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**Home Care in Australia:  
Some Lessons for Canada**

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## Home Care in Australia: Some Lessons for Canada

Home care has been defined as “an array of services which enables clients, incapacitated in whole or part, to live at home, often with the effect of preventing, delaying or substitution for long term or acute care alternatives” (Federal/Provincial/Territorial Working Group on Home Care, 1990). Pressure to establish a national home care program in Canada has mounted in the last fifteen years. In 1997, the National Forum on Health (1997) reported and indicated that home care is an important part of the health care system. This theme was repeated during the National Conference on Home Care in March of 1998, where having a national home care program was seen as an important way to rebuild and to modernize the Canadian health care system.<sup>1</sup> In September, 1998 the federal, provincial and territorial health ministers included home care when announcing key health priorities for future collaboration among them. These moves reflected growing public support for the inclusion of home care in Canada’s public health care system (e.g. The Berger Monitor, 1999).

Calls for a national home care system have continued, although progress toward it has been slowed as the larger issue of health system renewal has dominated the policy agenda. Home care is but one aspect of reforming the healthcare system. Several recent reports and commissions have recommended that Canada consider a national home care system (Romanow, 2002; Kirby, 2002). Romanow suggested that a home care program should focus first on three groups: people leaving hospital who need additional care to go home, palliative care patients and patients with mental illness. Pressure to have a national home care system that includes everyone who fits the 1990 definition of a home care recipient has continued to come from seniors’ groups, carers and other stakeholders in the home care system.<sup>2,3</sup> As part of the 2003 First Ministers’ Accord on Health Care Renewal, there was agreement that first dollar coverage would be extended only to short-term acute home care, including acute community mental health and end-of-life care. The Accord calls for Canadians to have access to quality home and community care services and indicates that by 2006, “available services could include nursing/professional services, pharmaceuticals and medical equipment/supplies, support for essential personal care needs, and assessment of client needs and case management.”<sup>4</sup> The federal government also agreed to develop a compassionate care benefit through the Employment Insurance Program and job protection through changes in the Canada Labour Code for people who need to temporarily leave work to be the carer for a gravely ill or dying spouse, parent or child. These latter changes have

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<sup>1</sup> Helen Patriquin of the Nova Scotia Association of Health Organizations authored the executive summary of the proceedings of this conference. It can be found at <http://www.hc-sc.gc.ca/hcf-fass/english/hmcare2.htm>.

<sup>2</sup>This task force was appointed by the government of former Prime Minister, Jean Chrétien but reported to the new Prime Minister, Paul Martin in February of 2004. The Task Force called for all levels of governments to work together to create a national home care program with national standards and advocated that seniors should have the same kinds of services to assist them remain at home as are currently available to veterans

<sup>3</sup> Canada’s Association for the Fifty-Plus, the Canadian Association for Community Care and the Canadian Caregiver Coalition have banded together to form the National Coalition on Home and Community Care.

<sup>4</sup> More information about the 2003 First Ministers Health Accord can be found at <http://www.hc-sc.gc.ca/english/hca2003/accord.html>.

been made federally and provinces have begun to amend their laws to provide for this type of carer support.<sup>5</sup>

At present, the provinces and territories fund most home and community care services; in some areas, municipal governments also fund services (Dumont-Lemasson, Donovan & Wylie, 1999).<sup>6</sup> The program, or lack thereof, has been described as growing by default rather than by design (Parent & Anderson, 2001). The federal funding is indirect, through general transfer payments for health and social services.<sup>7</sup> The types of home care services that are found in the various Canadian provinces, how they are paid for and the way they are organized to deliver home care can be quite different (Health Canada, 1999). Who receives home care, how eligibility is established, the nature of the services offered and extent of the care received may also vary. How funds are allocated to deliver services differs across provinces.

Australia is a country that is similar to Canada in many respects but different in one major respect. It has had a national home care program for almost 20 years. Because it is so similar in other ways, its experience may be instructive to Canadians about creating a national home care program. Like Canada, it has a small population (about 20 million people) that is spread out mainly along the coast (rather than the southern border) of the country, which occupies a large land mass. Much of the land mass is sparsely inhabited. Each country has a similar proportion of the population that is 65 years or more, and has a similar pattern of population ageing resulting from a post World War II baby boon and influx of immigrants. Many Australians live in cities and their suburbs while the remainder are spread out in small towns and villages in rural and remote areas. Australia's government is a parliamentary democracy and the country is divided into states and territories that relate to the federal level of government in a similar way to our provinces and territories, although the Australian federal government shares responsibility for health care with the states.<sup>8</sup> The Australian states and territories vary widely in population and geographic size, similar to the Canadian provinces and territories.<sup>9</sup> The health care systems, while somewhat different, share features in common. Both countries rely on general practitioners for primary medical care delivery, have well-trained specialists to provide secondary and rehabilitative care and an extensive system of publicly-funded hospitals, ranging from small rural hospitals to large tertiary care centres in major urban areas. Its citizens enjoy universal free or nearly free access to primary care medicine and publicly funded hospitals and use of a pharmaceutical benefits program that has helped to keep drug costs down and supplies elderly citizens with drugs at very low, if any costs.

This paper examines the current Australian home and community care system, particularly the Home and Community Care Program (HACC). It briefly traces its development, particularly

<sup>5</sup> Provincial governments have fallen into line and are also changing their labour laws to allow protected time off from work for carers. See <http://www.premier.gov.on.ca/english/news/JobProtected030204.asp>.

<sup>6</sup> A description of provincial and territorial home care programs can be found at [http://www.hc-sc.gc.ca/homecare/english/syn\\_2.html](http://www.hc-sc.gc.ca/homecare/english/syn_2.html)

<sup>7</sup> As of the end of March 2004, a new federal Canada Health Transfer care was agreed between the provinces and federal government. It included money for home care, but did not specifically indicate how much will be spent on home care.

<sup>8</sup> A constitutional amendment in 1946 added complexity to the division of powers between states and the Australian federal government and to their responsibilities for financing, providing and regulating health services. (See Donato & Scotton, 1998 p.35-36). The division of powers is less clear than in Canada.

<sup>9</sup> The words state, province and provincial when used subsequently include territories as well.

since 1985. The system that currently exists is described along with the major issues that it confronts. The changes that have been recently proposed by the Australian government for the system and the reactions of key stakeholder groups to these proposed changes are examined. In doing so, it attempts to develop some lessons for Canada that policy makers and other stakeholders may wish to consider as Canada begins to develop a national home care program.

## **Methods**

The research for this paper was done during a four-month period in early 2004 when the author was a visiting Professor in Australia at La Trobe University in Melbourne, Victoria (VIC) and at the University of Adelaide in South Australia (SA) and a visiting researcher at the Australian Institute for Health and Welfare (AIHW) in Canberra.<sup>10</sup> During her stay, she interviewed key stakeholders in the home and residential care fields, including carers organizations, agencies that deliver services and the organizations that represent them at the state and national levels, health professional organizations and state and federal officials responsible for oversight of the HACC and other related programs. As well, she had numerous informal and formal discussions with Australian academics and other researchers knowledgeable about and working in these fields. They and her own library and internet research pointed her to numerous articles and internet sites that describe the home care system nationally and in the various states.

Altogether, 40 people were formally interviewed, although a small subset of these interviews dealt only with the residential care system. Most interviews tried to establish the nature of the organization that the person represented and the way they tried to feed into and influence the policy shaping and making process regarding home and community care and/or residential care. (Government representatives at the state and federal level were asked their responsibilities and current policy initiatives.) Most interviewees were asked about perceived current strengths and weaknesses of the system and how they expected the system to change in the next two to five years. Whenever possible, the person interviewed was invited by email to review my extensive interview notes and correct any substantive errors I had made. People generally welcomed the opportunity to ensure that the notes were accurate and sometimes they elaborated on points in the notes. They often also supplied more information in the form of background materials, briefing notes, and other internal reports as well as pointing out where to find relevant information using the Internet sites of governments and other groups and in the recent scholarly literature.

## **Australia's national home care system: HACC**

**How did HACC come into being?** Lengthy policy legacies influenced HACC's development; it was created following four major review and inquiries into aged care services. The final and most influential of a series of reports was done by the Australian Government House of Representatives Standing Committee on Expenditure (1982). Both major parties developed a community care policy based on this all-party committee's report in the run up to the 1983 election. The incoming Labour government's policy (seen as left of centre) was far more centralist and reformist than the policies of the outgoing Liberal government (seen as right of centre), who would likely have left more responsibility with the states. (See Howe, 1997; Gibson, 1997 chapter 2 for a more detailed description of the history and early development of

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<sup>10</sup> AIHW is the Australian equivalent of the Canadian Institute for Health Information (CIHI).

the system.) Australia's national home care program, called HACC, was established under the Home and Community Care Act, 1985.<sup>11</sup> The program was formulated as part of a broader Social Justice Strategy of the incoming Labor government that had been elected in 1983. It was part of their attempt to improve equity in the distribution of economic resources, equality of rights, and fair and equal access to essential services and opportunity for participation in society (Australian Government, 1988).

HACC was developed to provide a comprehensive range of services to support frail aged people and people with disabilities in their homes and prevent their premature admission to residential care. It combined home and community care services that had been offered by different programs operating under different legislative and funding mandates into one more comprehensive program. Services funded under four separate previous federal Acts were included: Home Nursing Subsidy Act 1956, States Grants (Paramedical Services) Act of 1969, States Grants (Home Care) Act of 1969 and the Delivered Meals Subsidy Act 1970 and also some separate state programs. Although the funding, planning and administration of HACC are shared responsibilities of the federal and the state governments, neither is involved in much direct service delivery.

Some home care services were already on the ground in each state; but they differed in scope and quality. With the advent of HACC, the range and availability of home-based services were expanded. Traditionally home care services had included home nursing, homemaking and delivery of meals. Expansion occurred of personal care services, respite care (at home and in day centres) and transport. Gardening and home maintenance/ renovation assistance services were developed that previously had not existed in most states and territories (Gibson, 1997). All together, 17 different types of services are funded by HACC including allied health and nursing care, personal care, social support including banking and shopping, domestic assistance, respite care, home maintenance and modification, provision of meals service, centre-based day care, transport and case management and coordination. (See Table 1.)

The program has continued to evolve with time and has worked toward achieving national standards and improved equity in the system. During the 1980s, improving access and quality of care were the major drivers of the expansion of HACC services. More recently, HACC has also been seen as part of Australia's major initiatives in response to population ageing. Australia has been very conscious of the need to plan for an ageing population (e.g. see Bishop, 1999, Andrews, 2002). While the Australian population is relatively young compared to other industrialized nations, it has a comparatively rapid rate of population ageing. In 1992, people aged 80+ comprised 2.3% of the population; this figure has grown to be 3.2 % of the population in 2002. It is projected that its 80 year old and over population will reach 9.4% of the national population by 2051 and that its 65 and over population will be 26.1% of the total population at that point in time (Australian Bureau of Statistics, 2003).

There was an initial commitment to triennial reviews of the HACC program but only one happened, in 1987. However, there have been periodic reviews of HACC and the Aged Care Reform Strategy (e.g. Australian Government, Department of Health, Housing and Community Services, 1991a&b; Howe & Gray, 1999) that have led to refinements in the system. As well,

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<sup>11</sup> A copy of the Act is found at <http://scaleplus.law.gov.au/html/pasteact/1/694/pdf/HomeComCare85.pdf>

both the federal government and the states have grants programs that provide money for program development/improvement, innovation and research regarding HACC.<sup>12</sup>

**How has the HACC agreement changed over time?** The principal HACC agreement, signed in 1985, that specified the funding and administration of the program called for a complex administrative process that was very centralized. Both federal and state governments were involved in line-by-line approval of budgets of all agencies that delivered HACC services. New projects had to receive approval at both levels. This approach proved too cumbersome.

In 1999, the HACC Amending Agreement<sup>13</sup> was signed. It allows the federal government to monitor the extent to which states are delivering the type and volume of services that they have agreed to provide and sets out a new system by which funds are managed and distributed within a state. It formalized the current regional structure of the program and states and regions within them became responsible for planning that takes the specific needs of the local population into account. In keeping with the philosophic stance of the right-of-centre federal government that came into power in 1996, time-limited service contracts were introduced to encourage competition and HACC service provision was opened up to private, for profit providers (previously limited to non profit and government organizations). The Amending Agreement (Australian Government Department of Health and Ageing, 1999b) is also more prescriptive regarding the terms and conditions of service provider contracts, the types of data to be provided in reports, and the need for quality standards. It indicated that a national minimum data set was to be developed and implemented.

**How are funding and allocation of funds done for HACC?** Overall, 60% of HACC funding comes from the federal government while the states and territories contribute 40%(Australian Government Department of Health and Ageing, 2003a). The contributions of states vary as an attempt at equalization of services across states is occurring<sup>14</sup>. SA contributes 38% of the pool of money used for HACC in its state while VIC contributes 43% . However, a leading health economist suggests that when out of pocket expenses of recipients and the monies contributed by local municipalities is considered, the federal contribution is likely about 50% (Duckett, 2004) while the states contribute 30% and the remainder comes from user fees and local governments.

During the first 5 years of HACC, combined federal and state government expenditures increased rapidly (about 20% a year). Expenditures increased from \$192.2 million in 1985-6 to 619.6 million in 1993-4, a 134% increase in constant dollars (Gibson, 1997). By 2002-2003, \$674.1 million were contributed by the federal government while the combined federal, state and territorial contributions to HACC funding was \$1.086 billion. Increases have slowed in more recent years, as the federal government has set expenditure increases, beyond recurring costs, at 6%. In VIC, the money for expansion is 3.7% for the current year, while in SA expansion money is 5.2%. The federal government indicated that it expects to spend \$732 million dollars in the

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<sup>12</sup> For a review of a state run small grants program, see J Prideaux and Associates Pty Ltd & Howe A. (2003) *HACC Service Development Grants: Outcomes and Future Directions*. Melbourne, VIC: Department of Human Services Victoria.

<sup>13</sup> More information about the Amending Agreement can be found at <http://www.ageing.health.gov.au/hacc/amendagree/index.htm>

<sup>14</sup> The Australian Federal Grants Commission sets the amount each state pays using the Horizontal Equalization Formula.

2003-2004, for a total of \$1.2 billion in combined state and federal HACC funds; an 8.6% increase is planned for the following year.<sup>15</sup>

One of the problems that the federal government confronted during the period of rapid expansion of the program was that the states were not always willing to match federal funds (50% of total) at the agreed upon level (50% of funding); but, the federal government did not wish to return potential HACC dollars to the treasury. Thus when Community Options packages were introduced in 1990, for the first four years they were fully funded by the federal government. They then were included in the joint funding arrangement. The inclusion of this subprogram made the dollars contributed by the federal government move to 60% of the total amount from equal funding by federal and state governments. This Community Options (called Linkages in VIC) sub-program provides case-managed services to a group of the HACC target population who have more complex needs and require more services than the average. This initiative started after some residential providers began to innovate and keep people in the community who needed more support than was normally provided but did not want to move into the residential care system (Rungie, 1990).

Allocation of new money, called “growth funds”, is done using population-based planning methods<sup>16</sup> that attempt to assess need rather than demand while recurrent funds are allocated based on previous funding patterns. The provision of recurring funds is indexed, as set out in the HACC Amending Agreement of 1999. However, the indexation used by the state and federal governments may differ. The federal government argues that any wage settlements or other costs that are higher than the indexation factor it uses must be made up in productivity gains. It is not willing to consider distortions in the amount to be paid, caused by local issues. For example, in SA, privatisation and deregulation of electricity created much higher electricity costs for agencies. These increases were not covered by the indexation amount the federal government used. Large increases in nurses’ salaries in VIC have also caused problems. In each case, the state government spent money to defray these costs, outside of their normal share of HACC funding for their state.

**How is stakeholder input obtained?** Both the states and the federal government have advisory committees that provide input regarding the directions that the HACC Program should take. On several committees, HACC is considered within the broader context of aged care (both from the residential and community sector). For example, at the federal level, the Aged Care Advisory Committee advises the Department and Minister about a broad range of aged care issues. There is also a Commonwealth/State Aged Care Officials group that meets several times a year to discuss aged and community care issues that cross state/territory jurisdictions. States also have HACC Advisory Committees that advise their Minister and the federal Minister about program development needs to better meet unmet needs in the community and provide feedback on HACC program performance from their constituency’s perspective. These committees ensure that a wide range of voices is heard and that the stakeholders are aware of the roles of the

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<sup>15</sup> The projected increase includes both a cost of living increase for existing services and money for expansion of services. See <http://www.health.gov.au/budget2003/fact/acfact2.htm>

<sup>16</sup> For an example of the needs based funding formula used, please see Victorian Government Department of Human Service, July 2001.

governments in funding home care. Time limited consultative committees that work on technical issues are also used.

**Who does HACC serve?** National HACC Program Guidelines (Australian Government Department of Health and Ageing, 2002) indicate that the HACC program is designed to assist “(a) the target population comprising persons living in the community who, in the absence of basic maintenance and support services provided or to be provided within the scope of the Program, are at risk of premature or inappropriate long term residential care, including (i) older and frail persons, with moderate, severe or profound disabilities; (ii) younger persons with moderate, severe or profound disabilities and (iii) other such classes of persons as are agreed upon by the Commonwealth Minister and the State Minister; and (b) the carers of persons specified in subclause (a)” (p. 5) Five groups of people who have difficulty accessing services are especially targeted. These include aboriginal Australians, people from culturally and linguistically diverse backgrounds, people with dementia, people who live in rural or remote areas and the financially disadvantaged. HACC was also identified as the program of last resort for people who fall between the cracks of other programs.<sup>17</sup> The scope of the program is to provide basic maintenance and support services that are cost effective and address the needs of the individual to allow them to remain in the community. The guidelines specify that “packages” of service should be tailored to the individual’s needs and may include coordination of services not funded by HACC, such as financial counselling, with HACC services. Provision of basic support and maintenance services to people receiving “no growth” services such as rehabilitation and palliative services is specifically allowed.<sup>18</sup>

During 2002-2003, the Home and Community Care Program estimates that approximately 3,000 organizations provided care to some 275,000 people at any given point in time. About 700,000 people were served by HACC during the year. About 93% of clients were pensioners and 70% were 70 or more years of age. Just over half lived with another family member while 44% lived alone. The majority (60%) resided in cities or near cities (35%) while 2.4% lived in remote areas. The major sources of referral were self (26%), friends and family (16%), hospitals (16%) and community physicians (15%). The services most commonly received by clients were assessment, domestic assistance, nursing care, planning reviews and meals (Australian Government Department of Health and Ageing, 2003b). The HACC minimum data set did not receive data from all agencies so that various sources provide somewhat differing estimates of the people served (AIWH, 2003).<sup>19</sup>

**How much service is available?** The amount of service that HACC clients receive varies considerably and is related to their relative need for care. It can be one-time help with home maintenance or minor renovation to a wide range of services each week; these services can be

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<sup>17</sup> These programs may be targeted at veterans, people with psychiatric problems or rehabilitation needs or people who fall within supposedly “no growth” services within HACC.

<sup>18</sup> When HACC was initially conceived, post-acute services including rehabilitation and palliative services were labelled “no growth” areas. They were allowed to continue to be provided by the program at the level that existed prior to HACC, but no new funding was given to these services as they were seen as a state responsibility as states fund hospitals and these services are extensions of the hospital that allow people to go home earlier.

<sup>19</sup> A report of the latest HACC MDS output is found at <http://www.hacc.health.gov.au/download/files/haccmdsann0203.pdf>

offered with or without a Community Options package.<sup>20</sup> Individual clients served through this sub-program may receive a bit more or less than this as packages are assigned to agencies to manage and tailor to client needs rather than be administered by the client. Agencies broker and case manage the services the client receives. An agency can be creative with packages (e.g. sometimes use funding for four packages to support care for five people). Some ordinary HACC clients receive services that cost much more than an Options package, although this is rare. Although a client may be eligible for HACC services, they may not necessarily receive HACC services. Receipt of services is rationed on the ground by the availability of services; local providers are expected to ration services using need as the major criterion. There is growing concern that the limited resources available to deliver services provided is forcing agencies to mainly serve clients with high dependency needs to the detriment of providing low-level preventive care to people with less severe problems (Catholic Health Australia, 2002).

**What do clients pay?** HACC clients are expected to contribute financially to the care that they receive, if at all possible. However, no client is to be denied a service because of an inability to pay. A consultative process involving provider, consumer and government representatives was used to develop the National Fee Principles. The Home and Community Care Safeguards Policy was started in July of 1999 to promote greater consistency and fairness in the manner that HACC Program clients contribute to the cost of their care.<sup>21</sup> Clients are asked to complete a form that is a self-assessment of their income (HACC Income Assessment Form). The Agency then uses this information to set fees consistent with its fee schedule. Agencies have some discretion in the fees they establish provided the fee varies with client income. A client cannot be charged more than a set amount per week regardless of the number of services they receive. Clients who have difficulty paying their assessed fee may have their fee reduced consistent with Fee Reduction arrangements.

Although there are federal guidelines regarding when and how much a client should contribute to the cost of the care provided, these guidelines can be interpreted quite differently across agencies delivering home care services. According to many of the stakeholders interviewed, the fees set for clients can vary significantly across agencies for the same services.<sup>22</sup> Fees are also somewhat different from state to state (Australian Government Department of Health and Ageing, 2003c). The agencies that collect the fees are told that they should reinvest this money to provide more services for clients, but the extent of reinvestment is not monitored.

**How are HACC services delivered?** Differences exist by geography and state in the way HACC services are delivered. In rural and remote areas, the HACC provider is often stationed at the regional Multi-Purpose Services program<sup>23</sup> and may be a multi-skilled nurse or allied health

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<sup>20</sup> In 2003, Options packages were worth about \$11,300 in services and case management assistance to a client.

<sup>21</sup> Please see this website for a description of this initiative: <http://www.health.wa.gov.au/hacc/HACC-Safeguards%20Intro.html>

<sup>22</sup> States have tried to reduce discrepancies by developing fees policies. For example, see [http://www.health.vic.gov.au/agedcare/hacc/documents/hacc\\_fees\\_policy\\_july03.pdf](http://www.health.vic.gov.au/agedcare/hacc/documents/hacc_fees_policy_july03.pdf).

<sup>23</sup> These units usually provide a range of health and community care services and may include some residential care places. Some were previously small hospitals that have been closed. There are now more than 80 of these units in rural and remote communities across Australia. <http://www.health.gov.au/pubs/annrep/ar2003/2/5/1-1.htm> An evaluation of the Victorian Multi-Purpose Services (Sach and Associates, 2000) can be found at <http://www.health.vic.gov.au/agedcare/hacc/multi.htm>

professional who works for this not-for-profit or government organization that likely also provides all of the other services available. In the cities of VIC and SA, the Royal District Nursing Service provides home nursing care while a country nursing service, often associated with Multiple- Purpose Services or a rural hospital, provides care in rural regions. In VIC, local government councils deliver the majority of the other home care services. They are seen as having a strong, direct relationship with their communities. However, adjacent councils may value different services differently so the extent of availability of different service types can vary. Some councils use waiting lists while others do not as managing the waiting list is also expensive. Within one HACC planning region, more than 75 providers, including many small associations and agencies, may receive HACC funding. However, a few large agencies receive most of the funding.<sup>24</sup> In SA, Domiciliary Care, an agency of the state government, provides the bulk of non-nursing home care services. A great diversity of non-profit providers delivers services for particularly sub-groups in the population (culturally and linguistically different from the mainstream population). Within a suburban community, there are likely to be 10-12 HACC providers who may offer a single service or a range of services.

State governments work directly with agencies, particularly with small agencies, to build capacity. They may also provide money to smaller groups (which usually serve a particular group or single service) to partner with larger agencies so that the particular skills and knowledge needed to work effectively with that sub-group are transmitted more widely and the smaller group can benefit from the more sophisticated infrastructure of the larger organization. This association can help build capacity in the smaller organization; it can help them develop good governance structures and procedures that allow them to meet regulations, manage budgets and consistently deliver high quality care.

Mergers of agencies are beginning to happen and attempts are occurring to develop agencies that have broad capabilities, are flexible and are more efficient by joining with others to create economies of scale. Several of the larger players in the home care field, (e.g. Royal District Nursing Service (RDNS) and Carers' Association in Victoria, RNDS and Metro Domiciliary Care in South Australia) have begun to develop strategic alliances and affiliation agreements. These alliances allow the groups involved to retain their own Boards while creating efficiencies by sharing many aspects of their operations (telephone intake, volunteers, continuing education). Some affiliation agreements indicate that they will use resources and systems more efficiently by adopting common arrangement wherever possible, share research and systems development and co-locate their premises where operationally feasible. They are signed off at the Board level and are binding on the organizations involved. Only governance and Boards remain separate.

Despite deliberately opening HACC to the private sector, relatively little private competition has entered the field. Some stakeholders thought that is was because there is not much money to be made in home care. Also, some states have used commercial tendering only for services to the Department rather than the community. They have tried to consolidate and build more services using current providers to grow larger home care organizations that are managed efficiently and can benefit from economies of scale. Thus, they have continued to do direct allocation, especially when the service provider is delivering high quality care. When issues of performance

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<sup>24</sup> To promote consistency across agencies, states have developed HACC program manuals. See <http://www.health.vic.gov.au/agedcare/hacc/documents/progmanual.pdf> for an example.

or accountability exist, competitive processes are seen as appropriate. At present, some of the smaller non-government organizations are inefficient. Having private providers in the system sometimes demonstrates to these groups that their services can be delivered profitably at a cost-effective price.

**How do planning and accountability occur in the HACC program?** The Amending Agreement of 1999 and the HACC National Program Guidelines<sup>25</sup> reflect the continuing attempts to make the program more responsive to consumer needs and provider concerns and describe the current arrangements between the federal government and the states. They set out the responsibilities of each towards the overall program, service planning and how program reporting and accountability occur. The way these arrangements currently operate is described below along with some observations of stakeholders about them.

HACC Planning Regions<sup>26</sup> were formalized in the 1999 Amending Agreement so that planning can take into account the unique features of the population to be served in each region of the country and include consultation with key stakeholders in the region/state. Australian Bureau of Statistics' Statistical Local Areas form the building blocks of regions, allowing census information to be used for planning purposes. Boundaries for HACC regions can be redrawn with the consent of both the federal and state government.

Planning occurs at both the regional level and state level and results in a state plan using a three-year planning cycle. State Program Plans<sup>27</sup> are developed that describe overall services planned across HACC regions in each service category and are submitted for approval by the federal and state government. These individual State Program Plans are rolled up into the National Triennial Plan that sets out the agreed upon priorities for the HACC Program over a three-year period and how much funding the federal and state governments will provide over a three-year period.

The federal government subsequently examines whether the states have met their targets regarding the volume of services that they planned to deliver of each type in their HACC planning regions. Each state develops a year-end business report that reconciles the Plan with the services that were actually delivered. A 10 percent margin of over or under delivery is tolerated without the need for explanation. Greater discrepancies and failure to meet targets to grow services have caused delays in signing off on the State Program Plan for the subsequent year. Accountability to the federal government regarding how the money is spent is maintained while the states have the prerogative to approve individual projects and new initiatives.

Currently, all regions have a 2003/4 to 2005/6 plan that they update each year. By establishing targets for service provision in each of the HACC regions and three-year plans with the states and territories, the program aims to achieve equity in provision of services across the country by

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<sup>25</sup> These guidelines were approved in 2002 and replaced guidelines that had last been revised in 1989. A copy of the current guidelines can be found at <http://www.hacc.health.gov.au/download/files/npg.pdf>.

<sup>26</sup> For a description of the HACC planning regions and maps of the regions, see <http://www.hacc.health.gov.au/download/maps.htm>

<sup>27</sup> For a description of the current plans for the HACC regions in Victoria and the overall plan for this state: <http://www.ageing.health.gov.au/hacc/annualplans/index.htm>

2011. SA has four HACC regions and a population of 1.5 million.<sup>28</sup> VIC, which has a far larger population (nearly 5 million) but smaller geographic area, is divided into nine HACC planning regions. In VIC, the allocations to regions are made using a relative resource equity formula that tries to capture major need variables (Victorian Government Department of Human Services, 2001 & 2003).<sup>29</sup>

**How does monitoring occur in the HACC Program?** *HACC Service Standards.* The National Service Standards for the HACC program<sup>30</sup>, first developed in 1991, now include an instrument to evaluate whether those service standards are being met (HACC, 1991; Australian Government Department of Health and Ageing 2003a). The standards were developed by a working group whose membership includes representatives from each state and territory and the federal government. The research that developed the instrument used to monitor quality of care using the HACC Service Standards was done by AIHW before it was implemented. (See Jenkins, Butkus and Gibson, 1998 for a description of instrument development.) The standards cover the seven major objectives for HACC programs: to provide access to services; information and consultation; efficient and effective management; coordinated, planned and reliable service delivery; protect privacy, confidentiality and access to personal information; have mechanisms to handle complaints and disputes and do client advocacy. These objectives are described in 27 service standards that can be assessed by answering 29 questions that ask you to evaluate the agency's performance.<sup>31</sup> A three level rating is used (met, partially met and not met.)

A Consumer Survey Instrument (CSI) as been developed to get consumer input (Australian Government Department of Health and Ageing, 2003a). Developed by Jenkins and Gibson (2000), it obtains client feedback that mirrors the performance standards on which the agencies are asked to evaluate themselves and report.<sup>32</sup> Agencies are asked to have their clients (or a random sample of clients) fill out this survey before they complete the National Service Standards Instrument.

Agencies are expected to complete the National Service Standards Instrument yearly as part of their continuous quality improvement activities and send it to the department within their state government that manages the HACC program. The states also employ independent assessors to carry out agency reviews against these standards.<sup>33</sup> When the program is fully operational,

<sup>28</sup> The HACC funding priorities of South Australia can be found at <http://www.dhs.sa.gov.au/documents/hacc/2003/funding%20priorities%202003-04.doc> (accessed March 30, 2004).

<sup>29</sup> An example of how HACC funds are allocated within a state and the budgets of HACC regions can be found at <http://www.health.vic.gov.au/agedcare/hacc/growth2003-2004/index.htm#hacc> (accessed March 30, 2004) This site includes access to the current needs-based formula used to allocate funds to regions. See document "Better Planning and Funds Allocation for the HACC Program in Victoria".

<sup>30</sup> The first reporting of agencies against these National Standards is planned for mid-2004. States have been working with agencies on training and will also send in independent inspectors to confirm the self-assessments done. For further information about the National Service Standards see <http://www.ageing.health.gov.au/hacc/nssi/index.htm>

<sup>31</sup> A description of the instrument and instructions on how to complete it are found at <http://www.ageing.health.gov.au/hacc/download/haccguide.htm>

<sup>32</sup> The several versions of the consumer survey instrument and how to use it are found at <http://www.ageing.health.gov.au/hacc/download/files/caiguideonuse.pdf>

<sup>33</sup> See [http://www.health.vic.gov.au/agedcare/hacc/projects\\_in\\_hacc\\_program\\_200203.pdf](http://www.health.vic.gov.au/agedcare/hacc/projects_in_hacc_program_200203.pdf) for a description implementation plans for National Service Standards in Victoria.

expected by mid-2004, states will then aggregate these results and report them to the federal government when reporting on the State Plan.

*The HACC Minimum Data Set.* The HACC national minimum data set (MDS) was developed by the AIHW at the request of the HACC Officials Standards Working Group, to describe the population served (both care recipients and their carers) and the services received by these clients and to feed information into the planning process (Australian Government Department of Health and Ageing, 2003b). It was implemented in July of 2000. Information about how to complete the MDS is found at the HACC federal website<sup>34</sup> All individual service contacts are recorded except anonymous inquiries and group sessions, where number of sessions is recorded. The information is collected on an ongoing basis and summed for an individual by quarter and then submitted electronically to the national data repository four times a year.<sup>35</sup>

Some issues have been raised in the early stages of using the MDS. Agencies report this system is difficult to manage as they may also be seeing clients who are not supported with HACC funds but are funded from other state or federal initiatives that have differing reporting requirements. Some of the clients' services may be paid for by these other programs and some by HACC. An alphanumeric code is used to track clients across time within the system but record linkage difficulties have occurred, particularly if the client was seen by several agencies as they may vary in the way the code is completed. Also, there has been difficulty with reporting from some smaller agencies. Counts of services provided are more accurate than count of individuals using services or the number of different services that an individual has received. The states note that some MDS fields have not been completed well, particularly describing ethnicity and living arrangements of clients and there can be considerable missing information from some small agencies that tend to use paper reporting and have someone enter their paper files. Changes in the data dictionary have also led to some inaccuracies in the data as it takes a while for all agencies to report consistently after a change. The providers feel that they are not receiving adequate feedback about the information that they have contributed.

Considerable help is available to complete the MDS, both through resources on the Internet and through a Helpdesk run federally and at the state level, to improve the quality of data collection. The states and the federal government use these data to help plan services. They realize that it will take time to achieve the level of data quality that they seek. The Lincoln Centre for Ageing and Community Care Research (2003) at LaTrobe University recently completed a review of problems with the MDS that made recommendation about how the MDS and the data collection process can be improved.<sup>36</sup>

One of the criticisms of the current HACC MDS is that it does not provide information about client disabilities and the needs of the clients and carers. The federal government funded a research program to develop a measure of functional dependency for the HACC program. This screening questionnaire provides basic information needed to triage the person into the appropriate assessment and care provision (Eagar, Owen, Green, Cromwell, Poulos, et al., 2002)

<sup>34</sup> See <http://www.hacc.health.gov.au/mds/index.htm> for more information about the MDS, including technical information about completing forms.

<sup>35</sup> The most recent report describing information gained through the MDS is found at <http://www.hacc.health.gov.au/download/files/haccmdsann0203.pdf>

<sup>36</sup> See <http://www.latrobe.edu.au/aipc/projects.htm#LGC>

and is used by many agencies as a screening tool although it has yet to become standard practice.<sup>37</sup> The lead service provider does a more in-depth assessment of particular needs of the client as part of service planning.

National outcome indicators have been set for the HACC program. They include appropriate, high quality, effective care; use of services by special needs groups (in proportion to their distribution in the underlying population); use of service by those in greatest need, the range and level of service provision (against agreed upon targets), and efficiency and effectiveness of program management. The MDS, CSI and the National Service Standards along with the reconciled Plans of the states are to be used to measure these outcomes of the HACC program. However, the MDS and National Service Standard results are not linked together.

### **Initiatives Outside of HACC that have Broadened and Complicated Home and Community Care.**

Over the years, initiatives aimed at helping keep people at home have proliferated at the state and federal level. The reasons for this proliferation are several. A major reason was the inability of the state and federal governments to reach agreement on putting more money into HACC as their priorities (and often ideologies) differed. Lobby groups also played a role; both state and the federal government began programs to appeal to specific lobbies. Underspending in the federal program that provides residential care for seniors led to some of the biggest initiatives, as federal politicians and bureaucrats saw an opportunity to use these funds in other ways rather than return them to the treasury.

The federal government's Department of Health and Ageing currently funds 17 different community care programs aimed at enabling the frail elderly and disabled people to remain at home. (See Table 2.) Each of the states also has developed additional programs that target the same general group. A description of the major federal programs that are related to home and community care are provided below along with some assessment from stakeholders.

**Community Aged Care Packages (CACPs).** By far the largest influx of money into home care has come through CACPs<sup>38</sup> that were introduced in 1992 as a way of encouraging residential care agencies (and others) to offer home-delivered support to people who were otherwise eligible for admission to Commonwealth-funded hostels (Mathur, Evans and Gibson, 1997; Gibson & Mathur, 1999). Hostels are residential care facilities that offer low-level residential care, mainly personal care, social support and hotel functions, to the elderly. Hostels were merged with nursing homes under the 1997 Aged Care Act<sup>39</sup> to form a continuum of residential aged care and promote ageing in place; the old terminology continues to be used. A shortfall in hostel

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<sup>37</sup> Many agencies use this instrument or a local adaptation of it although it has not been formally adopted for use by HACC agencies.

<sup>38</sup> A "package" refers to dollars set aside to purchase services to support a person in their home using a case manager. Each person has a "package" of services but the mix of services provided is individualized and designed to meet the needs of the individual. A current description of community care packages is found at <http://www.ageing.health.gov.au/commcare/cacp.htm>

<sup>39</sup> The 1997 Aged Care Act, the legislation that also governs residential care facilities for the aged, governs all CACPs, Extended Aged Care at Home packages and Aged Care Assessment Teams. A copy of the Act is found at <http://www.health.gov.au/acc/legislat/aca1997/acaindex.htm>

development that emerged in the early 1990s triggered CACP development. The Midterm Review of 1990-1991 (Australian Government Department of Health, Housing and Community Services, 1991a and b) recommended CACPs receive the equivalent funding to what would have gone into hostels.

CACPs are replacements for residential care and have been used to strengthen community-based alternatives to residential care by shifting dollars from the residential care sector into the community care sector. Their development followed a period of experimentation to show that many people could be diverted from admission to hostels if they had some more support at home (McVicar and Reynolds, 1992). Currently about 90% of CACP providers are non-profit organisations while 10% are for profit. There is means testing for aged pensioners, the cost cannot be more than 17.5% of their pension while for those with higher income it may be up to 50% of earned income. A user fee is charged.<sup>40</sup> Housing-linked CACPs are targeted at people with financial hardships.

A description of the clients served by CACPs and the types of service they receive is provided in a census of everyone in the program during a week in 2002 (AIHW, 2004a). The average age of a CACP recipient was 80; 18% were assessed as having a mild dementia and 57% had a carer although 61% lived alone. Mobility and self-care were the two areas that were most often severely or profoundly impaired. They received varying levels of service: 8% received less than 2 hours of care, 70% received between 2-8 hours of care and 10% received more than 10 hours of care during the week. Interestingly, about 19% also received some assistance from the HACC program, 4% received assistance from Veteran's Affairs and 3% from Day Therapy Centres (described below).

The federal government uses a formula to allocate residential care beds of 100 residential care beds per 1000 population aged 70 and more. Since CACPs were created using funds originally allocated to the residential care system, they have the effect of decreasing the proportion of residential care beds over time per 1000 over 70. Since 1992, an increasing number of 'residential care beds' (now about 14 per 1000 people 70 or more years of age) have been set aside to become CACPs. CACPs have been released at a higher rate than new residential care beds (Gray, 2001). As of June 2003, 27,996 CACPs were available in the country. The federal government spent some \$287.9 million in 2002-03 on this program. This was an eightfold increase since 1995-96. (Australian Government Department of Health and Ageing, 2003d p.116.)

**Extended Aged Care at Home (EACH) packages.** The Australian government also introduced EACH packages in 2002 after a pilot program (1998-2001) showed that it was feasible and cost-effective to provide high level nursing home care to some people in their own homes (Siggins Miller Consultants, 2001). Technological improvements allow people who would previously have required fairly high level nursing home care to remain at home rather than be placed in a nursing home, particularly people who have a 24-hour-a-day carer at home. An increasing number of new EACH packages is offered each year.<sup>41</sup> In 2002-3, 160 new packages were

<sup>40</sup> In 2004 it was \$5.45 a day for a pensioner and higher for people with higher income.

<sup>41</sup> More detailed information about this program can be found by accessing <http://www.ageing.health.gov.au/commcare/comcprov/eachdex.htm>.

offered while in 2003-4 550 more packages were released. A total of 1000 packages was available nationally at the end of 2003. EACH packages are to reach a maximum of 5 per 1000 aged 70+; again, this money is set aside from the residential care sector budget and is usually given to providers of residential aged care to administer.

EACH clients usually have major impairments. According to the one-month census of EACH package recipients done in 2002 by AIHW (2004b)<sup>42</sup>, just over one third of the care recipients were age 85 or older. Almost a third of the EACH recipients had a dementia diagnosis. They were reported to need more assistance with activities of daily living, particularly those without a carer (26.0 hours). A small number without carers required very high service levels (over 40 hours a week). When a carer was present, demented clients received similar service hours (17.3 hours a week) to non-demented clients, 17.7 hours. Over 75% of EACH recipients lived with other family members. Over 98% needed assistance with bathing and dressing. More than 85% had mobility problems and most needed help with toileting and getting in and out of a chair or bed. Personal care, nursing care and domestic assistance were the major areas of assistance, required by more than 85%. Almost 40% used some respite in home. Some of these clients also received services through the HACC program and other assistance providers.

**The Aged Care Assessment Program (ACAP).** ACAP is funded by the federal government but managed and administered through the states.<sup>43,44</sup> To be eligible for CACP or an EACH package, the person must be assessed by an Aged Care Assessment Team (ACAT) that recommends whether they are eligible for a residential care facility or its alternative. (Australian Government Department of Health and Ageing, 1999b). If deemed eligible for a package, and if the elderly person and their carer are interested and there are packages available in that region, the person may remain at home and receive home care services under these programs. Eligibility does not entitle a person to a package. The availability of packages in the area, which are rationed by the federal government, affects entitlement.

ACAT teams assess about 200,000 people per year. About half of these assessments are reassessments since to be considered for increased funding at a residential care facility that moves your dependency-related care needs into the higher range, a reassessment is required. Of those initially assessed, about half are recommended for community care. Of these, stakeholders estimated that 60% are not getting enough community care to stay safely in the community. One third of the recommendations are for high level (EACH) packages but these are not available in the numbers needed to support the work of ACATs. The ACAT program has a built in, ongoing monitoring and evaluation component that provides feedback to ACATs.

**The Aged Care Planning Advisory Committees.** The Aged Care Planning Advisory Committee in each state, that includes state and local government representatives along with some consumer and community representative, advises the Department of Health and Ageing on the distribution of high and low residential care places, and CACP and EACH packages. This

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<sup>42</sup> This document can also be found on the web at <http://www.aihw.gov.au/publications/index.cfm?type=detail&id=9852>

<sup>43</sup> These teams were initially established to decide whether or not a person was eligible for a residential aged care bed. The operational guidelines for this program are found at <http://www.ageing.health.gov.au/publicat/opguides/acapog3.htm>

<sup>44</sup> The minimum data set associated with this program is found at <http://www.health.gov.au/acc/reports/acapmds.htm>

committee is a formal part of the 1997 Aged Care Act. The Minister of Health and Ageing sets the overall allocation for the country, in the context of the federal budget (Australian Government Department of Health and Ageing, 2003a).

**Stakeholders' Concerns about the CACPs, EACH and ACATs.** Because CACP and EACH are funded through the residential care system, HACC funded agencies may not be aware of who holds these packages.<sup>45</sup> Up to 20 different providers may have some CACP or EACH packages in a given HACC region. Further, the packages provided may be targeted at a specific kind of care recipient (housing-linked, dementia, veterans, aboriginal, people from culturally and linguistically diverse backgrounds) rather than be a general package. People do not know how many packages are available or who holds available packages. The packages are allocated on the basis of the proportion of the population that is 70+. Yet, since the average age of package holders is often above 80, some regions with a younger group of people 70+ may be getting too many packages while others are getting too few.

In some areas, people who have been receiving high levels of HACC services refuse a CACP when offered. Refusal occurs because under CACP, these individuals would need to pay for some services that they value (e.g. attending a day centre several days a week) and received free under HACC. In other cases, people could be moved from HACC funding to CACPs except that they require very limited nursing involvement, not covered under CACPs. Another criticism of CACPs is that they become inadequate to meet the needs of the elderly as they continue to age. There is too large a gap between the level of service that CACPs cover and the services provided by EACH, which includes nursing. Thus, CACPs only delay entering a nursing home for a short while.

There are some tensions about the appropriateness, timeliness and performance of ACATs currently. Waiting time has been an issue. There are also some acknowledged inconsistencies in the recommendations of ACATs. This is complicated by the fact that some people are maintained within the current HACC program on packages of care that are more generous than CACPs but have never had an assessment by an ACAT.

**Day Therapy Centres (DTCs).** DTCs<sup>46</sup>, funded by the federal government to subsidize a range of therapies for frail elderly people living in the community and residents of low-level residential aged care, are found scattered around the country. Therapy including podiatry, physiotherapy, occupational therapy, and speech therapy is offered to individuals and groups to assist them to either maintain or recover function. Transport and food, and in some cases, social work, are also provided. The centres predated the development of HACC and were functionally tied to nursing homes until 1988. In 2002, when a census was done of DTCs, there were 160 facilities funded at an annual cost of \$31million (AIHW, 2004c). Most DTC care recipients lived in the community with less than 20% coming from residential care. Most of the care received was provided at the DTC while 8% was provided in the recipients' home. However,

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<sup>45</sup> Stakeholders suggest that these arrangements were made so as to not offend large providers of residential care who would be seen to lose money if money initially targeted to residential care was moved to HACC providers.

<sup>46</sup> See the following web sites for more information about Day Therapy Centres: <http://www.ageing.health.gov.au/commcare/dayther.htm>. This website provides the report of the census done in 2002: <http://www.aihw.gov.au/publications/age/dtcc02/dtcc02.pdf>

several of the states also run parallel day programs that provide many of the same types of services.

**Services for Carers.** In each state, there is a Commonwealth Carer Resource Centre<sup>47</sup> that is housed with the state Carers' Association (a non-profit organization representing Carers that is subsidized by federal and state funding). The federal government has also sponsored a National Respite for Carers program to support carers. This program, run through 63 Commonwealth Carer Respite Centres (CCRCs) facilitates access to information, respite care and other support assistance, including counselling. It targets the carers of people who are living at home with dementia and/or challenging behaviour, people who need palliative care, frail older people, and younger people with moderate, severe or profound disabilities. It is hoped that by providing more support, carers can continue to care for people in the community and thus delay or avoid admission to more costly residential aged care homes. Federal funding for 2002-3 was \$92.2 million (Australian Government Department of Health and Ageing, 2003d).

VIC has a parallel carers' program that is funded by the state.<sup>48</sup> It provides a range of respite supports that include overnight, in-house and flexible community-based supports. Both programs are housed with the same agency (Carers' Association) that has to decide which pot of money it will spend on a given client, as there are slightly different rules. The federal Department of Family and Community Services also provides funds to CCRCs for carers of young people (i.e. less than 30 years of age) with severe or profound disabilities. These programs are run in conjunction with state programs of Carer support in both SA and Victoria.

**Other Programs funded by the federal Department of Health and Ageing.** The federal government has also established Commonwealth Carelink Centres<sup>49</sup> across Australia in 2001 to provide a 1-800 type telephone service and about 65 shopfronts to provide information about aged care and disability services and how to contact them. Carers and other members of the public can access these Centres for information. Most stakeholders described this initiative as a policy failure. Few people access the Carelink Centres because they provide information without having a good understanding of the needs of the clients and without facilitating referrals to the services appropriate to the needs of the client. The Centres receive only 11 calls per day on average.

The federal government has developed specific services for people with dementia and their carers. These include a National Dementia Behaviour Advisory Service for carers and respite care staff that can be accessed through a Dementia Helpline. This service is run through the Alzheimer's Association<sup>50</sup>. Training and education for carers and paid workers is provided through the Carer Education and Workplace Training Project. They have also invested in Psychogeriatric Care Units, normally attached to large public hospitals. These units are currently being reviewed with a view toward possible expansion to have national coverage in place in a

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<sup>47</sup> For more information about Carers' Resource Centres and the National Respite Program, please see <http://www.ageing.health.gov.au/carers/resocent.htm>

<sup>48</sup> (This is an example of successful lobbying at both the state and federal levels.)

<sup>49</sup> Information about Carelink Centres and there locations is found at <http://www.commcarelink.health.gov.au/aboutus.htm>

<sup>50</sup> Information about the dementia advisory service is found on the Alzheimer's Association's website. <http://www.alzheimers.org.au/>

few years (Australian Government Department of Health and Ageing, 2003a). They provide specialist clinical services as well as assisting carers and staff of residential facilities with approaches to dealing with demented people who exhibit difficult behaviour.

A National Continence Management Strategy<sup>51</sup> (NCMS) was funded for \$31 million over seven years (to 2005) to improve continence treatment and management, which also intersects with the group needing home care. There is a national Continence Helpline as well as Aids Assistance Scheme Helpline. NCMS has funded some research and public awareness campaigns. One of its most popular products is a map of the locations of public toilets in major cities.

A small innovative program, called Assistance with Care and Housing for the Aged (ACHA), connects vulnerable older people who live in insecure housing or on the street to public housing and home care, using housing-link CACPs. These projects, generally small, are found in the inner cities where there is a concentration of frail elderly who have insecure accommodations or may be homeless. The program, begun as an experiment, was evaluated as cost-effective (reducing the risk of prematurely institutionalizing a person when they can live in the community with less care and resources needed than residential aged care). The age used for entry into this program is sometimes lower than 65. Many of these people have had mental health and addictive problems. The housing used is supplied by a non-profit or public source.

**Programs funded by other federal departments.** Since 2001, Veterans' Affairs has run a parallel home care system for veterans<sup>52</sup>, although they may also receive some services through HACC as the Department of Veterans' affairs often employ the same agencies as HACC uses. (See Australian Government, Department of Veterans' Affairs, 2004). Similarly, there is a Commonwealth States & Territories Disability Agreement for the disabled.<sup>53</sup> It is to provide a range of services needed by young disabled people that are not provided under HACC. However, the disability program, in particular, is seen as relatively under funded and this has led greater use of HACC services by this group.

**Impact of these additional programs.** Although many of these programs, particularly those funded fully by the federal Department of Health and Ageing, were suggested as possible developments within the HACC program in the 1990-91 Midterm Review, because of disagreements among governments regarding what/how to expand first, the opportunity to fund some initiatives from residential care program funding and lobbying by some groups, they have grown separate from the HACC program, although providers overlap. For their part, the states have also developed more programs to support people to live at home. Unfortunately, these programs differ from state to state, so the whole idea of a national home care system with equity across the country is fraying at the edges.

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<sup>51</sup>For more information about this program see <http://www.incontinence.health.gov.au/ncms/index.htm>

<sup>52</sup> For more information about this program please see <http://www.dva.gov.au/health/homecare/mainvhc.htm>

<sup>53</sup>A copy of the current agreement, which will expire in 2007, is found at <http://www.facs.gov.au/internet/facsinternet.nsf/aboutfacs/programs/disability-csda.htm>

It is difficult for the average person to navigate this splintered system<sup>54</sup>. Within the HACC system, there are no central access points, although several large providers who deliver a range of services and may have some packages provide most care in a region. Smaller agencies often provide quite limited services, but cater to the needs of specific cultural groups (e.g. provide meals for a particular ethnic group) An enterprising client can end up with services from several programs and have two case managers from different agencies. Currently, rationing in the system is seen as opaque, inconsistent and unfair as it is left to providers to ration the money they are given.

## **Current Review of Community Care and Stakeholders' opinions regarding proposed changes.**

**Review of Community Care.** Most recently, the federal government prepared a Community Care Review consultation paper to which states and other stakeholders in the system were given an opportunity to respond. A New Strategy for Community Care Consultation Paper, released by the federal Department of Health and Ageing in March of 2003<sup>55</sup>, proposes to bring together all current programs, regardless of how they are funded and administered. The major changes proposed include common access points to the system, common eligibility requirements, common standards of service provision, common user fees, common accountability processes and a shared common information system across all similar programs (Australian Government Department of Health and Ageing, 2003e). In effect these reforms attempt to reunite a home and community care system that has grown increasingly splintered over time. (Please see Table 3 for a summary of the proposed changes.)

However, none of the changes proposed have yet been adopted, in this, a federal election year. The states are seen as "on side" to make changes although there is some concern about details at the state level. (See below.) Partially, the slow down in announcing and implementing changes is due to the fact that the changes proposed cut across the jurisdictions of two other federal departments (Veterans' Affairs and Family and Community Services). This complication has required that the full federal cabinet be involved in agreeing to the changes that will be proposed by the federal government. Stakeholders also note that until decisions are made about the financing of residential aged care system<sup>56</sup> that costs much more than home and community care system, the proposed changes in the home and community care will remain on the back burner.

**Stakeholders' views.** Despite the current delays in announcing new policy, the general shape and direction of the review and the concerns of stakeholders are quite clear. The system needs to be more flexible, with fewer separate programs that have their own rules for access to service

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<sup>54</sup> The major reasons cited for the splintered system were disagreements between the major political parties on priorities, conflict between state and federal governments and concerns about cost-shifting, and inter-professional rivalries.

<sup>55</sup> The consultation paper was released on the federal Department of Health and Ageing's website (<http://www.ageing.health.gov.au/research/consapcomm.pdf>) and feedback was requested from all stakeholder groups.

<sup>56</sup> This review was aimed at developing new strategies for funding the residential aged care system, particularly it is to recommend how capital costs can better be dealt with. It was released in May, 2004.  
<http://www.ageing.health.gov.au/rescare/acprtask/acprkeyp.htm>

delivery and that charge differing amounts of co-payment. It has to be less confusing to the potential user. However, stakeholders also have some concerns.<sup>57</sup> (See Table 3 and below.)

*Tiers of service.* Stakeholders generally support the development of service provision categories or tiers (e.g. from single service or one shot services to case-managed complex care) with clearly defined resources allocated to each. There is agreement that there should be tiers of service provision with dollars assigned to each band rather than fixed dollars for packages and no limits on non-packaged care. Most stakeholders think that at least three tiers of service provision are needed that approximate the tiers the Howe and Gray (1999) initially suggested.<sup>58,59</sup> These tiers differ substantially from the three tiers proposed by the federal government that suggests an access and information tier, a basic community care service tier and a packaged community services tier. Some stakeholders question whether an access and information tier proposed is really at the lowest level of service delivery or cuts across all tiers. They suggest that a suite of information, education and support services is needed that people can call whether or not they are already receiving services and whatever the intensity of current service provision.

Exactly where one tier should start and another end and the proportion of total dollars that should be allocated to each tier are contentious issues. Here, most argue that dedicated money must be available to protect low level, basic services that provide secondary prevention, or there is a risk that all dollars will be spent on higher-level care. They are unsure of the rules that should move people across these tiers as the federal government suggests there will be uniform rules but does not provide details.

Many of the stakeholders interviewed felt that a closer look was needed at the options available to provide services to very high cost clients, who often were young disabled individuals. The current models of service delivery are seen as unsustainable for this group that is eating up more and more of the HACC budget, while still proportionally a small group. While a typical client aged 80-plus who has a Options package is unlikely to have it for more than four years, young, disabled people will likely remain on a package for the remainder of their lives. Thus, the proportion of Options packages allocated to this group has continued to grow. Currently, CACPs are wholly funded by the Commonwealth and target the frail aged. If these two types of packages are pooled, the question of how to deal with the younger disabled people will need to be

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<sup>57</sup> An example of feedback received from a state HACC Advisory Committee can be found at [http://www.health.vic.gov.au/agedcare/hacc/documents/hacc\\_dac\\_resp\\_oct03.pdf](http://www.health.vic.gov.au/agedcare/hacc/documents/hacc_dac_resp_oct03.pdf). (Victorian Departmental Advisory Committee on the Home and Community Care Program (HACC), 2003a)

<sup>58</sup> Three tiers of provision were first proposed in the 1999 report *Targeting in the HACC Program* (Howe and Grey, 1999): (1) HACC Basic: that has broad eligibility criteria and open access; (2) HACC Plus: that requires a comprehensive assessment and is aimed at people needing more than a defined level of basic HACC services, taking into account what family caregivers are able and prepared to do; and (3) HACC Exceptional: that requires a comprehensive assessment and whose money comes from a high-needs pool at a State-wide level.

<sup>59</sup> The Victorian government's advisory committee also proposed three tiers of service: HACC basic, HACC plus (three funding levels approximating CACPS, Linkages and EACH packages) and HACC exceptional, which would be funded and delivered separately. See Victorian Departmental Advisory Committee on the Home and Community Care Program (HACC). (2003) *Better targeting for HACC, Linkages and Community Aged Care Packages in Victoria—some considerations*.

addressed or their needs will swamp the program to the detriment of older people.<sup>60</sup> Currently, 24% of HACC users are under 65 and they receive 34% of the funding.<sup>61</sup> Two states, New South Wales and Western Australia, have already created a Statewide high-needs pool for home-care clients to ensure that no individual agency carries the risk of paying for a number of very high-cost clients, at the expense of substantial numbers of people with more moderate needs. Some stakeholders feel that this group of clients should be removed from HACC entirely and funded separately.

*Entry to services.* The type and number of entry points is another area where there is some disagreement. Several states would like Carelink centres, seen as ineffectual, scrapped entirely. The information they provided has been too general to be helpful in most cases and they did not have the expertise to do assessment. Instead, they propose that one large provider (or several large providers in urban areas) would do screening by telephone and arrange appropriate referrals. The agencies used would have an existing capacity to undertake adequate screening and assessment using a standardized intake and referral protocol, have access to electronic service directories of available services at other agencies, and be committed to assessing the client's total needs and to referring to other agencies for services, when appropriate.<sup>62</sup> The federal government wants a more regimented system as it is concerned that consistency will not be gained if it does not have tight control over the initial screening and subsequent assessment process; it proposes to expand the role of Carelink Centres to include initial screening and referral.

*Levels of assessment and assessment tools.* All stakeholders concur that a simple, common initial screening process is needed that can be shared across the agencies that deliver services to home care clients. The carer module for this screening tool needs improvement and inclusion in the assessment of priority for service. More contentious is when ACATs will be used for assessment of clients who have more complex care needs and what this assessment tool might look like. The screening tool that is widely used within HACC, the ACAT assessment and the CACP assessment differ substantially from one another.<sup>63</sup> When the need is complex enough for referral for the type of assessment done by ACATs is not clear. Stakeholders are reluctant to see the delays associated with ACAT assessments increase.

Assessment is seen as part of care management and thus as an on-going process, involving the care providers, client and carer, that allows care to be tailored to the changing needs of the individual. Some stakeholders have suggested that, for most clients, any assessment beyond the first screening, if needed, should be targeted to understand the clients unique care needs and monitor progress. These assessments would explore only areas relevant to understanding the client's situation and needs. The client would be handed to a person who had the skills to assess

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<sup>60</sup> State governments are reluctant to suggest removal of younger disabled people from the HACC program. In the current federal-state funding agreement for disabled people, the states contribute 85% while the federal government contributes 15%. But, clearly young disabled need different kinds of services from frail, elderly clients. Their service needs include providing the supports that allow them to participate in education and employment.

<sup>61</sup> Personal communication, Shona McQueen, 2004.

<sup>62</sup> In SA, where Domiciliary Care delivers most of the non-nursing home care services, the agency proposed is also part of the state government although it has its own board and maintains an arm's length relationship with the government.

<sup>63</sup> A paper regarding the comparability of the three assessment tools was recently published (AIHW, 2004d).

the type of services a client needed. For example, a physiotherapist might be asked to look at someone with mobility issues while an OT might be asked to be the prime contact and service planner for someone who identified home safety issues as the major reason for referral. They might or might not become the principal service provider to the client.<sup>64</sup> They are afraid that any federally sanctioned instrument will gather uniform, but also much irrelevant information. The major issues appear to be whether there will be a single tool or a tool kit and who will be able to use this tool or tool kit.

*Concern about costs of assessment, monitoring and accountability.* Although program monitoring through a common MDS and standardized Quality Assurance program would cut down the administrative costs of agencies who now must account for the services they deliver to three or more programs, each with their own MDS and funding criteria, stakeholders at the state level are concerned that the reforms themselves will cost money. It will cost money to extend the Aged Care Assessment Teams to act as a comprehensive assessment authority for community care. There are costs for information technology to enable electronic referral and data sharing. In the past, the federal government has funded the software but not the hardware for data management IT projects. When the HACC MDS was rolled out, the federal government developed protocols, transmission requirements and a help desk to support it. Although 85% of provider agencies are now automated, many small providers are still not. Further, the hardware itself needs upgrading and replacement with time.

Other changes are needed that require money to be spent to make them happen. All stakeholders would like to see a measure of dependency and carer need developed that allow resources to be aligned to match client and carer needs but someone will have to pay for it. They are asking for the inclusion of a carer's section in the MDS and the development of a validated carer needs assessment tool. Support for carers should be included in priority of access criteria, which also need development. The federal and state governments would like to be able to track the dollars spent on a given person. The current system does not allow this to occur with certainty and ease. A sometimes veiled concern is the level of detail in the information that the federal government will demand to see, which is perceived as usurping power from the states.

*Case management and packages of care.* Some stakeholders take exception to the word "packages" used to describe a bundle of services tailored to a client's needs. The word is easily misconstrued as meaning that the client is entitled to a set dollar amount of services, as payment to agencies for delivering packages of care, including case management, are a fixed dollar amount. As noted previously, not everyone agrees about when case management is needed and some are concerned that too much money is spent for this when it should rather go for direct service provision.

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<sup>64</sup> In Adelaide, Metro Dom Care plans to use a multi-skilled group of health professionals from each major discipline as assessors and case managers/coordinators. They would be expected to handle simple service needs as part of the initial assessment and also to provide direct service to some clients whose case they coordinate or manage, depending on case complexity.

Not all people require case managers, even if they are getting a fairly high level of service. If a client's needs are relatively stable and not complex, a case manager may be unnecessary even when a client receives substantial quantities of care. Both family caregivers and clients themselves are often capable of undertaking the bulk of the case-management role (as is already recognised in Linkages guidelines in Victoria). Conversely, some people who receive less expensive services could use some case management or coordination of their care. Currently, packages imply case management will occur; case management is not funded otherwise. Case management, particularly the purchaser-provider split, is seen as taking far too much money from direct service in many federal programs.

*Adding unspent residential care money to the pool.* Money exists that the federal government has allocated to the residential care system for beds that are not operational currently, either because they are being redeveloped or have not yet been built. Some stakeholders suggest that these monies be used to finance more EACH type packages in the home care sector until such time as these beds become operational. This move would help ease some of the dollar pressures in the home care system.

*Harmonization with related programs.* The current federal consultation paper specifically focuses only on the home and community care sector, although it does acknowledge a need to harmonize with other programs in the future. Some stakeholders have argued that the review does not go far enough. Home care, residential care, hospital care, post-acute care and rehabilitation are necessarily all part of the same larger system. Thus, common assessment tools should be sought that will link across these systems.<sup>65</sup> The statistical linkage key that is used in HACC does not link with other programs (hospital, medicare, aged residential care and disability data are all separate from HACC data)<sup>66</sup> making it difficult to understand how these sub-systems relate to one another.

## **Assessment of the Australian Home and Community Care System**

The home care system in Australia, as elsewhere, is overshadowed by much larger hospital and residential aged care systems. Hospitals are seen as providing flashier services that can grab headlines and public attention quite easily. They are funded by states that may or may not have made substantial investments in rehabilitation, step-down and post-acute care. The residential aged care system in Australia, funded by the federal government and the people it serves, is seen to be in a funding crisis. It has been the subject of a major review of its financing that was

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<sup>65</sup> The Victorian government issued a Request for Proposals for a review of existing tools to assess the care needs of people with chronic health conditions and older people with complex care needs and for the identification of a validated tool applicable for these client groups across service settings in February 2004.

<sup>66</sup> One Victorian government official recently used the analogy that there is need to create a "common market" among these aspects of this system. Her common market would have a passport that allowed workers to move among the sub-systems readily, a common assessment tool that allowed clients to move across sub-systems depending on their needs, etc. The big question of course is what the currency used in the system will be. Without the equivalent of a Eurodollar, moving across boundaries becomes very difficult. This has been especially difficult because of the differences in which level of government fund what portions of the system. Privacy concerns also make sharing of information across systems more difficult.

reported in May, 2004 along with the government's response to its proposals.<sup>67</sup> Many stakeholders suggest that this larger, much more costly system has occupied the federal government. Until funding of this system is settled, changes to the home care sector will not be forthcoming.<sup>68</sup>

The reforms proposed for the home and community care system, if adopted, will go a long way toward fixing some of the major problems identified in the sector today. The home care program is too fragmented and rationed currently and needs to grow (Kelsall, 2004). The lack of a common initial screening tool and common system of assessment has made the services that clients receive sometimes capricious rather than well planned to match their circumstances and needs. The amount clients contribute to their home care also varies considerably. The volume of services provided through government-sponsored programs is seen as too little to support all the people who wish to remain in their own homes. As the Myer Foundation<sup>69</sup> states there is "a considerable gap between people needing formal assistance and those currently able to access services". (Myer Foundation, 2002)

Particularly HACC has been under tremendous pressure as the basket that catches things that fall out of the other systems (veterans, disabled, hospital, etc.). HACC was seen initially as having a secondary preventive role (to reduce risk of frail aged people needing much care) and is now mainly reactive. The clients served have higher levels of dependency now; a larger proportion is over 80 years old than when the program began. As dependency has increased, resources are increasingly skewed toward high need clients. Services are rationed so that most clients must rely heavily on informal carers to get by. Yet, the three-year plans of some regions have begun to react to this problem by clearly targeting money for earlier intervention rather than spending most of their money on highly dependent clients. This, unfortunately, means that some high need clients are not getting enough care and may exit prematurely into the residential care system.

A repeated concern raised by stakeholders was that the split between post-acute care/rehabilitation, which is seen as a state responsibility, and home care, is artificial. Sometimes this

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<sup>67</sup> This review was published on the Department of Health and Ageing's website in May, 2004 along with the government's response to it when the federal budget was announced. See <http://www.health.gov.au/investinginagedcare/summary/pdf/summary.pdf> and <http://www.health.gov.au/investinginagedcare/response/response.pdf>

<sup>68</sup> The federal government indicated in the budget it tabled in May 2004 for the 2004-2005 fiscal year that it will double the number of community packages (from residential care money) to 20 places for every 1,000 people aged 70 and over. It will also invest money to improve the timeliness of ACAT assessments, expand the role of ACATs in case management and strengthen the role of ACATs in community care; it proposes to develop a common assessment and entry processes for community and residential care.

<sup>69</sup> The Myer Foundation has played a role in helping home care become more centre stage and unifying various non-government stakeholders. More information about this medium-sized Australian charitable foundation and its broader initiative regarding aged care, can be found at <http://www.myerfoundation.org.au/>. In June of 2003, it sponsored a meeting of key players (consumers, carers, industry, professional and academic groups) in the field called the National Community Care Summit and commissioned papers about key issues in the aged care field. A second National Community Care Summit is to be held in the summer of 2004 in Canberra with a high profile keynote speaker to help keep the group's profile high. A consultant was retained to work with a steering committee from these organizations (now called the Community Care Coalition, (CCC)) to develop a comprehensive communications strategy to approach all governments and policy makers with a unified message that highlights the strategic importance of home and community care; the need for reforms to streamline programs, their accountability and reporting requirements; and the need for funding to meet increasing demand and complexity of care.

split causes people to enter residential care when, with good support at home (including some rehabilitation) after leaving hospital, they would be able to stay home as they would have retained more life skills and mobility. Various innovative pilot projects exist that help people return home.<sup>70</sup> These programs need to be built upon and brought into the home care system.

Despite continuing to face many challenges, there is much to celebrate about home care in Australia including the HACC program, the attention to carer's needs and respite opportunities and the development of CACP and EACH packages that keep people at home who would otherwise enter residential care and use money from the residential care system to do it. Having national programs has helped create more uniform standards of service provision across Australia. The current needs-based allocation methods for allocation of new monies within and across states are working towards uniform levels of service provision. Services offered are of relatively high quality and cover the range of services needed by people to stay at home. The national service standards and national minimum data sets allow monitoring of the quality and number of services provided and to whom they go. Evaluation has and continues to be used to improve the system. There is enthusiasm about making the system better and more responsive to client needs. There is a genuine concern about putting the client and carer first and figuring out ways to save dollars in administering the system so that more money can go to direct service provision. Considerable innovative thinking is going on about the system. There is an academic community with a strong interest in contributing to the development of the system.

## **Lessons for Canada from the Australian Experience:**

### **1. Regarding planning a national home care program.**

*1.1 All clients who need assistance to remain at home because they are coping with health problems that interfere with their ability to function should be eligible for home care services.*

Singling out some groups of people as eligible for a national home care system and disallowing access to these services by others who are equally needy sets artificial boundaries. It creates inequities and the borders of eligibility are hard to control. It keeps excluded people from having the highest quality of life possible given their health condition and increases their risk for institutional care. Eligibility does not ensure access. Rather, it ensures equity. It allows the assessment of relative need to decide whether and the type of access that will occur.

In Canada, the policy recommendations of the Romanow Commission and the Kirby Committee leave out the largest group of home care recipients, people with ongoing care needs either because they are physically disabled or elderly. This is surprising since, at least for the frail elderly, there is now fairly compelling evidence that for some elderly people, home care is a cheaper alternative than residential care, as well as being much preferred by frail elderly and

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<sup>70</sup> In South Australia, a coalition of aged and residential care providers developed a program called Acute Transitional Alliance that targets people in hospital assessed by ACATs as needing residential care. This program moves them from hospital to a residential care bed but with programming that is aimed at making them as mobile and independent as possible. Most participants are able to go home with some level of support rather than be institutionalized. These types of programs have developed in several states. An example of one of these programs can be found at <http://www.accasa.org.au/acca/servlet/page?pg=78&stypen=html>

their carers (Hollinger, 2001, Hollinger and Chappell, 2002, Hollinger, 2003).<sup>71</sup> There is an active lobby in Canada to ensure that all groups are included in a national home care program.<sup>72</sup>

*1.2 A home care program that includes only some people who require home care while excluding others who are equally needy of home care does not help the broader health care system function optimally.*

Focussing on some groups to whom to deliver home care services to the neglect of others causes problems in the wider health care system. The Australian home care program has chosen to serve disabled clients and frail, elderly clients and limited support to post-acute and rehabilitation services in the home, seen as “no growth” areas. Australia makes much greater use of hospitals (1.5 times the admission rate) and the length of stay in hospital is longer and has not dropped as quickly as other OECD countries (Duckett, 2004). Hospitals report that they have many patients awaiting long term care placement. Home care does not accommodate them and rehabilitation or transitional services are not widely available. Small pilot projects suggest that the lack of good post-acute/rehabilitation services consigns more elderly people to residential care than would need to be there if they received good post-acute care at home or in rehabilitation facilities. The home care clients, if not properly cared for, are likely to increase costs to the residential care and hospital systems.

*1.3 Carers are an essential part of a home care system and must be seen as clients as well as care providers.*

Informal carers (family and friends of the disabled person) provide much more home care than any formal system of home and community care can provide. Ensuring that they are also eligible for services and that appropriate respite services exist (both in the home and in the community) is vital to maintaining people at home. Attending to carer needs includes ensuring that when a person is placed in another setting so that the carer has some respite, behavioural regression and deskilling regarding activities of daily living are avoided. Australia has developed a range of respite models in an attempt to ensure the carer will not regret having taken a bit of respite. Carers’ organizations have lobbied hard to ensure carer’s needs are included in the new screening and assessment tools to be developed for home and community care.

*1.4 Experimentation is needed to find the best ways to deliver care and where home care is a cost-effective approach.*

The Australian government has a system whereby new initiatives are begun on a trial basis. They are funded for a fixed (often four-year period) as a non-recurring grant, usually with pilot projects in several states, and evaluated as part of the pilot period. However, unlike the Health

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<sup>71</sup> There is a continuing need for research to better understand when the crossover point comes and home care costs begin to exceed the cost of residential care.

<sup>72</sup> For example, the Canadian Association of Retired People (CARP) in its Presentation to Federal Liberal Caucus Task Force On Seniors in 2003 argued that “chronic, long-term care must be included in the national home care program of the Health Accord. Or, at the very least, any monies saved by the provinces/ territories as a result of new federal funding for home care must be reinvested in chronic home care.” See <http://www.50plus.com/carp/files.cfm>.

Transition Funds<sup>73</sup> or Primary Care Renewal funds, the ideas that will be piloted are usually clear and ready to implement before the funding period begins. This feature has made it more likely that a program can achieve a steady state and that measurable outcomes are available by the end of the evaluation period. Successful pilots are then rolled out generally.

*1.5 Avoid creating new home care programs when you would like to better serve needy program recipients.*

There is always a danger that politicians who seek recognition for their government's actions will want to create new programs rather than add money to existing programs to make them more inclusive and responsive to societal needs. It is much more efficient and effective to funnel monies to existing groups who have developed the infrastructure supports needed to run effective services than to start new initiatives. Rival governments at the state and federal levels in Australia have created a patchwork quilt of services, funded by different sources and with different accountabilities that may be offered by the same agency, creating an administrative nightmare, or by separate agencies, creating a system that is hard for consumers to understand and access. It is a lesson that is true whether one or two levels of government are involved in service delivery.

## **2. Regarding financing the home care system**

*2.1 Avoid structuring the financing of aspects of the health care system in a way that invites cost shifting and blame.*

In Australia, differences in which level of government funds or how much they contribute to funding care for disabled, residential aged care, hospital care (including post-acute and rehabilitation) and home care has created little incentive on the part of governments to take a holistic overview of the whole health care system and place new money in the areas that will maximize performance of the system as a whole. Further, the inability to link information about people as they move across these systems means that data crucial to planning are lacking; such data might convince governments of the wisdom of working more effectively with each other.

A way needs to be crafted for the Canadian government to participate in financing the system that ensures that cost-shifting arguments do not occur. The easiest way to avoid cost-shifting arguments is to have the federal government participate in the home care system to the same extent as it participates in the health care system in general. This would be a substantive change from the current system, where home care is considered an extended health service rather than an insured service. However, if home care is to be governed by the five principles of the Canada Health Act (universality, accessibility, comprehensiveness, portability and public administration), such financing makes sense. At the same time, the Australian experience suggests that money should be targeted to home care rather than simply enter the bigger health care budget without any indication of how it is to be used.

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<sup>73</sup> An excellent example of policy-relevant home care research was funded through the Health Transitions Fund. A summary by Evelyn Shapiro of this research program can be found at [http://www.hc-sc.gc.ca/htf-fass/english/home\\_care\\_en.pdf](http://www.hc-sc.gc.ca/htf-fass/english/home_care_en.pdf)

*2.2 Needs-based funding of home care expansion is required to ensure equity in the distribution of services across the country.*

The way HACC, EACH and CACP funding is distributed to and within the states is equalizing, albeit slowly, the level of services found in and across the various states. Population needs-based allocation of money to expand services is used throughout the country. There is a single formula for national allocation. Although the formulas used within the various states vary, all rely on data collected in national surveys such as the Survey of Disability, Ageing and Carers (Australian Bureau of Statistics, 2000) and the Census done by the Australian Bureau of Statistics. Population-based funding formulas use measures of need in the population such as the extent of poverty; age of the population, particularly the proportion over 80; the number of disabled people, etc. The Canadian government can play a significant role in ensuring that needs-based financing methods are used. First, it can help finance the research needed to develop the best possible approximations of need in the population. Second, it can ensure that periodic collection of population-based information needed to support needs-based funding occurs.

*2.3 Financing should be agreed upon over three to five year periods rather than be negotiated annually to support better planning.*

Australia has chosen three-year cycles for agreements regarding the financing of home care; particularly, expansion monies are readjusted every three years. This allows reasonable planning although some stakeholders would like the cycle extended to five years. It becomes harder for governments to predict revenues over longer periods.

*2.4 Avoid the use of user fees, if possible.*

In Australia, the use of user fees for home care was an ideological decision. Many of the states had not charged user fees in the past and only reluctantly began to do so. The costs associated with collecting user fees and problems experienced in ensuring fairness of charges suggest that they should be avoided. It is easier not to offer a specific service (e.g. home and yard maintenance) than to charge fees for all services. Further, user fees introduce perverse incentives to use fully publicly funded services rather than pay for needed service. Unfortunately, the use of publicly funded services often occurs later, when the person's condition has deteriorated and they require more expensive care. If user fees are introduced, an upper limit to yearly charges (cap) is required based on income.

*2.5 Keep decisions regarding financing of the system separate from decisions regarding implementation of the system.*

Having only one level of government involved in the actual delivery of home care programs and their financial monitoring reduces the complexity of service systems on the ground. In Canada, the provinces have played this role. The provincial government (and through delegation, regional health authorities where they exist) would continue to be responsible for implementing the home care program and managing the day-to-day running of the program including working with agencies regarding capacity building and service delivery issues.

### **3. Regarding accountability and quality assurance/improvement in the system.**

#### *3.1 Accountability measures should include more than simply increased availability of services and service delivery statistics.*

Improvements in the effectiveness and efficiency of the entire system should be seen if home care is functioning well. The quality of people's lives should also improve as fewer prematurely enter residential care or need to return to hospital because they have not had adequate rehabilitation after their hospital stay or are not receiving the services that they need to remain at home. Such concepts should be measured along with improved and more equitable service provision. Currently, Australia only measures the latter.

#### *3.2 The development of accountability and quality assurance mechanisms should be a shared federal-provincial responsibility.*

The development of accountability mechanisms is an important shared responsibility between the federal and provincial governments. National service standards that support continuous quality improvement are very important and will help ensure excellence in service delivery. An external check is needed on self-completed information about adherence to service standards to ensure that they are completed accurately. Canada already has a national non-profit organization that has taken the lead in accrediting health care facilities. It may be an appropriate body to implement national service standards.

#### *3.3 Supports are needed to ensure that a MDS meets planning and accountability needs.*

A minimum national data set for home care must meet the needs of provincial and federal governments and be useful to the providers who are asked to contribute data. To be maximally useful, the data should have a unique client identifier that is linkable to health care system data generally and current Canadian plans include the possibility of such linkage. The Canadian Institute for Health Information (CIHI) has already completed much of the work involved in developing such a MDS for home care.<sup>74</sup> The Internet makes it easy to provide assistance to people entering data for the minimum data set. Data dictionaries and other supports can be available on the web and regional help desks can be created.

Decisions still need to be taken about how the infrastructure needed to collect data will be funded. Home care agencies tend to be smaller and more diverse than hospitals and residential care facilities. They may require more assistance than to simply specifying the capabilities of computer systems needed to contribute data and sending them a disk with the data entry program. Australia has chosen not to provide such assistance; HACC data are still incomplete, nearly four years after implementation. Most state governments have put extra money into this initiative to improve the quality of data coming from their state.

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<sup>74</sup> The development of National Indicators and Reports for Home Care began in 1999 with the Canadian Institute for Health Information (CIHI) taking a leadership role.

[http://secure.cihi.ca/cihiweb/en/downloads/indicators\\_homecare\\_e\\_finalrepatr2001.pdf](http://secure.cihi.ca/cihiweb/en/downloads/indicators_homecare_e_finalrepatr2001.pdf). CIHI recently field-tested a possible minimum data set in several provinces.

[http://secure.cihi.ca/cihiweb/en/downloads/indicators\\_homecare\\_updateMar2003\\_e.pdf](http://secure.cihi.ca/cihiweb/en/downloads/indicators_homecare_updateMar2003_e.pdf)

### *3.4 Failure to meet performance targets should have consequences.*

Currently, the only performance targets used in Australia in a formal system of accountability are meeting national standards and delivering the volume of services agreed upon. Money is withheld if the latter targets are not met. It is difficult to enforce accountability except for the release of “growth funds” as other sanctions simply hurt the people getting services in the system. The release of unfavourable information may itself be a sanction if prior agreement has been reached that performance targets were appropriate and should be met. Positive intervention may be required to bring agencies up to standard.

## **4. Regarding Assessment**

### *4.1 The assessment processes used should match the anticipated resource needs required.*

Avoid setting up a complex assessment process for people whose needs are straight-forward or require little on-going care as the process is likely to be disproportionate to the care that they receive. These people can continue to be reassessed as part of the care management by their providers. Only when assessment is used to make a major decision, such as to decide where the person is best placed, should those assessing be different from the on-going care providers.

### *4.2 Create an assessment process for extended, high level home care and residential care that allows uniform decision-making across the country.*

The Australians have developed an Aged Care Assessment Program that assesses people who either need to enter residential care or need fairly high levels of support to remain at home. Although uniformity of judgement is not always seen, some process like this is needed to ensure that people in some parts of Canada are not shunted prematurely into residential care or receive no services while people in other areas receive care at home. Some debate needs to occur within Canada about what it values and for whom it will provide extended home care. Many stakeholders felt that this debate had not occurred in Australia and needed to take place.

## **5. Regarding Service Delivery**

### *5.1 Carefully designed mechanisms are needed for coordination of care across differing aspects of the health care system.*

The entire health care system requires integration and coordination so that the person moves smoothly from primary care to hospital to post-acute/rehab to home care, if needed, without having to repeat their medical and social history and constantly re-explain their needs. Adding bits on to a system without sorting through how those bits will relate to create a coordinated system for the clients does not lead to a viable system that is easy for people to navigate. Ways are needed to ensure continuity of information and coordination of care across systems and to ensure that clients are in the part of system that best meets their current needs.

*5.2 Avoid splitting the case management and direct service provider roles.*

This arrangement introduces another layer of administration between case managers and direct service delivery and increases the cost of administration in the program. The high administrative costs are seen in the EACH and CACP programs as a result of using this model. Further, when someone is receiving care, assessment is an on-going process that is part of care planning, not a process that begins and ends with an assessment session.

*5.3 Some elderly people require both housing and home care supports.*

Supportive housing models are needed for vulnerable elderly who are poor as well as frail aged and have mainly lived in boarding homes of various kinds or on the streets. The Australians have developed a small but important program to deal with these vulnerable people that helps stabilize their insecure housing.

*5.4 Develop mechanisms that support diversity as well as promote economies of scale in agencies delivering home care.*

Canada, like Australia, has many different ethnic and cultural groups who would like to be involved in supporting programs for their seniors. Small groups often uniquely serve the needs of cultural minorities by providing social and other supports in the preferred language of the clients, including serving meals associated with that particular culture. Keeping these small players involved in the home care system while working to raise their capacity for good governance and service delivery is important. Partnering with larger agencies to achieve economies of scale and to share the knowledge they have about specific sub-populations provides benefits to both organizations. Strategic alliances are a mechanism that Australian agencies have used to become more efficient and seamless in service delivery to home care clients.

*5.5 Avoid setting up centres that simply provide information about what is available and do not include initial screening and referral services.*

The home care system should be easy for clients and carers to access. The initial contact points should provide information, initial screening and appropriate referral for further assessment, if needed, and linkage with services.

*5.6 Including clients with mental health problems in the home care system is difficult because the workers needed to assist them require special, different skills from workers who generally assist home care clients.*

Although the Australian HACC program has handled younger physically disabled clients well, there are few services for people who are disabled by mental health problems. These people tend to get overlooked by the home care system, likely because many cannot advocate for themselves. Plans for a Canadian home care system specifically include services to this group. This visibility in planning may increase the likelihood that their specific needs for service delivery will be considered. They need supports that will allow them to access employment and educational opportunities and allow them to function in the community.

## **Conclusions**

The home care system in Australia has continued to undergo expansion and changes and has often used experimentation and evaluation to help improve it. The Australian home care experience has many lessons for Canada. Some lessons speak to what to avoid in developing a home care system while others provide important ideas about how to better structure a home care system and make it as equitable as possible.

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**Table 1**  
**Types of Assistance Offered through the Home**  
**and Community Care Program\***

<b>Domestic Assistance</b>	Normally provided in the home and includes services such as dishwashing, house cleaning, clothes washing, shopping and bill paying
<b>Social support</b>	Normally provided in the client's home but may include accompanying the client on an excursion or trip. The support is provided to them as an individual and helps them to participate in society. It includes keeping the client company, helping to do paper work and accompanying clients on such chores as shopping, banking, paying bills and appointments
<b>Nursing care</b>	Health care provided to a client by a registered or enrolled nurse.
<b>Personal care</b>	Normally provided in the home, and includes helping the client with daily self-care tasks, including eating, bathing, grooming ,toileting, and medication monitoring
<b>Allied health care</b>	A wide range of specialist services, including: Podiatry, Occupational therapy, Physiotherapy, Social work, Speech pathology and advice from Dietician/Nutritionist
<b>Respite care</b>	Assistance provided to Carers so they may have relief from their caring role and pursue other activities or interests. The motivation underlying the assistance to the Carer is essential: a substitute carer is being provided so the carer gains time out.
<b>Centre based day care</b>	Assistance provided to the client to attend/participate in group activities and is conducted in a centre-based setting. It includes group excursions/activities conducted by centre staff but held away from the centre.
<b>Food services</b>	Includes Meals on wheels, meals at a community or day centre, food prepared in the home and advice on nutrition, food storage or preparation
<b>Home maintenance</b>	General repair and care of a client's home or yard provided by an agency, to help the client to live comfortably and safely in their home, including handyman work, basic repairs, lawn mowing, rubbish removal and wood chopping
<b>Home modification</b>	Minor structural changes to the client's home so they can continue to live and move safely about the house, including the fitting of rails and ramps, alarms and other safety and mobility aids.
<b>Transport</b>	Assistance provided so that the client may get out of their house and do chores, attend other activities or community centres, and participate in the community. This includes modified buses, volunteer cars and taxi vouchers or subsidies
<b>Other HACC services</b>	Assessment and referral, case planning / review and coordination/ management , counselling / support, information and advocacy

\*Adapted from <http://www.health.wa.gov.au/hacc/>

**Table 2**  
**Australian Home and Community Care Programs funded by the Australian Department of Health and Ageing in 2003-2004**

	<b>Program Name</b>	<b>Programme Objective and Funder(s)+</b>
1	<b>Home and Community Care (HACC)</b>	To provide basic maintenance and support services including home nursing care for frail aged people, younger people with disabilities and their carers to enhance quality of life and/or prevent inappropriate admission to long term residential care. +Funding/Administrative arrangements include bilateral funding agreements between Commonwealth and State and Territory Governments. Commonwealth contribution to total funding approximately 60%, service delivery is contracted by State/Territory Governments
2	<b>Community Aged Care Packages (CACP)</b>	To assist people with complex care needs otherwise eligible for low-level residential care to remain in the community.
3	<b>Extended Aged Care at Home (EACH)</b>	To provide high level care at home as an alternative to high level residential care.
4	<b>Aged Care Assessment</b>	To provide comprehensive multi-disciplinary assessment of needs of frail older people, including delegated authority to approve people for Commonwealth subsidised care through residential aged care, Community Aged Care Packages and flexible care. +Funded through Commonwealth grants to State and Territory Governments that operate 123 Aged Care Assessment Teams (ACATs) and Evaluation Units.
5	<b>Care Package Establishment Grants</b>	To assist residential care providers establish services for CACPs and EACH package provision (one time grants).
6	<b>Day Therapy Centres</b>	To assist older people to maintain or recover functional independence through the provision of therapy services to allow them to remain in the community or in low level residential care. Predated development of HACC; provide some services in "non-growth areas" for HACC
7	<b>National Respite for Carers</b>	To provide support for carers of the frail aged and people with disabilities through the provision of information, advice, coordination and delivery of respite care services. Includes Carer Respite Centres, 9 Carer Resource Centres, a National Dementia Behaviour Advisory Service and Carers Education and Workforce Training
8	<b>Carers Information and Support</b>	To provide information and support for carers of frail aged and people with disability to assist them in their caring role.
9	<b>Continence Aids Assistance Scheme</b>	To defray the cost of continence products and equipment for people of working age with both permanent disability and permanent incontinence.
10	<b>National Continence Management Strategy</b>	To prevent the development of incontinence through health promotion and primary prevention strategies and assist in the management of incontinence in the population
11	<b>Commonwealth Carelink Centres</b>	To provide a single point of information about the range of community, aged and disability services. There are 65 Centres.
12	<b>Psycho-Geriatric Units</b>	To raise quality of care for residents with dementia and challenging behaviours through expert assessment, diagnosis, advice and support services. +Commonwealth grants to State/Territory Governments.
13	<b>Dementia Education and Support</b>	To provide information and referral services for people with Dementia and their carers, includes a 24 hour National Dementia Hotline.
14	<b>Dementia Support for Assessment</b>	To support ACATs in rural areas to assess the special needs of people with dementia. +Commonwealth grant to state governments.
15	<b>Assistance with Care and Housing for the Aged (ACHA)</b>	To assist financially disadvantaged older people who are renting or who are homeless to access both home and community care and accommodation.
16	<b>Safe at Home</b>	To evaluate the effectiveness of personal alert systems for frail older people living in the community. Currently a pilot programme.
17	<b>Support for national bodies</b>	Department's Community Sector Advocacy Support Scheme

+Unless otherwise indicated, the Commonwealth directly funds the program and is responsible for program implementation and monitoring.

**Table 3**  
**Proposed Changes to the Home and Community Care System**

<b>Goal*:</b> Inclusion of all programs in home and community care currently funded by federal government, states or jointly funded by them in a new National Framework for Community Care to create an integrated, seamless system		
<b>Principles*</b>	<b>Proposals*</b>	<b>Stakeholder concerns</b>
Family carers are crucial to any community care system and require support in their caring role.	To ensure easy to access, appropriate, responsive services are available to support carers in their role, placed carer support services at the lowest tier	Want to ensure at a carer module is part of screening/assessment and carer's needs are included in any assessment of priority for services
Access to community care services needs to be clear and straightforward.	Eliminate multiple entry points to the system to make navigating the system; initial point of access links people to relevant services and also houses the regional care recipient and service provider databases	A single entry point is proposed that does not take into account historical ways of organizing care; see federal government as trying to usurp power from states; afraid federal government is trying to find a role for Carelink centres
The service delivery system should be person-focused and responsive to the needs of individuals.	Greater attention to service quality and outcomes; identifying strategic points in care pathways where interventions and support can reduce the risk of acute or residential care.	Need to develop these pathways; research and development needed as well as training of personnel
Case coordination and management of services is most important and cost-effective for those care recipients with very high level or complex needs.	Plan clearer delineation between care coordination and case management and care provision; brokerage role for case manager (purchaser-provider split is implied)	Not all clients with high care needs require case management while some clients with less service do need it; do not think purchaser-provider split is an efficient way to deliver services; many have tried it and moved away from it as too expensive
Appropriate care is underpinned by appropriate assessment.	A two-tier assessment process is implied: initial and comprehensive (for those who have complex or high care needs); standardized intake and assessment processes, including using Aged Care Assessment Teams for complex cases	At least three levels of assessment are likely needed; concern about using Aged Care Assessment Teams as already have long waits for assessment; appropriate assessment tools need to be developed
A consistent and sustainable mix of community care services should be accessible for care recipients and carers from all geographic regions.	Allocation to ensure that early intervention at lower levels of care occurs uniformly across regions; standard eligibility requirements for various types of services; three service tiers (information and support tier; basic care tier, packaged care tier)	Not sure of extend of rationing implied. Disagree with service tiers proposed; not clear about criteria to be used to move from tier to tier
The care system should be financially sustainable.	Government resources used to maximize service outputs; coordination and cohesion between services in region	Not sure about the extent of rationing implied; concern about impact of high cost clients, particularly young disabled

<b>Table 3: Proposed Changes to the Home and Community Care System (cont'd)</b>		
<b>Principles*</b>	<b>Proposals*</b>	<b>Stakeholder concerns</b>
Information flows must support continuity of care and minimize duplication in information gathering.	Service providers across relevant agencies able to access relevant assessment and care information (with care recipient agreement); streamlined administration including planning and resource allocation, accountability and reporting, care recipient contributions to care, quality assurance and information management	Concerned about the costs of infrastructure development; also extent of intrusiveness into planning and resource allocation, previously state responsibilities, is not clear; concern that need to think more broadly and include harmonization with the acute and residential care system
People using community care services should be assured of quality services.	Mandatory, uniform service delivery standards with effective monitoring of them	

\*Information abstracted from Australian Government Department of Health and Ageing.(2003) A New Strategy for Community Care Consultation Paper. Canberra: Department of Health and Ageing.

**Table 4**  
**Lessons for Canada from the Australian Experience**

<b>Topic Area</b>	<b>Lesson</b>
1. Planning a national home care program.	<p>1.1 The home care system should include all clients who need assistance to remain at home because they are coping with health problems that interferes with their ability to function.</p> <p>1.2 A home care program that includes only some people who require home care while excluding others who are equally needy of home care does not help the broader health care system function optimally.</p> <p>1.3 Carers are an essential part of a home care system and must be seen as clients as well as care providers.</p> <p>1.4 Experimentation is needed to find the best ways to deliver care and where home care is a cost-effective approach.</p> <p>1.5 Avoid creating new home care programs when you would like to better serve needy program recipients.</p>
2. Financing the home care system	<p>2.1 Avoid structuring the financing of aspects of the health care system in a way that invites cost shifting and blame.</p> <p>2.2 Needs-based funding of home care expansion is required to ensure equity in the distribution of services across the country.</p> <p>2.3 Financing should be agreed upon over three to five year periods rather than be negotiated annually to support better planning.</p> <p>2.4 Avoid the use of user fees, if possible.</p> <p>2.5 Keep decisions regarding financing of the system separate from decisions regarding implementation of the system.</p>
3. Accountability and quality assurance and improvement in the system.	<p>3.1 Accountability measures should include more than simply increased availability of services and service delivery statistics.</p> <p>3.2 The development of accountability and quality assurance mechanisms should be a shared federal-provincial responsibility.</p> <p>3.3 Supports are needed to ensure that a MDS meets planning and accountability needs.</p> <p>3.4 Failure to meet performance targets should have consequences.</p>
4. Assessment	<p>4.1 The assessment processes used should match the anticipated resources required.</p> <p>4.2 Create an assessment process for extended, high level home care and residential care that allows uniform decision-making across the country.</p>
5. Service delivery	<p>5.1 Carefully designed mechanisms are needed for coordination of care across differing aspects of the health care system.</p> <p>5.2 Avoid splitting the case management and direct service provider roles.</p> <p>5.3 Some elderly people require both housing and home care supports.</p> <p>5.4 Develop mechanisms that support diversity as well as promote economies of scale in agencies delivering home care.</p> <p>5.5 Avoid setting up centres that simply provide information about what is available and do not include initial screening and referral services.</p> <p>5.6 Including clients with mental health problems in the home care system is difficult because the workers needed to assist them require special, different skills from workers who generally assist home care clients.</p>