

The Winston Churchill Memorial Trust of Australia

Report by Ian Hardy

2008 Churchill Fellow

The Vincent Fairfax Churchill Fellowship to investigate
“consumer-directed” aged care policy and practice.

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INDEX

INTRODUCTION	3
EXECUTIVE SUMMARY	4
FELLOWSHIP PROGRAM	5
THE CONCEPT OF “CONSUMER DIRECTED” CARE	6
OVERVIEW	7
OBSERVATIONS	8 - 18
SOME REFLECTIONS	18 - 19
RECOMMENDATIONS	20 - 21

CHURCHILL FELLOWSHIP REPORT

INTRODUCTION

The Fellowship enabled me to travel to Japan, the UK, Germany and Austria to study “consumer directed” aged care policy and practice by which care funding is provided directly to consumers of care services to enable them to choose and purchase the mix of services most suitable to their needs and preferences.

There is an emerging policy debate in Australia about ways in which aged services can be further developed to give future consumers more choice of, and control over, the ways in which they are supported in old age.

My observations overseas, and my engagement in public policy development in Australia, will allow me to contribute actively to this discussion.

I would like to express my grateful thanks to the Churchill Trust, and to the Vincent Fairfax Family Foundation which sponsored my Fellowship.

EXECUTIVE SUMMARY

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The Fellowship was undertaken between 14 October and 24 November 2008. My purpose was to explore the aged care policies, practices and outcomes in a representative group of countries where the principles of consumer choice and control have been adopted. I visited government representatives involved in policy and implementation, service providers, academics undertaking relevant evaluation and research, consumers and consumer advocacy bodies.

Highlights:

- Meeting Prof Satoko Hotta at the University of Tokyo, who researches care system outcomes and contributes to government policy development;
- Hearing from a group of consumers at Oldham (UK) of their experiences in being able to “self-direct” their care arrangements;
- Spending time with Prof David Challis (Manchester University) who led the evaluation team for the British Government’s recently concluded “Individual Budgets” pilots in 13 Local Authority regions;
- Visiting the Liebenau Foundation, one of the largest providers of aged and disability services in Germany;
- Gaining invaluable insights from Dr Stefan Wallner, Secretary-General of Caritas, Austria;
- Being invited to address senior classes at the Universities of Weingarten (Germany) and Vienna (Austria).

Recommendations:

- The aged care sector and consumer advocacy bodies such as Council on the Ageing (COTA) and National Seniors should work together to promote community-wide discussion and debate on consumer control and choice in both long-term care and Respite care;
- Government, the aged care sector and consumers should jointly plan pilots of “consumer directed” care arrangements;
- A single access and funding mechanism which covers all forms of care is increasingly the “international standard” and should be seriously considered;
- Government should consider commissioning Productivity Commission research into the potential for separating the care components of residential care from the accommodation components, to give consumers greater freedom to choose the location in which they live and receive care;
- Further examination should be undertaken of overseas experience, especially in relation to consumer outcomes, system costs, risks, and implications for family carers;
- International experience suggests that most, although not all, older people are cautious about managing their care arrangements; the provision of an external care advisor/manager would need to be part of any move towards greater choice;
- We should value our relatively consistent national approach to aged care policy!

THE CONCEPT OF “CONSUMER DIRECTED” CARE

Australia spends about \$9 billion per annum on aged care, largely by tied allocations to care provider organisations (both not-for-profit and commercial) which operate residential care facilities and a variety of home care and respite services.

Debate is now occurring about whether consumer should have the prerogative and means to specify, or directly purchase, the support and care services they need, according to their individual preference. In the words of Aged and Community Services Australia (“ACSA”): *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.*

At one level, consumer prerogative may mean a genuine choice between moving to a residential care facility or remaining at home. At another level, it may mean the degree of control which the individual consumer has over the way in which services are funded and managed to provide support at home.

Many developed countries have adopted the guiding principle of consumer direction as the basis of their national aged care policies, and this Fellowship provided an opportunity to investigate the operation and outcomes of those approaches in four countries.

OVERVIEW

A vital consideration in looking at the international experience is to recognise that every country has a unique history, social conventions, demography, and system of government – which means that observations generally provide a stimulus to reflection without necessarily providing specific models which would lend themselves directly to the Australian circumstance.

All four countries visited have moved over the past 10-15 years to give consumers some level of choice and control over how they are supported. In the UK, experience over many years in resourcing the consumer in the disability field is being widened to include aged services, with a series of “personalisation” pilots and an extensive evaluation having been conducted over the past three years.

Japan and Germany have brought residential and community care under the same assessment and funding umbrellas to facilitate real choice (and mobility) between and within the two, while in the UK and Austria consumer flexibility tends to be concentrated within community care services.

In contrast to Australia, however, in all four countries these national policies are interpreted and administered at municipal or provincial level, leading to significant differences in application and outcomes.

A frustration repeatedly referred to in all countries was the difficulty of effectively disseminating information to the public, health professionals and social services about service types and their availability – a lament familiar to us in Australia.

All countries are struggling to find effective – and non-intrusive – ways of measuring quality in home care; and interestingly, given that three of the four countries visited include cash payments to consumers as one of the support options, there was generally little concern or apparent evidence relating to financial abuse of consumers.

OBSERVATIONS

Context

While the funding framework is outside the scope of my investigation, it is worth noting that Japan (since 2000) and Germany (1997) operate Long Term Care (LTC) Insurance schemes which provide the majority of funding to those qualifying for care. The UK and Austria draw care funding from general revenue. In Japan, insurance premiums for LTC are means tested, but co-payments for services are limited to 10% of cost; in Germany, insurance premiums are linked directly to income levels.

For an Australian observer, one striking characteristic common to all four countries visited is that care policies which are set by the national government are, in each case, administered at local levels – frequently resulting, it would appear, in varying approaches and therefore inconsistent client outcomes. In Japan, policy is implemented by municipalities, which set LTC insurance premiums and influence access to services, notably the level of residential care home capacity. In England, Social Care policy is administered by Local Authorities, which have significant latitude in the application of the client assessment mechanism, the “care management” of individual consumers, the pricing of services and the level of accountability required in those cases where consumers opt for a direct cash payment. Municipalities in Germany govern residential care capacity and service pricing, and in Austria national social care policy is administered by the nine Provinces – with widely varying practices.

All four countries have a mix of not-for-profit and private providers, although only not-for-profit organisations operate residential care homes in Japan.

Consumer Access, Eligibility and Choice

The **Japanese** Long Term Care Insurance scheme was established in 2000 with three broad aims: to “socialise” care responsibilities (ie, moving towards community, rather than family, responsibility for care of the elderly), to move from a welfare paradigm to a contributory, insurance-based approach, and to encourage an adequate range and supply of services (which appears to have occurred – there was

a doubling in the number of home care providers in the first five years of the LTC scheme).

The LTC insurance scheme, eligibility processes, prices for each care service, and co-payments are centrally determined and uniformly implemented. Fees are set centrally, with the intention that providers compete on the basis of quality of care.

Assessment of need is undertaken by a Care Manager (usually private) who does a home visit using an 87-question nationally-consistent tool which is then considered by a five-member multidisciplinary team. The client will then be assessed as requiring either “Support”, for preventative purposes (at one of two levels), or “Long Term Care” at one of five subsidy levels. In theory, the client has the choice of utilising that funded care entitlement in either a residential care facility or their own home, and there is an associated entitlement to funding for equipment purchase (100,000 yen per year) and one-time home modifications (200,000 yen).

However, choice is inhibited by:

- Capacity of the family to assist in caring at home (cash payments to families have been considered in the past and rejected, but may be considered again);
- Increasingly restricted availability of care home beds;
- Competence/knowledge of the appointed Care Manager.

Approved Long Term Care is planned by a Care Manager (for a fee, which is covered by insurance), although the client has the prerogative to develop their care plan entirely independently if they wish.

Providers are mostly private (commercial or semi-commercial) entities, and most, but not all, tend to specialise in one discipline (such as nursing, physiotherapy, social support).

Interestingly, only 50-60% of the home care funding to which a person is entitled is typically expended (see Appendix 1). There is no hard data on the reasons for this, but contributing factors may include:

- the unavailability of some services in many areas;

- a choice on the part of the client to minimise their 10% co-payment;
- the Care Managers' encouragement of "self-sufficiency";
- or because Care Managers are not sufficiently well aware of the services available locally.

Each municipality controls the number of care home beds in its area; there is a tension between operators wanting to expand their residential care businesses and municipalities wanting to contain numbers because:

- there is a philosophical view that care at home is preferred;
- if a person enters residential care, the operator receives the full LTC entitlement, in contrast to the lower expenditure typically incurred in the home setting;
- accreditation and licensing costs are higher for residential care.

Labour inefficiency resulting from travelling time expended in providing professional services in the home is seen as an increasingly unsustainable cost - an additional LTC subsidy may be necessary to offset this, so there is a view developing that congregate living (such as retirement villages) are going to be important for the cost-efficient and affordable delivery of "home" care.

There is little hard data on consumer satisfaction or the effectiveness of the system in facilitating real choice between residential care or home care. However, there is a view that the substantially higher actual expenditure per capita in residential care (compared with the partial take-up of the entitlement at home, as above) is leading government at national and municipal levels to restrict the growth of such facilities, thereby reducing the capacity for choice.

Choice in the nature and provider of services at home seems, at least in theory, to have been facilitated by growth in the service provider sector, which is seen to be a direct result of the LTC Insurance scheme. However, there are concerns about the distribution of effective information on service availability and efficacy, even given the presence of professional Care Managers who undertake assessments and assist in setting up individualised home care arrangements. And, as in Australia, access to services is difficult in less populous parts of the country.



Ian Hardy with Professor Satoko Hotta at Tokyo University

I was very surprised to find that in the **United Kingdom**, the “Social Care” framework under which people are supported to remain living in their own homes is accessible only to those who are “financially disadvantaged” – generally those with assets under £22,000. Those with assets above this threshold generally do not receive subsidised services, nor access to information, counselling or referral and coordination services. There is therefore a major challenge to extend the benefits – via provision of the necessary resources – to these “self-funders” (as they are termed). It is also worth noting that the UK’s Social Care system does not include nursing or any other medically oriented service, which must be accessed through the National Health Service (NHS). This can make timely coordination of a “package” of support services very difficult to achieve.

Notwithstanding this two tier approach, and the separation of social and medical supports, the UK’s current “personalisation” initiatives - which are occurring as part of a broader initiative that includes an emphasis on preventative strategies – are a very significant step towards consumer control.

Traditionally, councils have purchased care directly, often through large-scale block contracts for standardised service delivery which have proved cost-effective for councils and offered market security for providers. Under “personalisation”, if a consumer meets eligibility criteria and is allocated a personal budget they can

choose to receive direct (cash) payments and purchase services themselves. They also have the option of letting the local council manage their personal budget on their behalf.

As part of the personalisation agenda, the UK government established in 2006 a series of pilots in 13 council areas to trial Individual Budgets – intended to draw together one or more funding streams to create either a virtual budget or a cash payment, from which the individual consumer could construct a preferred set of support arrangements. The pilots included services for people with physical and intellectual disabilities and mental illness, as well as older people. The resulting **ibsen** (Individual Budgets Evaluation Network) evaluation was published in October 2008.

As part of these pilots and the ensuing roll-out of personalisation practices to other local authorities, consumers are assessed by the local council according to “Eligible Need” at one of four levels:

- Low
- Moderate
- Substantial
- Critical

When the related financial entitlement has been determined, the consumer has a choice of:

- Traditional service provision
- “In Control” arrangements

If the client opts for Direct Payments (cash), they are supervised/supported by the Direct Payments Unit of the council. This means they forego their entitlement to a Social Worker, in favour of the Unit’s services which include referring to providers, channelling payments, undertaking an annual review, etc. Direct Payments have not, to date, allowed employment of family members who live with the client (in contrast to Germany and Austria), nor have national parameters specified any limitations on how the money may be spent.

During the pilot conducted at Oldham (outer Manchester), 52% of consumers chose “traditional” provision. But at another council, 80% of people previously using a Day Centre chose not to continue, but to spend the money saved on another service.

Challenges emerging from the experience of “personalisation” include liberating the imagination of council and provider staff to think laterally and encourage consumer initiative, finding effective ways of helping consumers understand their options and associated outcomes, and developing cost-effective mechanisms for supporting consumers who choose to employ care assistants directly.

Observations drawn from the Individual Budgets pilots included, amongst many:

- West Sussex has established an in-house management system for Individual Budgets – akin to operating a bank account for each client – which tracks the expenditure commitments made for the services chosen by each client;
- The need to track individual consumers “virtual” or actual spending has seen software suppliers starting to develop products to meet the need;
- Individual Budget account management was originally seen as achieving as much “personalisation” as Direct Payments, but quickly became too complex and unwieldy at that level of flexibility;
- In some cases, it was most practical for councils to agree an individual annual payment with a provider, and then “allow” the provider and client to sort out the service detail (probably not very different from the Australian situation with the planning of a Community Aged Care Package);
- Management of Individual Budgets can be very complex in the case of a person with rapidly changing needs.

There is an unresolved policy question surrounding the status and resulting acquittal requirements of Direct (cash) Payments: should such payments be seen as a “Benefit” (and therefore be non-acquittable), or should they be seen as a response to the specific needs/deficits of the client, and therefore be regarded as relating directly to the alleviation of those deficits (therefore with expenditure being acquitted against appropriately relevant services?). It is likely that the UK National Audit Office will be asked to rule on this.

An Individual Budget entitlement can be “underspent” and accumulated for periods of illness or higher needs.

A key **ibsen** finding in relation to older people’s support needs was that “*many older people...do not appear to want...the additional burden of planning and managing*

their own support.” And “Evidence from different strands of the evaluation suggests that older people often approach services at a time of crisis when they feel vulnerable or unwell, find decision-making difficult and hence are likely to experience support planning as stressful. The evaluation suggests that a potentially substantial proportion of older people may experience taking responsibility for their own support as a burden rather than as leading to improved control.”

Notwithstanding these observations, a numerically significant group of older consumers has utilised this increased capacity for individualised planning.

Another important element of the personalisation agenda is to increase the consumer’s role in identifying their own needs – this has resulted in a number of councils modifying the national RAS (Resource Allocation System) template or introducing other mechanisms to support this aim.

Policymakers have identified a number of challenges posed by the prospect of more users purchasing care directly: Direct Payment recipients may hire personal assistants who effectively are competing in the market with home care provider organisations. And it may be difficult – or at least much more costly - for providers to sell their services to many individuals with a range of preferences, rather than to a single council, as has been the traditional model.

Such issues were raised in the **ibsen** evaluation of the individual budget pilots. One large provider said that block contracts had enabled it to train all its staff to level three because it could plan three to five years ahead. However, as individual budgets were rolled out, it expected it would have to end this training for new staff because it could not forecast demand more than a few months ahead.

One suggested solution to this conundrum is a preferred provider list by which councils recommend a number of providers to service users, thereby increasing their prospects of business. To qualify, providers go through a competitive tendering process with councils and must offer bulk discounts, thereby giving councils economies of scale, as with block contracts. But this does seem likely to build in a tension between affordability and flexibility – indeed, some providers have warned that offering bulk discounts necessitated providing the excessively standardised services that personalisation was supposed to end.

In relation to whole-of system cost implications of the national roll-out of Individual Budgets, the following observations emerged in discussion with researchers and local councils

- There is some evidence that consumers are relatively modest in expressing their support needs, but “any individual client savings will be offset by additional demand”;
- Individual Budgets’ support costs are likely to be higher than previous councils’ block (purchasing) contract approach;
- It is assumed that a reduction in applicability of block contracts will drive up unit costs. The question is whether consumer satisfaction will go up proportionally;
- Previously, care services delivered through block-contracted providers has been subject to an annual efficiency dividend which will be much harder to achieve with more individual management;
- Councils are sensitive to the “family payment” cost impact of paying for care previously provided free by family members (in contrast to the German and Austrian models which acknowledge that cash payments are a de facto compensation to family members who provide care and support).

In terms of consumer choice at the higher level of residential care versus home care, the policy-enabled flexibility seen in Japan is not part of the thinking in the UK – indeed, Local Government has a “Duty of Best Value” obligation (government imposed) to achieve required social outcomes at the lowest cost – this can mean, for example, residential care will be “imposed” if it means that a client is able to be supported appropriately at a lower cost than at home.

The **German** Long Term Care insurance scheme came into being in 1997; it is administered by health insurance funds and requires an employer/employee contribution of 1.7% of gross income. There is also a small private insurance scheme, federally regulated.

Needs assessment is undertaken jointly by a doctor in respect of medical needs, and by a nurse in relation to activities of daily living (ADL) support. Assessment staff are

generally linked to the relevant insurance company - and one could conjecture that this tends to act as a constraint on service levels and expenditure.

Care needs are assessed at one of three levels, and within each level the consumer has – in descending order of funding - the choice of residential care, care at home with professional (“in kind”) services, or a cash payment to the family. The residential option entails the highest level of care payment within each of the three needs categories, but requires an additional payment by the consumer or their family for “hotel” costs. For care at home it is possible to choose part-cash/part-services, and of those remaining at home about 32% currently choose this mixed arrangement. The all-cash option is decreasingly chosen.

There is a growing gap between average formal care costs (either residential or professional home care) and the insurance benefit which is paid, due to very infrequent government indexation; this may distort patterns of choice and result in lower asset/income consumers tending to opt for either a cash payment (to avoid a co-payment), or residential care where there is a municipal “safety net” for those who cannot afford to pay “hotel” and gap costs.

Planning for residential care capacity is generally undertaken at the municipal level so should in theory reflect local demand; adequate matching of residential supply to demand is important in understanding whether real choice is able to be exercised.

Outside the more densely populated cities and regions, the reality of choice in Germany is likely to be heavily conditioned by geographic proximity to residential homes and home services providers (as in Japan), lending weight to the argument that strategies to increase the diversity of care provision are important if the system is to provide true consumer choice.

Professional, independent “care advisors” are just beginning to enter the market.

One large provider put the view that Germany’s different payment levels for residential/ professional/family care does not encourage true choice, which in their opinion requires more equal funding within each needs category to make the home-based options more viable.



Ian Hardy (centre) with Dr Berthold Broll (r),
Director of the Liebenau Foundation, Germany, and interpreter

Austria provides a contrasting example.

There are two main elements to the system:

- A cash payment, which is not means tested, at one of seven levels (€150–1100/A\$300-2200 per month) , based on a doctor's assessment; this payment may be taken as cash, used to employ an individual(s), or used to access professional services;
- “Social Transfer System” which provides funding for additional services, where deemed necessary – the operation of this funding varies widely between the provinces, which also manage the nationally-mandated co-payment policy. Co-payments are typically 30-50% for professional services, but they vary because of the different policies of the nine provinces.

The family unit remains strong in Austria, so it is very much the norm for the older person to be living with, or near, their family. The “cash for care” payment is a legally enforceable right as a payment to the consumer and/or their family; there are no parameters for expenditure, nor any acquittal requirements. At the introduction of the cash payment, a significant majority opted for cash only, but it has been steadily reducing; early experience was that the cash payment immediately reduced demand for residential services.

Pricing of professional services is determined by the province, regardless of whether the service is purchased via the local authority or directly from a provider.

Some care homes have a “try before you buy” option – which is very much facilitated by the flexibility inherent in the single payment.

The Austrian situation has been significantly affected by the availability of a “grey market” of workers from the former Eastern bloc, who work unofficially (ie, untaxed and uninsured). This has given many families the opportunity to use their cash payments to employ such workers, often for 12 or 24 hour days at €50 per day. This has given many families the opportunity for effective working day or “around-the-clock” supervision of their relative – a real and effective alternative to institutional residential care for many.

There appears to be little quality measurement of home care under the cash payment system, the usual practice being a visit from a qualified nurse visits 2-4 times a year. Abuse was not identified as a significant social issue.

A national evaluation of care benefits was conducted in 2006 – a major outcome was the satisfaction of families who “now felt recognised for all their work” by the cash payments they receive.

SOME REFLECTIONS

- As noted earlier, a common theme in all countries visited has been that national policy is implemented by local authorities or municipalities which are socially diverse and which apply their own ideologies, strategies and financial controls, resulting in quite diverse application of the policy principles. Australia, in contrast, does benefit from a relatively consistent national administration through the Department of Health and Ageing;
- Some UK pilot examples of highly-informed and intensively-supported Direct Payment expenditure are probably not scalable across the wider population because:
 - Average subsidy levels, and their availability, are based on block-purchase pricing, which will be too low to allow true flexibility;
 - The levels of staff motivation, imagination and skills may not be achievable across the whole system, at least in the short term;

- Political sensitivity (requiring tight service boundaries to be instituted);
- In the UK and Germany, ageing needs and disability needs are managed through the same (care delivery) system, so the silo issues endemic in Australia are largely unknown;
- Whole-of-system cost is likely to rise when cash payments are introduced for the first time, as such payments naturally flow to family members, many of whom do – and would - provide the same support to their relative without payment. In the UK, some Local Authorities pointed to this as an area of caution; in Germany it was noted that the “cash” tier of benefits is already available to the families of qualifying consumers, but was seen as a valid use of resources given that payments to families are at a lower rate than professional home services;
- Individual Budgets which are not a cash payment have to be “managed” financially – that is, the chosen and agreed basket of services have to be priced individually and monitored. So there is a back room cost, which will increase if there needs to be frequent variation in what those services are
- As noted, a constant theme in all countries is the difficulty for consumers in getting good information;
- It is important to remain aware that most European countries’ systems do require some co-payment for residential or professional home care services. In Germany and Austria, families have a legal obligation to cover these co-payments (including hotel costs in Care Homes) if the client cannot.



Ian Hardy(r) with Professor Marianne Egger de Campo (centre) and senior Nursing and Social Work students at the University of Ravensburg-Weingarten

RECOMMENDATIONS

- The aged care sector and consumer advocacy bodies such as Council on the Ageing (COTA) and National Seniors should work together to promote community-wide discussion and debate on consumer control and choice in both long-term care and Respite care, and canvas consideration of consumer control in the Australian environment, including such options as consumer participation in planning agency-delivered services, the concept of an “individual budget”, and the potential for direct cash payments;
- Government, the aged care sector and consumers should jointly plan pilots of “consumer directed” care arrangements;
- A single access and funding mechanism which covers all forms of care is increasingly the “international standard” and should be seriously considered; this would be much more transparent than current arrangements, allow consumers to weigh their options with a more complete understanding and lead to the development of greater effective choice;
- Government should consider commissioning further Productivity Commission research into the potential for separating the care components of residential care from the accommodation components, to give consumers greater freedom to choose the location in which they live and receive care;
- Further examination should be undertaken of overseas experience of consumer control strategies, especially in relation to consumer outcomes, system costs, risks, and implications for family carers;
- International experience suggests that most, although not all, older people are cautious about managing their care arrangements; the provision of an external care advisor/manager would need to be part of any move towards greater choice;
- There is a tension between cost containment and consumer choice – in Australia, “unbundling” the care and accommodation components of residential care, and an effective retirement incomes policy, will be important for the achievement of improved choice and control;
- We should value our relatively consistent national approach to aged care policy!

The information and insights gained through the Fellowship will be disseminated through my continuing to speak at national forums associated with the future of ageing and health, by contributing to specialist and general media, through publishing my observations on sector and organisational websites, and through my continued involvement in government advisory processes.

APPENDIX 1

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日独仏韓の在宅給付の比較

