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The impact of the home care reforms on the older person, the aged care workforce and the wider Health System

authors

Dr Mikaela Jorgensen
Research Fellow
Centre for Health Systems and Safety Research
Australian Institute of Health Innovation
Macquarie University
Email: mikaela.jorgensen@mq.edu.au

Dr Rebecca Haddock
Director
Deeble Institute for Health Policy Research
Australian Healthcare and Hospitals Association
Email: rhaddock@ahha.asn.au

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The Jeff Cheverton Memorial Scholarship has been established by the Australian Healthcare and Hospitals Association (AHHA), together with Brisbane North Primary Health Network and North Western Melbourne Primary Health Network, to honour the memory of Jeff Cheverton.

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Key messages

- The Australian Government Department of Health should commission research with a large and representative sample of older adults to monitor the implementation of consumer directed care and identify ongoing barriers and evaluate implemented solutions to accessing home care.
- Collecting data on unmet demand for home care in the wider community, including those from special needs groups identified under the Aged Care Act 1997, should be prioritised. This could occur through adding questions about needs for formal aged care services to an existing population survey such as the Australian Bureau of Statistics Survey of Disability, Ageing and Carers.
- The Australian Aged Care Quality Agency and the Australian Government Department of Health should prioritise the collection and public availability of information on the quality of home care providers to inform consumer choice.
- Existing data sources from across the health system should be utilised to evaluate the impact of the home care reforms on the outcomes of those both receiving and waiting to receive home care.
- Future home care reforms should be co-developed with consumers and other key stakeholders and based on evidence from rigorous research studies.

Executive summary

The Australian aged care system is in the midst of an overhaul. A ten-year reform plan released in 2012 aims to create a sustainable, consumer-driven and market-based aged care system. Many of the policy changes have focused on packaged home care services, which provide support for older people who are eligible for residential aged care to remain in their own homes.

This Issues Brief synthesises government and non-government policy and research documents that have examined the impact of recent home care reforms on older people and their carers, the aged care workforce and providers, and the wider Health System. Recommendations are made to fill identified gaps in the development and evaluation of the home care reforms.

Firstly, this Issues Brief examines reforms that target access to home care for older people and their carers, including the creation of My Aged Care, the Home Care Packages Program, and the national prioritisation queue. Older adults' experiences of consumer directed care, both in Australia and internationally, are discussed. The availability of information on provider quality to inform consumer choice and the measurement of outcomes of people using home care services are also examined.

Secondly, the importance of understanding the effect of the reforms on a home care workforce under pressure is highlighted, including the need for monitoring work conditions and quality of care under new emerging models.

Finally, this Issues Brief calls for the use of public data collections to examine the impact of the home care reforms on the wider Health System for those both receiving and waiting to receive home care.

Policy reform is needed to ensure that our aged care system can meet the needs of Australia's rapidly ageing and increasingly diverse older population. However, these reforms should be guided by consumer input and the recommendations of independent reviews where these are based on research evidence.

A rigorous evaluation plan should be built into future home care policy reforms to ensure improved monitoring of the impact of changes on older adults and the people and systems that support them.

1 Background

1.1 Aged care sector reforms

The need to reform the aged care sector is a product of a rapidly ageing and increasingly diverse older population (Ferris, 2013).

In 2010, the Australian Government Productivity Commission conducted an inquiry into the options for structural aged care reform. The Commission released a report, *Caring for Older Australians*, in 2011, highlighting a number of weaknesses in the current aged care system (Productivity Commission, 2011). These included challenges in navigating the system, limited consumer choice, variable quality, inconsistent or inequitable financing arrangements and concerns about workforce skill shortages and wages.

The *Caring for Older Australians* report recommended that the Australian Government move towards a consumer-driven and market-based system, while maintaining oversight of quality and safety standards (Productivity Commission, 2011).

In response, the aged care peak body, The National Aged Care Alliance, released a Blueprint for Aged Care Reform which supported many of the recommendations made by the Productivity Commission (National Aged Care Alliance, 2012).

1.1.1 Living Longer, Living Better

Subsequently, the Australian Government implemented a reform package known as *Living Longer Living Better* (LLLB). The LLLB reforms were announced in 2012 and legislated in 2013 (Aged Care (Living Longer Living Better) Act 2013), with a plan for progressive implementation in three phases over 10 years.

A number of amendments have subsequently been legislated, including the Aged Care Legislation Amendment (Increasing Consumer Choice) Act 2016 (Cwlth), known as *Increasing Choice in Home Care* (ICHC).

The LLLB reforms included an increasing focus on providing aged care services in the community (see box below) (Commonwealth of Australia, 2012). These changes are consistent with the reform aims of consumer choice and sustainability. That is, the majority of people prefer to remain in their home as they age (Australian Institute of Health and Welfare, 2013a) and the cost of formal care for people with the highest level of needs is cheaper at home (Dept of Health, 2018b).

Aged care provision ratio

The aged care provision ratio determines the maximum number of allocated home and residential care places relative to the population. By 2021-22, the home care provision ratio will almost double from 27 places to 45 places per 1,000 people aged 70 years and older and the residential care provision ratio will reduce from 86 to 78 places (Aged Care Financing Authority, 2017a).

1.1.2 Community care reforms

Home and community-based aged care (community care) is utilised by over one million older Australians (see Appendix) (Aged Care Financing Authority, 2017a). Reforms effecting the community care system are outlined in Table 1. Many of the changes have focused on packaged home care services, which provide support for older people who are eligible for residential aged care to remain in their own homes.

Table 1: Key milestones for recent community care reform in Australia (Aged Care Financing Authority, 2017a; Dept of Health, 2017h)

Year	Month	Milestone
2013	Jun	Living Longer Living Better (LLLB) aged care reforms legislated
	Jul	My Aged Care website and contact centre launch as an information service
	Aug	Home Care Packages Program commences
		Consumer directed care is introduced for all new home care packages
2014	Jul	Australian Aged Care Quality Agency now reviews home care services
		Formalised income-testing for home care packages introduced
2015	Jul	Consumer directed care now applies to all packaged home care
		Commonwealth Home Support Programme commences
		My Aged Care expands to include assessment, referral and a central client record
2016	Jan	Independent Aged Care Complaints Commissioner established
	Mar	Increasing Choice in Home Care (ICHC) amendment legislated
2017	Feb	Home Care Package now follows the consumer
	Sep	Legislated review of aged care reforms (Tune Review) tabled

Broadly, the implemented reforms in community care have aimed to:

- integrate, simplify and improve access to care;
- allow individuals greater choice and control over the care they receive; and
- create a more sustainable aged care system.

1.1.3 The Tune Review

A five-year review of the aged care reforms was legislated within the LLLB reform package. The review, undertaken by former public servant David Tune and termed the *Tune Review*, was published in 2017 (Dept of Health, 2017h).

The *Tune Review* examines the LLLB reforms' effect on unmet demand for aged care places and equity of access for different population groups. It also examines the effectiveness of current means testing arrangements, pricing arrangements and workforce strategies (including education, recruitment, and funding). The *Tune Review* does not examine quality and safety issues in aged care in depth.

Recommendations around new means-testing measures were immediately ruled out by the Australian Government (Hunt and Wyatt, 2017). However, as part of the 2018-19 Federal Budget, a commitment has been made to allow unused residential care funding to be redirected to fund extra home care places (Dept of Health, 2018f). An additional 14,000 higher-level home care packages over four years was also announced within the 2018-19 Budget.

1.1.4 Future directions for community care reform

The Aged Care Sector Committee was established by the Australian Government in 2014 to provide advice on aged care policy (Dept of Health, 2018a). The Committee comprises representatives from across the aged care sector and is independently chaired by David Tune (Dept of Health, 2018a). In 2016, the Committee released a roadmap for future directions in aged care reform (Aged Care Sector Committee, 2016).

The Aged Care Sector Committee supports proposed aged care reforms to integrate the Commonwealth Home Support and Home Care Packages programs to create a single home care system. Originally slated for implementation in 2018, this home care system reform is still under discussion and current funding arrangements have been extended until July 2020 (Aged Care Financing Authority, 2017a).

Aged Care Quality and Safety Commission

The Australian Government has recently announced that an independent Aged Care Quality and Safety Commission will be established in July 2019 (Dept of Health, 2018f). The Commission will bring together the Australian Aged Care Quality Agency and the Aged Care Complaints Commissioner.

From July 2019, aged care providers will also begin to be assessed against a new single set of quality standards that will apply across both home and residential aged care (Dept of Health, 2018e).

From January 2020, the Aged Care Quality and Safety Commission will take over the aged care regulatory functions of the Australian Government Department of Health.

This will create a single point of contact for older Australians and their families to raise concerns and may also improve monitoring of consumer directed care.

1.1.5 Special needs groups under the Aged Care Act 1997

Special needs groups

The Aged Care Act 1997 (Cwlth) aims to ensure that aged care services are targeted towards the people with the greatest needs for those services. The Aged Care Act 1997 (Cwlth) recognises nine population groups as having special needs, including people from Aboriginal and/or Torres Strait Islander (ATSI) communities, those from culturally and linguistically diverse (CALD) backgrounds, and people who identify as lesbian, gay, bisexual, transgender and intersex (LGBTI) (see Appendix).

Aged care stakeholders have identified three additional groups not listed in the Aged Care Act 1997 who may experience challenges in accessing care (Dept of Health, 2017h):

- people with dementia;
- people with a disability; and

- people with mental illness.

The Diversity Sub-group of the Aged Care Sector Committee released the Aged Care Diversity Framework in December 2017 (Dept of Health, 2017d). The Framework is an overarching set of principles designed to embed diversity in the design and delivery of care and to address barriers to accessing safe, equitable and quality care. Three separate action plans to support the framework are currently under development for people from LGBTI, CALD and ATSI communities (Dept of Health, 2018h).

2 Reforms to improve access to home care for older people and carers

The following major reforms have aimed to integrate, simplify or improve access to care for older people and their carers.

- the creation of the My Aged Care contact centre and website;
- the creation of the Home Care Packages Program; and
- allocating home care packages to individuals rather than providers.

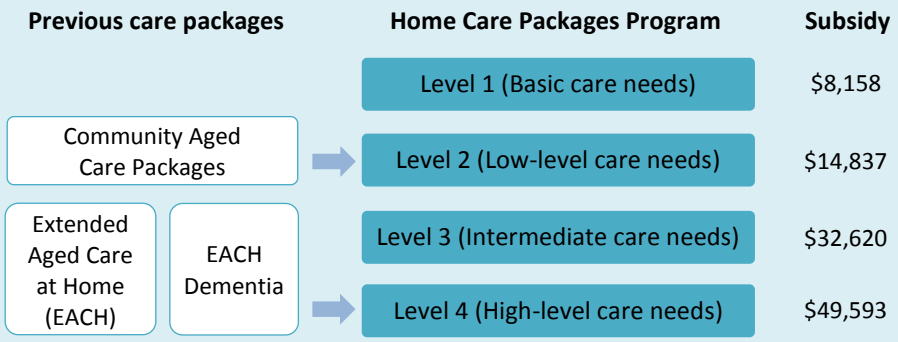
My Aged Care

Prior to the 2013 LLLB reforms, there was no single point of information or access for aged care which meant the system was "complex and difficult to navigate" (Productivity Commission, 2011).
My Aged Care was introduced as an information service on 1 July 2013. Following significant expansion in 2015, it is now a website, contact centre, electronic client record and assessment and referral service that acts as a central gateway for accessing Australian Government-subsidised aged care services (Dept of Social Services, 2015a).

Home Care Packages Program

Packaged home care services are available to support those who are eligible for residential aged care to remain in their own homes. The Home Care Packages Program was created in 2013 to enable a seamless continuum of care at home (Commonwealth of Australia, 2012). The Program split two existing levels of support for care needs into four and converted the three existing package types into Level 2 and Level 4 Packages (see Figure 1).

Figure 1: Creation of Home Care Packages Program and current annual basic Australian Government subsidies (Dept of Health, 2018b)



Allocating Home Care Packages to the individual

Prior to February 2017, care providers applied for new home care places in an annual competitive approvals round. After being approved for care, consumers waited on individual provider queues. However, being offered a package by an individual provider was not based on waiting time or care needs (Low et al., 2015), as there was no policy requiring prioritisation.

Following the implementation of the Increasing Choice in Home Care amendment in February 2017, home care packages are allocated to individuals rather than providers.
This involved two key changes for older people:

- funding for home care packages follow an individual if they decide to leave a provider,
- a 'national prioritisation queue' was established, whereby people approved for care are placed in the queue based on (i) the time they have waited for care and (ii) whether they have been assessed as having an urgent need for care ('high priority') or not. Upon reaching the front of the queue, and as a place becomes available, people are assigned a package.

2.1 Evaluation of My Aged Care

A number of evaluations have been conducted on behalf of Healthdirect Australia and the Australian Government Department of Health to investigate experiences and perceptions of My Aged Care, the aged care system and aged care reforms more generally (see Table 2) (AMR, 2016; AMR, 2017; AMR, 2018).

Table 2: Australian Government-commissioned evaluations involving care recipient and carers views of My Aged Care (AMR, 2016; AMR, 2017; AMR, 2018)

Date study commenced	n answering satisfaction question	Sample size as % of total population*	Sample characteristics	% satisfied with contact centre	% satisfied with website
Jan 2016	**393** contact centre OR website users	<0.2% of calls; <0.03% of website visits (year 2016-17)	n=12 CALD or ATSI***	76% (recipients) 65% (carers)	66% (recipients) 59% (carers)
Oct 2016	**1,654** contact centre and **547** website users**	As above	7% CALD 2% ATSI	79% (recipients) 77% (carers)	74% (recipients) 66% (carers)
Aug 2017	<**45** of 215 home care recipients surveyed	<0.2% of those receiving or waiting for home care	5% CALD 3% ATSI 40% 80 years+	87%	78%

Culturally and linguistically diverse (CALD); Aboriginal and Torres Strait Islander (ATSI); * (Dept of Health, 2017a; Dept of Health, 2017f) ** Figures obtained from Aged Care Information Section, Australian Government Department of Health [Catherine Burkitt, Email correspondence (April 10, 2018)]; *** Additional respondents "captured randomly' from general public but figures not reported.

The evaluation conducted in October 2016 showed that the majority of care recipients and carers surveyed were satisfied with the My Aged Care contact centre and the website (see Table 2) (AMR, 2017).

However, other evaluations, conducted simultaneously, reported lower levels of My Aged Care user satisfaction. For example, data collected by National Seniors Australia showed that only 54% of over 800 people who had used My Aged Care were satisfied with the information received (McCallum and Rees, 2017), compared to 77-79% of recipients surveyed in the Government evaluation (see Table 2).

Qualitative interviews conducted by the University of Sydney, in partnership with aged care provider The Whiddon Group, also suggested that many older people continued to feel ill-informed about the range of available aged care services, their eligibility and the costs involved (Community Care Review, 2017a). COTA Australia reports that many people still feel unsupported or uninformed to navigate the system (COTA Australia, 2017b).

2.1.1 Sufficient sample sizes and inclusion of special needs groups in evaluations

Results of the My Aged Care Program evaluations should be interpreted with caution given the small sample sizes (see Table 2). Small sample sizes reduce the statistical power of a study, resulting in inefficient research. The generalisability of the findings may also be limited.

A representative sample is also needed to minimise bias. Only 5% of those surveyed for the My Aged evaluation identified as culturally and linguistically diverse, compared to 20% of the wider Home Care Package population (see Table 2) (Australian Institute of Health and Welfare, 2017e).

People from culturally and linguistically diverse and Aboriginal or Torres Strait Islander backgrounds have reported lower levels of satisfaction with the My Aged Care contact centre and website than the rest of the surveyed population (AMR, 2017). Aged care assessors, providers and GPs have identified that there is a lack of support for these populations, who may be reluctant to engage with My Aged Care over the phone (AMR, 2017).

It is therefore important that sufficient numbers of people from culturally and linguistically diverse and Aboriginal and Torres Strait Islander backgrounds are included in future evaluations in order to definitively determine whether My Aged Care is improving aged care accessibility**.**

People with cognitive and communication impairments may also have difficulty in using either web or phone-based systems (AMR, 2017). It is unclear how many of these people were included in the My Aged Care evaluations or whether these groups will be targeted in future evaluations.

2.1.2 My Aged Care website – fit for purpose

Over 50% of those aged 65 years and over do not use the internet regularly (Australian Bureau of Statistics, 2018), and 42% of people aged 80 years and over have never accessed the internet (Australian Communications and Media Authority, 2016). The My Aged Care website therefore cannot be considered fit for purpose as a way to access aged care for many older Australians and older carers.

Excessive waiting times to reach staff at the contact centre have also been reported (AMR, 2017), meaning that those without the digital literacy or support to navigate the online portal may be missing out. The Australian Government has recognised these issues and provided funding to revamp My Aged Care to improve public access (Hunt and Wyatt, 2017), including iterative improvements to the portal (Dept of Health, 2017b) and proposed face-to-face navigator and outreach services (Hunt et al., 2018). A rigorous evaluation plan should be in place to monitor the impact that this funding has on access.

2.2 Determining unmet demand for home care

As part of the 2013 LLLB reforms, the maximum number of home care places that are available each year was increased. However, the increase in the number of home care places does not necessarily mean that all those who need home care services are now able to access them.

The terms of reference for the *Tune Review,* established in the 2013 LLLB legislation, required consideration of whether unmet demand for home care places had reduced since the introduction of the reforms (Dept of Health, 2017h). To date, no data source has been established for this purpose.

The *Tune Review* relied upon existing data sources, including the Australian Bureau of Statistics (ABS) Survey of Disability, Aging and Carers (Australian Bureau of Statistics, 2016) and Commonwealth data based on approvals for, and usage of, existing government-funded aged care services. However, these data sources have significant limitations for determining unmet demand.

For example, the ABS Survey of Disability, Ageing and Carers (Australian Bureau of Statistics, 2016) includes questions about individuals' general needs for support, rather than aged care needs specifically and therefore cannot be used to determine changes in unmet demand for aged care (Dept of Health, 2017h).

Aged care assessment figures and the national prioritisation queue also may not reflect underlying levels of unmet demand in the community, where some special needs groups are reported to have difficulty accessing the aged care assessment process through My Aged Care (AMR, 2017).

The *Tune Review* concluded that the impact of the 2013 LLLB reforms on unmet demand for home care cannot be ascertained as there is 'no accuarate estimate' of unmet demand in the community (Dept of Health, 2017h).

2.2.1 Establishing a data source to determine unmet demand is essential

Both the Productivity Commission and the Aged Care Sector Committee recommended phasing out the limits on the maximum number of aged care places ('uncapping supply') in order to increase choice and competition between providers (Aged Care Sector Committee, 2016; Productivity Commission, 2011). Uncapping supply would also ensure those with assessed need for home care services have the potential to be able to access them. Over 80% of seniors are supportive of the provision of aged care based on demand (McCallum and Rees, 2017) and the right to access care is supported under the Australian Charter of Healthcare Rights(Australian Commission on Safety and Quality in Healthcare, 2008).

However, without reliable data on unmet demand, there is no way to determine the potential fiscal impact of uncapping supply and therefore the limits on the number of home care places will not be phased out. One potential way to collect data on unmet demand for home care in the wider community would be to include additional questions around the need for formal aged care services to an existing population survey, such as the ABS Survey of Disability, Ageing and Carers.

2.2.2 The need for a public narrative around aged care resourcing

As a result of population ageing, aged care spending is projected to double as a proportion of GDP over the next 40 years (Australian Government Treasury, 2015). Leading Age Services Australia has argued that a public narrative needs to be built around greater resourcing (both public and private) for the aged care sector (Leading Age Services Australia, 2018).

The *Tune Review* recommendations focused on private resourcing through care recipient contributions, including changes to the basic and income-tested fees for home care and abolishing caps on annual and lifetime fees (Dept of Health, 2017h). However, the recommendations around means-tested caps and assest testing have been ruled out by the Australian Government (Hunt and Wyatt, 2017), creating limits as to how the system can adapt to the rising number of people who will need care as the population ages.

Given the large number of people currenlty waiting to receive home care (Dept of Health, 2018g), those who are less able to navigate the system may increasingly miss out.

2.3 Home care packages follow the consumer

Allocating packages to individuals rather than to providers aims to achieve greater choice for the consumer by allowing them to take their package and move to another provider. Currently there is low consumer awareness of the new option to change providers (AMR, 2018). 50% of providers surveyed in late 2017 indicated that none of their clients had transferred to another provider (AMR, 2018).

The Australian Government Department of Health has indicated that validated data on the total number of people who have changed providers is currently unavailable (Senate Community Affairs Committee, 2017c). However, providers are required to notify the Commonwealth within 31 days of a client ceasing care (Dept of Health, 2017e).

Routinely monitoring movement between providers using these notifications would allow the effectiveness of this reform to be examined and also identify providers with high transfer rates who may be providing poor quality services.

2.3.1 National prioritisation queue for home care packages

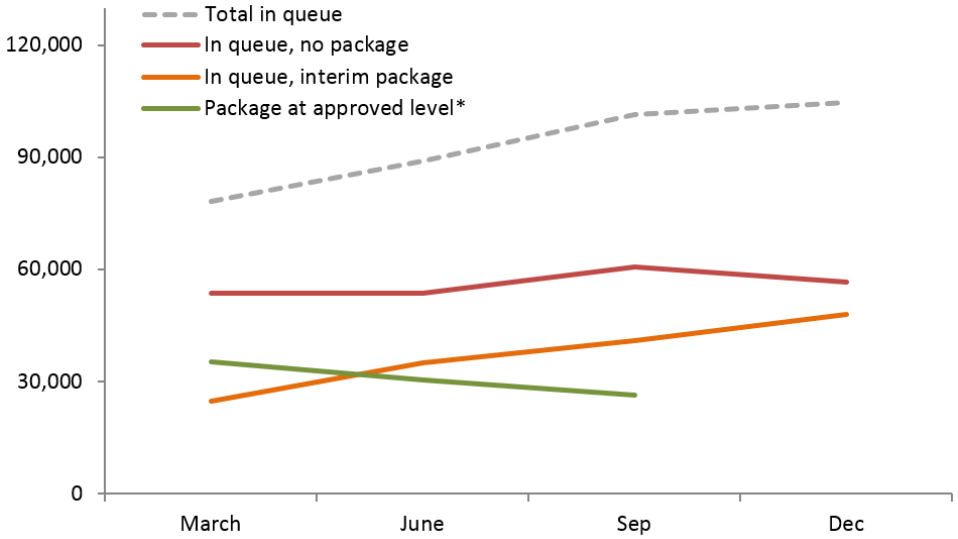
Despite its limitations, the establishment of the national prioritisation queue as part of the 2017 ICHC reforms has created an opportunity to better understand unmet demand for services, as the size of individual provider queues was not previously monitored.

The Australian Government has committed to releasing information about the people on the national queue quarterly (Dept of Health, 2017f; Dept of Health, 2017g; Dept of Health, 2018g), although the 2018 March quarter data has not yet been released (Community Care Review, 2018b). On 31 December 2017, there were nearly 105,000 people in the queue, including 82,000 waiting for higher level care packages (Levels 3-4) (Dept of Health, 2018g). 46% of people in the queue had been assigned an interim package allowing them to receive care at a lower level than they were assessed as needing (Dept of Health, 2018g). The total number of people in the queue is far greater than the estimated number of people receiving care at their approved level (see Figure 2).

There is no publicly available data from before the creation of national queue to compare the size of the waiting list before and after the reforms. However, national aged care peak bodies have expressed concern about the above trend growth in the queue since the reforms, including the impact on informal carers (Carers Australia, 2018) and entry into residential aged care for those on interim packages who may not be receiving enough support to stay at home (Leading Age Services Australia, 2017b).

A potential driver of growth in the queue is an increased number of daily aged care assessments (Dept of Health, 2018g). This may be due to mass provider advertising to attract clients under the new system. Nevertheless, 25% of those assessed in the December 2017 quarter were approved as having an urgent need for care ('high priority') (Dept of Health, 2018g), highlighting the large number of people with urgent unmet aged care needs in the community.

Figure 2: Size of the national prioritisation queue for home care packages in 2017 (Dept of Health, 2018g)



* Estimated number receiving package at approved level (total in home care minus total allocated interim packages)

While there is no evidence to suggest that inappropriate assessments are taking place, the Australian Government Department of Health has cautioned assessors about the rate of high priority approvals (Community Care Review, 2018a).

2.3.2 Waiting time for home care packages

Over recent years, access to healthcare has been measured using waiting time rather than waiting list size (Australian Institute of Health and Welfare, 2018b). For example, less than 2% of people on elective surgery waiting lists for public hospitals wait over 12 months to be admitted for surgery (Australian Institute of Health and Welfare, 2017c). By comparison, 27% of those in the queue for home care packages have an approval dating back more than 12 months (Dept of Health, 2018g). The overall elapsed time from assessment to entering home care services has also increased since the 2013 LLLB reforms. In 2013-14, 86% of people entered into home care within 9 months (Dept of Health, 2017h). By 2016-17, only 72% entered into home care within 9 months (Dept of Health, 2017h).

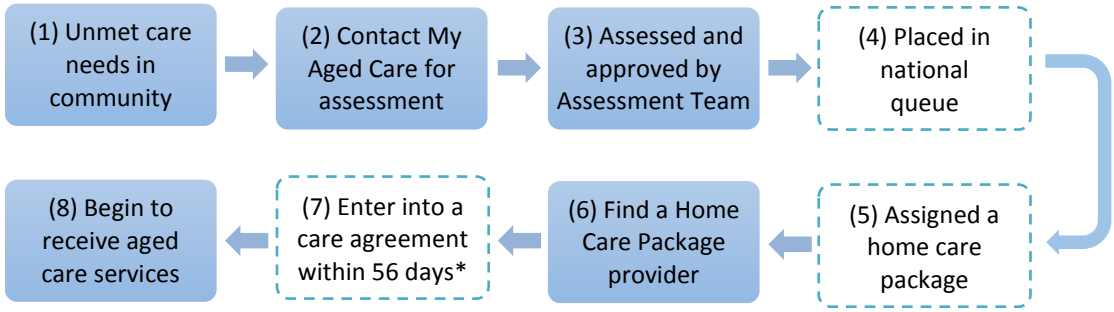
In 2017, the Australian Government announced the release of 6,000 higher level packages converted from unused lower level packages (Hunt and Wyatt, 2017), as well as an additional 14,000 higher level packages over four years (Hunt et al., 2018). However, these measures do not address the underlying mismatch between community expectations about accessible and timely healthcare and the current rationing of home care places. Taking steps towards removing the cap on the number of home care places is necessary to ensure those with assessed need have the potential to be able to access home care.

2.3.3 New pathway to accessing home care packages

Despite clear demand, there has been a reduction in the growth in the number of people actually receiving home care over the last year. The additional steps to access care created by the establishment of the national queue (see Figure 3) may be a contributing factor.

Research undertaken by the Australian Government Department of Health has identified that 45% of people who had recently been assigned a package did not understand what they needed to do next (Community Care Review, 2017d). In response, the Department has begun sending a 'Home care readiness letter' in English at approximately 90 days before a person is likely to be assigned a package to encourage them to start researching providers (Community Care Review, 2018c). Under the previous system, the process of finding a provider could be facilitated as part of discharge planning for the 25% of older people who receive their aged care assessment in hospital (Australian Institute of Health and Welfare, 2011).

Figure 3: The pathway to accessing home care packages from February 2017 (new steps in white)



* A 28-day extension can be requested

The Department has reported that 14% of packages assigned between March and June 2017 received a 28 day extension to enter into a home care agreement (Senate Community Affairs Committee, 2017e). However, they are currently unable to enumerate how many people did not ultimately activate their package (Senate Community Affairs Committee, 2017e).

Determining who is having difficulty navigating the new home care pathway, through tracking package activations and undertaking research with those who do not activate their package, would enable better targeting of resources and supports.

2.4 Access to home care for special needs groups

The *Tune Review* examined whether the 2013 LLLB reforms have been successful in creating more equitable access to care for special needs groups (Dept of Health, 2017h).

While aged care access for Aboriginal and Torres Strait Islander and other culturally and linguistically diverse populations appears to have been moderately improved by the 2013 reforms, the *Tune Review* found that 'in most cases data are inadequate to monitor the patterns of access for different groups' (Dept of Health, 2017h).

Prior to the 2017 ICHC reforms, home care places were subject to specific conditions of allocation, for example, that the provider give priority access for certain population groups or target services to a particular location (Parliament of Australia, 2016). Following these reforms, special needs groups are not prioritised for care, as packages are allocated to individuals based solely on their time in the queue and whether they have an urgent need for care.

However the current home care packages reports (Dept of Health, 2017f; Dept of Health, 2017g; Dept of Health, 2018g) do not include information on how many people in the queue are from special needs groups, or how many people with special needs are having difficulty entering into a home care agreement.

Giving people the opportunity to identify as belonging to one or more special needs groups during their aged care assessments would allow for the monitoring of the impact of the reforms on access to care for these groups.

3 Consumer directed care

What is consumer directed care?

From 2013, all new home care packages were required to be delivered on a consumer directed care basis and all packages from July 2015. Consumer directed care means (My Aged Care, 2018b):

- you get more say in the care and services you access, how they are delivered and who delivers them to you;
- you have conversations about your needs and goals;
- you work with your service provider to develop your individual care plan;
- you agree how much involvement you have in managing your care package;
- you know how your package is funded and how your individual budget is spent through monthly income and expense statements; and
- your service provider will ensure that your package continues to meet your needs with ongoing monitoring and formal reviews.

3.1 Evaluation of consumer directed care

In 2017, the quality of care delivered in residential aged care facilities was reviewed (Carnell and Paterson, 2017; Groves et al., 2017; House of Representatives Standing Committee, 2017; Senate Community Affairs References Committee, 2017a). Despite the introduction of consumer directed care as a major component of the community care reforms, the *Tune Review* did not consider consumer directed care in its review (Dept of Health, 2017h). This means that the evidence around the effectiveness of this reform has not yet been collated to inform future policy directions.

Consumer directed care was piloted with 1,000 older Australians who were allocated packaged care by the government through the Innovative Pool Program between 2010 and 2012 (KPMG, 2012). A further 500 consumer directed care places were provided to carers under the now defunct National Respite for Carers Program. An evaluation of the pilot program commenced in 2011, and two further evaluations were undertaken following the implementation of consumer directed care (see Table 3).

Table 3: Government-commissioned evaluations of consumer directed care involving consumers (KPMG, 2012; KPMG, 2015; TNS Consultants, 2016)

Date study commenced	Purpose	Methods
Jun 2011*	Pilot study of consumer directed care (CDC)	Surveys of care experience and quality of life for **216** CDC and **181** non-randomised controls; Provider data on service use for **700** CDC participants; Semi-structured interviews with **51** CDC participants
Nov 2014*	Evaluation of the implementation of the Home Care Packages Program and implementation of CDC	Qualitative interviews with **57** consumers and carers
Jun 2016	Experience and satisfaction with CDC and views on upcoming reform where package follows the consumer	In-depth interviews with **62** consumers and carers

* The majority of the evaluation data collection activities started from this date

The initial pilot study indicated that while no significant differences were measured in the quality of life between the consumer directed care and control participants, those receiving consumer directed care had higher levels of satisfaction with the care they had received (see Table 3) (KPMG, 2012).

Subsequently, the qualitative evaluations undertaken in 2014 and 2016 found that the benefits of consumer directed care following widespread implementation had been highly variable for consumers (KPMG, 2015; TNS Consultants, 2016).

This suggests that some groups may need access to government-funded additional practical supports such as administrative, financial and professional services (Simons et al., 2016) to achieve benefits under the new system.

3.2 The international experience of consumer directed care

Models of consumer directed care

Consumer directed home care programs are in place across a number of European countries, the United Kingdom and the United States (Gadsby et al., 2013). Consumer directed care models typically consist of person-centred approaches to needs assessment and planning, as well as one of the following models for managing care services and funding (KPMG, 2012):

'Cash-for-care' models: cash or vouchers are provided to people to purchase their own care; or
'Self-directed' models: people can choose among a continuum of care ranging from traditional case management through to cash-for-care.

The majority of consumer directed home care programs in the United Kingdom and Europe are 'cash-for-care' models (Gadsby et al., 2013). Consumer directed care models have been found to be more cost-effective than provider-directed models where the model is based on cash-for-care (KPMG, 2012).

Internationally, there is less evidence for the effectiveness of consumer directed care models for older consumers compared to case managed or integrated care models (Low et al., 2011). Consumer directed care models are often reported to improve satisfaction with care, but do not improve quality of life or other clinical outcomes (Bulamu et al., 2017; Low et al., 2011; Ottmann et al., 2013).

The majority of older people do want greater control over the services that they receive (Ottmann et al., 2013), which is one of the key components of all consumer directed care models. Most older Australians also want a flexible model of care, including the ability to save unspent funds and choose their provider (McCaffrey et al., 2015). However, many see the administrative or financial responsibilities associated with consumer directed care as burdensome rather than empowering (Carers Victoria, 2010). In the United Kingdom, it has also been reported that some older people experience poorer outcomes and greater anxiety related to managing budgets (Glendinning et al., 2008). These outcomes should be explicitly examined in future evaluations of the Australian implementation of consumer directed home care.

3.3 The relevance of consumer directed care for older Australians

Choice of provider

In Australia, the term 'consumer directed care' is now often used to refer to both the person-centred approach to the delivery of services that was rolled out from 2013, as well as the 2017 Increasing Choice in Home Care (ICHC) reforms that allowed for packages to follow the consumer.

Although packages are no longer allocated to providers, care recipients must choose a single provider to be the fund-holder for their package budget. The provider then expends the budget as directed by the care recipient. Providers can sub-contract or broker out services if they are unable to provide a requested service. However, older Australians would prefer to be able to choose home care services from multiple service providers (Kaambwa et al., 2015).

Research undertaken by National Seniors Australia in early 2018 found that older people were ambivalent about the benefits of consumer directed care (McCallum et al., 2018). The Australian Government-commissioned evaluation that examined views on the upcoming 2017 ICHC reform reported that "the personal relevance of the reform was questioned by older consumers (75+ years)" (AMR, 2018). In 2016, 84% of people using the Home Care Packages Program were aged 75+ years (Australian Institute of Health and Welfare, 2017e). This suggests that the reforms may not be important to the vast majority of people receiving packages.

Including older people as active partners in the planning and implementation of the aged care system is a key element of the Aged Care Diversity Framework (Dept of Health, 2017d). Future reforms should take into account the preferences of older people and their carers to ensure these reforms are consumer directed.

3.4 Future priorities for consumer directed care research

The Australian model of consumer directed care is a self-directed model, but is unique internationally in that it has no option for consumers to purchase their own care. In contrast to the majority of international models which have largely extended from changes in each country's disability sector (Gadsby et al., 2013), the Australian model was specifically designed for aged care (KPMG, 2012).

Consequently, large scale evidence of the effectiveness of the Australian model relies mainly on the Australian Government-commissioned evaluations (see Table 3). Further evaluation is needed to improve our understanding of the impact of consumer directed care in several key areas:

- **Capacity to participate:** participants in the Australian consumer directed care pilot were selected on the basis of having sufficient 'capacity' to participate or having a carer actively involved in the older person's life (KPMG, 2012). Given that recipients with cognitive impairment comprise at least 12% of those who access home care (Senate Community Affairs Committee, 2017d), further attention on how to most effectively deliver consumer directed care for this high needs group is required (Low and Fletcher, 2015);
- **Cost-effectiveness:** the cost-effectiveness of self-directed models, including the Australian model, has yet to be fully determined (Ratcliffe et al., 2014); and
- **Cultural considerations:** consumer directed care aims to facilitate individual rather than communal control. This conflicts with the cultural values of many Aboriginal and Torres Strait Islander people (Senate Community Affairs References Committee, 2017b). While the acceptability and effectiveness of consumer directed care in Aboriginal communities is starting to come under investigation (IRT Group, 2017; Ottmann, 2018), evaluation with a large and representative sample of care recipients is needed to determine the impact of the reforms on people from a range of cultural backgrounds and special needs groups. Where models of care are viewed as not relevant to a population group, a truly consumer directed system would allow for alternative models to be considered.

3.5 Quality review of providers' implementation of consumer directed care

From July 2014, the responsibility for reviewing the quality of service delivered by aged care providers against the Home Care Standards transferred to the Australian Aged Care Quality Agency (Aged Care Financing Authority, 2017a). All home care services undergo a quality review at least once every three years (Australian Aged Care Quality Agency, 2017).

The proportion of reviewed services not meeting one or more of the Home Care Standards increased from 10% to 12% between 2015-16 and 2016-17 (Australian Aged Care Quality Agency, 2016; Australian Aged Care Quality Agency, 2017). In the 2016-17 report, two of the four areas that were most commonly not met by home care providers related to components of consumer directed care ('service user reassessment' and 'care plan development or delivery') (Australian Aged Care Quality Agency, 2017).

These details on areas not met by providers have not previously been reported by the Australian Aged Care Quality Agency. Inclusion of these details in future annual reports would allow for improved public monitoring of the implementation of components of consumer directed care.

3.5.1 Complaints about the delivery of consumer directed care are increasing

There has been considerable growth in the number of complaints to the Aged Care Complaints Commissioner about home care packages.

12% of all aged care complaints in 2015-2016 were about home care packages, rising to 15% in the 2016-17 period (Aged Care Complaints Commissioner, 2016; Aged Care Complaints Commissioner, 2017) when the most common complaints were about:

- fees and charges (31%);
- lack of consultation and communication (21%); and
- communication *about* fees and charges (12% of complaints) (Aged Care Complaints Commissioner, 2017).

The nature of these complaints indicate that the communication and budget components of consumer directed care are not always being implemented adequately. These issues could be addressed by providing additional support to those aged care providers have indicated difficulties with the administrative requirements of consumer directed care (TNS Consultants, 2016).

3.5.2 Examining administrative fees and efficiency

Competition is a powerful incentive for providers to improve efficiency (Productivity Commission, 2011). In the Australian Government-commissioned pilot of Australian consumer directed care (Table 3) (KPMG, 2012), 27% of the average home care package budget was used for administration and case management. An examination of care recipients' monthly statements, carried out by Flinders University and the University of Sydney in 2015-2016, found that administrative expenses accounted for 40% of package expenditure on average (Community Care Review, 2017b). Significant variation in financial statements was also found among providers.

The Australian Government Department of Health does not currently collect data on administrative fees for home care packages (Senate Community Affairs Committee, 2017b).

Without standardised and longitudinal tracking of this information, there is no way to examine whether individual budgets and monthly statements have improved administrative efficiency or supported consumers to access additional care**.** Requiring providers to disclose their administrative fees on My Aged Care, as they are currently required to do for maximum exit amounts, would be a first step towards monitoring this information.

3.5.3 Data on provider quality to inform consumer choice

The aim of the 2017 ICHC reforms was to take steps towards creating a market-based aged care system with increased choice and competition, in order to "[lead] to enhanced quality and innovation in service delivery" (Dept of Social Services, 2015b). However a lack of evidence demonstrating that competition and choice have improved the quality of aged care overseas (Lewis and West, 2014) should be considered in an Australian context.

While the principles of choice and control are important to health and wellbeing (Marmot and Bell, 2012), there are differences in people's abilities to exercise this choice and control. Making informed choices about aged care can be impacted by cognitive ability, literacy levels, availability of a carer and level of education (Australian Commission on Safety and Quality in Health Care, 2014). Many of those surveyed as part of the My Aged Care evaluations were not even sure whether they were in receipt of a home care package (AMR, 2017; AMR, 2018).

A market-based system therefore has the potential to exacerbate inequalities for those who do not have the necessary knowledge, skills and abilities to navigate the process.

Consumers also need accessible and valid information to choose between aged care services and providers. The Aged Care Financing Authority notes that comparing the prices of home care services is difficult because providers are publishing prices in different formats (Aged Care Financing Authority, 2017b).

The Australian Government has acknowledged that transparent, comparable information about quality in aged care is important to aid consumer decision-making (Dept of Health, 2017c). Robust and valid data is also important to support providers to measure and monitor their performance and undertake continuous quality improvement (Dept of Health, 2017c).

Publicly available information for consumers to compare the quality of home care service providers is limited (see Table 4). This also means there are few data sources that can be used to determine whether the home care reforms have actually improved the quality of aged care.

Table 4: Current availability of Government sources of information on provider quality (Aged Care Complaints Commissioner, 2017; Australian Aged Care Quality Agency, 2017; Australian Aged Care Quality Agency, 2018; Community Care Review, 2016; Dept of Health, 2017c; My Aged Care, 2018a; Wyatt, 2018)

Source	Details	Current availability
National Aged Care Quality Indicator Program	Pilot indicators included consumer experience and quality of life, goal attainment and time to access services	Not currently available; Pilot undertaken in 2016 with 121 services
Consumer Experience Reports	Interview questions undertaken by the Australian Aged Care Quality Agency with a sample from each provider	Not currently available; Pilot currently being undertaken
Aged Care Complaints Commissioner	Service to lodge concerns about the quality of care and services being delivered	Not publicly available; Aggregate sector figures published
Final Quality Review Reports	Reports of reviews against the Home Care Standards undertaken by the Australian Aged Care Quality Agency	Not publicly available; Aggregate sector figures published
Provider performance rating against quality standards	Recommended by the Review of National Aged Care Quality Regulatory Processes	Announced by Government in April 2018 for residential aged care only
Notices of non-compliance and sanctions	Issued by Australian Government Department of Health	New notices and sanctions Searchable on My Aged Care from February 2017

3.6 The uptake of self-management of home care packages

Under consumer directed care, care recipients can choose how much involvement they would like in managing their care package and budget.

What services are care recipients spending their budgets on?

Individual budgets and monthly expenditure statements were introduced as part of consumer directed care to enable consumers to know how their package is funded and decide how to spend their package funding. In the Australian consumer directed care pilot, participants tended to choose similar types of support as those under standard packaged care, although some did use their funds for innovative or non-traditional supports (KPMG, 2012).

The type and volume of services utilised under the Commonwealth Home Support Programme is reported annually (Productivity Commission, 2018). This information should also be reported for the Home Care Packages Program to allow a greater understanding of how consumers are using services.

In the United Kingdom, uptake of schemes for managing individual budgets and care has been relatively low (Williams and Dickinson, 2016). Consumers who do not have the capacity to self-manage their package have to allocate a larger portion of their subsidy to case management fees (Simons et al., 2016). This suggests that individual budgets have the potential to widen inequities for these groups.

In Australia, COTA Australia is currently investigating the success of self-management of home care packages and also developing consumer toolkits to increase people's capacity to undertake self-management (COTA Australia, 2017a). However, public information on the total number of people managing their own home care package is not available. Monitoring the uptake of self-management is important to determine whether any groups are having difficulty accessing this element of consumer directed care.

4 Monitoring the outcomes of home care service provision

The *Tune Review* does not consider whether the aged care reforms have improved the outcomes of those receiving home care (Dept of Health, 2017h).

Moving towards outcome measurement

Outcomes can broadly be defined as the impact of an activity on a person or group of people. The 2011 Productivity Commission inquiry into the options for structural reform of aged care recommended developing outcomes-based data standards to assist with the measurement of service effectiveness (Productivity Commission, 2011). Stakeholders have also regularly advocated for a shift in focus from compliance and "tick-the-box" process indicators to quality outcomes in aged care (Australian Aged Care Quality Agency, 2015; Dept of Health, 2017j).

There are several data sources that could be used to evaluate the impact of current and future reforms (see Table 5). Potential outcomes include traditional 'hard' measures, such as whether services keep people in their own home for longer, and patient-reported measures, such as whether services improve psychosocial wellbeing.

Table 5: Australian Government sources of information on outcomes in home care (Australian Institute of Health and Welfare, 2017a; Australian Institute of Health and Welfare, 2018a; KPMG, 2017)

Source	Outcomes	Method	Limitations
GEN website (AIHW)	Exits from home care	Sourced from Aged Care Management Payment System	Currently high levels of missing information on exits
Pathways in Aged Care (AIHW)	Length of stay in home care	Linked data from aged care assessments and program use	Not routinely linked; currently includes program use and deaths only to 2014
Report on Australian Government Services: Aged Care	Social participation	ABS Survey of Disability, Ageing and Carers	General population survey; does not identify those receiving aged care services
Report on Australian Government Services: Aged Care	Maintenance of physical function	Score collected on entry and exit from program	Transition Care Program only
National Aged Care Quality Indicator Program	Quality of life	Survey of care recipients during annual review or reassessment	Not currently collected

The National Aged Care Data Clearinghouse (NACDC) was established as part of the 2013 LLLB reforms with the explicit purpose of assisting policy research and evaluation (Australian Institute of Health and Welfare, 2014; Commonwealth of Australia, 2012). The NACDC is an independent and centralised repository of information on care recipients and services across national aged care programs.

The GEN aged care data website, launched by the Australian Institute of Health and Welfare in 2017, is the current way for the public to access data from the NACDC (Australian Institute of Health and Welfare, 2018a). GEN contains non-identifiable information about all individuals entering and exiting home care, including their length of stay in home care and whether they were discharged to residential care.

Data sourced from GEN could be used to examine whether the reforms have resulted in a home care system that allows people to live independently in their homes for longer.

However, the proportion of exits from home care classified as 'unknown' has increased from **16% in 2013 to 42% in 2016** (Australian Institute of Health and Welfare, 2017d). The proportion of exits where Aboriginal and Torres Strait Islander status cannot be determined has also increased from **0.1% in 2013 to 32% in 2016** (Australian Institute of Health and Welfare, 2017d). Investigating quality issues with these exit data should be a priority as they are a timely population-based source for examining the outcomes of home care for different groups.

4.1 Utilising outcomes data routinely collected by providers

Despite the current limitations around information on home care outcomes (see Table 5), aged care providers are increasingly starting to implement their own electronic data systems (Douglas et al., 2017). This provides additional opportunities to examine outcomes on a large scale. For example, a recent Australian study conducted by the Australia Institute of Health Innovation at Macquarie University utilised routinely collected care management data for over 1,000 people using home care package services (Jorgensen et al., 2018). After accounting for significant factors such as age and care needs, the study found that each additional hour of home care received per week was associated with a 6% lower risk of entry into residential aged care (Jorgensen et al., 2018).

The Australian Government has increasingly recognised the importance of measuring person-centred outcomes in aged care such as quality of life and social participation (KPMG, 2017; Productivity Commission, 2011). However, no data source examined (see Table 5) currently allow for evaluation of the reforms on patient-reported measures.

A number of recent partnerships between care providers and universities have begun to explore the routine use of wellbeing tools in home care. For example, the Australian Community Care Outcome Measurement (ACCOM) tool, developed through a research-industry collaboration, is based on the Adult Social Care Outcomes Toolkit and has been piloted in NSW (Cardona et al., 2017). The Australian Community Participation Questionnaire (ACPQ) and the ICEpop CAPability measure for Older people (ICECAP-O) are two other validated tools that have been found to be useful and acceptable for monitoring person-centred outcomes in home care (Siette et al., [Epub ahead of print]).

Routine measurement of wellbeing outcomes would provide a mechanism for monitoring the impact of future reforms and the effectiveness of home care services more broadly. This could occur through prioritising the roll out of the National Aged Care Quality Indicator Program in home care.

4.2 Outcomes of informal carers

The majority of aged care is provided by informal (unpaid) carers. Informal carers are typically comprised of family, friends and neighbours (Australian Bureau of Statistics, 2016). The aged care reforms have not sufficiently accounted for, or enabled planning in relation to, informal carers (Senate Community Affairs References Committee, 2017b).

The stress and burden experienced by many informal carers was highlighted in a recent report released by National Seniors Australia, including the impact on physical and mental health (McCallum et al., 2018).

As the population ages, the number of informal carers is predicted to decline (Deloitte Access Economics, 2015) resulting in additional pressure on the aged care system. Although the cost of providing direct care at home is markedly lower than the cost of residential aged care (Wübker et al., 2015), there remains an important debate about the valuation of informal care that often supplements formal home care services (Wübker et al., 2015).

The cost-effectiveness of reforms that aim to keep people at home for longer need to account for the outcomes of informal carers and expenses associated with informal caregiving.

5 How have the reforms impacted the aged care workforce and providers?

The provision of quality aged care services and the success of the reforms in creating greater choice and control for consumers ultimately relies on those working within the sector. The most significant workforce measure in the 2013 LLLB reform package was the introduction of a workforce supplement that was intended to be used to increase wages in the sector (Dept of Health, 2017h). Following a change in Australian Government in 2013, the supplement ceased and the funding allocation was directed into the sector more generally (Dept of Health, 2017h). However, the aged care workforce and providers have been impacted by the broader reforms, as outlined below.

5.1 Aged care providers

5.1.1 Size and coverage of the provider market

A move away from block funding

Prior to the 2017 ICHC reforms, new home care places were allocated each year by the Australian Government within geographic areas called Aged Care Planning Regions (Dept of Health, 2016). Care providers applied for the number of new packages they believed their workforce could service and were awarded a total subsidy for a block of packages ('block funding').

The 2017 ICHC reforms aim to create a more competitive and innovative market by allocating packages to individuals (Aged Care Sector Committee, 2016), allowing them to choose from any approved provider. However, increased competition also has the potential to introduce new risks for providers and reduce choice for consumers (Rodrigues and Glendinning, 2015).

Without block funding, care staff have no guarantee of volume of work or income and the provider market is at risk of consolidating (Rodrigues and Glendinning, 2015). As home care places are no longer allocated to geographic areas, there is less incentive to provide care to those living in rural and remote areas where travel costs are greater. Previously, providers could cross-subsidise people living in rural and remote areas or those with very high needs from their total block funds.

The number of approved providers has been published quarterly as part of the reports on the national prioritisation queue (Dept of Health, 2017f; Dept of Health, 2017g; Dept of Health, 2018g). Following the 2017 ICHC reforms, the number of approved providers increased by 53% over the year to December 2017 (Dept of Health, 2018g). The proportion of people in home care across metropolitan, rural and remote regions has remained stable and there are at least two providers within each aged care planning region (Dept of Health, 2018g), suggesting there has been no market collapse in rural and remote areas.

However, the reported provider figures consist of those approved to offer services in an area, rather than those actually providing active services. Reporting the number of providers with active services is essential to accurately understand the effect of the reforms on the size and coverage of the provider market.

5.1.2 Quality review of home care providers

How and when will new providers be reviewed?

The 2017 ICHC reforms also simplified the process for organisations to become providers. 54 mandatory criteria have been reduced to 6 key areas (Dept of Health, 2018d).

The Australian Aged Care Quality Agency, recognising that there are risks associated with new services entering the market who have not previously provided aged care, have developed a risk matrix to determine which services are high priority to review (Australian Aged Care Quality Agency, 2017).

The details of this risk matrix are not publicly available, nor are the strategies for managing the increased number of quality reviews that will be needed to cover the influx of new providers.

New models of home care are emerging as a result of the aged care reforms, as well as wider changes in the service economy. Uber-style or peer-to-peer home care involves individual care workers becoming self-employed sole traders and connecting with care recipients via a website or app (Australian Ageing Agenda, 2017b). This allows users of these platforms to bypass providers with high administration fees and to choose their own care workers based on their profile and previous ratings.

At present, the Australian Aged Care Quality Agency does not publicise the number of sole traders that have been reviewed or their performance against the quality standards. Monitoring the standards of care provided through these new platforms should be a priority.

5.1.3 Provider perspectives on consumer directed care

Providers have experienced considerable administrative costs and challenges associated with the implementation of consumer directed care (KPMG, 2015; TNS Consultants, 2016).

Greater transparency about planned future reforms is also needed. For example, the Australian Government Department of Health released draft aged care standards in January 2018 for a proposed mid-year implementation date (Dept of Health, 2018e). Providers noted their concern about the minimal public information about the pilot and the timing of the release of provider guidelines in the lead up to the implementation (Australian Ageing Agenda, 2018b). Government funding to assist with the transition to the new standards applies to residential care only (Dept of Health, 2018f).

Greater consideration of home care providers by the government is needed to ensure they have adequate time and resources to implement reform changes successfully.

5.1.4 Satisfaction with My Aged Care among providers and health professionals

The 2017 government-commissioned evaluation of My Aged Care revealed below 50% provider satisfaction across all questions relating to use of the portal (AMR, 2017). Aged care assessors and hospital referrers also reported satisfaction of lower than 40% and 30% respectively for most measures. GP satisfaction was between 40-60%.

As a consequence of the government-commissioned evaluations, the Australian Government Department of Health has improved the experience and functionality of My Aged Care, including undertaking an ‘accelerated design’ process and quarterly updates to the system (Dept of Health, 2017b).

However, aged care providers and referrers have also noted that low levels of health literacy of some contact centre staff has had flow-on effects around the appropriateness of referrals to the aged care assessment team (AMR, 2017).

Revising the National Screening and Assessment Form used by My Aged Care staff and integrating referral forms with existing GP patient management software may improve the appropriateness of referrals and transfer of clinical information to assessment teams (Dept of Health, 2017h; Leading Age Services Australia, 2018).

5.2 The aged care workforce

The aged care reforms have created a model that seeks competition on costs. This has generated concerns about the skills, remuneration and conditions of the home care workforce (Senate Community Affairs References Committee, 2017b).

5.2.1 Workforce shortages and casualisation

Despite the increasing number of approved providers, the sector is experiencing an ongoing shortage of aged care workers. The 2016 National Aged Care Workforce Census and Survey reported a decrease in the total home care and home support workforce of 13% since 2012 (Dept of Health, 2017i). This is despite an increase in the number of people receiving home care (Australian Institute of Health and Welfare, 2017e).

There has also been a decrease in the proportion of the direct home care workforce who are Registered or Enrolled Nurses (16% to 13%) and a decrease in the proportion of non-direct care workers who are care managers/coordinators (33% to 30%) (Dept of Health, 2017i). This means that there are fewer skilled workers to care for the growing number of people with complex needs at home.

A decrease in the proportion of workers on casual/contract arrangements was also reported, although greater numbers of brokered staff were being used to "match staff to peaks in service use demand" (Dept of Health, 2017i). Yet, 53% of providers in a different survey reported an increase in the use of casual staff as a result of uncertainty in their business pipeline (AMR, 2018).

There are concerns that current data capture methods for the Workforce Census underestimate the proportion of casual and other non-standard employment arrangements (Senate Community Affairs References Committee, 2017b). Accurate data on the aged care workforce is needed to support the development of aged care workforce policy.

5.2.2 Volunteers in the home care workforce

Currently, there is one volunteer for every three people in the paid home care workforce (Dept of Health, 2017i). There has been a 21% decrease in the number of volunteers recorded between 2012 and 2016 (Dept of Health, 2017i). The willingness of volunteers to engage with the home care sector may be further comprised by the reforms moving the sector towards a competitive profit-driven market.

Future reforms should plan for, and taken into account the potential effect on, the volunteer workforce (Senate Community Affairs References Committee, 2017b).

5.2.3 Workforce skills and conditions

A declining workforce in the face of population ageing has been recognised by the Australian Government as a major challenge. A 2017 senate inquiry into the aged care sector workforce made 19 recommendations around education and training, minimum nursing requirements and the establishment of an Aged Care Workforce Strategy Taskforce (Senate Community Affairs References Committee, 2017b). The government supported eight of these recommendations, primarily around the establishment of the taskforce and its work (Australian Government, 2018).

The Taskforce was established in November 2017 and has undertaken extensive engagement and consultation processes with stakeholders (Dept of Health, 2018c). However, a robust analysis of national and international evidence on the aged care workforce also needs to take place to ensure the Taskforce can better evaluate the merits of stakeholders' opinions (Australian Association of Gerontology, 2017). The Aged Care Workforce Strategy Taskforce handed its report, *A Matter of Care – Australia's aged care workforce strategy*, to the government in July 2018 (Australian Ageing Agenda, 2018c). The report has not yet been released to the public.

Workforce pay

Care workers in aged care are among the lowest paid people in Australia (Australian Ageing Agenda, 2017a).

Growing use of the peer-to-peer style model has the potential to place further downward pressure on wages. While carers working as sole traders are able to set their own hourly rate, a current average reported cost of $25-35 per hour on one large platform (Better Caring, 2018), needs to include professional indemnity and public liability insurance, superannuation and travel costs, along with a 10% service fee to the platform.

Training and development opportunities that are typically offered through traditional aged care providers also need to be considered (Australian Ageing Agenda, 2018a).

5.2.4 Workforce perspectives on consumer directed care

While the reforms emphasise the role of market competition to improve care quality (Dept of Social Services, 2015b), older Australians perceive the care relationship with individual workers as key to quality of care (Day et al., 2017).

Aged care staff are supportive of consumer directed care as a means to empowering their clients and giving them a greater say (Gill et al., 2017; Prgomet et al., 2017; You et al., 2017). However, some staff report that there is little difference between the delivery of the new consumer directed model and how services were previously delivered (Gill et al., 2017).

While direct care workers believed that the new model would not significantly affect their day-to-day work (Prgomet et al., 2017), case managers described a number of potential complications including having less time to spend with each client and difficulties accommodating client preferences for particular workers (Prgomet et al., 2017; You et al., 2017).

Further research is needed to understand the impact of the reforms on the roles and work activities of the workforce and the support that they need to deliver high quality care.

5.2.5 Technology and the workforce

Technology and digital systems are largely absent from the Aged Care Sector Committee's Aged Care Roadmap which sets out the vision for future reforms in aged care (Aged Care Sector Committee, 2016).

A survey undertaken by the Aged Care Industry IT Council in 2014 found a low level of digital maturity among home care providers and an unequal distribution of adoption of technological infrastructure (Livingstone, 2014).

The Aged Care Industry IT Council has released a technology roadmap to accompany the Aged Care Roadmap (Aged Care Industry IT Council, 2017). The technology roadmap emphasises the opportunities that new technologies and digital infrastructure can provide for the workforce and care recipients, as well as highlighting the need to increase the readiness of the sector for these technologies through ongoing training and upskilling and a formal workforce technology development strategy (Aged Care Industry IT Council, 2017).

Outside the aged care sector, there is evidence that integrated digital information about patient health and management can improve adherence to quality guidelines and patient outcomes (Dowding et al., 2015).

Greater investment in digital infrastructure and building a technology-enabled workforce will be essential to driving quality in aged care.

6 How have the reforms impacted the wider health system?

The Home Care Packages Program does not exist in a silo. Many people use and transition between different forms of aged care (Australian Institute of Health and Welfare, 2011). People who receive aged care services interact with other sectors of the health care system, such as hospitals, at a higher rate than the general population (Australian Institute of Health and Welfare, 2013b). Reforms that target the home care system therefore have the potential to impact the wider Health System.

6.1 The Commonwealth Home Support Programme (CHSP)

The Australian Government Department of Health recommends that those approved for home care access the Commonwealth Home Support Package (CHSP) while waiting to be assigned a package (Senate Community Affairs Committee, 2017a).

The Commonwealth Home Support Programme (CHSP)

The CHSP provides support for older people who require lower levels of care than the Home Care Packages Program (Dept of Health, 2017a) and is the most common entry point into the aged care system (Australian Institute of Health and Welfare, 2011).

Unlike home care packages, CHSP service providers are awarded blocks of funding to run a variety of services and care recipients are not formally means-tested. This creates a disincentive for those using CHSP services to move to a home care package where means-testing can be applied (Dept of Health, 2017h).

The *Tune Review* has consequently recommended introducing mandatory means-tested contributions for CHSP services (Dept of Health, 2017h).

As a result of the unmet demand for home care packages, CHSP providers have reported that their program outputs are exceeding their block funded grant agreements (Leading Age Services Australia, 2017a). Nearly 25% of people using the CHSP access three or more service types, indicating complex needs that would be better managed by a home care package (Community Care Review, 2017c). While issues with under-reporting of CHSP activity (Productivity Commission, 2017b) means that the impact of the reforms on this program cannot be reliably examined, greater resourcing for community-based services is clearly needed.

Additional services under the CHSP are accessed by 3% of home care package recipients, indicating that their needs are not being met by their home care package (Leading Age Services Australia, 2017b). The introduction of a Level 5 package (see Figure 1) of equivalent value to the average cost of a residential aged care place would allow people with high care needs to access the level of support required to continue living at home (Dept of Health, 2017h).

6.2 *Aged care as critical to health and wellbeing*

At a basic level, aged care ensures people have access to adequate nutrition and personal hygiene that is necessary for maintaining health. Aged care is also vital for supporting the provision of health services (e.g. transport to appointments), and for preventing sentinel health events (Clemson et al., 2008). Nearly 30% of people use some of their home care package funding for clinical nursing services, physiotherapy or occupational therapy services (AMR, 2017; Jorgensen et al., 2018).

While aged care is an important component of Australia's health system (Productivity Commission, 2011), it is not designed to be used as a substitute for health specific services (My Aged Care, 2017). In this regard, aged care occupies a unique place between the health and social care systems.

Changing attitudes to improve population outcomes

Formal aged care is often seen as a safety net for those who do not have access to informal support, with services reported under welfare spending (Australian Institute of Health and Welfare, 2017b).

Shifting the public view of aged care away from 'caring' to a sector that is critical to health and wellbeing may support increased workforce pay and access to aged care as a universal right, as it is in healthcare more broadly (Australian Commission on Safety and Quality in Healthcare, 2008).

The incorporation of aged care as one of six priority areas for Primary Health Networks established by government in 2015 demonstrates a recognition that aged care is vital to improving population health outcomes.

The current conceptualisation of consumer directed home care is inconsistent with practices across the rest of the health system. Person-centred approaches that are increasingly common in acute and primary care settings are not designed to leave patients to self-manage their care, nor do they support physicians capitulating to patient requests against best evidence (Epstein et al., 2010).

The focus on self-management of home care packages will likely result in less clinical input and support for care recipients to guide their service choices beyond fulfilling basic physical needs. While there is strong evidence that social support improves physical health (Reblin and Uchino, 2008), these services

are less likely to be chosen by care recipients in systems where individual budgets are utilised (Simons et al., 2016).

Under consumer directed care, older Australian also appear to want to 'save for a rainy day' in case care needs increase in the future (Leading Age Services Australia, 2018; StewartBrown, 2017). This may result in people forgoing necessary care which ultimately leads to a greater demand for more intensive and expensive care in the long term.

Consideration needs to be given to the effect of changes on consumer behaviour and the subsequent impact it may have on the health system in its entirety.

6.3 Data integration to monitor system-wide impacts of the home care reforms

Investing in home care has the potential to alleviate pressure on other parts of the health system. On the other hand, restricting access to home care may increase the use of more costly forms of care such as permanent residential aged care (Leading Age Services Australia, 2017b).

A population-wide analysis of the outcomes of those waiting in the national queue for home care should be undertaken to determine whether the costs associated with being unable to access care are greater than the costs of increasing the supply of home care packages.

The National Aged Care Data Clearinghouse was established to support aged care research and evaluation (Australian Institute of Health and Welfare, 2014). However, interactions between home care and the rest of the health system are not well captured by the Clearinghouse. While the Australian Institute of Health and Welfare's Pathways in Aged Care work has linked health and aged care datasets (Australian Institute of Health and Welfare, 2011; Australian Institute of Health and Welfare, 2017a), this resource does not appear to have been utilised to evaluate the impact of the home care reforms on the health system.

The Australian Government has recently endorsed strategies that promote return on investment from public data collections (Productivity Commission, 2017a), and has created a cross-portfolio data platform to analyse the long-term effectiveness of public policy (Dept of the Prime Minister and Cabinet, 2017). Public consultations are also underway on Australia's national digital health strategy, which includes a focus on maximising interoperability of clinical data between care settings (Australian Digital Health Agency, 2017). These changes should further facilitate the evaluation of aged care reforms on a large scale, and inform future reforms to support measurable improvements in outcomes.

7 Conclusion and recommendations

Policy reform is needed to ensure that our aged care system can meet the needs of Australia's rapidly ageing and increasingly diverse older population. However, these reforms should be guided by consumer input and the recommendations of independent reviews where these are based on research evidence. A rigorous evaluation plan should be built into future home care policy reforms to ensure improved monitoring of the impact of changes on older adults and the people and systems that support them.

This issues brief has identified limitations in the development and evaluation of the reforms to the home care system. Priorities to improve the success of current and future reforms, and ultimately the care of people using home care services, are outlined below.

7.1 *Recommendation 1: Undertaking rigorous research to identify barriers to accessing home care and consumer directed care*

Evaluations of My Aged Care and the implementation of consumer directed care have primarily consisted of small qualitative studies with few people from diverse backgrounds. The Australian Government Department of Health should commission independent research with a large sample of older adults that is representative of the broader community in order to:

- Identify ongoing barriers and evaluate implemented solutions to accessing home care via My Aged Care and the national prioritisation queue; and
- Monitor the implementation of consumer directed care particularly for those with cognitive impairment and from diverse backgrounds.

7.2 *Recommendation 2: Establishing data sources to quantify unmet community demand for home care*

There is currently no accurate estimate of unmet demand for home care in the wider community. The collection of this information should be prioritised in order to take steps towards uncapping the supply of home care places, a move which is supported by the Productivity Commission, the Aged Care Sector Committee and the wider public.

Adding questions about needs for formal aged care services to an existing population survey, such as the Australian Bureau of Statistics' Survey of Disability, Ageing and Carers, is one potential way to collect these data.

7.3 *Recommendation 3: Monitoring access to home care services for special needs groups*

The Aged Care Act 1997 (Cwlth) aims to ensure aged care services are targeted towards people with the greatest needs for those services and recognises nine population groups as having special needs. Three additional groups not listed in the Aged Care Act 1997 (Cwlth) may also experience challenges in accessing care: people with dementia, people with a disability and people with mental illness.

However, for most of these groups, there is inadequate data to monitor patterns of access to home care. Giving care recipients the opportunity to identify membership of special needs groups during their aged care assessment would facilitate monitoring access to home care for these population groups, including enumerating the number of people with special needs waiting in the national prioritisation queue.

7.4 *Recommendation 4: Informing consumer choice through the availability of information on provider quality*

Although the aged care reforms emphasise increased choice and control for consumers, there is little public information on provider quality to inform consumer choices. The Australian Government Department of Health and the Australian Aged Care Quality Agency should prioritise:

- The public availability of information already collected on the quality of home care providers, for example through publishing the Final Quality Review Reports of home care services; and
- The collection of richer sources of quality information, for example through implementing the National Aged Care Quality Indicator Program in home care.

7.5 *Recommendation 5: Utilising and improving the quality of aged care data collections that measure outcomes*

The Australian Government provides funding for a central repository of national aged care data and endorses return on investment from public data collections. Quality issues with data on exits from home care in the National Aged Care Data Clearinghouse should be investigated as these data are a timely population-based source for examining the outcomes of home care.

Existing data sources from across the health system should also be utilised to evaluate the impact of the home care reforms on the outcomes of those both receiving and waiting to receive home care.

7.6 *Recommendation 6: Developing home care reforms that are supported by consumers and research evidence*

The current consumer directed home care model is only partially supported by research on consumer views. The Aged Care Workforce Strategy Taskforce has undertaken engagement and consultation with stakeholders, but it is not yet known whether a review of international and national evidence has been undertaken to better evaluate the merits of stakeholders' opinions.

Future home care reforms should be co-developed with consumers and other key stakeholders and be based on evidence from rigorous research studies.

Appendix

What is home and community-based aged care?

Home and community-based aged care (community care) is designed to support older people to live independently in their own homes. Services are accessed by people who need ongoing help with daily living tasks and clinical nursing care, support after a hospital stay, respite from caring responsibilities, reablement services such as home modifications and social support to remain connected with the wider community.

There are currently two major types of government-subsidised community care in Australia (Dept of Health, 2017a):

1) the Home Care Packages Program, which provides ongoing support for people with complex care needs who have been approved for residential aged care; and
2) the Commonwealth Home Support Programme (CHSP), which provides entry level support.

Over one million older Australians utilised these community care programs in 2015-16, at a cost to the government of $3.7 billion (Aged Care Financing Authority, 2017a). Those receiving care personally contributed an additional 5% towards the costs of their care . By comparison, government expenditure for the nearly 235,000 people in permanent residential aged care was $11.4 billion in 2015-16 (Aged Care Financing Authority, 2017a).

From July 2018, the Commonwealth will have full funding, policy and operational responsibility for the delivery of aged care services across Australia (Dept of Health, 2017k). At this time, Western Australia will be the final state to transition its current entry level home support program to the CHSP (Dept of Health, 2017k). The Australian Government Department of Health is responsible for the operation of the Aged Care Act 1997 (Cwlth).The Aged Care Act 1997 (Cwlth) governs the provision of the Home Care Packages Program and residential aged care services, but not the CHSP (Dept of Parliamentary Services, 2016).

Currently, the government controls the number of people able to access government-subsidised aged care by specifying a maximum number of home care and residential aged care places that it will subsidise each year (Aged Care Financing Authority, 2017a). Most aged care is provided informally by family, friends and communities (Australian Bureau of Statistics, 2016). Formal (paid) aged care is considered a safety net for those who do not have access to these supports, with services reported under welfare spending (Australian Institute of Health and Welfare, 2017b). However, formal aged care is also considered an important component of Australia's health system (Productivity Commission, 2011).

Under the Aged Care Act 1997 (Cwlth), nine groups are recognised as having special needs:

- people from Aboriginal and/or Torres Strait Islander communities;
- people from culturally and linguistically diverse backgrounds;
- people who live in rural or remote areas;
- people who are financially or socially disadvantaged;
- people who are veterans of the Australian Defence Force or an allied defence force including the spouse, widow or widower of a veteran;
- people who are homeless, or at risk of becoming homeless;
- people who are care leavers (including Forgotten Australians, Former Child Migrants and Stolen Generations);
- parents separated from their children by forced adoption or removal; and
- people from lesbian, gay, bisexual, transgender and intersex communities.

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Contact

Dr Rebecca Haddock
Deeble Institute for Health Policy Research
Australian Healthcare and Hospitals Association

E: deebleadmin@ahha.asn.au
T: 02 6162 0780
Tw: @DeebleInstitute