very few aged care consumers, and/or their families, are able to negotiate the purchase of care services without some assistance from experienced aged care intermediaries (Howe 2003). She found that early versions of 'cashed out' CDC in the USA had been popular amongst families and individuals with low incomes where a cash benefit made a significant impact on family incomes. On the other hand, many families were unable to negotiate complex administrative hurdles and the programs required the provision of support services to guide such families (Howe 2003: 6). Howe also noted that CDC had been introduced in Japan in the 1990s in 'default', as a means of responding to unmet demand for community care (Howe 2003: 6).

She argues that there has been a gradual move away from the advocacy of complete consumer 'freedom' to a recognition that successful CDC is underwritten by the public provision, at substantial cost, of brokerage services, financial and employment advisers or negotiators, counselling services to assist individual consumers and their families identify required services, quality assurance monitors, auditors etc., most of which are more easily provided through the aegis of existing packaged aged care providers. CDC may also require some investment in complaints systems, and worker training schemes (Howe 2003). There is *almost* universal recognition that only a limited cohort of consumers will want to, or be able to, take on CDC. There is also a due wariness in the community care sector that governmental interest in CDC may signal a turn towards 'individualised services' that may undermine the role of existing providers across the sector.

A study by the University of Wollongong's Centre for Health Services Development into options for the future of the Veterans' Home Care program (Eager, Green, Owen and others, December 2007) considered the benefits of the USA 'cash and counselling' models of consumer directed care. Eager and others (2007) found that participants in the cash and counselling demonstration projects were likely to be people with an existing informal (unpaid), live-in care giver, and members of 'some ethnic groups' with 'strong family networks that emphasize caring for one another' (138). They cited a US evaluation of the demonstration projects which indicated that 'a sizeable percentage of the eligible population would not be interested in a consumer directed option' (Mahoney and others 2004, quoted in Eager and others 2007: 139).

Australian Aged & Community Care Response to CDC

There are mixed views about CDC within the aged and community care industry with some embracing a choice and rights approach while others have serious reservations about the potential impact it would have on the care delivery system.

Not-for-profit providers have moved well along the track towards providing individualised services and care within an established provider structure. South Australia's *Helping Hand* (Uniting Church), for example, has incorporated individualised service choice as part of an overall evolution of aged care delivery which has seen the integration of their community and residential care programs since July 2006. *Helping Hand* aims to provide their clients with choice as to whether they receive care in a residential facility or at home, and the freedom to choose the components of their individual care regimes. All clients are encouraged to nominate elements that individualise their care. While relatively few choose to add to the standard program of care, *Helping Hand* has a policy that "'nothing's a no' until we have investigated all the options for providing the requested service" (Vicky Yardley, Residential Care Facility Manager, *Helping Hand*). *Helping Hand* has called for government policies and funding change to support these evolving delivery modes, including coordination and alignment of State/Territory and Commonwealth funding arrangements. The *Helping Hand* program has built up a suite of adjunct services to provide interested consumers with easy access to information, decision-making support staff and case managers, and a "one-stop shop" to respond to people's enquiries about care.

However, *Helping Hand* hesitates to designate this model as "Consumer Directed Care" because they consider these innovations as a natural continuation of their encouragement of consumer participation, rather than the introduction of a pre-set, or branded, CDC programming 'model'. This view reiterates a strong message from the literature and from the sector that consumer choice is already integrated to a considerable extent into community care delivery in Australia (eg. Howe 2003).

This reticence to label programs offering elements of individualised care as CDC attests to the identification of CDC with a prescribed model of care, or rather a model of funding, in which cash or vouchers are given directly into the hands of consumers to spend in the 'care market' – as outlined by Julie Bishop in 2005 'where public and private dollars follow the person rather than the provider' (Bishop: 25). This model, as so described, envisages a free-floating, market savvy, economically rational and nimble consumer or consumer advocate and a 'care market' eager and able to respond rapidly to 'consumer demand'. Such a model – which raises in the minds of many providers the spectre of an undermined community care sector - sits at the extreme end of a continuum of consumer control models.

> *The Allen Group found that in the US, advocates of CDC argue that consumer directed care should become the opt in option, provided the care recipient, their family or nominated guardian, can demonstrate the necessary decision-making capacity; and that where that capacity is lacking, entry to CDC should be enabled by the allocation of professional support to assist client decision-making (Allen Group: 52). According to the Allen Group,*

> *[t]his is where flexibility of program design is important. Concerns about how to meet the diverse needs and wants of the community care clients can be allayed by allowing the clients themselves to decide, with the support of their informal carers, on the level of control they want to exercise over their care. … Initial discussions of this approach in consultations with clients of community care suggest that this would be well received' (Allen Group: 52).*

While the Allen Group identified 'mixed views' about CDC (Allen Group: 51), it also identified a strong commitment across the Australian aged care sector to the development of options which respond creatively and realistically to the capacities and interests of aged care consumers and their families to exercise more control, including that small cohort who are deemed likely to express an interest in taking a high level of control of their own care.

Viewed as a set of options along a continuum rather than as a prescribed framework or model for care delivery, CDC may provide positive benefits and opportunities for both providers and consumers of community aged care. Primary amongst the considerations that should be taken into account when CDC is proposed are the two issues of whether clients are capable of taking on the management of self-directed care, and whether 'the community care market [is such as to] allow client choice to be exercised effectively' (Allen Group: 51).

The degree to which consumers currently have access to individualised community care differs widely from one provider to the next in Australia, but in general, individual budget programs are undeveloped. One Victorian carer was recently reported as being approved for direct personal control of a relative's EACH dementia package after a three year negotiation with the Department of Health and Ageing.[3] In this case, the consumer's only link with a recognised provider is the purchase of administrative support from Uniting*Care* Community Options. Few carers have the capacity to negotiate at this level.

Strategies for Greater Consumer Control

The Allen Group put forward three strategies for expanding and developing community care in the direction of more consumer control. Strategy one focuses on promoting the independence of clients rather than addressing their dependency needs. Strategy two 'puts the onus on existing providers to drive changes needed to make the sector more oriented towards and responsive to client needs' (Allen Group: xi). The third strategy, denominated specifically as 'consumer directed care', is 'based on the premise that the client should be able to have choice and control over the care they receive from paid providers' (Allen Group: xii). Clearly, there is a degree of confusion in the literature as to whether CDC is a care 'direction' or a more specifically defined program. Any conversation about CDC will need to clarify this at the outset to avoid discussants talking at cross purposes.

The Allen Group identified three models of CDC, which vary in terms of how much decision-making, control and autonomy are shifted from community care professionals and agencies to clients. The three models proposed by the Allen Group provide a suite of options for clients rather than progressive CDC 'stages' (Allen Group: xiii). Their clear position, as with most other commentators, is that CDC 'would never replace the existing model of service provision, but rather would sit alongside it as one part of a reformed community care system' (Allen Group: 55).

The first model would see the allocation of cash or vouchers direct to the client who is 'given discretion to select those services or goods deemed most essential. They can either manage the funds themselves or pay a small fee for an agent to manage the funds instead' (Allen: xii). This 'opt-in' system of direct cash benefits or vouchers would, they contend, 'be suitable for those with less complex needs' (Allen Group: xiii). In UK direct funding programs operated along the lines of this model 'the client must provide audited accounts to the local authority at the end of each year' (Allen Group: 49, Box 5.2).

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[3] *The Senior*, "Care deal win for mum, son" (March 2008).

Model two, '*assisted choice of provider'*, would see case managers assigned 'to assess which programs [clients] are eligible for, and how many hours of service they can receive'. Once this is established, 'clients are free to engage the providers of their choice to deliver services they have selected as best meeting their needs'. In this model, funding is distributed to (or through) providers (Allen xii). They acknowledge that Australian packaged care programs already 'provide some scope for clients to exercise choice… however, there are few opportunities for clients to direct or choose the type of community care services they receive, or from which provider they receive them' (Allen group: 49).

Model three, '*monitored choice of service and provider*', would see clients being 'able to engage the providers of their choice to deliver the clients' chosen services, with mandated guidance from case managers who not only determine their eligibility and assist them … at the beginning of their care program [as in model 2], but also then monitor the quality and effectiveness of service provision over time according to an approved care plan' (Allen: xiii).

Models two and three, with a case managed approach in each case, would be more suitable for clients who use multiple services and have complex needs (Allen Group: xiii).

The Allen Group acknowledges that 'consumer directed care would not be appropriate for, or desired by, many consumers' (Allen Group: xiii), and clients could return to standard community care provision if they found the demands of CDC too onerous or unsuited to their needs (Allen Group: xiii). They advocate the piloting and evaluation of all three models.

Regarding the ability of the market to meet demand for real choice, the Allen Group (53), following Bruen (2005) points out that '[really] increasing consumer choice means increasing the supply until it exceeds demand' (Bruen 2005 quoted in Allen Group: 53), a state of competition that, they acknowledge, may not sit well with the not-for-profit sector. They argue, therefore that:

> *If choice is to be introduced into community care in Australia, it is therefore most likely to be without competition. Clients would be allowed to choose the type of services that best meet their needs. Clients could elect to manage their own services, or have them managed by an agent. Introducing choice in this way would facilitate the provision of responsive, flexible, individualised services, even in the absence of competition (Allen Group: 53)*

The Allen Group report argues that a further locus of competition and choice could be instilled into the market for care if clients were able to choose between receiving care in a community care or residential setting (as *Alzheimer's Australia's* Rees has proposed, and as *Helping Hand* is already delivering). 'Providers would [then] have a clear incentive to improve their responsiveness to clients' needs and wants so as to retain clients', instilling an element of real choice into a single aged care 'market' (Allen Group: 53).

Trialling CDC in Australian Aged Care

At ACSA's 2008 Community Care Conference (Sydney), Glenn Rees argued that, internationally, CDC pilots and programs have been shown to 'provide better outcomes than those that rely on mainstream agency delivered programs'. However, he acknowledged that some programs have strayed towards 'welfare on the cheap', and that 'in some countries, consumers take the cash option when it is less in value from an equivalent service on offer from an agency' (Rees 2008).

Alzheimer's Australia's 2007 community consultations found that while 'the response to the consultations was overwhelmingly in support of trialling CDC', there was a strong preference for a middle-way approach to CDC. The consultations concluded that 'the majority view was a preference for a stronger say in the determination of the services received and to have an individual budget that a service agency would administer in line with an agreed plan' (Rees 2008).

Rees (2008), on behalf of Alzheimer's Australia, called for the trialling of three options:

1. **Applying CDC to Australian Government Care Packages.** Funds for CACPs, EACH and EACHD packages are now funded on the basis of a fixed subsidy to a service provider on behalf of an approved recipient. Subsidies are 'pooled' and then distributed according to individually assessed needs. 'CDC would allow the care recipient to inform the care package provider of the service they would like and who they would want them delivered by, within the limits of the care recipients "budget"'. The provider would work with the recipient to develop the 'shape' of the package and inform the recipient of the costs of the package. The provider would then arrange these services, including services from other providers, and their payment.

   Rees notes that this option 'is very close to what should constitute good practice in CACP and EACH provision' already, and is the model followed in the case of carer George Vassilios and Uniting*Care* in Victoria. Vassilios successfully negotiated control of $30,000 out of his mother's $48,000 EACHD package which provides 35 hours per week of care, with the agency as the legal employer of the carers. Vassilios says the negotiations 'took years', but 'there is nothing in the Aged Care Act that prohibits individualised funding' (ABC RN *The National Interest* 8/08/2008).

   Uniting*Care* and the Deakin University School of Nursing have secured funds for a 3 year pilot along these lines.

2. **Providing a cash option to users of respite care.** Despite the National Respite for Carers Program, culturally appropriate and timely respite still eludes many. This trial would see carers able to select for themselves the type and timing of respite care most appropriate to their needs. Funds and arrangements could be administered through Carer Respite Centres.

   The Dementia Collaborative Research Centre for Consumers, Carers and Social Research is at present writing a protocol for a systematic review of evidence on CDC with respect to respite care.

3. **Choice between home-based care and residential care.** This trial would make high level at-home care available to persons assessed as being eligible for residential care. Subsidies would be provided at the equivalent of the residential care subsidy, enabling consumer choice and enabling consumers to 'make their own trade offs'. According to Rees, models such as these have been trialled in Wisconsin and in the UK (Rees 2008).

Addressing the question of CDC from a position that privileges consumer directed care; Tilly and Rees identify the program elements that might contribute to 'dementia-friendly' CDC programs. Their 'opt-out' approach positions CDC as the normative future option in the debate over the future of community care. However, many of the key features outlined by Tilly and Rees strengthen community care infrastructure to support CDC. The key features of dementia-friendly CDC programs identified by Tilly and Rees are:

- Recognition that not all recipients and/or their carers will want to participate in CDC.
- The issue of whether a recipient and/or their carers need the assistance of a representative, counsellor or case manager to negotiate CDC should be addressed when the initial care need assessment is done. CDC participants should not be left to fail before this assistance is provided.
- Effective CDC must address the wellbeing of carers.
- Recipients' representatives may need training to enable them to identify the recipient's preferences.
- Agencies may be best positioned to provide training to their own staff, to representatives and to carers on management tasks, hiring, firing, supervising, responsibilities of payments to those they hire, recognition of signs of abuse or neglect and their legal duties of care etc., and to support Quality Assurance.

- Service coordinators will need to have frequent direct contact with CDC participants.
- Quality Assurance will also need to be supported by collection, analysis and reporting of data.
- Agencies will need to provide financial management support. These will support CDC participants in their planning and also handle tax, payroll and related functions.

Tilly and Rees suggest that Aged Care Assessment Teams could take on the job of assessing carers' ability to take on CDC and of identifying the type of assistance for which they should be funded. They argue that consumer input is already a feature of HACC, CACP and EACH programs 'in that the case manager receives a cashed out benefit with which to provide or purchase services for the care recipient'. 'It would only be a small step to allow the care recipient (or the carer), to manage his or her own care in some cases with this cashed out subsidy' (Tilly and Rees: 9). Brokerage funds are already available through the National Respite for Carers Program and Carer Respite Centres. Small program changes, argue Tilly and Rees, could allow carers and their supporters to have input into how the funds are spent.

A 'more radical' experiment in CDC could see eligible recipients and their carers aggregating their community care and residential care subsidies to pay for 'at home' residential care (Tilly and Rees: 9). Tilly and Rees argue that 'the challenge to governments is to devise the flexibility in program arrangements that might make this possible' (Tilly and Rees: 9). Alzheimer's Australia has called for a variety of CDC-oriented options to be piloted along these lines (Tilly and Rees: 9).

Tilly and Rees list three approaches to CDC that could provide a framework for program development:

- making the brokerage options we have work better at the professionally managed end;
- providing cash, vouchers or budgets in place of the current packages, enabling direct purchase; and
- giving people with dementia (or other conditions) 'genuine choice' between residential and at home care', and between low and high care, CACPs and EACH/EACHD.

What Do Consumers Want?

The evidence from CDC programs for younger people with disabilities indicates that what consumers most valued, and therefore are most likely to want to purchase with personally managed budgets, are 'reliability of staff, continuity of care, kindness and understanding, cheerfulness and appropriate manner, competence, flexibility and knowledge and experience of users' needs and wishes' and flexibility as to what services the carer is permitted to perform (Henwood 1999: 4). Choice of provider may be less important than control over what and how care is delivered, and continuity of the worker relationship. Recipients may also want to purchase specific cultural attributes and services (eg. same language carers, cultural competency). Agencies that can provide these elements will command consumer loyalty and have a competitive advantage in a competitive environment.

For many care consumers the care worker may be amongst their few visitors and they may be regarded as a significant social contact or as a friend or helper. Reliability, regularity, predictability are all high on the list of desirable qualities, as is the manner in which the care is delivered. A care consumer may value what is objectively lower quality care if the qualities of sociality and continuity are present (Henwood 1999:4).

These findings cast some doubt on Bishop's idea that aged care consumers will demand a broad range of 'lifestyle' options. It suggests that the range of wants will be both somewhat predictable and limited, raising questions as to likely demand for fully fledged CDC in aged care in an environment where approved providers are already actively responding to consumer demand for individualised care within those predictable parameters.

Howe concurs that too much choice may be overwhelming, especially for aged consumers. She notes that when veterans using HACC services were offered choice of provider under the Veterans Home Care (VHC) program, the majority stayed with their existing provider (Howe 2003: 11).

As noted, *Alzheimer's Australia* is currently advocating the inclusion of CDC elements into programs. Bruen and Rees for *Alzheimer's Australia* have argued that while 'good practice' in HACC, CACP and EACH/d programs already prescribes a significant level of consumer choice and input, more specific CDC elements could be incorporated into them (Bruen and Rees: 5). CDC increments would see consumers choose from the range of services within an assessed or agreed subsidy limit, most of which are already provided, but with an added component of tailoring – e.g. enabling the employment of same-language speakers. Services might have to buy in from other services to meet the requests of their clients, thus opening up a free market in care services (Bruen and Rees: 5).

Having a CDC commitment might also see clients being invited to choose between residential and home-based care. If subsidies were allocated to the recipient rather than to the service, this would allow more choice as to whether care should be received in a residential facility or at home. ACATs would assess for the level of care rather than for location of care. The required level could be purchased by the consumer as home-based or residential care. 'However, considerable work would have to be carried out to develop an assessment methodology which could be applied fairly when determining the level of care subsidy across both residential and community care' (Bruen and Rees: 7). They note that the new Aged Care Funding Instrument (ACFI) does not support such flexibility.

According to Michael Kendrick, the extension of effective CDC (or CDC elements) within care programs will require:

- policies and standards that equalise knowledge and promote open communication between clients and providers;
- the development of appropriate training and practice opportunities; and
- the development of a sensibility across the sector of comfort with 'the messiness of the participatory process' and of 'welcoming dissidence as a natural part of expressing autonomy' (Kendrick and others 2006: 12, 14).

Consumer Views

The UK has undertaken a major evaluation of its Individual Budget program which provides some feedback directly from people using the program. The early stage feedback from a limited number of Individual Budget (IBSEN Program) recipients (14 only), including older people, produced a mixture of positive and negative responses.

- Positive views emerged about the potential for IBs to improve the long-term quality of life by offering more choice and control, rather than just focussing on routine personal care.
- Interviewees had to think creatively 'outside the box' in developing their support plans and sometimes needed help with this. Early support plans seem to focus on personal assistance, but already they were being extended to include transport, small pieces of equipment and the 'little things' important to individuals' self-esteem and social inclusion – such as visits to the hairdresser.
- 'Freedom' and 'independence' were terms commonly associated with IBs. Most notably IBs were seen as more flexible than other forms of support, for example in meeting fluctuating needs. IBs were also seen as simpler to manage than Direct Payments.
- There were conflicting views about the possible impact of IBs on informal carers and families. One the one hand, IBs could give more opportunity for longer-term support to help relieve the pressures on informal carers – 'family can become family again'. But for others, the management of support arrangements required even greater input from

families and friends, and this was a particular problem when the IB was less than the value of existing support services.

- There were mixed views over the IB processes. Self-assessment was seen positively by some, being more empowering and simpler than conventional approaches. However others felt there was insufficient information and were confused over what they could and could not use their Individual Budget for, and the different funding streams involved. The process also seemed lengthy at the early stage of implementation.
- A strong theme to emerge was the importance of support outside of the users' own caring networks. Access to free brokerage, professional advocates and/or mentoring by someone who has been through the process were seen as crucial to getting the most out of IBs. Without this support interviewees thought it would be difficult for IBs to work for people with complex support needs, who have little family support, or who do not want to rely on their families for help with managing their IB (IBSEN *A Summary of Early Findings*: 4).

As these preliminary UK findings show, the fully independently consumer-managed purchase of services through allocated cash or vouchers is likely to be the preferred option for a small cohort of consumers only, but fully supported individual budget programs are popular.

All commentators agree that CDC will be chosen by a limited subset of those people eligible for community care.

CDC Issues for Service Providers

An issue of concern for providers was highlighted in Julie Bishop's statement that 'there *could* still be a role for intermediaries or case managers' in the new environment. For existing providers, the possibility that CDC might herald a transition from existing community care models to a 'care market' model selling care to individuals with portable funds, is a challenging prospect.

There are, arguably, both opportunities and threats to existing community aged care providers in the visioning of CDC. At one end of the 'vision spectrum' are existing services that have already moved to bring more consumer direction of care into their services models. At the other end is an economic rationalist model that wishes to transfer the bulk of decision-making and management responsibility onto the consumer, irrespective of consumer demand. The latter must pose as much of a threat to aged care consumers – relatively few of whom will fit Bishop's profile of the market-oriented, savvy and highly capable consumer able to negotiate 'the aged care market place' - as it does to existing agencies.

Administration and Management

Professor Caroline Glendinning, now principal investigator with the IBSEN project, reports that in the Netherlands, 'Personal Budget funding has led to a modest increase in the number of home-care agencies [and] users express great satisfaction with their enhanced choice and control', but, at the same time, 'there is controversy about the administrative burden and lack of support for Personal Budget holders' (Glendinning and others 2004: 19). As Geron has argued, 'for those consumers who are unable or ill-prepared to take on these tasks [of self-management of care], too much choice may not result in greater independence, but rather in a sense of powerlessness' (Geron 2000). Coyte and others (2008: 12 – 13) have also noted the 'administrative burden' that falls on recipients without appropriate skills.

ACSA particularly notes the consumer rejection of direct funding programs in the UK in preference for the more moderated Individual Budget programs which are comprehensively supported by services provided by community care agencies (IBSEN *A Summary of Early Findings*:4). Some services have created specific in-house individual budget support, planning and brokerage services, but some of these roles are also provided by the private sector (IBSEN Newsletter 1, May 2006: 2).

Financial Issues

Financial blow-out was an emerging issue in the IBSEN pilot projects. Far from reducing the costs of care, IBSEN researchers found that ‘in all [pilot] sites it was clear that IBs offer a challenge to financial planning in keeping the packages cost-neutral. Most sites were top-slicing global budgets by 10-25% to create a financial safety net. … Risk also came from the unknown potential for new demand from eligible (but previously self-sufficient) users’ (IBSEN Newsletter 1, May 2006: 2). Program establishment costs were substantial.

Brokerage or CDC?

Brokerage through existing agencies, or through agencies using existing delivery models is likely to be a more popular model of CDC in Australia, except in the few cases where consumers and their families show a specified desire to exercise a high level of self-directed ‘consumer directed care’. The Rudd Government’s proposed Compact with the community sector should provide a platform for the development of models based around, but perhaps not limited to, existing providers with a not-for-profit focus.

Providing Choice or Privatising Costs of Care

There is general concern that the buzz word ‘choice’ might signal a process of choice limitation, especially for those unable to supplement grants and vouchers with personal wealth, and for those without appropriate ‘marketplace’ skills. There is further concern that CDC will be rolled out as a cost cutting exercise on the part of governments rather than as a consumer empowerment exercise.

Such fears are not without some basis in experience. Coyte and others, reporting in 2008 for the World Health Organisation and the European Observatory on Health Systems, found that ‘the potential hazards of direct payment systems include ‘additional income being used for general household use rather than for care’, with the result that, when additional care was needed, it was unable to be purchased.

An earlier UN/WHO study found that many (CDC) programs were ‘cashed out at a marginal rather than average cost’ of services. ‘This saves money for the government but makes it difficult for consumers to purchase formal services and could not be seen as real market compensation for informal care’ (WHO 2003).

In the disability field CDC has, in many instances, been compromised by pressures from governments that have seen programs actualised as ‘welfare on the cheap’, ‘rendered programs shadows of what their advocates had hoped they might become’ (Burgess and Stephens 2004: 1-2). Cost discounting had been a factor in the failure of programs in Germany and elsewhere where cash benefits were discounted at 50% of the cost of services from agencies (Howe 2003: 16). The introduction of CDC in the expectation of cost saving by governments raises real questions about the exploitation of labour, and the viability of existing community services in an environment where funds are attached to consumers and are portable rather than being vested in providers (Howe 2003: 15). Successful CDC is unlikely to be a ‘cheap’ option because enabling consumers to exercise real choice, in most cases, will require an array of supports, such as case management, brokerage services, fiscal agents, counsellors, advocacy.

Howe also notes the opposition of some Japanese feminists to cash payment schemes which direct purchasing power to individuals, seeing it as a means of shoring up the obligations for care-giving upon women, ‘reinforcing the traditional roles that women were seeking to escape’ (Howe 2003: 6).

Similarly (though the tilt is more positive) in Germany, where personal budgets were ‘intended as an incentive to informal care’ and were cashed out at a lower rate than the cost of ‘in kind’ services. The cashed-out option was consistently more popular than the more expensive ‘in kind’ option and has ‘increased the capacity of informal care, thus helping to shift the balance from institutional to community-based care’ (Glendinning and others 2004: 13, 20). Clearly, one’s point of view flavours the interpretation of the pros and cons of the cost-shifting that can be associated with CDC.

Undermining Service Infrastructure

In contrast to Glendinning, Anna Howe argues that

> *“the wider risk of increased consumer direction comes from a possible shift in responsibility for outcomes of community care programs from government and providers to clients and carers, and an undermining of service infrastructure that may not be replaced with a care market in which consumers with small amounts of cash can find high quality bargains (Howe 2003: 18).*

Howe challenges Bishop’s assumption that there is a widespread demand for CDC from aged Australians and their families. She cites evidence from the UK and the USA of slow uptake of cash options (Howe 2003: 7). Howe notes that ‘one aim of providing cash benefits in the UK appears to have been to stimulate the “care market” by way of provision of services by commercial agencies as an alternative to statutory providers, notably Local Government’ (Howe 2003: 7). Such programs demand a heavy level of input from the aged ‘consumer’ and their families, and she doubts whether (for example) ‘older people want to enter into enterprise bargaining to negotiate an individual workplace agreement with paid care staff’ (Howe 2003: 9).

Practical Concerns

While there was substantial theoretical support for CDC a number of practical concerns about CDC were aired by Australian aged care providers in a series of seminars conducted by Jane Tilly around Australia during June and July 2007:

- *Difficulties for nominees with managing employment, OH&S and insurance issues. Difficulties with employing family members.* Dr Tilly argued that an agent would be necessary to mediate, while still leaving final choice of employee to the recipient and their carers.
- *Monitoring quality of care; management of training.* Dr Tilly agreed that this needs to be monitored externally.
- *Lack of choice, especially in rural and remote Australia.* Dr Tilly felt that CDC would increase the supply of carers as they responded to availability of payment, and payment for family member carers.
- *CDC is seen to be too stressful for people with dementia and their carers.* Dr Tilly foresees that agents could be employed to assist here, as well as counsellors (akin to case managers) who alert consumers to what options are available, and also monitor quality of care (etc).
- *Is CDC a cheaper option?* According to Dr Tilly, CDC should not be viewed as a cheap option, unless governments discount payments. There may be some long-term savings through delayed entry to residential care but savings should not be expected from CDC as such. Governments can limit the number of CDC places as they do with current programs (Bruen and Rees: 4).

Considering the Introduction of CDC in Australia

The New South Wales Council of Social Services (NCOSS 2006) notes the pitfalls that have been associated with the transition from ‘a welfare state mode of service support into a market based approach’. They argue that governments have habitually sought ‘to control what is provided (not unlike the Welfare State) but to distance [themselves] from the risks and responsibilities of provision’.

NCOSS argues that funding models and delivery frameworks need to be carefully thought through so that they primarily empower, rather than primarily cost-shift (NCOSS: 1, 3). Care models that invite consumers’ direction of care have often seen complex funding agreements and contractual arrangements, increased levels of accountability to government (but not to communities), an increased focus on governance and administrative arrangements, and outcomes based funding that has the capacity to skew the client base (eg cherry-picking of the easiest or cheapest clients) (NCOSS:3). Providers are wary that CDC has become entangled with competitive tendering.

NCOSS advocates that ‘local and regional planning negotiation with existing service providers should be the first step in distributing funding, whether new or existing, with Expressions of Interest [usually deployed when requesting a new service to submit or ‘testing the market’] seen as a last resort process where agreement cannot be reached’ (NCOSS:12). Existing care agencies have a proven skills set and deep knowledge of the service system in which consumers are operating, and should be given priority in the allocation of funding and oversight roles for programs such as consumer directed care. There should be open discussion with existing providers as to ‘the circumstances under which each model is most appropriately used, the benefits they confer and the problems they may create if used inappropriately’ (NCOSS: 8). Of significance, ‘NCOSS is mindful of the need to remember why government has traditionally funded ‘not for profit’ community organisations, and what may be jeopardised by the over zealous or inappropriate application of business processes and principles to the delivery of human services’ (NCOSS: 8). Such organisations have historically contributed to the social capital of the community and are not merely market players.

According to NCOSS, in order for individualised funding to work effectively, it must have the following characteristics:

- Links to quality improvement and standards (including OH&S)
- Planning and matching of service provision: matching needs with availability and ability to move to what is needed
- Flexibility
- Supported decision-making
- Portability
- Accountability (NCOSS:13).

As NCOSS argues,

> *It is also critical that funding is used to support and improve service infrastructure rather than undermining it or replacing it through the tendering out that has come to be associated with individualised funding where the dollar follows the client (NCOSS: 13).*

Here, again, NCOSS expresses the apprehension in the sector that individualised funding will be used to undermine not-for-profit, public sector infrastructure, rather than being offered to that limited proportion of consumers and their families who want to, and are able to, enter into the responsibilities and opportunities offered by consumer directed care as one option amongst a suit of care options.

NCOSS is particularly critical of voucher models (NCOSS 14). Vouchers, they argue:

- potentially distort the system
- actually limit choice for those without additional funds
- erode in value over time, and
- represent a government abdication of responsibility (NCOSS: 14).

On a more general level, the NCOSS paper argues, as have others, that if services were adequately funded to respond to individual needs across the board, there would be no need for ‘individualised funding’ models.

> *‘It could be argued, therefore, that if the service system were to address individual need in a more responsive and tailored manner, the call for individualised funding could be greatly reduced. This of course raises the importance of integrated case management and brokerage, and services being assisted to be of the highest quality’ (NCOSS: 14).*

CDC and the Compact

Consumer Directed Care should be primarily about the empowerment of aged people. In the past two decades, however, CDC has become associated with an ideological agenda that has seen not-for-profit providers pressed into competition with open market commercially-focused providers. Outcomes for clients have not always been positive. As a result, not-for-profit peak bodies in various countries have now moved to develop ‘compacts’ with governments to ensure the continuation of robust not-for-profit sectors, and to promote the mutual recognition of the intrinsic value to communities of community-oriented, not-for–profit providers of community care.

At the ACOSS Conference in April 2008, Parliamentary Secretary Ursula Stephens announced the Government’s commitment to develop a National Compact with the not-for-profit sector. The Compact will recognise the expertise and commitment of the NFP sector, and re-establish its advocacy role. Under the Compact, the NFP sector will be formally recognised as a crucial partner with government in developing policies and practices, and delivering services that work towards overcoming social disadvantage and promoting social inclusion. The Compact will develop new guidelines and principles to strengthen the position of NFP providers, particularly in tendering and contracts, by recognising their experience and expertise in identifying community need, and in designing and delivering and evaluating effective community support programs.

The Compact will establish effective partnerships between the community sector and government and underwrite the Rudd Government’s social inclusion agenda. It recognises that the community sector is, as its name suggests, a vital link to the community, and a key to building social participation and social inclusion. Specific clauses in the Compact should include commitments to good communication between government and community organisations and an acknowledgement of the mutual interdependence of the two sectors, whilst also acknowledging the independence of each and the likelihood of disagreements. The Compact should support transparency, ethical negotiation and accountability so as to promote mutual respect, innovative thinking, flexibility and responsiveness to community needs.

On a very practical level it should promote opportunities for the voluntary and community sector to:

- contribute to program design;
- legitimise the inclusion of relevant elements of overhead costs in estimates for providing a particular service;
- implement longer term funding agreements
- ensure that monitoring requirements are proportionate to funding and focus on outcomes;
- build the capacity of the sector; and
- respect the independence of the sector.

The proposed Compact between the Commonwealth and the NFP sector should reinforce the position of the NFP sector in the provision of Community Care, enabling experienced community sector providers to enter into the provision of innovative consumer directed programs with enthusiasm and drive. The Compact will ensure that the social capital value of experienced NFPs is taken into account in tendering.

Next Steps

This paper presents a broad scan of research and views around consumer directed care. ACSA needs to develop a sustainable industry policy position on CDC as there are now indications that Government is more actively considering trialling or introducing consumer directed care. ACSA currently has an interim policy position which is at Attachment 1 and may provide a starting point for the discussions.

There are a range of questions and discussion points to consider in developing such a policy. They fall into a number of themes and categories and are listed below to assist in consideration of the content of an industry policy.

Consumer Issues and Considerations

- Who will want CDC? What model of CDC will they want?
- What capacities and functional levels will an aged care consumer (and/or their carers) need to have to engage effectively in CDC?
- How will this capacity be assessed and monitored?
- Do older people and family carers agree on the attractions of CDC?
- Will CDC create a care gap to be picked up by unpaid (predominantly female) family carers?

Potential policy elements/principles

CDC should be viewed as one option within a universal care program. Choice in aged care is only real choice if consumers have the personal and family will and capacity to take it on. Therefore the fundamental framework of community care should be maintained for the bulk of consumers whom, experience suggests, will not choose CDC.

Provider Issues and Considerations

- How will existing community care providers respond to the expressed care needs of people who might be interested in CDC?
- Can individualised care planning and delivery by providers address expressed care needs as well or better than CDC?
- What effect will CDC have on the development of the ‘care market’, including its effects on existing care services?
- What is the potential impact of CDC arrangements, including ‘voucher’ schemes, on service provision infrastructure and sustainability?

Potential policy elements/principles

Providers must respond to consumer demand for varying degrees of individualised tailoring of care programs. If CDC is introduced in any sort of cashed out or “voucher” model, funding must be made available for the necessary range of supports for consumers including financial services, employment services, payment agents, case managers, advocates etc. There will also need to be a guarantee of indexed longer term funding arrangements so that the costs of setting up CDC are compensated.

CDC Model Issues and Consideration

- Should all models be made available?
- What would it cost to let the ‘care market’ operate freely – identifying and providing different models?
- How will models that enable the dollars to follow the person affect industry planning?
- How would a voucher/cash system respond to changing costs of care in an open market (especially in an inflationary environment)?
- Should CDC funding be allowed to purchase care from unqualified and family carers?
- Does CDC open the door to unregulated care?
- What safeguards need to be built into CDC programs for consumes and funding outcomes?
- How will quality of care be assessed and maintained?

Potential policy elements/principles

Different models of CDC should be piloted with additional funding made available to existing providers to do so. The trials can be used to gauge demand for, and effectiveness of, the various models.

Those who participate in the pilots should be able to continue to be supported that way regardless of the long term decisions regarding CDC.
Existing providers should be engaged in the development of the new models and vision for the system overall.

Pricing Issues and Considerations

- What level of subsidy should apply to aged care clients who want CDC?
- How will the price of care be monitored?
- At what level of financial/agency assistance does CDC become financially/practically unviable?
- Should considerations about the cost of care override a personal preference to be cared for at home?
- Would Governments expect to discount the price of care for CDC assuming a cost reduction for care not delivered by a service provider?

Potential policy elements/principles

Governments should not think of CDC as a cost saving measure. Savings will be made through delayed entry of people into residential care as an outcome of comprehensive home-based care.

Cost cutting through cost discounting may deny older people any real choice.

Government Issues and Considerations

- What changes to Government funding and policy settings would be required to support the various models?
- What changes to regulatory and quality management regimes would be needed to support CDC?

ACSA is seeking your views on CDC more broadly and specifically on what an industry policy position should contain.

You can have input by forwarding your views to us via email to: mstephens@agedcare.org.au or psparrow@agedcare.org.au or mail to

Aged & Community Services Australia,
Level 1, 36 Albert Road,
South Melbourne, VIC 3205.

Whatever method you choose please forward your comments by 5/12/2008.

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