ACSA National Conference 28th September – 1st October 2008

CONSUMER DIRECTED CARE PANEL – THE AUSTRALIAN SCENE

Thank you for the invitation. I congratulate ACSA on including Consumer Directed Care or CDC in the Conference and on their discussion paper on CDC.

I will focus on the policy and political context of CDC in Australia.

I start from the view that aged care is not on the national political agenda. That is so despite concerns about the sustainability of the system and its capacity to meet the challenges of an ageing population. The question is what vision do we have for the future of aged care?

For two decades the driver of aged care policy has been the expressed preference of older people to have the choice to live for as long as possible at home. That simple idea drove the reform of aged care in the 1980s. But what we mean by choice? It is the debate we need to have in the Australian context.

Good economic and social policy is driven by values that are supported and understood in the community. And that is why I am passionate about consumer directed care.

The driver of our aged care system in Australia should be to enable older people to have control over their own lives to the extent they are capable and wish to do so.

The idea of Consumer Directed Care is not the monopoly of the consumer. The Productivity Commission in the research paper it published last week ***"Trends in Aged care Services: some implications"*** observed that "A growing and increasingly diverse cohort of older Australians are expected to demand higher quality aged care services and greater choice in the services they consume." The emerging challenges of the demand side the Commission suggests will create pressure for the supply side to be more flexible, responsive and efficient.

The Commission identifies among the four elements of an improved framework for aged care "the feasibility of introducing consumer centred arrangements to enhance the potential for older people to influence the nature and scope of the services they receive."

Evidence overseas suggests that CDC delivers better outcomes in a wide variety of different health and care contexts. It is likely to result in greater consumer satisfaction with the services they receive. It may enable consumers to drive the dollars available further. It may have particular benefits for special groups in networking in their own communities. I see no reason why Australia should be any different.

Nothing in aged care is entirely new. The principle of CDC has been embraced to some degree in a range of different contexts in Australia in the younger disability sector and in community options and transition care programs. Australia's health care system gives considerable choice to consumers. If we believe in the principle of person centred care why not let a better informed consumer help to drive it?

And as the excellent ACSA discussion paper shows service providers embrace to varying degrees the principle of CDC in their service provision in promoting consumer participation in their services.

In my experience in talking about this issue over the last 2 or 3 years the exciting thing about CDC is that enthusiasm for it in the Australian context is not confined to consumers. It is a dream shared by service providers and care staff who want to be unshackled from the constraints of current programs that stop them responding to what they know the clients really need. It is a shared vision.

I see CDC as a model of care that should govern the way all our programs operate through the availability of the range of options - whether cash, vouchers, individual budgets or consumer participation in agency service delivery. Our consultations have not indicated that cash would be the preferred choice.

The power of CDC is that it would change the way we think about aged care and delivering services.

If an older person or their family carer wants to be a case manager and drive the budget further why should they not be empowered to do so by having cash instead of service?

If consumers want a service provider to hold a budget for them but to be able to negotiate on equal terms with a service provider the services they want, why should they not be able to do so?

If the many consumers who want more flexible respite so that it delivers to them what they want, when they want it and where they want it, why should they not be able to access what they need through holding the cash or having an individualised budget?

And why should the link between accommodation and care not be broken so that the older person and the family carer can have the choice of where the care will be provided? In that sense CDC has the power to change the way we think about the structure of our programs and the way they operate particularly in respect of where care is delivered and the role of residential care.

In those terms, CDC is not a soft option. It requires a change in the way we think in Australia about older people and the extent to which we are risk averse.

Ian is going to talk about the issues to be addressed in delivering CDC. The Productivity Commission have identified five: user preferences and decision making capacity; scope of services; information and quality assurance, the market for aged care services and the role of trials.

And going back to where I started, if we have a shared vision about the values that should drive aged care, perhaps in the end, we will have more success in Australia getting aged care onto the political agenda.

The question for me is not whether to embrace CDC but how to do it. And to have the commitment from government as we did in implementing the aged care reforms of the 1980s to a staged process of implementation and trials that enable us to have a truly world class aged care system by 2020.

Thank you.