

**OFFICE OF THE
PUBLIC ADVOCATE**

**Is community care a cost saving preventative
measure or a genuine alternative to residential
care?**

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Discussion paper prepared for the Office of the Public Advocate

By

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Table of Contents

Executive Summary and Key recommendations	3
1. Introduction	5
2. The transition from Institutional to Community Care	5
3. Changing Demographics of the Australian and Victorian population	6
4. What is Community Care	6
5. Community Care Funding	7
6. Victorian Community Care System at Present	9
6.1 Home and Community Care (HACC)	9
6.2 Linkages	10
6.3 Community Aged Care Packages (CACPs)	10
6.4 Extended Aged Care at Home (EACH)	11
6.5 HomeFirst	12
7. Unmet Need	12
8. Case Management	13
9. Eligibility Criteria and Assessment	14
10. Current Overlap in Service Delivery	14
11. Informal Carers	15
12. Influences and Realities of the Current Situation	16
13. Current Reviews, recommendations and Ways Forward	16
14. Commonwealth "New Strategy for Community Care"	18
15. Critique of the "New strategy for Community Care"	19
16. Conclusion	21
17. Key Recommendations:	22
References	24

Executive Summary.

This discussion paper was prompted by the Office of the Public Advocate to inform the Office of the current issues under debate at a local, state and Commonwealth level and to provide a general overview of the current community care system. The Office of the Public Advocate has a particular interest in the needs of clients with complex care needs, which is a specific group that is often failed by community care services. The variety of community care packages designed to cater to complex need clients often operate in isolation from each other despite overlapping target groups and this has added to what is described as a 'complex and fragmented system'.

A review of the literature indicates that Community care is in a state of crisis and has been for some time. Community care in Victoria is provided through a range of different organisations and packages. HACC is the largest provider of community care and provides basic levels of care to large sections of the community. For clients whose needs exceed core HACC services, there is also a range of packages designed to accommodate complex care needs. An examination some of the main community care packages available, including Linkages, CACPs, EACH and HomeFirst highlight common themes and concerns. These recurrent themes include extensive waiting lists, inadequate levels of funding per package, inadequate amount of packages and the complex nature of the system for both service providers and recipients of community care. Ultimately, the range of packages created to fill gaps in the system appears to have contributed to the complex and fragmented service system and to have fostered a culture of 'gap filling' rather than the provision of holistic & integrated services.

Another area of major concern expressed in the literature across the range of community care packages is that funding levels have not increased in line with CPI and the rising costs of service provision. The increasingly limited purchasing power of packages often results in the inability of specific packages to meet their stated aims and objectives. The inflexibility of Community care packages calls for funding which would allow services to respond to individual need on a case-by-case basis rather than the current package model that assumes that recipients can fit into pre-conceived and pre-determined packages. Funding related challenges are also compounded by escalating waiting lists and predicted increased demand. In the light of these concerns, it becomes even more essential that community care is reformed to ensure a sustainable, efficient and effective system.

In recent years a number of reports have reviewed the community care system and offered recommendations for extensive restructuring. More recently The Commonwealth Government has released a consultation paper 'A New Strategy for Community Care' (2003). However, the "new strategy" fails to address the multitude of deficiencies identified in previous reports. Despite the rhetoric of "streamlining" and "restructuring", the proposed changes are envisaged within existing funding and do not tackle the urgent issue of unmet complex care needs and the inflexibility of the system. The projected financial advantages of the new framework are not quantified and the entire proposal is

loosely conceived and non-specific. Despite the potential advantages of standardised assessments and reporting mechanisms proposed in the 'new strategy', service providers question if this new strategy will be implemented and if so what the actual benefits will be.

The pilot and subsequent implementation of the Extended Aged Care at Home (EACH) program has reported in its evaluation that nursing home level care *can* be provided in people's homes at no extra cost. Community care is in keeping with Governments' recognition of the social and economic benefits of keeping people in their homes. However, until Governments cease to approach community care as a cost saving device it will continue to fail to provide the alternative to residential care that it has the potential to be.

Key Recommendations:

Recommendation 1: That the funding allocated to Community Care Packages, whether operating in isolation or in an integrated model, needs to be increased so that the services available do in fact meet their target groups' needs. Funding levels for community care should be determined by demand & in response to need rather than a cost cutting measure for the residential care sector.

Recommendation 2: Community Care needs to be funded in a more flexible way and provided in response to individual need on a case by case basis rather than a package model that assumes that recipients can fit into pre-conceived and pre-determined packages.

Recommendation 3: Community Care packages with overlapping target groups need to be merged so that care services for particular target groups are presented in a less complex manner.

Recommendation: 4 The level of funding allocated per package needs to be evaluated as it is evident that subsidy rates have not increased in line with the increased cost of service provision and CPI.

Recommendation 5: That a person's assessed level of need is aligned with the appropriate level of funding in community care in the way in which it is currently done in the residential care sector.

Recommendation 6: That the EACH program is expanded so that clients with high care needs who are eligible for residential care are provided with the genuine option of community care funded at the same subsidy rate.

Recommendation 7: The individual and social benefits of community care should determine our overarching commitment to community care rather than financial considerations and cost cutting agendas.

1. Introduction

It is commonly acknowledged that it is extremely difficult for people to navigate their way through the range of Community Care Services available to support people in the home (Commonwealth Department of Health and Ageing, 2003a). The wide range of community care packages designed to assist the elderly and people with a disability to remain independent creates a complex task when needing to identify and obtain the best option. The range of community care services and packages often operate in isolation from each other which generates a system which has been described as fragmented, complicated and under resourced (Myer Foundation, 2002: Seih, 2002)

The 'development, delivery and cost effectiveness of care in the community' is undoubtedly a critical issue (Municipal Association of Victoria (MAOV), 2002: 81). In response to concerns from both the community and industry, regarding the complexity and lack of consolidation of the current system, the Commonwealth Government has initiated a review of community care (Commonwealth Department of Health and Aging, 2003a: 3). The current level of unmet need combined with escalating demand make it increasingly essential that the community care sector is sustainable, efficient and effective in meeting the needs of the diverse populations it serves.

This discussion paper was prompted by the Office of the Public Advocate (OPA) in order to provide the office with an overview of the community care system. The OPA has a particular interest in the needs of complex care clients, which is a specific group that is often failed by community care. This discussion paper examines the key components of the current community care system in Victoria, exploring some of the major challenges facing the sector including the issue of changing demographics, unpaid carers and unmet need. The paper outlines the structure and evolution of community care and the influences including funding which impact on the current situation. In discussing the major community care packages available, specific problems as well as recurrent themes will be highlighted. In the process of drawing on the body of literature the challenges and limitations of the system will also be discussed.

2. The transition from institutional to Community Care

In the mid 1980s in Australia there was a Government policy shift from residential care to community care. This move away from institutional care was consistent with Governments' identification of the 'financial and social benefits of de-institutionalisation' (Commonwealth Department of Health and Ageing, 2003a: 8). The process of de-institutionalisation has been described as the 'most significant human service event of the 20th century' (Chenoweth, 2000 as cited in Johnson, 2002: 145). Government policy continues to encourage people to remain in their homes for as long as possible and community care aims to prevent premature admission to residential care.

A snapshot of Victorian Disability Services in 2002 reported that 81% of disability service users were receiving in-home or community care (Vic Health,

2003). At the same point in time, approximately 17% of Victoria's senior population were receiving Home and Community Care Services (HACC) and only 5% of seniors reside in institutional care (Vic Health, 2003). Evidence suggests that if previous patterns of care for older people had continued in the ten-year period from 1986 to 1996 there would have been 25% more elderly people in institutional care (Australian Institute of Health and Welfare, 2000 as cited by Myer Foundation, 2002)

3. Changing Demographics of the Australian and Victorian Population

Demand for community care services is continually increasing. It is agreed that this demand will continue to increase due to the trend for an ageing population structure in developed countries around the world (Victorian Government, 2003). The increase in demand is also influenced by advances in health care, which in turn increases the number of people with disabilities and their longevity (Commonwealth Department of Health and Aging, 2003a: 8). The incidence of severe or profound disabilities increases with age (DHS, 2003b) and the number of Australians with dementia is expected to more than double over the next 30 years (Myer Foundation, 2002:15).

In Victoria, population projections indicate that the proportion of the population aged over 65 is expected to increase from 12.9% in 2001 to 18.6% in 2021 (MAOV, 2002: 8). The proportion of people aged over 85 will almost double increasing from 1.4%, in 2001 to 2.1% in 2021 (MAOV, 2002: 8). In 1999 the ABS estimated that 18% of the Victorian population currently has a disability (ABS, 1999). It is estimated that the numbers of Victorian people with a profound or severe disability will rise from 78 per 1,000 in 2001 to 95.5 per 1,000 in 2011 (MAOV, 2002). It is also estimated that during this time the total number of people requiring help with daily activities is expected to increase by 37.1% (MAOV, 2002: 8). The greatest increases will be in health care, home maintenance, home help, meal preparation, mobility and self-care, which constitutes the essence of community care (MAOV, 2002: 8).

4. What is Community Care?

Community care is an ambiguous term and means different things to different stakeholders. Community Care is loosely defined as people being cared for in their communities regardless of whether it is formal or informal care (Myer Foundation, 2002: 4). Community care can encompass a wide range of support services that cater for all groups in society. For the purpose of this paper, community care refers specifically to in home aged and disability services, which support independence. These services include personal care, home care, nursing and allied health care, transport, social support, recreation, respite, home modification, equipment and aids.

The aged-care and disability sectors as well as the client groups involved have a preference for people to remain in their own homes for as long as possible or until the only reasonable option is residential care (DAC, 2003: 5, ACSA, 2003, Vic Health, 2003). This preference is expressed by individuals' and their carers' demand for a system that supports individual lifestyle choices and

continued community living (ACSA, 2003). The services required for individuals to remain in their own homes depend on the person, their disability and their individual needs. Due to differing levels of need, clients can require varying amounts of services and the types of services that community care packages offer differ enormously. The range is from basic community care to specific community care packages, which provide low-level to high-level care. Low-level community care packages are intended to provide the equivalent of low-level residential care and high-level community care packages are regarded as an alternative to high-level residential care.

For many, independence and/or maintaining independence hinges on the provision of formal services in the home and the amount of services available commonly enable or hinder this independence. Barnett and Schultz (1993) report that it is a person's perception of their ability to manage and their access to required supports, which instils the sense of security needed to retain independence (Barnett and Schultz, 1993). Catholic Health Australia (2002) claim that levels of dependency and disability for community care recipients are in many cases similar to clients in residential care. Sundstrom (2003) concurs that it is the provision of public services, whether they are used or not, which fosters continued independent living. Ultimately, the determining factor of continued independence is access to adequate supports, formal and informal, and not necessarily a person's level of disability and dependency. Evidence suggests that community care approaches, which 'maximise dignity, control by the individual or family, individualisation, community inclusion and support when required will in many instances reduce longer term dependence on the service system' (CCIN, 2003: 6)

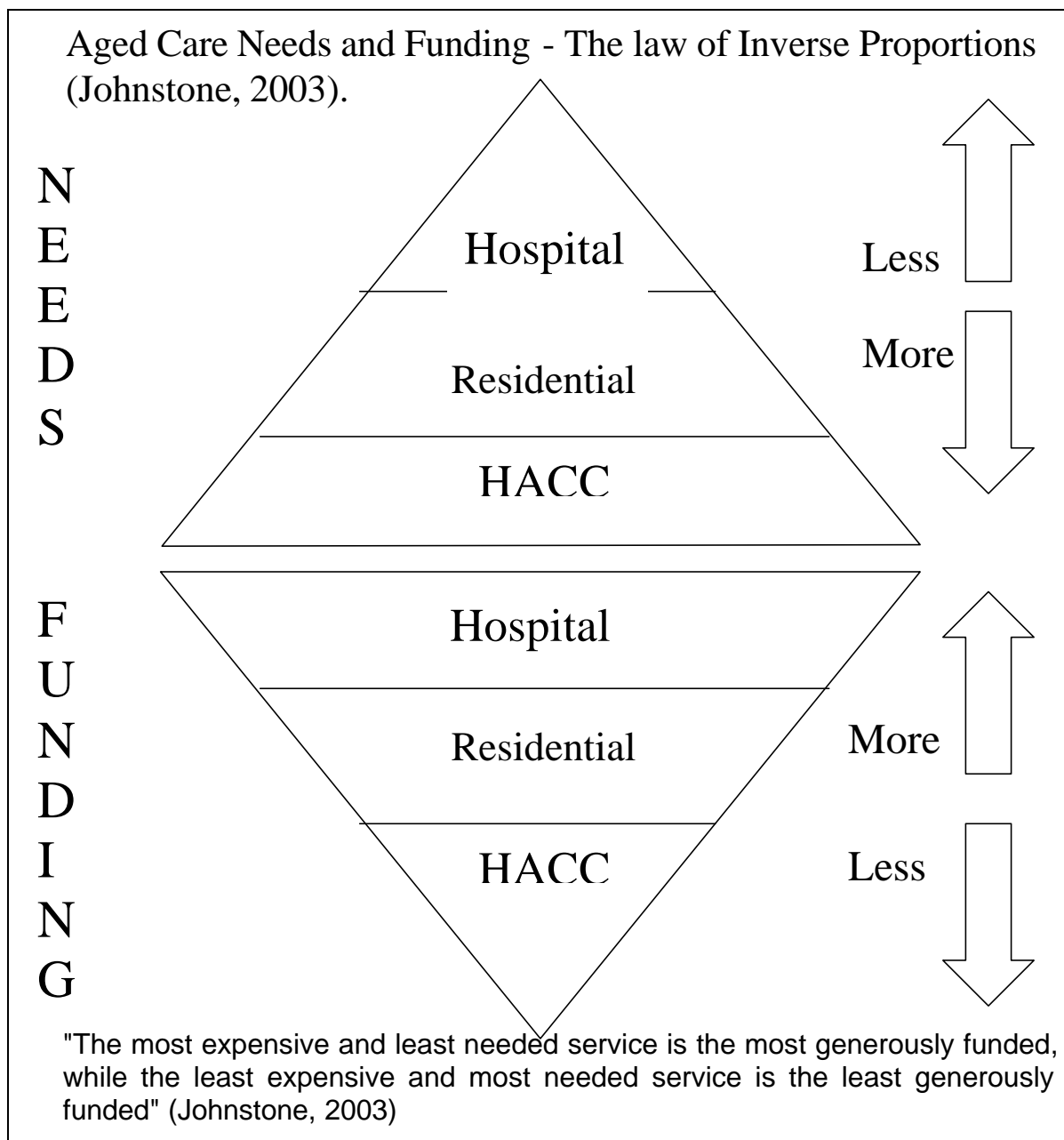
5. Community Care Funding

Community care is provided across Australia by over 4000 service providers and is provided through Government, private and not-for-profit sectors (Myer Foundation, 2002). Direct Government provision of services has been progressively reduced since the 1980s and the role of the Government has increasingly become that of funder and enabler and less direct provider of services (Fine, 1997). Government policy and the current community care system are cemented in the broader context of a general move away from large bureaucratic institutions to smaller more specialised and privatised service providers (Fine, 1997). The wide range of funded community care service providers is seen to offer flexibility and choice to consumers and to operate more efficiently than their previous Government counterparts (Fine, 1997). The funding of various community service providers also stems from a desire to localise community care.

Funding for community care is administered by three tiers of Government (i.e. Federal, State and Local Governments). The Federal Government identifies itself as the major funding source of community care and assumes responsibility for leadership of care provision (Commonwealth Department of Health and Aging, 2003a: 3). The respective State Governments are responsible for support services, accommodation and respite. However, it is at

a local level of Government that home and community based services are coordinated and provided (City of Melbourne, 2002: 13).

This three-tiered funding approach has influenced the complex and fragmented nature of the system (Myer Foundation, 2002: 26). The three systems in operation have a tendency to cost shift between jurisdictions which is not conducive to an integrated and cost efficient system. The problems involved in separate funding allocations means that savings in one area are not recognisable to another, which provides little incentive to provide a consolidated approach. For example, the Commonwealth Government attempts to save money by trying to limit admissions to residential care and the States cut costs by keeping people out of hospitals. Ultimately the shortfall is felt by community care although it remains the least funded of the Aged and Disability Service sectors (VAHEC, 2003a).



Community care is currently provided to over half a million Australians. In 2001, total Government spending on community care and support was \$1.2 billion as apposed to total expenditure on residential care, which was \$6.6 billion (Allen Consulting Group, 2002). Residential care was estimated to account for 1.01% of GDP and community care accounted for 0.18% (Allen Consulting Group, 2002). Interestingly, Community Care is the most demanded service area of the aged and disability sectors although it is the least funded (VAHEC, 27/10/03).

6. Victorian Community Care System at Present

Community care in Victoria is provided through a range of different organisations and packages. HACC is the largest provider of community care and provides basic levels of care to large sections of the community. Under the HACC umbrella services such as basic home care, personal care and respite are available. In addition, for clients whose needs exceed core HACC services there is also a range of packages designed to cater for more complex care needs. I will briefly discuss HACC, Linkages, CACPs, EACH and HomeFirst to illustrate the variety of available community care packages. While this list is not exhaustive it represents the majority of packages and highlights issues that affect the whole sector.

6.1 Home and Community Care (HACC)

HACC is the main provider of community care services and is funded by Commonwealth, State and Local Governments. In Victoria, expenditure on HACC services is \$360 million per year, \$289.8 million distributed by the Commonwealth and State Governments and \$70 million from Local Government (MAOV, 2002). The HACC program was established in 1985, bringing together a wide range of separately funded community based services (MAOV, 2002). The stated aim of HACC is to provide a comprehensive and integrated range of basic maintenance and support services for frail aged people, people with a disability and their carers. HACC services are provided to 17% of Victoria's senior population (Vic Health, 2003) and approximately 25% of HACC services are provided to people with disabilities under 65 years of age (Myer foundation, 2002).

HACC generally provides low levels of care and is not funded to provide case management (MAOV, 2002: 60). It is reported that 90% of elderly HACC clients receive less than 14 hours per month and many less than an hour a week (Myer Foundation, 2002: 18). Forty percent of low need service users (HACC's target group) account for only 10% of total resources (City of Melbourne, 2003: 22). However, 10% of high need service users account for up to 50% of HACC resources and some clients cost more than \$25,000 per year which costs HACC a total of \$21 million per annum (Myer Foundation, 2002: 18).

The demand for HACC services currently exceeds the supply and consequently the amount of services a client receives is determined by availability of services rather than need (VAHEC, 2003b). In addition, complex

care clients contribute further strain on a limited HACC budget. Preventative low-level HACC services are increasingly diverted away from the target group due to limited resources and the need to prioritise clients in most need (Catholic Health Australia, 2002).

The creation of HACC represents an attempt to consolidate and rationalise the community care system as a whole. However, there is increasing concern with regard to HACC's "ageing bias, regional inequity, particularly rurally, and funding formulas which severely limit capacity and capacity building" (Bridge, C., Kendig, H., Quine, S. & Parsons, A., 2002:10).

6.2 Linkages

Linkages is a community care package, which is an extension of HACC and is funded through the Commonwealth and State Governments. Linkages expenditure in 2001/02 was \$32.81 million supplying 3,066 places costing at \$10,700 each, which are unevenly spread across Victoria (MAOV, 2002). The aim of Linkages is to support people with complex care needs to live independently. Linkages providers receive "brokerage" funds to cover the costs of case management, and to purchase a flexible package of services designed to meet the specific needs of individual clients. It is estimated that up to a third of all Linkages packages are provided to people aged between 16 and 64 (CCIN, 2002). However, the median age of a Linkages client is 66 years old (MAOV, 2002: 22).

Recipients of Linkages who were previously HACC clients continue to receive their HACC services (which is called Maintenance of Effort, (MOE)) and the Linkages package provides additional services. A Linkages package covers the cost of case management, operation and the purchase of additional services. In the past 15 years the value of Linkages packages has only minimally increased, by approximately \$1200 per package per annum. The reduction in the purchasing power of packages exacerbates the inability of the package to meet the needs of their specific target group (i.e. clients who have complex care needs) (CCIN, 2002). With current funds unable to cover the cost of all Linkage clients, the cost of providing above average HACC and Linkage hours is often borne by general HACC agencies, estimated to cost approximately \$16 million annually (DAC, 2003:8).

The unmet support needs of current clients in conjunction with the unmet needs of clients on waiting lists are a source of increasing concern (CCIN, 2002). In 2001, there were 1096 clients on Linkages' waiting list indicating an unmet demand for a third as many additional packages, which would cost a further \$12 million per annum (DAC, 2003: 8). Current funding is unable to meet existing demand and given the anticipated growth there is an urgent need for the development of a Linkages system, which provides adequate assistance based on need rather than available resources (CCIN, 2002).

6.3 Community Aged Care Packages (CACPs)

Community Aged Care Packages (CACPs) are funded by the Commonwealth Government and have been operating since 1992. CACPs expenditure in 2001/02 was \$72 million supplying 6,558 places in Victoria costing at approximately \$11,000 per year. CACPs are designed to support frail older people with complex care needs to remain living independently in the community. The packages are described as an alternative to low-level residential care (MAOV, 2002). Eighty percent of CACPs recipients are aged 80 or over and 58% of clients live alone (MAOV, 2002).

Despite increases in funding, subsidy rates have not increased in line with CPI and increasing costs of service provision and services struggle to adequately cater to clients with complex needs. Service providers consistently raise concerns in regard to the actual decline in the services provided by CACPs due to inadequate resources allocated per package and that the amount of services provided by a CACPs package is often less than the service provision provided by basic HACC agencies (Catholic Health Australia, 2002). The stated purpose of CACPs is to provide an alternative to low-level residential care. However, in effect a CACPs package provides on average only 4 hours of service, which severely limits its viability for complex care clients. Another area of concern is that clients who receive CACPs are not eligible for funding to purchase aids and equipment including mobility and incontinence allowances.

There was a 93% increase in the number of agencies that provide CACP programs from 1999 to 2001. In 2001 there were 141 agencies in Victoria providing CACP packages (MAOV, 2002). However, this increase in providers has not tackled the current unmet demand and CACP programs consistently have lengthy waiting lists often up to 12 months or more (Catholic Health Australia, 2002). Each provider has its own waiting list and the process of contacting all CACPs providers in an area can be a daunting exercise for clients. Once a package is allocated, the agency then has to contact all the other providers in the area to remove the recipient from their waiting lists. Although it is often assumed that a variety of service providers equals increased options for clients many question 'whether choice of provider has meaning for recipients who have limited basis for exercising a choice or in many cases are happy to accept a service offered by any provider' (MAOV, 2002: 14).

6.4 Extended Aged Care at Home (EACH)

The EACH program has been operating nationally as a pilot program since 1998 and has recently been developed as an additional community care package. EACH is a Commonwealth Government initiative and is provided as an alternative to high-level residential care for elderly clients. EACH provides approximately 18 to 20 hours per week of direct care and the daily subsidy rate is \$108.14* per day (equivalent of RCS2*). Thirty five percent of EACH clients are over 85 and 10% are under 65 years of age. Interestingly, 76% of all

EACH clients live with family although this varies from provider to provider (EACH, 2002).

Currently there are 84 places in Victoria provided through 3 agencies. It is estimated that by the end of 2003 there will be an extra 92 new places and 77 Exchange of Care places. Exchange of Care places are designed to facilitate relocation from supported accommodation to independent living (Commonwealth Department of Health and Aging, 2003b). Due to current unmet demand, the increased amount of EACH packages will be filled by existing waiting lists and the service will be unable to take on new clients. In December 2002 there were up to 50 people on the waiting list and many others who were eligible did not put their names on the list due to the fact that some clients had been on the waiting list for up to 2 years (Seih, 2002).

The EACH program began as a pilot to test the feasibility and cost effectiveness of providing nursing home level care to people in their homes. Significantly, the EACH pilot program has indicated in its evaluation that high-level quality residential care *can* be provided in the community at no extra cost (Myer Foundation, 2002: 19). The EACH program also reported that their clients have 'less attendance at Emergency Departments and their overall length of hospital stays is reduced, thereby decreasing demand on an already overburdened public health system' (Benjamin, 2003: 5). The evaluation of the EACH program also confirmed that while safety issues for the elderly in their home are different, they are at no greater risk than those in residential care (Benjamin, 2003).

6.5 HomeFirst

HomeFirst is underpinned by the first goal outlined in the State Government's Disability Plan (DHS, 2002a). The broad goal of HomeFirst is to enable people with a disability to "pursue their own individual lifestyles" through providing appropriate supports which cater to the individual's needs (DHS, 2003a). HomeFirst is a recent initiative and currently receives annual funding of \$10.4 million to support the needs of an estimated 271 people in Victoria (DHS, 2003c). The aim of the HomeFirst program is to enable people with disabilities to continue living in their own home and/or acquire the skills and supports necessary to move to more independent living arrangements. Depending on need, HomeFirst provides up to 34 hours of services per week at a cost of approximately \$47,000 per package per annum which represents the most comprehensive community care package available. This service is in great demand and in April 2003 there were almost 1000 people on the Support Needs Register whose needs were classified as urgent or high priority awaiting the allocation of HomeFirst packages (VCOSS, 2003a).

HomeFirst provides support for people with varying degrees of need and '*should* be available to people with lower levels of need in a developmental/preventative capacity' (DHS, 2003a: 6). Despite, the inclusive nature of the identified target group, due to the inevitable prioritisation of applications and lack of resources, eligibility does not necessarily mean

entitlement and many eligible candidates do not succeed in receiving services (DHS, 2003a & DHS, 2002b).

7. Unmet Need

The demand for Community Care Packages is increasing. However, the proportion of services has not expanded in relation to population growth (Myer Foundation, 2002: 14). It is reported that in some circumstances this unmet need has resulted in a decline of the level of care provided (Myer Foundation, 2002: 14). An ABS survey of Disability, Ageing and Carers in 1998 found that 40% of all people with a major disability living independently and requiring assistance reported that their needs were only partly met (Myer Foundation, 2002: 14).

While there is a vast array of community care packages provided by Aged and Disability Services at a State and federal level, it is widely accepted that there is a growing unmet need (Myer Foundation, 2002: 14). Access to services and the quality of services available varies due to a number of reasons including the State and region that a client resides in. The level of funding and also the demand in the particular region dictate access and availability of services. Limited funding and resources have impacted on the amount of packages available and the level of care, which is provided by the particular package.

Providers of packages and services have expressed their concern in regard to the inability of the packages to provide the basic supports outlined in the specific aims and objectives of the package (Seih, 2002: 3). Seih (2002) comments that the Aged Services Network has found that there is great concern amongst members about the level of care that community care packages currently provide. The purchasing power of packages has reduced significantly over the years and providers claim that the main benefit of being allocated a package is the case management aspect. With case management the only incentive, some clients are advised not to accept a package and to continue with or obtain services outside of packages (Seih, 2002).

8. Case Management

Case management was originally developed in the 1970s and 80s in the United States and was later described as the 'cornerstone of high quality care' (MAOV, 2002: 75). Recent studies indicate that it is not cost effective to provide case management to clients without complex care needs requiring the coordination of multiple services (Myer Foundation, 2002:19). Consequently, community care packages are tailored to suit complex need clients and provide case management as apposed to clients who receive basic HACC services.

This contracted out service system is complex in nature due to the proliferation of services and the confusion as to what each service provides creates a challenging task for both service users and service providers. This arises due for a variety of reasons including the structure of the system and complex care needs, which extend beyond the services provided by basic community care

services. Therefore, the coordination of services is increasingly organised by case managers who, on behalf of clients, coordinate services for clients with complex care needs. Case management is a funded element of the majority of community care packages. The case manager is generally not a service provider but a broker who merely oversees the provision and coordination of a range of services.

Fine (1997) describes case management as an attempted solution to the problems that exist in a complex and fragmented service system. Case management is 'a piecemeal response to an enormous health and social services problem' and 'by itself, case management cannot alter biases and shortages in the delivery system' (Austin, 1992). However, case management is accepted in community care packages as an essential component in order to coordinate and navigate services within the current system. Case management exists because of the system but also sits outside of it, which enables the case manager to work creatively across systems instead of being confined by any particular agency (CCIN, 2003)

9. Eligibility Criteria and Assessment

Assessment processes for packages vary depending on the package and the process involved in the assessment for that specific package, which is often perplexing for clients (Myer Foundation, 2002). In the climate of limited funding, eligibility criteria are often narrow and complex assessments can prove time-consuming and frustrating for clients in need of services (Myer Foundation, 2002). The assessment process itself can be very traumatic for clients and the whole process boils down to the fact that the individual's future services are determined by an hour-long assessment (Fine and Graham, 1992).

How need is defined and services are allocated is a political concept and therefore service assessments invariably involve the process of determining if an applicant is suitable and if the agency is able to offer the services needed (Fine and Graham, 1992). Whilst assessments are continually becoming more standardised the process of assessment can be rather arbitrary due to the lack of clear eligibility guidelines (Fine and Graham, 1992). The other scenario is that eligibility does not necessarily equate to receiving services. Again, due to limited resources, the allocation of packages is a process that often involves the prioritisation of eligible clients and many people remain on waiting lists for extended periods of time.

In the community care sector there are no set levels of need, which correspond to the cost of the required care, unlike the residential care system (MAOV, 2002). Therefore a client's assessed level of need does not automatically mean entitlement to a certain level of funding and or allocation of services. Recent research has indicated that in the absence of linking assessed dependency levels and costing allocations, the level of community care allocated to many high dependency clients is inadequate and is based on what can be provided not what the assessed level of need is (MAOV, 2002: 1).

10. Current Overlap in Service Delivery

Care services are typically outsourced by the various packages and the providers of services often provide services for multiple providers. A Victorian study reported that 84% of CACP agencies are also HACC providers (53 out of 63). Sixteen agencies provide both CACPs and Linkages packages, 37 of the 63 CACP agencies provide HACC services but not Linkages packages and 7 agencies provide linkages but not CACPs (DAC, 2003: 11). Due to this extensive overlap, some have suggested that it would be unproblematic and more cost-efficient to merge programs with overlapping target groups (DAC, 2003: 11).

A report carried out by Community Care Issues Network (CCIN) called Complex Care Needs - Complex Issues studied Linkages clients between the ages of 16 and 64 who have high cost care needs. The report discovered that a number of clients were combining packages (i.e. HACC, Linkages and HomeFirst) in order for their needs to be met. The receipt of a combination of programs results in policy makers having little understanding of the overall costs of complex care clients. It also highlighted that clients who are receiving above average Linkages services under the age of 65 would also be eligible for HomeFirst although due to waiting lists the majority of these clients will not be allocated a HomeFirst package even when their care needs escalate. This evident overlap in target group and eligibility criteria has not led to a greater understanding of the nature and levels of assistance clients require and the report concluded that no package is currently funded adequately to meet complex care needs (CCIN, 2002).

11. Informal Carers

The ABS estimates that there are currently 2.3 million informal carers in Australia who provide the majority of community care and supply approximately 74% of all in-home support and assistance to people with a disability and frail older people (Commonwealth Department of Health and Ageing, 2003: Carers Victoria, 2003). HACC has a national budget of more than \$800 million annually which meets only 9% of identified care needs and conservative estimates calculate that unpaid carers save the Australian economy \$16 billion per annum (Carers Victoria, 2003).

In the aged care sector statistics report that almost 70% of people aged 65 or over in 1998 with severe needs lived with relatives (i.e. adult children, spouse, etc) or others (Vic Health, 2003). Significantly, 21% of carers are over 65 years old themselves which highlights the vulnerability inherent in many informal care arrangements (DHS, 2003b; Carers Victoria, 2003). Similarly, of the 51% of disability service users who require a carer, 79% reside with their carer and 67% are the parent of the client (DHS, 2003b). Further, 54% of primary carers claim that they provide care because 'alternative care is unavailable or too costly' or 'they consider they have no choice' (Carers Victoria, 2003).

Recognition of the amount of care provided by unpaid carers has increased. The amount of support provided to carers has also improved although this has

also highlighted the challenges faced by people who do not have a carer and/or live alone. The CCIN report provided a number of case studies illustrating the fact that for clients with complex care needs without a carer the services available to meet their needs are comparatively more limited (CCIN, 200). The majority of community care packages available work in conjunction with the unpaid caring provided by informal carers and packages remain unable to meet all the complex care needs of many clients.

12. Influences and Realities of the Current Situation

Decisions about restructuring and improvements lie squarely in the political arena. Politics determine how need and eligibility is defined, what services are provided and what is deemed adequate (Fine and Graham, 1992). Financial considerations impact on all decisions made and without looking at aged care and disability services holistically one would fail to recognise the systematic structures that influence the current situation. The shift to community care is influenced by the cost implications of institutional care the notion that community care costs significantly less to provide. The matter is further complicated by the fact that the Commonwealth Government is responsible for residential care funding and only shares the responsibility for community care with State and Local Governments. With no one level of Government responsible for community care, the shift to community care has involved a degree of cost shifting to State and Local Governments and creates a complex funding structure (Fine and Graham, 1992). Fine (1999) argues that the fragmented community care system can not be resolved until Governments themselves are more coordinated in their funding and leadership which would in turn provide a more consolidated system.

At a national level funding issues dominate. At the local level providers of community care face allocation dilemmas. With limited resources, service providers are faced with questions about who to help and how much help can be provided. Allocation decisions dictated by financial considerations influence the implementation of strict targeting strategies in the community care sector. Targeting strategies are adopted to assist in assuring that services are provided to those most in need. However, limited resources and targeting strategies are a contributing factor to the increasingly crisis driven response of the majority of community care packages. With limited resources and escalating waiting lists target groups and eligibility criteria are becoming more rigidly defined and packages increasingly cater to a more select high-need group (Fine & Graham, 1993).

Strict eligibility and unmet demand for community care can prompt applicants waiting for the allocation of services to prematurely apply for residential care due to the understanding that the services they need or will shortly need are not readily available. This is supported by Barnett and Schultz's research (1993) that suggests that peace of mind and security in the form of flexible, accessible supports enables people to remain in the community and without this, residential care becomes the more attractive alternative. However, residential care is an expensive alternative and it is essential that Governments recognise the consequences including increased costs in other

funding streams (i.e. Hospitals and residential care) of failing to provide readily available community care.

13. Current Reviews, Recommendations and Ways Forward

In recent years there have been a number of comprehensive reports, which have reviewed community care and concluded that widespread change is urgently required. Despite differences in focus and subsequent recommendations, a recurrent theme in many recent reports has been the restructuring of the sector.

The Municipal Association of Victoria's report 'Targeting Home and Community Care (HACC) Services - Local Impacts: A local Government perspective on Future models of care for high need clients' released in 2002 contained an extensive review of the literature and a survey of a number of ACAS, HACC and CACP providers. The report compared national and overseas strategies and provided Local Government's perspective on recommendations for future models of community care with a particular emphasis on high need service users.

The report highlights the complex nature of the system and the difficulties it poses for clients with complex needs. The authors claim that a major contributing factor in the current confusing situation is the way in which the wide range of packages works in isolation from each other, regardless of overlapping target groups. The report favours the relative simplicity of HACC services and their method of provision, despite limitations in their scope due to funding restrictions. The MAOV (2002) report claims that although HACC services aim to provide low level care, due to limited complex care packages, HACC is forced to cater to high need clients, which in turn puts financial strain on the HACC budget (MAOV, 2002).

The MAOV report proposes an integrated community care system, which would consist of a three-tiered model. The tiered HACC model would comprise 3 levels of HACC: HACC Basic, HACC Plus and HACC Intensive. HACC Basic would continue to provide the current services up to approximately 5 hours per week. The middle tier, HACC Plus, would provide between 5 to 10 hours per week and case management. HACC Intensive would provide 10+ hours a week, and include intensive case management (MAOV, 2002). The proposed model incorporates varying levels of funds to cater for varying levels of need within tiers and advocates for adequate allocation of funds to each tier in order to eliminate the risk of one tier compromising and depleting another. The report also identifies the issue of unmet demand and the need for increased funding in order for an integrated model to be successful in meeting current and projected demand (MAOV, 2002).

MAOV suggests that the separate community care packages are collapsed and all funds are injected into HACC in order to offer continuity of care and flexible service provision. The recommendation of a multi-levelled HACC service would address the complex and fragmented nature of the existing system. It would enable a uniform assessment process and the model would

eliminate the need for clients to be referred to the complex range of packages if their care needs escalate or decrease. The report claims that the proposed model addresses the most urgent issues identified in their research relating to 'access, confusion, adequacy, responsiveness, continuity, quality and the funding of services' (MAOV, 2002: 3).

Since the MAOV report (2002) a number of other documents have been released including a discussion paper prepared by The Victorian Departmental Advisory Committee (DAC, 2003) entitled "Better Targeting for HACC, Linkages and Community Aged Care Packages - some considerations", which with minor adjustments, incorporates a number of the recommendations put forward in the MAOV report.

The revised 3 tiered model proposed by DAC (2003) would also consist of 3 levels in keeping with the MAOV model. However, the tiers would be funded in a slightly different manner: HACC Basic would essentially remain the same and HACC Plus would consist of 3 funding levels priced at the approximate levels of CACPs, Linkages and EACH packages (i.e. \$15,000, \$20,000 and \$30,000). The third tier, HACC Exceptional as opposed to HACC Intensive, would be funded and delivered separately from HACC Basic and HACC Plus. The creation of HACC Exceptional is rationalised as an attempt to ensure that accommodation of clients with complex care needs does not compromise levels of services provided through the first 2 tiers.

The need to increase funding in relation to the increasing cost of providing services, CPI and differing and fluctuating levels of need is an issue that is prominent in both reports. The 3-tiered models proposed by MAOV and DACC do incorporate flexible funding levels for complex care clients although without the political will to increase funding levels the consolidated model would continue to inadequately provide flexible levels of care. Therefore, failing to address inadequate funding levels could compromise the benefits achieved in any restructuring including a consolidated 3-tiered HACC framework.

14. Commonwealth "New Strategy for Community Care"

More recently the Commonwealth Minister for Ageing initiated a review of community care, which prompted the release of the Commonwealth Department of Health and Ageing (CDHA, 2003a) consultation paper named 'A new strategy for Community Care'. The consultation paper was released in March 2003 and has provoked a variety of different responses from key stakeholders.

The Commonwealth 'New Strategy for Community Care' proposes a three-tier model similar to the current structure. However, the "new strategy" is visualised as a tiered system comprising an access, information and support tier, a basic community care tier and a packaged community care tier. The "new strategy" has a particular emphasis on the development of Regional Access Centres, which would provide access, information and support in the form of shopfronts also providing intake and referral for Tier 2 and 3. In addition, Regional Access Centres would maintain regional databases, to enhance coordination and the

sharing of information between care recipients, service providers and governing bodies (CDHA, 2003a: 23). The basic community care and packaged care tiers would remain as entirely separate programs although guided by a new National Framework.

The National Framework would preserve the diversity and breadth of programs with an overarching system, which would facilitate consistency of standards, access, eligibility requirements, user fees and a common information system across services (CDHA, 2003a: 18). Standardised assessment processes would include basic and comprehensive assessments. Basic assessments would be carried out for all people requiring basic services and comprehensive assessments would be completed for clients whose needs are more suited to packaged or residential care based on current ACAS practices. It is reported that the National Framework is to be implemented within existing funding.

The National Framework particularly focuses on administration arrangements, structure, planning processes, funding allocation mechanisms, information management, accountability, quality assurance and the roles and responsibilities of all levels of Government (CDHA, 2003a). The Commonwealth's report claims that the New Strategy would offer a more streamlined community care system with infrastructure addressing the complex nature of access, assessment and inconsistencies across services. The need to improve interfaces between community care and other health and care systems is acknowledged although the Commonwealth prioritises the need to improve the internal workings of the community care system.

15. Critique of the "New Strategy for Community Care"

The Commonwealth Government's (2003a: 3) 'New Strategy for Community Care' sets out a blueprint for a more streamlined and cost-efficient system, which it claims would 'better utilise current resources'. However, it does not appear to incorporate many of the recommendations made by the DAC and MAOV reports. Under the 'new strategy' community care packages would not be collapsed and the existing range of packages would continue within existing funding but under the umbrella of a new National Framework. Inadequate funding is an issue that is prominent in all reviews of community care and failing to address this critical issue could compromise the benefits achieved in any consolidated framework. Current funding is consistently described as inadequate and with the failure of packages to increase in line with escalating costs the ability of packages to provide the level of care they were designed to deliver will continue to be a problem.

It is unclear as to how this "new strategy" within existing funding will improve the complex service system for recipients of community care or address increasing levels of unmet need and anticipated escalation of demand. The Commonwealth's report does not quantify the estimated savings of the National Framework, which would appear to be a major oversight if the proposed restructuring is to foster an optimistic response from service providers (VAHEC, 2003c: 11).

The Commonwealth report claims that the restructuring proposed by the 'new strategy' would achieve standardisation and streamlining of assessment processes and administrative requirements, which is anticipated to redirect more resources into service provision and to reduce the complexity of the system. Although there is support in the sector for the streamlining of administrative requirements across programs without extensive research and feasibility studies it is unclear as to how much these changes will redirect resources to service provision. Again although the standardisation of assessments is welcomed by key stakeholders, without an adequately funded system, assessments, no matter how standardised they are, will continue to be unable to initiate adequate service provision.

The Commonwealth's proposal is extremely broad and it is difficult to envisage what the National Framework will 'look like at the point of service delivery' (VAHEC, 2003c: 5). The Commonwealth acknowledge that for the framework to be successful it will need the cooperation of all parties involved. However, the VAHEC response to the proposal also states that the framework 'has come out of an internal - informal review, not inclusive nor based on any academic research' which raises questions in regard to how this model was conceived and tends to 'breed suspicion rather than a genuine attempt at consultation' (VAHEC, 2003c: 6). Therefore, it is recommended that for the "new strategy" to be successful the Commonwealth must conduct a more comprehensive consultation process.

In the 90s Hokensted and Hohanasson (1990: 225 as cited in Neysmith, 1992: 30) commented that community care was provided so as to ensure that "no family member is forced to substitute informal care for formal care'. This approach is consistent with the current community care system in Australia, as care is provided as a last resort which complements but does not substitute the care provided by informal carers. The inevitable prioritisation of clients dictates that the existence of an informal carer invariably diminishes the need for formal services in the process of assessment. Clients with complex care needs who have no informal carer or exhaust their sources of informal care are often confronted with the realisation that the available formal care is insufficient to meet all their care needs. The consequence of this is an increased number of people who could remain in the community with appropriate supports but who are forced to resort to residential care.

The balancing act between informal and formal care is evident in the EACH program, which claims to provide the equivalent to high-level care and has stated that high-level care *can* be provided in people's home at no extra cost (EACH, 2002). The EACH program is the first Aged Care service that is funded at the equivalent of high-level care subsidy rates (RCS2) and suggests that the Government is genuinely piloting the idea of funding community care at the equivalent of residential care rates. However, it is presently an extremely small program which excludes it as an alternative for the majority of people with high-care needs. Further, 76% of EACH clients reside with family and, therefore the ability to provide the equivalent to high-level care in the community appears to rely heavily on informal care for a significant number of people.

The National Framework appears to be modelled on cost saving and demand management strategies. The Commonwealth National Strategy indicates that Community Care continues to be envisaged primarily as a cost saving strategy and Governments consistently fail to address the level of unmet need and inadequate funding. It is an historical fact that the promotion of community care was influenced by the heavy financial burden and cost implications of residential care although Governments continue to promote the idea that community care is favoured in response to the preferences of care recipients themselves (Neysmith, 1992: 29). Although it is increasingly clear that Community Care is utilised by a much wider group than those at risk of institutional care, with limited and decreasing funding, at best it currently serves to prevent premature admission rather than providing a genuine alternative to residential care (Neysmith, 1992: 30).

16. Conclusion

A review of the literature indicates that the community care system is in a state of crisis and has been for some time. There is widespread agreement that the entire sector is in need of major review and restructuring. Limitations are inherent in the low level of funding allocated to community care as apposed to 'residential care by the Commonwealth and the hospital system by the State' (VAHEC, 2003a). If Governments intend to address the shortfalls of the current community care system increased funding is essential (VAHEC, 2003a). The need for a cost effective, streamlined, well-coordinated and efficient community care service system is also increasingly evident due to the challenges currently involved in providing high quality community care and in the context of our ageing population.

The Commonwealth Government's 'New Strategy' fails to address the multitude of deficiencies identified in the literature. The range of packages which have been created to fill gaps appear to have created the complex and fragmented service system and it is unclear if the 'new strategy' will in fact address this issue. Despite the rhetoric of "streamlining" and "restructuring", the proposed changes are envisaged within existing funding and do not tackle the urgent issue of unmet complex care needs and the inflexibility of the system. The projected financial advantages of the new framework are not quantified and the entire proposal is loosely conceived and non-specific. Despite the potential advantages of standardised assessments and reporting mechanisms, service providers question if this new strategy will be implemented and if so what the actual benefits will be. We are in the midst of an indefinite consultation process and the forthcoming election may also stall the process further.

Community care can prevent premature and inappropriate admissions to residential care. However, a lack of recognition and inadequate funding will continue to limit the potential of community care and to support people with complex care needs to enjoy continued community living (VAHEC, 2003a). True reform of community care will require a holistic view of care, which would include improving the interface between community care and residential care.

Community care is in keeping with Governments' recognition of the economic benefits of keeping people in their homes and until Governments cease to approach community care as a cost saving device, it will fail to provide the alternative to residential care that it has the potential to be.

Key Recommendations:

Recommendation 1: That the funding allocated to Community Care Packages whether operating in isolation or in an integrated model needs to be increased so that the services available do in fact meet their target groups' needs. Funding levels for community care should be determined by demand and in response to need rather than being designed as a cost cutting measure for the residential care sector.

Recommendation 2: Community Care needs to be funded in a more flexible way and provided in response to individual need on a case by case basis rather than as a package model that assumes that recipients can fit into pre-conceived and pre-determined packages.

Recommendation 3: Community Care packages with overlapping target groups need to be merged so that care services for particular target groups are presented in a less complex manner.

Recommendation: 4 The level of funding allocated per package needs to be evaluated as it is evident that current levels of funding have not increased in line with the increased cost of service provision and CPI.

Recommendation 5: That the EACH program be expanded so that a greater number of people with high care needs, who are eligible for residential care, are provided with the genuine option of community care funded at the same subsidy rate as residential care.

Recommendation 6: The individual and social benefits of community care should determine our overarching commitment to community care rather than financial considerations and cost cutting agendas.

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