national
AGED CARE alliance

Aged Care Reform Series - Assessment and entitlement (including the Gateway)

The National Aged Care Alliance (the Alliance) developed this paper to provide additional advice to Government, through The Hon Mark Butler, MP Minister for Mental Health and Ageing, as it considers the proposed aged care reforms from the Productivity Commission's Caring for Older Australians report which was released in August 2011. Assessment and entitlement is one in a series of six papers available on the Alliance website (www.naca.asn.au), other papers in the series include: Financing aged care in Australia, Palliative care, Quality of care, Wellness and Workforce.

Background

The purpose of this paper is to discuss how assessment and entitlement would work in a reformed aged care system. The paper is structured around eight assessment and entitlement related questions and concludes with recommendations on the priorities for reform.

Overall the Alliance supports the recommendations made by the Productivity Commission (the Commission) on entitlement and assessment.

Operation of an entitlement system

An entitlement to support for aged care operates as a complement/supplement to a whole of system response to the impacts of ageing, and the needs of older people and their families.

An entitlement approach to provision of aged care needs to deliver access to both general community based supports (predominantly attending to activities of daily living, community engagement, wellness and reablement) and/or a defined allocation of resources. This would ensure entitlement to a continuum of supports for older people starting with low end support (social capacity/community asset based models) through to high care and specialised clinical services and accommodation settings.

One of the aims of implementing an entitlement approach is to support increased consumer choice. A reformed aged care system must allow older people and their carers to articulate their needs, preferences and aspirations and their entitlement needs to operate in a way that enables them to access services that best fit with these.

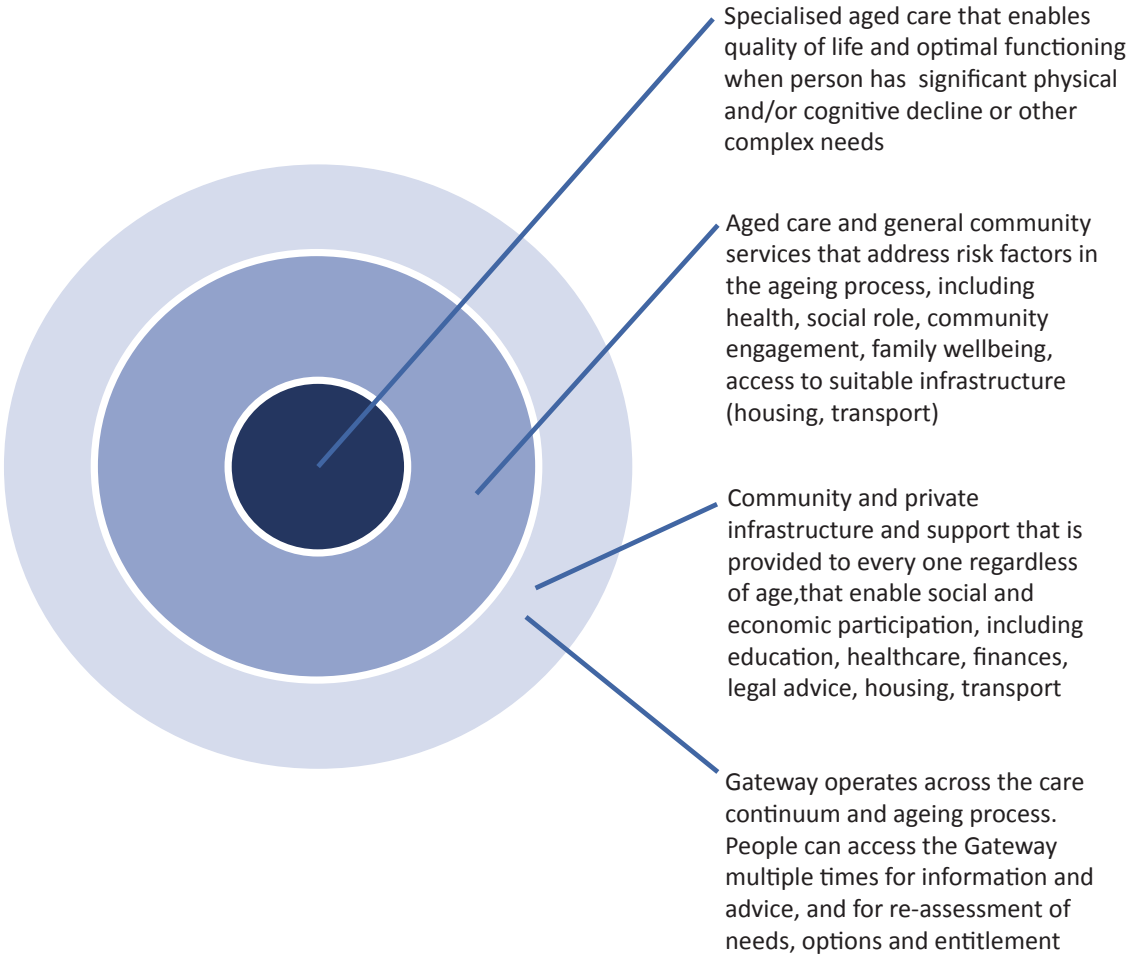
There is a need to review the content of and measures of compliance with regulatory requirements and quality standards to ensure they align with different expectations about access to services and what comprises a quality experience for an older person, their family and carers[1].

Figure 1 below illustrates a tiered approach to responding to the needs of older people in a community and indicates how the Gateway operates across this tiered system.

In the outer ring **general community infrastructure continues to meet older people's needs along the ageing and care continuum**, and help protect older people from losing access to the components of a decent life that everyone in the community is entitled to access.

[1] This issue will be also considered in the paper on Quality

Figure 1



In the second ring, **risk factors associated with ageing are addressed, by both general community infrastructure** (e.g. community transport, social connectedness programs and activities) **and by specialised support programs** (e.g. home maintenance and modification, family support and respite).

In the inner ring, is support for older people with higher needs and their families who require specialist skills, equipment or support services either at home or in a purpose built facility.

An entitlement, based on assessed need, would provide an individual with a level of resources (a set funding limit per person per year derived as a result of the assessment, this would be common across defined levels of need for individuals and operate in a similar way as packaged care or ACFI funding) to meet their needs. It should not be a menu driven prescription for particular service types or hours/visits/episodes of care; rather, the services able to be provided as part of an entitlement would be all those in the inner ring and some in the second ring. There would also be no artificial service type exclusions, as currently occurs with nursing for CACPs for example.

The entitlement would then be used to fund services accessed from approved providers. The level of the entitlement would be incremental, and respond to changes in need, including the outcome of moving to a lower increment if a person recovers some functions as a result of reablement programs.

The reforms discussed in this paper should also support a change of focus around referral and case management so the aim is clearly on improving the integration of information sharing, advice, support and care.

One of the differences from the existing system is that the older person and their family could seek assistance from a case manager or co-ordinator to navigate the service system as part of their entitlement. This could be provided by the Gateway or other organisations specialising in longer term case management (such as current Community Options services in some states).

The entitlement will make clear the issues the funding is intended to address, and older people and their families, in consultation with the Gateway and local service options will identify key goals and services that will assist in meeting their aspirations and preferences. The determination of entitlement funding, including episodic and emergency respite, should be sufficiently flexible as to incorporate a component of spontaneous service not planned ahead as this is one of the great deficiencies experienced by carers managing the caring role. The provision of equipment and aids and assistive technology should also be part of the entitlement.

Information and support will need to be part of this stage of the process so older people and their families can envisage 'what could be' rather than what is, establish aspirations and preferences and coordinate support services to enable goals to be reached.

The Commission has defined the range of services that it recommends be entitlement based[2] and the Alliance supports this definition. However, the Alliance favours the inclusion of as many services as possible under an entitlement model, and the limiting of block funded services, or service types, to as few as possible. The Alliance supports retention of some block funded services as proposed by the Commission, either to ensure provision to particular remote regions or for special needs groups, or as general community access services. The Alliance noted that there may be a case for low intensity domestic assistance services to be available through the block-funded community support services, as well as a part of an entitlement. Reablement services will be provided free of charge as a way of encouraging their take up. All funded aged care services should be both person and family centred and promote health and wellbeing.

Given the lead time likely to be involved in developing an entitlement based aged care system, the government should act very early on the Commission's recommendation to increase the supply of community care places by 20% above the current planning ratio, including the introduction of an intermediate level of care between a CACP and EACH package.

Following establishment of the Gateway and initial bedding down of an entitlement approach, there should be scope to develop more flexible allocation systems, like 'vouchers', 'cashed out' service entitlements and self-management of allocations of funds. However, the Alliance supports a cashed out respite care program as a stage one priority, and the lessons learned from this will inform potential broader use of cashed out funding arrangements in later stages of the reform process. There are concerns about the workforce impacts such an approach would create, so there is not universal support for this in the Alliance membership. Further discussions are occurring between Alliance members to identify the various issues and identify if, and how, these could be managed under such circumstances.

[2] Caring for Older Australians, Vol. 2, pp 169 – 171 (Box 9.10 & Figure 9.6).

Managing costs to Government in a more choice driven system

In the system envisaged by the Productivity Commission, only one of the existing government incurred cost control mechanisms is being removed (i.e. supply side place allocations). The Government will continue to control eligibility via the Gateway and to control the price (even though the AACC pricing recommendations make this a more public process). It will continue to control the block funded part of the system as happens now.

There will always need to be a balance between providing the most up to date and appropriate services to people (particularly as people come to expect a higher level of care, and the sector continues to develop new technologies), and managing the cost of care to government. The Government will maintain responsibility for determining the assessment and entitlement framework and the level of subsidy provided to support approved service types. This framework should be based on a commitment to maintain access to adequate services whilst controlling fiscal risk in the longer term, knowing that if the cost becomes too great, the system will have to be sustainable.

Assessment system and process

Individuals over the age of 65, and their carers, would have to be assessed by the Gateway to receive an individually allocated (as opposed to 'block funded') aged care service entitlement as would people defined as having special needs under the current Aged Care Act including indigenous people. However, there are sometimes people under the age of 65 who have care needs associated with them experiencing the impacts of ageing at an earlier stage in life due to disability or illness.

There may be a case for example, for a younger person living with HIV, a severe disability or younger onset dementia to be assessed through the Gateway and receive an entitlement. The entitlement, and the persons informed choices of the services and support they require, should be funded through the State/Territory disability services program until the person attains the age of 65[3].

In some locations (e.g. regional and remote) and in some groups (e.g. CALD, GLBTI, Indigenous, homeless, mental illness) the Gateway may seek to contract assessment to people who have particular expertise or pre-existing relationships with the older person and their carers. Equally important is the availability of, or access to, interpreters and people who are familiar with particular cultural norms. Where appropriate, such agents might also hold the delegation to approve an entitlement (e.g. a medical officer providing outreach services in a remote community).There would need to be appropriate training and practice standards for assessment, and auditing of the consistency of these assessment outcomes as compared with general Gateway assessments.

The Gateway would use standardised assessment tools (the work on ACFI, NITACC, ACCNA-R and CENA-R needs to be reviewed in this context). The assessment would be broadly the same across residential and community care but must take account of some variations within settings and for people with different capacity to inform the assessment process.

Initial needs identification could be done over the telephone and individuals and families could self assess. There would need to be a monitoring and recall system where this has occurred. Assessments will also need to be conducted in peoples own homes and other care settings. People should not have to physically attend a specific Gateway location to be assessed.

[3] The need to build workforce capability in this area of service delivery will be included in the paper on Workforce issues.

Where individuals or carers and families have already been assessed the information from these earlier assessments would be made available to the Gateway (with the individual's consent) to reduce duplication. Good IT systems and e-health should assist in streamlining this process, and lessons need to be learned from implementing e-records in GP networks, so the same mistakes are not repeated.

Dementia diagnosis and care planning must be core components of the Gateway assessment process. Behavioural issues have a major impact on the way services and support are provided and designed.

The Gateway will work closely with medical specialists such as geriatricians and other health professionals and may establish sub-contracts with such personnel in cooperation with state/territory health authorities and private practitioners.

The Gateway would provide access to the full range of services and providers to afford genuine choice as opposed to a referral to a specific care provider.

At the point of assessment, care co-ordination would include support to access choices and it may also require some referrals (some may need to be supported), advocacy. The Gateway could also provide a limited follow-up service for people assessed as not being able to advocate for their own needs if these are not being met.

More detailed care planning and case management is likely to occur at the service provider level given the longer term nature of the relationship. Consumers will choose whether they self-manage their care services, or case management is provided by the Gateway or the service provider. As people move across the care continuum and as their entitlement to support grows, protocols/performance criteria for transfer of case management responsibility will need to be established. If people are self-managing, then the Gateway should be responsible for an annual audit and for providing advice and support to ensure successful self-management.

Monitoring, review and reassessment is an important aspect of the process. This needs to be done for people receiving block funded services (outside of the entitlement system) and the Commission recommends this occurs after 12 weeks. This could be done by the service provider, with scope for independent assessment if requested by the service user. Referral back to the Gateway could be triggered if there has been a significant change in the older person's circumstances (e.g. a major health event or loss of carer) which requires a broader reassessment of the person's needs. Direct care staff will have an important role in day to day monitoring and feedback of relevant information to the service provider.

A similar approach could be taken for people receiving entitlement based services but there would need to be clarity about when another independent assessment was required given resourcing implications. The Alliance believes consumers should have a choice about whether the reassessment is completed by the Gateway or by their service provider.

If the service provider completes the reassessment, the Gateway would conduct desktop audits that apply a risk based approach as outlined by the Commission, to monitor the integrity of these reassessments.

A possible risk in this reassessment process is that the Gateway will not be sufficiently resourced to ensure timeliness of the process. This could be mitigated by monitoring and reporting on performance criteria/standards for the Gateway in terms of time for the reassessment and determining related changes to the level of entitlement (both from a consumer and provider perspective).

Carer assessments

As the needs of older people and their carer are often interdependent it is preferable that wherever possible their needs would be assessed together rather than separately. This would best be done at the Gateway.

The system for carers should operate in the same way as it will for older people. Carers who have only low level service needs may directly access block funded services, with follow up after 12 weeks. Where needs are higher, either for the carer themself or the person for whom they are caring, assessment for entitlement would be undertaken by the Gateway. Where an older person has refused assessment or services the carer should still be able to have their needs assessed directly by the Gateway to ensure they can access entitlement based services which are only available through that process. A carers entitlement could include planned respite as well as block funded carers support services such as education and training, emergency respite, counselling, peer support and advocacy. Carers, as much as older people in receipt of care, should be confident that they will receive the services they are assessed as needing. It will be critical that carers can access both entitlement and block funded services as needed.

Assessment of capacity to pay

Assessment of capacity to pay should be separate from assessment of needs and entitlement to a quantum of funding. Centrelink should assess capacity to contribute to the costs of services. The means testing function of Centrelink should be very much 'back of house'.

Research has shown that older people can be uncomfortable with dealing directly with Centrelink, and would prefer communication from Centrelink to be in written letters posted to their residence, not via phone or email. The Centrelink assessment process must also be simple for older people and their carers to undertake.

The Gateway

The Gateway is critical to support an entitlement system. Its design consolidates a number of roles and outlines new roles/responsibilities that will provide better outcomes for older people and more effective management of Government resources by providing:

- easily identifiable community information (positive ageing and aged care) hubs;
- support to make sense of the information, make informed choices and navigate the system;
- inclusion of a reablement/strength based assessment and capacity to offer reablement services (free of charge) and reduce dependency on higher cost and/or ongoing service provision;
- guidance and advice and/or case management to assist people make the right choices to meet their needs;
- standardised and consistent assessment nationally including telephone and other forms of assessment; and
- facilitation of discussion that supports the older person and their carer to express their needs, aspirations and preferences through assessment approaches and tools.

Gateway infrastructure would be resourced by reallocating funds from DoHA and from state and territory systems used for planning, allocation, oversight, management of existing assessments and allocation programs to run the Gateway. The Gateway infrastructure would include:

- Central co-ordination – resourced by re-allocating funding and resources currently used for planning and allocation, monitoring ACAT program, and administration of DoHA funded programs.
- Community-based presence – need DoHA to cost current allocation of Federal Government funding to ACATs, Carelink, Respite Centres, Access Points and determine whether we need more to resource a Gateway as described by the Commission. This approach assumes HACC assessment resources would become part of the Gateway for the entitlement program, except for those assessments undertaken by block funded services for their own service types and in the interim in Victoria and Western Australia.

Additional funding may be required to ensure there is adequate resourcing which avoids the Gateways becoming a bottle neck (direct access to block funded services is designed to assist this potential problem); and having long waiting times for assessment and re assessment. The Gateway's need to provide accurate and independent advice that people can trust to make hard decisions at vulnerable times in their lives. Performance indicators and standards (including maximum waiting time for assessments, relationships between the Gateway and the services within their region) for the Gateways should be established and monitored.

The Government controls eligibility via the Gateway and it controls the price (even though the AACC pricing recommendations make this a more public process). Refer Appendix 1 for further detail on establishment and operation of the Gateway.

Staging

The Gateway and AACC are the basic architecture of the reformed aged care system, and will both drive and enable a different approach to needs assessment and service responses.

Whilst Gateway and funding entitlement processes get established, case managed care would be the norm, with further reforms to enable self-managed care enacted once systems are in place to support and audit this. Funding for case management services would need to be defined from within existing resources.

Choice in aged care

At several points along the ageing process, and along the support and care continuum, choices should be available to people, and support should be provided to exercise these choices, including through independent advisors and advocates. Older people, their carers and families should be able to choose the setting for support and care, the type of support and care they prefer (within a choice of recognised approaches) including emerging technology and the provider of that care. Over time, people would also be able to choose whether they cash out their entitlement, and whether they self-manage funding allocations.

A critical change needed in the service system is more diversity in the type of housing and care available, not only diversity of providers of similar types of housing and/or care. Choice is only meaningful when there is a real diversity of options. In particular locations and for groups with specific needs, block funding of services will be critical to ensuring genuine choice. In some regional and remote locations, it may only be possible and/or more effective to block fund one service.

For people with impaired cognitive function, including decision-making capability, support should be available to ensure they are given every reasonable opportunity to express their preferences and interests. This should include support for family members to undertake this role, and an option for a delegated independent person to take on this role. There is significant expertise in the disability sector in recognising expectations and preferences of people with impaired communication and cognitive capabilities. This expertise could be used to support extension of consumer led decision making in the aged care system.

At any time, people should be entitled to determine the extent of choice they wish to exercise. The table below illustrates a continuum of decisions from totally delegated to totally self-managed:

DELEGATED				SELF-MANAGED
Choice of a service provider who determines service package	Choice of services offered	Directing own funding within a service	Managing own service package, with delegation of staff employment to services	Self or carer management of funding, including employing staff

As part of the reform process, resources will need to available to support people and the system to adopt a more consumer oriented model of provision. This includes:

- supporting older people, their families and carers to imagine what could be rather than have their choices and decisions constrained by what currently is available on offer;
- building capacity and diversity of service options offered by services that are the single provider (eg in remote locations, or specialised in responding to specific needs);
- increased transparency of assessment and allocation decisions and improved access to review mechanisms;
- access to independent advice, recommendations and advocacy;
- workforce competence in recognising, facilitating and responding to consumer and carer or family choices; and
- service model approval/registration/accreditation/quality systems that are outcomes focused, not guided by existing models of care or methods of provision.

An illustration of how different levels of choice could be exercised is in Figures 2 and 3:

Figure 2

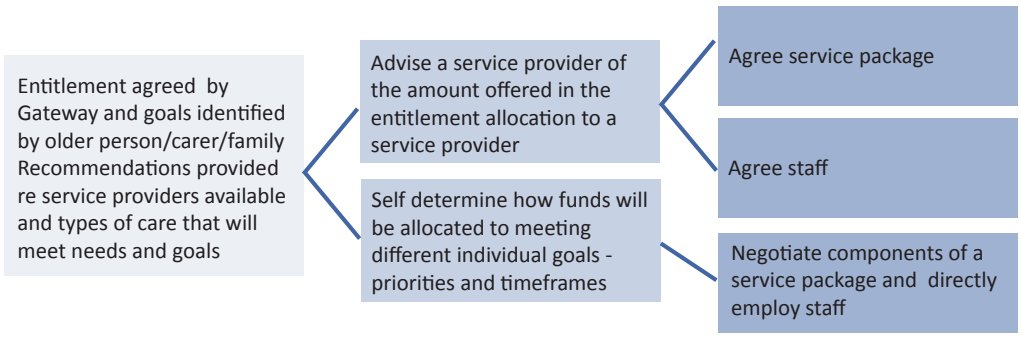
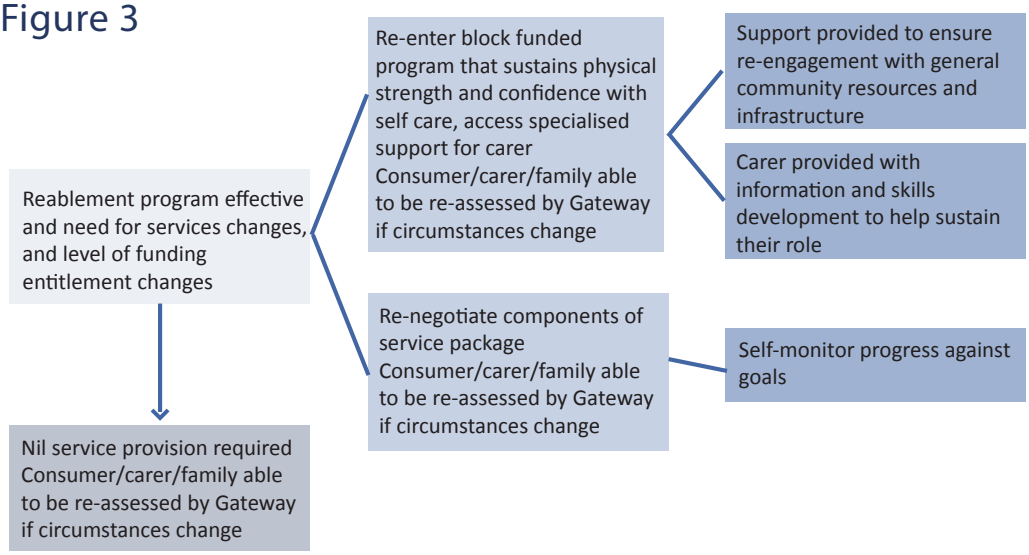


Figure 3



HACC and aged care reform

In the current system HACC is often the first point of call in community care services. HACC services are critical to providing community care in the reformed system but HACC would need to cease operating as a separate program in most states. Its resources would be combined with all other existing community programs such as the National Respite for Carers Program (NRCP) and other separately targeted programs. This would remove current duplication and boundaries in the system where some services can or can't be provided under packaged care and/or under HACC.

In Victoria and WA (while they remain with the HACC Program in State hands) it is envisaged that the existing HACC assessment hubs would be maintained and it and the Gateway will need to ensure good information and partnerships between all services.

Demand for residential and community aged care

Data on this is collected but is not made generally available (eg ACAS data) and only approximations can be made with some of the existing data sets that are made public, such as HACC, Packaged Care, ABS Survey of Disability and Carers.

There is a high level of unmet demand for carer support services, including education and training, counselling, peer support and advocacy.

Based on existing demand for services, occupancy rates in residential aged care and expressed consumer desires it would seem that the largest unmet demand is for care at home for as long as possible. The recommendation to introduce an interim intermediate care level between CACPs and EACH is supported.

Demand for low level residential care is decreasing, as people have better access to community based options and are entering residential care at later stages and for shorter periods of time. However, low level residential care in regional areas, and in some metropolitan populations, has provided an affordable housing option. The loss of low care as a housing option creates a real gap in the housing market for older people. It is hoped that the separation of accommodation and care funding will enable new models of supported housing to evolve to address the growing housing issues, and homelessness of older people, particularly older women.

There will continue to be demand for residential care. People with dementia in particular will need longer term, high level residential care. While there are now higher vacancy rates in some residential care services there is still strong demand for single rooms with ensuites in well located, quality services.

It is anticipated that greater short-term provision of services like rehabilitation, palliative care and respite will create a new and different demand for residential care services.

There is an increasing number of people over the age of 65 living with disabilities and mental illness becoming eligible for aged care services. There is demand for services that can effectively meet these needs. Attention will need to be paid to building both workforce competence and service models that provide appropriate, high quality services to meet different needs, both in mainstream and specialist services.

A comprehensive system

The entitlement will be based on a resourcing level, an agreed framework for identifying and responding to needs and where necessary a specific care plan. The Alliance believes the different components will fit together at the individual client level.

Block funded services can be accessed directly or via the Gateway as part of a service entitlement. Where the person or their carer has a need for block funded services, such as meals, that if not provided would seriously affect the person's well being and/or trigger demand for a higher level of care (particularly entry to residential care), it should be incorporated into their entitlement. A consistent methodology for reimbursement of costs from the entitlement to the block funded community and carers support services will need to be established.

Information provision

The Gateway will become the information and assessment hub in local communities/regions. It will need to take a broad view of older people's needs, and be able to refer them onto a wide range of community resources. It does not need to be the expert in all areas in order to achieve this.

However it should be acknowledged that they are unlikely to become the only information point in the community as GPs, local community and private services and others will continue to provide information across a range of issues to older people and their carers.

It is essential that the Gateway works closely with the new Medicare Local agencies. If not there will be substantial duplication of services and information resources, because GP's workloads are predominantly with older people.

The Gateway would need to have a physical (as well as virtual) presence in regions that make sense locally. In some cases this may be an LGA and in others it may be alignment with a Medicare Local. The goal should be to ensure accessibility and local relevance, including integration with existing service centres.

The Gateway should have support personnel able to assist with accessing information, navigating online information and accessing/understanding recommendations that will inform decision making about healthy ageing, block funded services, and specialised aged care options.

Different models of care enabled by aged care reform

- Integrated co-ordinated care at home
- Appropriate take up of support via TeleHealth and TeleCare options – using technology in the home to monitor chronic conditions and get alerts when needed
- Supported group cluster housing with care access
- Supported seniors accommodation models with care
- Service options that incorporate attending to wellbeing, accessing funds to overcome social isolation and providing community integration support
- Affordable housing approaches that enable healthy ageing and better responses to impacts of ageing especially for single older people with low wealth
- Self-directed care plans and funding management
- Better demand management strategies such as developing responses to the older frequent presenters to local acute hospitals

THE GATEWAY

The Productivity Commission (PC) recommended the establishment of a Gateway agency as a key part of the aged care reform architecture. It was recommended, following advice from COTA, as a way of addressing a range of significant issues older people experience in accessing aged care services, existing assessment processes and ongoing care co-ordination and management issues.

Consumer confusion and dissatisfaction with the current system is wide spread. Many submissions from consumers and providers to the Productivity Commission Inquiry called for improvements to aged care entry requirements. The need for this has been reinforced recently through the Minister for Mental Health and Ageing's *Conversations on Ageing* where people are keen to know how the Gateway would operate and have supported the general concept.

This paper attempts to flesh out the issues and explain why the Gateway is required, the functions it would perform, and outline possible operational models for the new agency. It is at a high conceptual level and further work would be required to fully develop the system.

FUNCTION	ELEMENTS	EXISTING	COMMENTS
Provision of Information and Support to Use/ Make Sense of the Information Available	• Positive/healthy ageing information	• Limited focus through health services	• Older people not prime target audience of existing information
	• Online and walk in	• Aged Care Australia website and private companies	• Poor usage by the community
	• Information on general services to support ageing		
	• Information on specific regional services to support particular needs	• Some with services, ACATs, Access Points etc	• Dispersed and difficult to access
	• Support to understand what the information tells you and to take action on it by providing advice and referral	• Does not exist except in ad hoc way	• Consumer views indicate this is a required and necessary value add
Care/Support Needs Assessment for people aged over 65	• Consistent assessment tool creating consistent outcomes	• Range of tools used	• Inconsistent application and dependent on which ACAT/ provider you see
	• Assessment of the individual and the carer – interlinked but also independently	• Range of assessors but not for carers at all	• Inconsistent outcomes for individuals and variable use/control of Government funding
	• Wellness approach and consideration of reablement needs and how they can be met	• Done in some HACC programs (WA and Vic) but not a systematic approach	• To make prevention gains, and save resources, needs to be applied systemically
	• Clarity about the needs and goals for each individual	• Focus on types of services available to support a particular need	• Provider/ACAT, and availability, driven
Creation of the Entitlement	• Allocate level of resources for an individual	• Advise services required	• Service/menu driven approach, not individual
	• Outline goals and purpose of resources being made available (developed in partnership with the older person and their family)	• Focus on the type of service that can be provided to support a particular identified need	• As above
	• Referral to the full range of services available within an area (this will mean more when there is more choice available) that will meet the agreed goals and purposes for each individual	• ACATs provide a list of relevant providers for individuals/families to follow up. Individual providers recommend own services	• No support to access

FUNCTION	ELEMENTS	EXISTING	COMMENTS
Financial Capacity Assessment	• Means test by Centrelink and determine care contribution	• Centrelink assesses for bond payments. Different HACC fees policies, different application of packaged care fees (due to HACC issues)	• Inequity, inconsistency and disincentives to accept or change services as needs change
	• Application and monitoring of the stop loss limit		• No linkage/monitoring of what an individual is paying overall
Reassessment and Monitoring of Individual Clients	• Ongoing monitoring of client progress/needs	• At and within the service provider	• Provider capture, but monitoring changing needs generally well done
	• Increase/decrease resources as required	• Services continue, very few time limited or decreased service provision	• As above
Service Directory and Data	• Keep up to date information on all services for older people within a region	• Some areas have this, eg. in Victoria local governments have this information	• All regions would have this for older people to access
	• Data would include vacancies to assist people access services and obtain them as needed	• Generally not available in current system	• Ensure people know who to go to if services required urgently rather than referrals that result in waiting/no services
Case Co-ordination/ Management	• Assist in developing package	• Dictate/standard package content?	• Limited range of services and support available either as result of Guidelines or service capture
	• Organise package (if required)	• Yes available, self management only available by exception	• Done by service provider, focus on own provision
	• Actively manage and create innovative ways to address people's needs	• Yes, within a service	• Focus on what can be provided by the organisation. Linkages broker in Victoria
	• Ongoing point of contact that can assist	• Yes, but service dependent	• Assists client capture
	• Maintain fair use of resources for case management/on costs and direct service delivery	• Variable based on provider management, not transparent	• Central and standard control ensure max $ on client service delivery
	• Change package as required	• Yes, within organisations	• Broader view of range of services/providers available
Contracting and Management of the Assessment Functions including standard setting and monitoring	• DoHA Program Management	• Variable and program specific	• Not able to create consistent outcomes for older people

Issues with the current access and assessment arrangements

- People don't know where to go to access information about aged care services;
- There is a variety of information sources that are not all consistent or of the same quality. There is no single authoritative body responsible for ensuring the quality and accuracy of information provided to consumers and service providers;
- People are assessed differently by different organisations (including ACATs) with different care and financial outcomes for individuals;
- Different assessment and allocation processes create variable financial outcomes for Government funding;

- People are assessed multiple times to access the same services;
- People are not assisted to access services. At best the ACAT provides a list of all available services within an area and the older person and their family are then left unsupported to assess and determine the best places for care and support;
- People are 'captured' by service providers. Once assessed independently (through the ACAT for residential and packaged care) aged care service providers undertake ongoing assessment and review. Not surprisingly most providers assess and recommend their own services to clients, very rarely are people referred on unless it is from community to residential care or to health services;
- There is a lack of transparency and independence which enables service capture; and
- Individual providers manage their budgets and in packaged care and COPS determine how much resource goes into overheads and case co-ordination/management and how much for direct service delivery. This is variable across the country and in some cases up to 50% of the total funding per individual may be used on case management and overhead costs.

There have been numerous attempts to address these issues over the years; all have failed to some degree. In part this is due to jurisdictional issues in HACC (e.g. Access Points while positively building on local infrastructure lack national consistency so they continue to assess and operate differently across the country resulting in differing outcomes for individuals and costs to Government) and ACATs which are effectively controlled by state health systems.

The system also has a number of other co-ordination and assessment points in CareLink and Commonwealth Respite Centres. Recently Government introduced a consistent 1800 number to try and streamline access. These initiatives have not been entirely successful because they only deal with certain aspects of the issues highlighted above.

One of the main aims of bringing these programs together as Federal Government responsibilities is to achieve standardised and consistent approaches to information, access and assessment. This means that Government would have to go through some process of consolidating and redesigning these programs, whether that is within existing Departmental structures or the development of an external body as proposed by the Commission. In the Alliance's view the creation of the Gateway will be the best approach to effectively address the issues older people experience on a daily basis with the aged care service system.

Information, access and assessment functions

The following table identifies the functions required to address the above issues and comments on how, and if, they happen in the current system.

In the existing approach there are multiple agencies involved in all functions – DHA, State Government Departments, ACAT/S, and Individual Providers - with limited ability to control what individual parties are doing. This creates wastage in Government funding and variable outcomes for older people.

Existing regional infrastructures that could be used to deliver these functions

An alternative to the creation of the Gateway is to resource and identify an existing regional infrastructure as the Gateway (or whatever name is finally determined).

The following table explores the various options and their perceived advantages and disadvantages:

EXISTING REGIONAL INFRASTRUCTURE	ADVANTAGES	DISADVANTAGES
Local Governments	• Established regional boundaries • Well known in local communities	• Variable interest in, and knowledge of, ageing and aged care (except Victoria) • Potentially too many of them • Ongoing jurisdictional issues, level of control and national consistency
Individual Service Providers	• In Regional, Rural and Remote (RRR) areas this may be the only appropriate option	• Conflict of interest with service delivery • Lacks independence and transparency on which reformed system is based • Varying governance arrangements
Medicare Locals	• Newly established • Roles still being defined so ability to integrate ageing and aged care	• Lacks any national consistency • Not well established, varying governance arrangements • Very large/not local as Tasmania only has one. • Embeds ageing and aged care in a medical (primary health) framework which is only part of ageing and aged care • Focus predominantly on co-ordination and linkages rather than any form of service delivery
ACATs	• Well established infrastructure • Known boundaries • Knowledge of ageing and aged care (Federal only programs)	• Many ACATs are placed in state based hospitals system, ongoing jurisdictional issues • Embeds in medical model • Current variability issues especially in extent of how multidisciplinary they are • Difficult to achieve organisational cultural shift required • Predominately seen as gatekeepers • Low level sector belief that this would create change/reform to the system
Carer Respite Centres/ Carelink	• Already exist in local areas	• Not well utilised • Very variable profile, some with good connections to communities, others not so • Narrow focus
Department of Human Services (Centrelink and Medicare).	• Well established infrastructure • Known boundaries • Already undertakes financial assessment for bonds • Co-location with Medicare will provide a good local platform • Building mobile services to improve rural and remote access	• Not core business • Knowledge of ageing and aged care • Combines service and financial functions • Older people generally reluctant to use

There are two overall disadvantages with any of these approaches:

The Department of Health and Ageing (DoHA) would continue to fulfil the management and contracting roles which has not been effective to date in creating consistent assessment tools, approaches and outcomes. Ongoing DoHA control combined with use of Centrelink (for example) makes this a very bureaucratic option. Continuing Departmental involvement in service management and contracting is not supported by the Commission which advocates for its role to be confined to policy development and Ministerial support. There is strong agreement with this proposition within the sector.

Some of these agencies would have limited authority in the system and potentially be in a weaker position to ensure the consistency that is required.

Gateway approach to delivering these functions

The Gateway creates one focal point for these functions and one point of control. It is envisaged there would be a small central Gateway Agency responsible for contracting and management of services at regional level. This would include:

- setting standard assessment tools;
- procedures, and managing and assessing performance to ensure consistency and fairness;
- operational policies and procedures;
- IT systems and software that will support e-health records and enable consistent audit and reporting to occur; and
- branding.

The central Gateway Agency would contract the regional service delivery function to the most appropriate provider in each region. This may be a local government, a new or existing service provider (but if an existing aged care provider applied it would have to create the Gateway as a separate and independent function from its own service delivery arm), a Medicare Local, Centrelink or another appropriate body. In determining this, acceptability and use by the local community would be a key consideration. The Gateway central body would undertake quality control, review complaints made about individual Gateways and take appropriate action.

It would be somewhat like a franchise model in a similar way that Australia Post operates throughout Australia (particularly in RRR areas) or IGA Supermarkets. In agreeing to operate as the regional gateway the organisations would have to use the standardised assessment tool which is more likely to result in the same outcomes for individuals and tighter control over Government funding. Consistent application of these would be a mandatory requirement to fulfil contractual obligations.

The central Gateway agency could alternately establish branch operations where it was not satisfied that franchising arrangements would not be appropriate, effective or sustainable but this would not be a frequent or common occurrence.

Resourcing the Gateway

Gateway operations would be substantially resourced by reallocating funds currently used for planning, allocation, oversight and management of existing access and assessment programs. There may be a need for one off capital funding for the development of new systems to support the efficient operation of the Gateway.

The Gateway infrastructure would include:

- Central Gateway Agency – funding and resources currently used for planning and allocation, monitoring ACAT program, and administration of DoHA funded programs; (DoHA to cost)
- Regional Gateways - funding to ACATs, Carelink, Carer Respite Centres, Access Points, HACC assessment funding. This approach assumes HACC assessment resources would become part of the Gateway for the entitlement program, except for those assessments undertaken by block funded services for their own service types and, in the interim, in Victoria and Western Australia. (DoHA to cost).

Additional funding may be required to ensure there is adequate resourcing which avoids the Gateways becoming a bottle neck (direct access to block funded services is designed to assist this potential problem); and having long waiting times for assessment and re assessment.

Advantages of the Gateway approach

- One body creating a consistent and transparent process and approach to assessment and entitlement
- Enable major structural change and reduction in duplication of roles
- Easily identified in each region
- Consistent functionality in each Gateway
- Consistent and overall approach (rather than current piecemeal approach and practice)
- A consistent and robust national system for determining eligibility for subsidies is essential to manage the Federal Government's fiscal risk
- Greater consistency also leads to better cost control for Government (e.g. standard % spent on case management and overheads) and better outcomes for individuals
- Enables new service and organisational cultures to develop around the reform principles rather than existing systems trying to incorporate this within what they are already doing
- Separation from DoHA consistent with the Commission separation of policy and service delivery (generally accepted within the sector as appropriate and necessary)

Disadvantages of the Gateway approach

- Could be portrayed as the creation of a new bureaucracy (rather than a flexible and innovative mechanism)
- Requires significant transition arrangements as dismantles existing programs/structures to create new, however this is probably required for any other solution given issues with the current system

Both of these perceived disadvantages can be managed with a well planned, defined transition phase and clear communication of purpose and function. Not all of the advantages can be gained with any other model.

Transition and sequencing

The Gateway needs to be established early in the process to drive change in the system and provide consumers with early indications of changing arrangements. This is critical to create the cultural shift from a rationed, provider dominated system to an entitlement, consumer driven system and to manage the Federal Government's fiscal risk.

One of the first tasks required will be the identification of the various funding sources and determination of overall funding for central and regional Gateway functions.

The Central Gateway Agency will need to be established first to undertake development of the various requirements and arrangements. This will then be followed by a contracting period. While this occurs existing assessment and access arrangements would continue with notification of the date existing arrangements cease. This would be a 12 – 18 month process.

Some of the existing regional agencies may decide to compete for the contracts to be the regional Gateway. If they are unsuccessful their existing redundancy arrangements etc would be applied. There would need to be overlap time from the operation of the existing body ceasing and the new body commencing to ensure a smooth transition. The sector is anticipating that there will be major structural change to access/front end arrangements so contracting of this nature should not create major surprise or consternation.