ACSA
Aged & Community Services Australia

AN INTEGRATED HOME CARE SYSTEM

# ACSA DISCUSSION PAPER

**Stage 2 of the Increasing Choice in Home Care Reforms**

May 2017

# ABOUT ACSA

Aged & Community Services Australia (ACSA) is the leading aged care peak body supporting over 700 church, charitable and community-based, not-for-profit organisations. Not-for-profit organisations provide care and accommodation services to about one million older Australians.[1]

ACSA represents, leads and supports its members to achieve excellence in providing quality affordable housing and community and residential care services for older Australians.

Aged care providers make a significant $17.6 billion contribution to the economy by producing outputs, employing labour, paying wages and through buying goods and services. [2] This is akin to the contribution made by the residential housing, beef and dairy industries. In many regional and rural areas aged care is the largest employer, which is where the majority, if not all, providers are not-for-profit.

ACSA members are important to the community and the people they serve, and are passionate about the quality and value of the services they provide, irrespective of their size, service mix or location.

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[1] Australian Government, Department of Health, Report on the Operation of the *Aged Care Act 1997*, December 2016.
[2] Deloitte Access Economics, Australia's aged care sector: economic contribution and future directions, Aged Care Guild, June 2016, page 24.

## Discussion Paper

This paper aims to start a conversation on Stage 2 of the Government's *Increasing Choice in Home Care Reforms* to integrate Home Care Package Program (HCP) and the Community Home Support Program (CHSP). As these reforms are scheduled for introduction from 2018, it is important to formulate our position now so ACSA can effectively represent the industry in discussions with Government.

## Introduction

The Government announced its *Increasing Choice in Home Care Reforms* in the 2015 Federal Budget. The reforms are intended to integrate existing programs and establish one home care/support program, remove disincentives and give the consumer control over the services they receive. This reflects the desire of many Australians to remain in their homes for as long as possible as they age, and to have greater control over the support they receive.

Stage 1 of the reforms focussed primarily on HCP and the assignment of packages to consumers rather than providers. The changes include a centralised system of prioritisation and allocation of packages to the consumer and portability of packages to the provider of choice. Stage 1 was subject to consultation with the service industry and consumers. Implementation commenced on 27 February 2017 and will be monitored closely by Government and industry.

Under Stage 2 of the reforms, a more integrated care at home system will be developed by bringing together the CHSP and HCP into a single home care program. This reform is to be introduced from 2018, and the Government will consult with the service industry on the design and implementation of the new program.

ACSA is already actively working with Government on the reforms through various stakeholder groups including the National Aged Care Alliance (NACA) and the Aged Care Sector Committee. The Aged Care Sector Committee has prepared an *Aged Care Roadmap*[3] that sets out future directions for aged care. The Roadmap envisages an environment of uncapped supply in a consumer driven market. That is, a service system where the consumer is assessed for care and services and can then decide to receive these in any setting they choose. The Roadmap identifies the short, medium and long-term actions required to transform the current system into a sustainable, consumer-driven and market-based system. The integration of the existing home based programs into one single program is part of this vision for the future.

The integration of programs through Stage 2 of the reforms raises significant questions for the aged care industry. ACSA, as a leading peak for the industry, will determine a position that is guided by its members and the best outcome for the industry as a whole. These once in a generation reforms require careful consideration and collaboration, which ACSA is committed to.

The core issues are outlined below, followed by a brief examination of the strengths of the current programs, funding issues, and what is evident from reforms in other programs. A number of questions are then posed to focus discussion on issues that are likely to be dealt with in consultation with Government.

**Your feedback is critical to this process. Please complete the survey and attend an ACSA member consultation in your State/Territory.**

[3] Aged Care Roadmap, Aged Care Sector Committee, 2016

## The Challenges & Opportunities

It is clear that changing demographics and costs are important drivers of reforms to home based aged care - the ageing of the population, growing expectations and the increasing diversity of older Australians seriously challenge the capacity of the current service system and its financial sustainability. However, a range of other factors are also at play, the increasing desire of consumers to remain in their own homes (or accommodation settings of their choice), the need for greater flexibility in the service system and a stronger focus on wellness, reablement and restoration. In addition, consumers are seeking greater control over the delivery of services, including choice of service.

What is emerging through the current reforms is the need for a more integrated service system that aims to respond to these issues. The reforms also highlight a fundamental philosophical shift in the service system from one where the primary funding and service relationships are currently between government and service providers to a future where they will be market based relationships between consumers and service providers.

For all these reasons, the reforms present significant challenges for the industry and Government. These include:

### Determining the features of the new program

Designing a new home based aged care program based on the strengths of the existing programs and clear direction about eligibility; how consumers gain access; the assessment procedures; the service quality and safety measures; and expected outcomes for consumers.

### Allocating funding and setting fees

The extent to which Government will support services to all older people (with consumers that can afford to contribute doing so), or signify a greater focus towards the most vulnerable who cannot afford to pay for services; the fee structures, subsidy levels, means testing, and co-payments; the balance between program (or block) funding and individual funding; and the capacity for consumer self-management.

### Supporting the industry's capacity to respond

The industry will need support to respond to the reforms through improved workforce strategies; enhanced technology; piloting and testing of new programs and systems; close monitoring of the impact for specific population groups including people with dementia and carers; and an agreed role for volunteers.

### Ensuring service system sustainability and managing risks

The financial sustainability of an integrated program needs to be assured through careful modelling taking account of the issues raised by industry, and initiatives that ensure local service provision in rural and remote communities; a review of the legislation and consideration on the most appropriate governance approach for the future reforms; adequate consumer protections; and risks to government, industry and consumers are mitigated. In addition, the changing roles and responsibilities of government, consumers, carers and service providers in a market based aged care system need to be carefully identified and clearly articulated.

## The Current Programs

Home based aged care services are currently funded through a mix of government grants and subsidies and limited co-payments (fees and contributions) from consumers. The services are capped by limiting supply of packages or services and the level of support available to consumers.

The eligibility of consumers for services is assessed by MyAgedCare (MAC) with Regional Assessment Services (RAS) and Aged Care Assessment Teams (ACAT) assessing the specific needs and goals of consumers and developing a support plan. The service provider then works with the consumer to agree the details of service delivery. The framework to determine the fees and charges for services varies between the programs. Consumers are not able to self-manage funding.

Details of the current programs are summarised below:

### Commonwealth Home Support Program (CHSP)

The CHSP is a grants based program that provides entry-level home support for older people who need assistance to live independently. The program commenced on 1 July 2015 and is a consolidation of the previous Commonwealth Home and Community Care Program (HACC), planned respite from the National Respite for Carers Program (NRCP), the Day Therapy Centres Program (DTC), and the Assistance with Care and Housing for the Aged Program (ACHA). HACC being the largest of all of these programs.

The HACC program commenced in 1985 and in 2014/15 the Australian Government provided funding of $1.3b for Commonwealth HACC (and $579.7m to Victoria and Western Australia where the HACC program had not been transitioned to the Commonwealth and was still being administered by State Governments)[4].

There were approximately 1600 providers (including Vic & WA) delivering services to approximately 810,000 consumers across Australia. There was considerable variation in the level of fee contribution made by consumers, however the Department of Health (Department) has estimated this to be about 10 percent of total funding. [5]

ACSA understands that on average HACC clients in 2013/14 received $2500 in supports over a full year period. Similar data for CHSP is not yet available.

The program has a significant investment in volunteers and traditionally services have developed from within communities as an attempt to address service gaps.

The types of services funded under CHSP are specific and include:

- Meals
- Other Food Services
- Transport
- Domestic Assistance
- Personal Care
- Home Maintenance
- Home Modifications
- Social Support-Individual
- Social Support-Group (formerly Centre-Based Day Care)

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[4] 2014-15 Report on the Operation of the Aged Care Act

[5] Fourth Report on the Funding and Financing of the Aged Care Industry July 2016

- Nursing
- Allied Health and Therapy Services
- Goods, Equipment and Assistive Technology
- Specialised Support Services
- Planned respite in a range of community settings
- Assistance with care and housing
- Sector Support & Development

In 2015, the department released a Client Contribution Framework and National Guide to the CHSP Client Contribution Framework. These documents are available to guide the development of local client contribution policies and practices with the expectation that client contribution levels will increase to approximately 15 per cent of overall funding.

### Home Care Package Program (HCP)

The HCP provides older people who want to stay at home with access to a package of ongoing personal services, support services and clinical care that help them with their day-to-day activities. Packages were first introduced in 1992 to provide services to fill the gap between the HACC services (now part of CHSP) and residential aged care.

The program supports people who have complex needs that can only be met by a coordinated package of care that has an element of funded case management available to those consumers that need it. HCP enables consumers to have choice and flexibility in the way that their aged care and support is provided at home.

There are four levels of home care packages, spanning from basic care needs through to consumers with high care needs. All HCP have been delivered from a consumer directed care (CDC) approach since 2015, allowing the consumer greater control over the supports they receive and how the funds are allocated.

There are four (4) levels of Home Care Packages:

| |
|---|
| Home Care Level 1 to support people with basic care needs - $8045 subsidy. |
| Home Care Level 2 to support people with low level care needs - $14633 subsidy. |
| Home Care Level 3 to support people with intermediate care needs - $32171 subsidy. |
| Home Care Level 4 to support people with high care needs - $48906 subsidy. |

Previously the Government home care subsidy was paid to providers for home care places occupied by a consumer. From February 2017, this changed and the HCP funding will follow the consumer, allowing them to choose, direct and move package funding to the provider that best meets their needs.

In addition to the base level of subsidy for a home care package, consumers across all levels of home care packages may be eligible for one or more of the following supplements, which is also paid to the home care provider:

- Dementia and Cognition Supplement and Veteran's Supplement;
- Oxygen Supplement;
- Enteral Feeding Supplement;
- Viability Supplement;
- Top-up Supplement (EACHD consumers); and
- Hardship Supplement.

In 2014 -15 the Commonwealth made payments of $1.28b to providers on behalf of consumers for 72,702 packages. Consumers contributed around 10 percent of revenue[6]. (Note: this is a similar estimated amount of client contribution made in CHSP).

## Strengths and challenges of the existing programs

The current service system has been operating in the community for over 30 years. Local communities rely on the quality services delivered to older people in their homes; the local workforce opportunities they create; the social capital they facilitate and their investment in the local economy, particularly in regional, rural and remote areas. The new integrated program must capitalise on these strengths.

Many of the challenges for these programs relate to the restrictions imposed on the types of services that can be delivered and the allocation or distribution of those services. Not all older Australians can access the same types of service across all locations. These historic funding anomalies have created inequitable service distribution patterns across the country which must be addressed in an integrated program.

These restrictions relate to the competitive tender process and allocation of grants by service type in CHSP and the annual allocation of packages via the Aged Care Assessment Round (ACAR) to HCP 'Approved Providers' and the legislative framework.

This landscape has begun to change from 27 February 2017 in HCP with the centralised prioritisation queue and assignment of packages. Funding for a package now follows the consumer to wherever they choose to receive services. However, this is only a first step towards a less regulated more consumer driven market in aged care and will require rigorous monitoring by government and industry.

Both programs also struggle with the challenges of client contributions or co-payments: HCP is means tested and CHSP is not; CHSP is designed to provide relatively small amounts of service and therefore contributions tend to be smaller; HCP clients are expected to pay the same basic daily fee for services regardless of the level of their package and the amount of service they are receiving. Some consumers receive more services at a lower level cost through CHSP, which blocks new people receiving entry-level services. These financial disincentives must be eradicated in a new integrated program.

[6] Australian Government Aged Care Financing Authority

Access and the current assessment process through MAC has presented many challenges for the industry. MAC was created as the entry point to aged care in 2013 and was designed to provide a structured assessment for eligibility to the CHSP program from July 2015 through the RAS. The ACAT complete the comprehensive assessment of potential HCP consumers and have operated under MAC since February 2016. HCP and CHSP providers are reliant on these assessments for the delivery of appropriate services at the local level. They are required to deliver services as prescribed in the assessment and support plan. This process has stopped consumers being able to access small amounts of low level of service directly from providers.

CHSP providers are monitored on the basis of outputs rather than outcomes and outputs are determined through episodes of service and measured in a variety of ways. CHSP providers now feel they have little control over the growth of their client base, and subsequent outputs, as they are solely reliant on referrals through the MAC system. The current assessment and referral system must be improved if an independent assessment of an individual is to determine the appropriate type and level of service and supports in a future integrated program.

One clear distinction between the two existing programs is that Case Management for consumers is only included in the HCP program. Case management was previously available under the HACC program and was removed as a service type under CHSP on the basis that more complex care clients would receive case management through the HCP program. Instead, a 'linking service' is available via the MAC to support the most vulnerable CHSP clients with short–term case management as necessary. However, this is not well advertised and it is unclear how this is operating and how many people are using the service. As a result, the service is not functioning as it was originally designed and vulnerable clients are falling through the system.

Other interface issues identified in the existing programs must also be considered in the design of a new integrated program. These include provision of respite care, purchase of assistive technology and modifications to the home.

## Planning for an Integrated Program

ACSA supports an aged care system that is consumer-driven, market-based and less regulated and therefore supports the direction of the Aged Care Sector Committee's Aged Care Roadmap. ACSA envisages individuals receiving aged care based on their assessed needs, whereby older people can be effectively and consistently assisted to live satisfying self-directed lives. A combination of government funding and user-pay options will facilitate the provision of ageing care and support services, which older people will be able to select according to their needs at home or in a residential care setting.[7]

Integration of the community programs require agreement on a preferred model and then a clear plan for design, piloting, transition and implementation. ACSA is hopeful that a preferred model can be agreed by industry and government by 2018 with a staged implementation plan to follow based on the specific elements of the agreed model.

[7] ACSA Submission to the Legislated Review 2016

## Assessment and access to services

Assessment is at the core of any aged care program. It is the process by which all parties understand what supports are needed and expected.

ACSA supports a system with multiple entry points for service provision based on the type and length of service required, similar to the system proposed by the Productivity Commission – Caring for Older Australians Report 2011. Some types of service, such as a single transport service, should not require a lengthy assessment process and could be accessed directly through service providers with an assessment undertaken in the future if the consumer's needs change and/or they require on-going services. ACSA also proposes a streamlining of the system for those that require a full assessment, combining both ACAT and RAS functions to create one assessment process and workforce.

A skilled assessment workforce with access to multi-disciplinary professionals is also essential to effectively assess need and contain expenditure on follow up, multiple assessments and unnecessary early reassessment.

This system needs to be underpinned by an IT infrastructure that effectively provides information for good service delivery and business to government interactions.

## Funding (Program and Individual)

To meet the objectives of the reforms, it is proposed that there will be a mixed funding model with funding being directed:

- to consumers (individual funding) to promote their capacity to choose between providers and services,
- to providers (program funding) to ensure that sufficient service infrastructure and choice is in place.

Determining what should be program funded (and how it should be distributed) and what should be individually funded will be critical. This will need to be informed by significant input from the industry as well as financial modelling based on demographic changes, population ratios, types and length of care and program features including potential caps on supply and/or on services.

In a thriving competitive commercial market where consumers have the purchasing means there may be no need for government subsidies or funding – consumers would simply choose providers based on their own opinion of the quality and value of services. However, aged care services operate in an artificial market where the provision of services is highly regulated and providers are held accountable for public funding and the provision of supports to all consumers irrespective of their capacity to contribute financially.

The level of funding and the way it is distributed must ensure the most vulnerable people in the community receive the services essential to their continued independence regardless of their ability to pay. This approach will build on existing social capital and strengthen the economic and social cohesiveness of local communities. ACSA advocates a simplified system for funding and a review of consumers' lifetime and annual caps for a fair and equitable service system.

## Options for program (block) and individual funding

There are a range of options for allocating program and individual funding. ACSA supports the Roadmap and recommends that the level of care/support is based on individual assessed need irrespective of the accommodation setting preferred by the consumer. ACSA also supports an uncapping of supply and recognises that staged implementation of a mixed funding model is necessary.

A flexible funding model is required to ensure the needs of all consumers, including those with special needs (as defined by the Aged Care Act 1997), can be met.

Rural and remote providers face additional extraordinary costs in providing aged care including for example food, travel and staff remuneration and training costs. Despite the viability supplement paid in HCP, these additional costs are not adequately compensated for resulting in inequitable service delivery to consumers living in rural and remote communities as opposed to those living in metropolitan communities.

The NACA CHSP Design Paper 2013[8] outlined the following recommendations for program/block funded options:

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

ACSA considers these options are still relevant with the inclusion of the following options:

- Base level funding for existing CHSP services with a focus on episodic entry level support that is time bound and has an emphasis on reablement and restoration;
- Specialised assessment, industry support, and 'connectors/navigators' that build the capacity of individuals to navigate the aged care system across both program and individually funded services.

ACSA supports a review of the current CHSP Sector Support & Development functions with a view to an approach across the new integrated program that supports both consumers and the service system.

Individual funding could include:

- Services that are individual in nature and based on the assessed needs and goals of the consumer (and carer). These could include nursing, personal care, domestic assistance, home maintenance, and possibly respite care, meals and allied health services. Consumers requiring multiple service types could receive a 'packaging' of services from one or multiple providers.

ACSA agrees with the NACA position that trials of individual funding options (including cashing out) should be undertaken to inform this decision.

[8] NACA Commonwealth Home Support Program Design September 2013

## Changes to Residential Care Funding

Government is currently considering how residential care funding should be structured and provided. Options generally discussed as a result of this work include case-mix; minor adjustments to the existing ACFI; and mixed models with fixed and variable components.

As a general rule it would make sense for funding models across residential and home care to either be the same or similar to make transitions easier. This is an opportunity to consider funding models and co-payments across all aged care services.

## Considerations for supply and expenditure

The government currently controls supply and expenditure through a number of methods including aged care planning ratios. The Road Map and the Productivity Commission Report have both suggested that the market needs to be less restrained through an uncapping of supply supports for consumers.

In a system based on assessed need and uncapped supply, government and the industry need to be fiscally responsible and carefully consider the opportunities for controlling expenditure. Responses could include:

- restrictions to eligibility;
- time limited program funded services; and
- capping of upper limits to individual packages.

Each of these possibilities must be carefully considered in the development of the integrated program. ACSA's position is that government provide assessment and means testing, determine subsidy level and appropriate consumer protections and then all other aspect of service delivery and co-payments are determined in negotiation between provider and consumer.

## Co-payments

With demand for aged care services set to increase dramatically in the coming decades, sustainable and responsible funding mechanisms are critical. Funding must be sustainable and predictable for both providers and the government, taking into account both government and individual consumer contributions.

It is widely accepted that consumer co-payments are necessary to ensure the sustainability of the service system. It is also clear that the level of co-payment should relate to the level and cost of the service and reflect the financial capacity of the consumer.

Introducing a fair co-payment will require a transparent mechanism for assessing capacity to pay. ACSA considers that means testing arrangements (both income and assets) should apply consistently for both residential care and home care recipients. However, this may be over reaching for consumers requiring small amounts of service with assessment and collection costing more than the revenue generated. Further consideration about the viability of assessing the existing 800,000 CHSP clients is necessary when industry estimates indicate that approximately 85 percent of these consumers are full pensioners.

Many Australians, including pensioners, have their wealth invested in their family home and there is ongoing debate about this being included in means testing, using products such as equity release, to support individuals to pay for the services they need. In addition, housing costs, the cost of medications, caring for family members including grandchildren, and travel costs associated with living in rural and remote communities also need to be considered in setting the co-payments.

A transparent and simple system for assessing capacity to pay and determining a tiered rate of co-payment will be necessary to drive a cultural shift across the industry. The system must provide for a tiered co-payment structure that is linked to the level of service and also takes account of immediate financial circumstances of the individual consumer.

## The NDIS Experience

Like the reforms currently being implemented in the aged care industry, the National Disability Insurance Scheme (NDIS) has at its core a shift in control of services from government and provider to the consumer. While there are a number of similarities between the NDIS and the reforms in aged care there are also significant differences.

Government considers that one discerning factor that sets the two programs apart is that disability is an unexpected life event whereas ageing is an inevitable stage of life and can be planned for. While this may be true for future generations, the current cohort of older people was not necessarily well informed about the need to plan for their financial independence in the later stages of life.

Unlike aged care, NDIS is funded as an insurance scheme, with all taxpayers paying an 'annual premium' through the Medicare levy, and consequently co-payments are not required. NDIS takes a lifetime approach, investing in people with disability early to improve their outcomes later in life. It will provide approximately 460,000 Australians under the age of 65 with a permanent and significant disability with the reasonable and necessary supports they need to live an ordinary life. Details of NDIS can be found here - what is NDIS?

Of particular interest to our industry, as we pursue the aged care reforms, are the following features of NDIS:

- Services are largely uncapped and entitlement based;
- Prices for services are set by the National Disability Insurance Agency (NDIA) and packages of support are determined by independent assessment and articulated through a support plan approved by the NDIA;
- Consumers may self-manage, or have a provider manage funding;
- Program funding is available for industry supports and capacity building, not just for actual services.

One of the major advantages of the NDIS has been the staged piloting and implementation that led to a number of changes in the scheme prior to its full rollout. This is an essential consideration for future aged care reforms.

As the NDIS full implementation rolls out across Australia over the next few years this will also have a major impact on the aged care industry as services lose their HACC Disability and Disability Program block funding and transition to individual supports administered through the National Disability Insurance Agency (NDIA). Many organisations provide both aged care and disability services and this may see some additional changes to the service system as organisations determine their viability within the industry.

## The overseas experience

A number of overseas countries are far further advanced in terms of their analysis of the global ageing population, increased demand for consumer choice and control, the role and capacity of carers, the fiscal restraints, policy setting and potential integrated models of service.

Countries such as Japan which has the oldest population with the proportion of aged people projected to almost double by 2050 - to 40%,[9] relies on insurance schemes and co-payments, both financially and in-kind, from carers and family. This social insurance model has been funded by a tax on all citizens over the age of 40 since 2000.

A recent report on the UK experience suggests that "The social care system in its current form is struggling to meet the needs of older people … Six consecutive years of cuts to local authority budgets have seen 26 per cent fewer people get help. No one has a full picture of what has happened to older people who are no longer entitled to publicly funded care: the human and financial costs to them and those who care for them are mounting."[10]

In Australia, there is a level of resilience built into the current aged care funding model in both HCP and CHSP. Both programmes have formulas for continued growth either as a proportion of the ageing population or a percentage increase. Sustaining a growth pattern is essential to avoid the same issues experienced in the UK and must be considered in an integrated program.

## Risks – the importance of clarifying roles

There are risks in pursuing the fundamental changes embodied in these reforms. It is important that these are identified and that measures are introduced to protect consumers and the service system. Government and industry must determine the most suitable governance structure for an integrated program within the context of the full range of programs and services available in aged care (including residential care). Further discussion is required about the existing protections available to all consumers and businesses to ensure these are sufficient for the aged care industry.

In particular, the roles of government, consumers and providers will need to be clearly articulated. The role of government is especially important during transition as it is leading the reforms and will be required to respond to any unintended consequences of the reforms.

## Transition and Sequencing

The process of transition and the appropriate sequencing of these reforms are essential to maintaining a strong aged care industry. The changes need to be implemented in a measured, orderly and prioritised way by the many different government departments and agencies with aged care related responsibilities. This will allow industry peaks, providers and consumers to work collaboratively to operationalise the changes, provide feedback and make adjustments as needed.

[9] Long-Term Care – A Review of Global Funding Models, by S. Elliott, S. Golds, I. Sissons and H. Wilson, 2014

[10] Social care for older people Home truths, by Richard Humphries, Ruth Thorlby, Holly Holder, Patrick Hall, Anna Charles, September 2016

ACSA proposes a consultation and engagement process to determine an agreed model for the integrated home care program by 2018, followed by piloting and staged implementation from 2019 – 2021. This also allows for both Victoria and Western Australia to have finalised transition to CHSP prior to implementation.

There are a number of measures that can be implemented in parallel to the program design phase including:

- a streamlining of the system for those that require a full assessment to one single assessment process, combining both ACAT and RAS functions and workforce;
- implementing an equitable fees and charges framework across aged care that is based on the individual consumer's capacity to pay and the level of service being received with a safety net for those that do not have the capacity to pay;
- the repositioning of the CHSP sector to compete in a market based environment, which may include capacity building and a freeing up of the CHSP service type funding restrictions for a smooth transition to an integrated program; and
- a review of Service System Development functions to determine best approach for industry and consumers.

ACSA supports the current NACA model for stakeholder engagement with Government and recognises that changes of this magnitude within the industry will require additional engagement processes. ACSA is committed to engaging and representing its members and regards this discussion paper as the first step in that process of engagement about the future integrated home care program.

## Models and Options for program design

Multiple design approaches and models must be considered for the future. The following provides four (4) possible options to start the conversation. These models are not definitive and the final position may include a mix of elements from each of these models or an alternate approach. ACSA is interested in your views and any suggestions you may have. Any proposed model for the integrated home care system will require costing before final design.

### Next Steps

**All ACSA members are encouraged to provide input into the final position on the future integrated home care system.**

You can provide feedback by completing our short survey, attending a workshop in your State/Territory, and discussing your thoughts with your local ACSA policy staff.

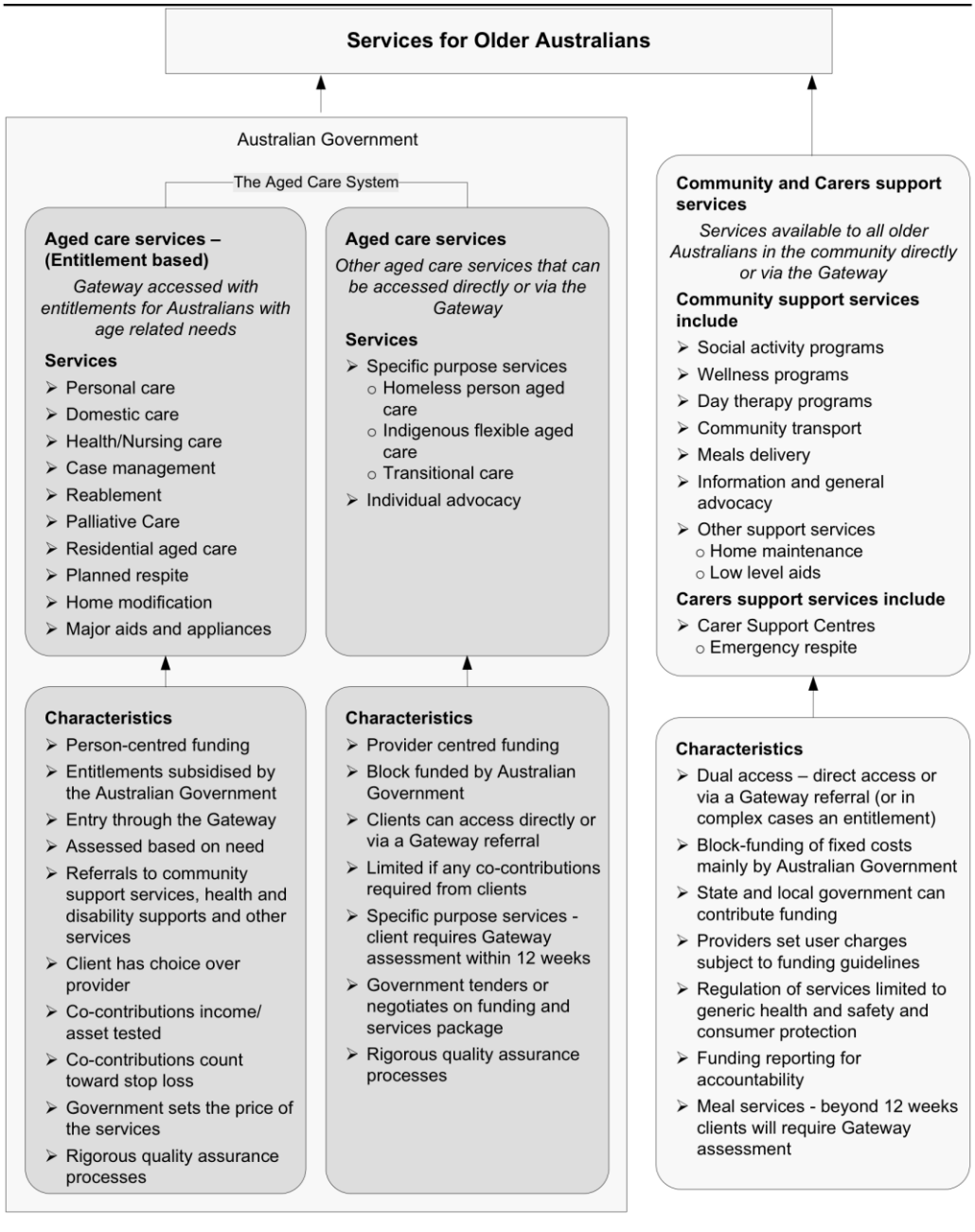
**ACSA intends to finalise the Integrated Home Care System Position Paper by 30 July 2017.**

## Suggestions and possible models for program design

There are multiple design approaches and models for the future. The following provides four possible options for discussion.

## OPTION A

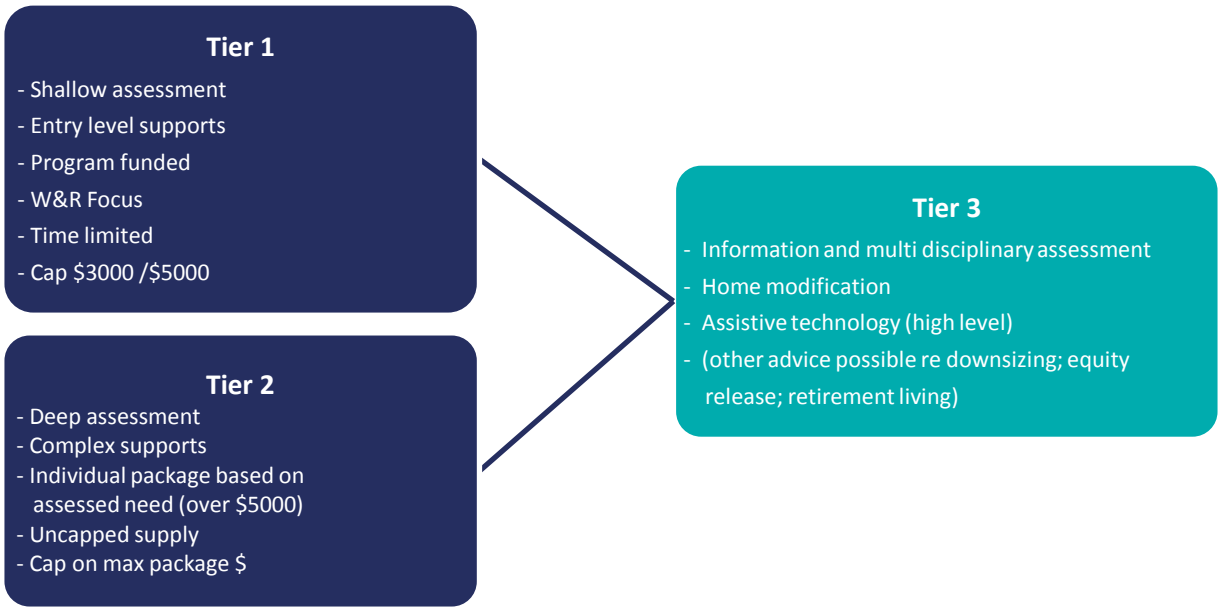
*As recommended in the Productivity Commission Report – Caring for Older Australians 2011*




*Productivity Commission 2011, Caring for Older Australians: Overview, Figure 5, p XLVIII*

## OPTION B

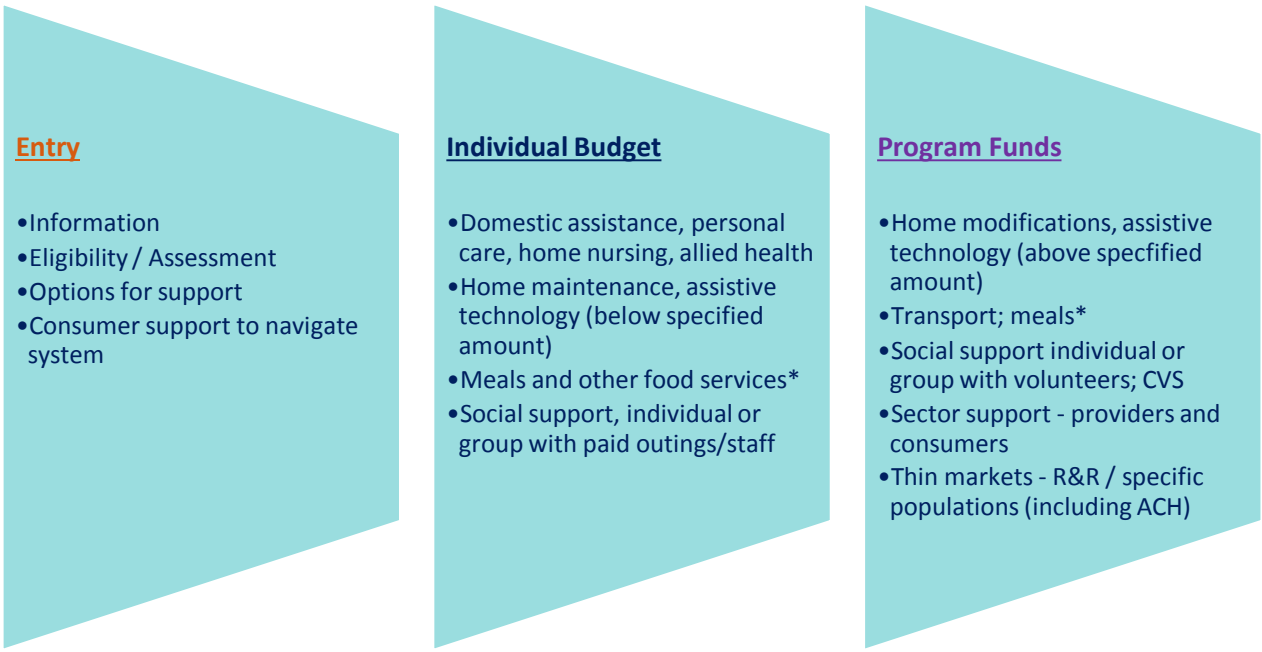
Existing CHSP services program funded and individual packages with no 'levels' – service based on assessed need up to max threshold equivalent to entry supports in residential.




### Characteristics

- **Tier 1** – Entry Level - Continue with grant funding for CHSP:
    - Emphasis on Wellness and Reablement
    - Assessed need up to a maximum eg. $3000 or 5000?
    - Time limited (and then reassessment option)
- **Tier 2** – Complex Supports - over $3000 (or agreed Tier 1 cap) package of supports:
    - No specific package levels
    - Assessed need to determine package amount
    - Capped max package based on need up to level of residential care (initially)
    - Uncapped supply
- **Tier 3** – Option for home modifications, equipment and assistive technology as separate and requiring specific assessment. Available on its own or in addition to Tier 1 and Tier 2.

## OPTION C

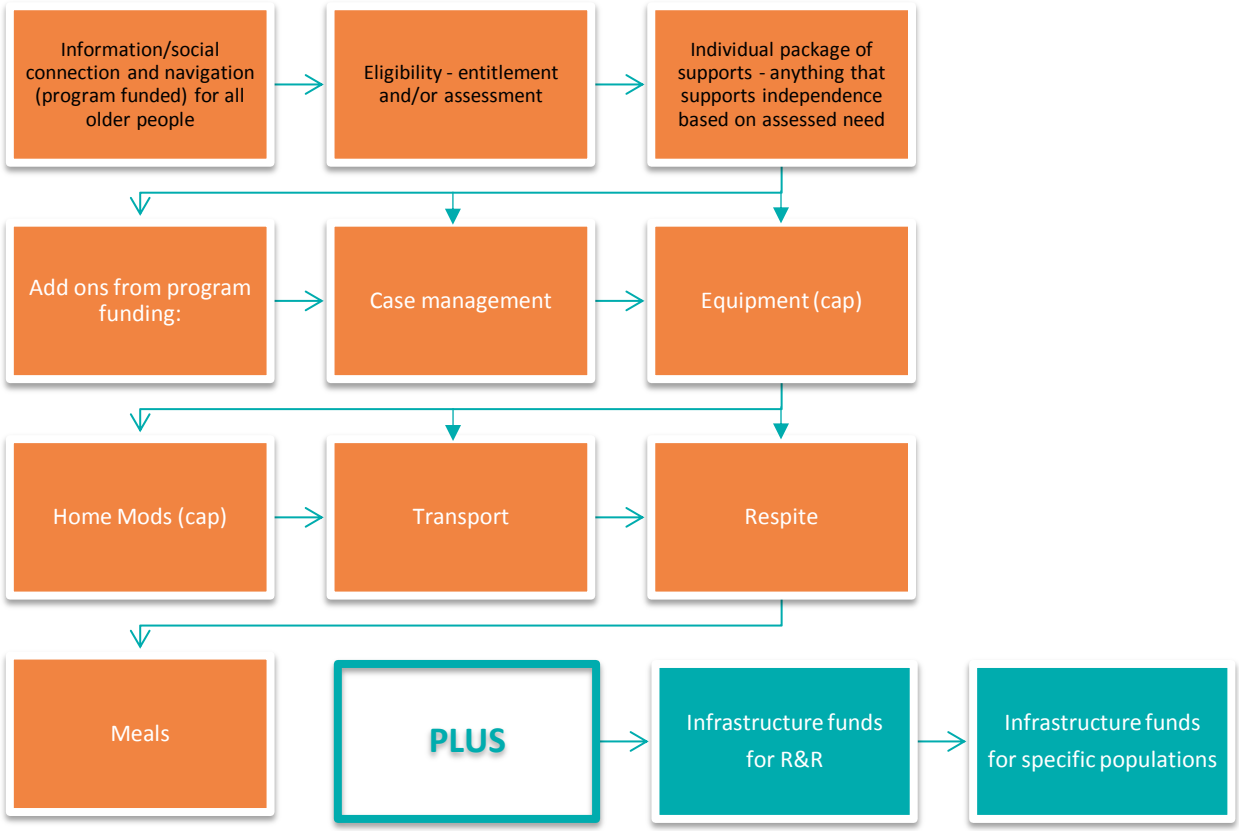



### Characteristics

- Individual budget
    - Domestic assistance, personal care, home nursing, allied health and therapy
    - Home maintenance; equipment and assistive tech (below specified amount)
    - Meals and other food services*
    - Social support paid outings and centre based with paid staff
- Program Funding (block grants)
    - Home Modifications, equipment and assistive tech (above specified amount)
    - Transport
    - Social support (volunteer), community visitors scheme
    - Meals and other food services*
    - Sector support – providers and consumers
    - Thin markets – R&R / specific populations
    - Assistance with care and housing
- Carers Support – separate program or mixed funding model

* *Requires discussion*

## OPTION D




### Characteristics

- All older people can access information and social connection through telephone; on-line; community hub
    - For some, this will be enough
- Navigators/Connectors to assist most vulnerable/disadvantaged through the system
- Assessment for those that require funded supports/services
- Individual package that supports independence at home/community setting
- Consumer add-ons from program (block) funding
- Infrastructure funds for R&R / specific purpose / specific population groups from program (block) funding