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Sustaining aged care support through active assessment:

A White Paper

Access Care Network Australia

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Evaluate

Evaluate was formed in September 2016, to bring fresh thinking to policy and economic questions, particularly those in the social sphere.

Our particular goal is to identify long-term solutions to ensuring the sustainability of Australia's admirable social compact, including universal access to healthcare and education, and the supply of aged care, housing and other social infrastructure.

Our approach is based on a traditional microeconomic toolkit, moderated by the knowledge that social services are accessed by people with a vast variety of experiences, needs and resources. Consequently, we have no bias towards either public or private supply of services, noting that the access and welfare needs of different Australians typically require a mix of both.

The Principals of Evaluate are experienced professionals, and we complement this with external expertise where appropriate.

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This research was requested and funded by Access Care Network Australia (ACNA).

ACNA provides assessment, coordination and case management services to connect eligible people with supports that build on their strengths. ACNA is the largest not-for-profit supplier of assessment, coordination and case management services in Australia, delivering high-quality services on behalf of Federal and State Governments. ACNA's method of assessment – the Active Assessment Method – is recognised as the gold standard by State and Federal Governments.

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Executive Summary

Meeting the 'individual needs' of older Australians is the foundational principle of this white paper. These needs have been recognised by the recent Royal Commission into Aged Care Quality and Safety, which noted that *"Aged care is a personal experience, and there needs to be personalised information and support for people seeking to access and use aged care services".* Further, the Royal Commission noted that *"It should be easy for older people to access the aged care they need. Having easy access means a person can get the information, support or care they need, when they need it. It also includes getting aged care appropriate to a person's individual needs, including care that is culturally appropriate and safe."* [1]

While the concept of 'needs' is complex, it is comprised of an individual's preferences for the support they receive, including where and from whom; what is considered professionally necessary to support that person's health, safety and quality of life; and what support is locally available and the additional support to access it.

ACNA's approach of active assessment – as outlined in this paper – is critical as it departs from the traditional aged care assessment and considers how best to maximise an individual's independence and autonomy. Central to this is the pursuit of reablement via an active assessment.

The reablement approach emphasises improvement rather than potential decline. Importantly, it extends beyond the simple goal of supporting people to stay for as long as possible in their own homes or 'age in place' to a higher purpose of enabling older Australians to thrive. Focusing on what older Australians can do, and how they do it, rather than what they can't do, ACNA's Active Assessment Method seeks to increase the efficiency of aged care expenditure both by avoiding unnecessary growth and by maximising both the privately consumed and public impacts of aged care and other ageing support.

Across more than 400,000 assessments, the Active Assessment Method's unique features have proven to deliver better outcomes for both older people and those funding the services they receive. These features include an active 'show me' component that involves a person demonstrating what they can do to the assessor; the assessor taking the time to show a person how tasks might be managed more easily or more safely; and a discussion of reablement strategies to help a person understand how they can achieve their goals and maintain or, in many instances, regain their independence.

To meet both Government and consumer goals, assessment would ideally:

- Build independence, delaying and in some cases avoiding the need for higher levels of home care;
- Reduce avoidable demand for hospital care, by ensuring older Australians are safe and well-supported in their preferred/appropriate environment;

[1] Royal Commission into Aged Care Quality and Safety, *Final Report: Volume 2: The Current System*, 1 March 2021, p.59. https://agedcare.royalcommission.gov.au/publications/final-report-volume-2 Accessed August 2022.

- As a corollary, support ageing in place to the extent it is both preferred and does not require more expensive hospital services as a support mechanism; and,
- Associated with this, delay and in some cases avoidance of residential care, which saves accommodation costs.

From an economic perspective, there are three sources of savings – less home care, less hospital care and less residential care – and one source of costs – the cost of care services as ageing in place becomes more demanding. Strong evidence exists across all these sources of savings, including an Australian study from 2012 demonstrates the benefits of active assessment in delivering savings in terms of less home care with a traditionally-assessed group showing that only 18.0% of consumers needed no ongoing care after 12 months whereas, for the actively assessed group who also received a period of intensive reablement support, 49.3% required no ongoing care.[2]

Most of the economic benefits of ACNA's Active Assessment Method and reablement are likely to be found in constraining progression between CHSP to HCP levels and, in turn, from the HCP system to residential care.[3] This is the focus of the economic calculations undertaken later in this paper.[4]

The benefits of active assessment are, however, both the efficiencies gained from more appropriate service allocation and the particular benefits of reablement. What flows from both sources is consumer stability, reducing progression to higher-cost services and freeing up budgets to support individuals in greater need.

The cost-benefit analysis in this paper finds that, in future years, the incremental cost of active assessment will be $51 compared to savings on CHSP services per client of around $100 at the mean. This represents a return of investment of 2:1 and, in practice, equates to $6.2 million in expenditure annually with savings of $6.7 million in the second year and $6.9 million in the third year. The report notes, that within an annual CHSP budget exceeding $2.5 billion, the additional cost is negligible.[5]

Beyond the economic case, from an ethical perspective, increasing self-reliance is a more worthy objective than simply funding support services, so reablement is simply the right thing to do, especially given there is no evidence that suggests it delivers worse outcomes. This, together with the savings cases, means active assessment is recommended to be used in all cases and, in addition, further longitudinal research and standardisation of assessment and reablement should occur.

[2] Gill Lewin et al, "A randomised controlled trial of the Home Independence Program, an Australian restorative home-care program for active adults", *Health and Social Care in the community*, 2013 (21:1)

[3] in an academic trial of their method, 16.4% of clients did not require ongoing government-funded services with no deterioration in quality of life measures – despite a significant proportion of people not receiving ongoing support.

[4] These outcomes may vary with the move to a more continuous system of aged care funding, but average savings from more appropriate allocation of care should be similar.

[5] Australian Healthcare Associates, "Evaluation of the Promoting Better Ageing: Independent Living budget measure for the Australian Government Department of Health", May 2021, p.45.

Introduction

"The human mind is built to think in terms of narratives … in turn, much of human motivation comes from living through a story of our lives, a story that we tell to ourselves and that creates a framework of our motivation."[6]

The critical realisation of contemporary economics is that traditional models of economic thought fail to capture the truly human dimensions of our decision-making: and for that matter, the human consequences of those decisions, both good and bad. Understanding that all aspects of life are inherently personal, and that people want to work within their own expected narrative trajectories, is central to the reform of economic thinking.

In recent years, both market and policy economics have progressively evolved to recognise that we interact with people as individuals, not as data. Nowhere is this more apparent than in the recent *Royal Commission into Aged Care Quality and Safety*, which noted in part:

"Aged care is a personal experience, and there needs to be personalised information and support for people seeking to access and use aged care services."

And this:

"It should be easy for older people to access the aged care they need. Having easy access means a person can get the information, support or care they need, when they need it. It also includes getting aged care appropriate to a person's individual needs, including care that is culturally appropriate and safe."[7]

The focus on meeting the 'individual needs' of older Australians is the foundational principle of this white paper. In saying this, it is acknowledged that the concept of 'needs' itself is complex, and is comprised of:

- An individual's preferences for the support they receive, including what, where and from whom; as well as,
- What is judged professionally necessary to support that person's health, safety and quality of life; and,
- What support is locally available and the additional support – including information and education – required to access it.

These three filters are fundamental to allocation of aged care and associated ageing support services in Australia. They allow the fine line to be balanced between self-directed care and ensuring that those with

[6] George A Akerlof and Robert L Shiller, *Animal Spirits: How Human Psychology Drives the Economy, and Why it Matters for Global Capitalism*, New Jersey, Princeton University Press, 2009, p.51.
[7] Royal Commission into Aged Care Quality and Safety, *Final Report: Volume 2: The Current System*, 1 March 2021, p.59. https://agedcare.royalcommission.gov.au/publications/final-report-volume-2 Accessed August 2022.

diminishing capacity still receive the help they need. At the same time, the filters are sensitive to community variation in service availability and the need to make access clear and easy. As much as possible, they are about ensuring people are able to control the narrative of their own lives throughout their later chapters.

This is where ACNA's approach of active assessment – as outlined in this paper – becomes most potent, because it departs from the traditional classification and rationing approach of aged care assessment to a question of how best to maximise an individual's independence and autonomy.

Central to this is the pursuit of reablement via an active assessment. Rather than regarding changes in health or capacity as signs of inexorable and irreversible decline, the reablement approach emphasises improvement and, where appropriate, both compensation and work-arounds. This may not remove the need for formal care supports, but it should delay or minimise them as well as amplify their impact.

Importantly, this approach goes beyond the simple goal of supporting people to stay for as long as possible in their own homes or to otherwise 'age in place' to a higher purpose of enabling older Australians to thrive.

But at the same time, it should benefit the broader economy and Commonwealth finances in particular, as even a substantially expanded aged care budget remains finite. ACNA's approach seeks to increase the efficiency of aged care expenditure: to avoid unnecessary growth; and to maximise both the privately consumed and public impacts of aged care and other ageing support.

Consequently, the principal evidence base in this paper is twofold and examines:

1. The gains to ageing Australians from the combination of active assessment and reablement; and,
2. The relative return on investment from this approach compared to more traditional assessment.

One of the principal conclusions of this paper is that, while there are some demonstrated gains, the evidence base remains incomplete and more extensive longitudinal research and standardisation of assessment and reablement are recommended.

Aged care in Australia

Aged care covers a range of services designed to support older Australian's physical, psychological, medical, social and cultural needs with the aim of supporting them to undertake their day-to-day activities and, where possible, to enable them to remain connected with their community. Most aged care in Australia is provided informally by families, friends and volunteers but a large element is government funded.

Government's main roles in relation to aged care are to regulate and fund aged care services with the majority of aged care funded being home support, home care packages or residential care.

Eligibility for aged care funded by Government is determined via an assessment of need.[8]

A large and growing number of older Australians utilise aged care services. In 2019–20, over one million people received support from aged care services in Australia.[9] These included:

- Around 840,000 people who used the Commonwealth Home Support Programme which provides entry-level services to help people remain independent at home and in the community;
- Around 245,000 people who lived permanently in a residential aged care facility at some point during 2019–20;
- Around 175,000 people who were supported by a tailored package of care under the Home Care Packages Program to help them remain living at home;
- Around 67,000 people who accessed short-term respite care in residential aged care; and
- Just under 25,000 and 4,500 people who were assisted by transition care and short-term restorative care respectively.[10]

In the ten-year period since 2010–11, the number of Australians using home care has tripled.[11] Use of other aged care programs has also grown but not to the same extent.

Assessment and reablement in reports and inquiries

Assessment and reablement features prominently in a number of major reports and inquiries into aged care.

These include, for example:

- The Productivity Commission Inquiry into *Caring for Older Australians,* which strongly informed the *Living Longer Living Better reforms* undertaken in 2012, noted that:

"The Commission's proposals…aim to deliver higher quality care. The focus is on the wellbeing of older Australians — promoting their independence, giving them choice and retaining their community engagement. Under this integrated package of reforms, older Australians would:

[8] David Tune AO PSM, *Legislated Review of Aged Care 2017,* 31 July 2017. https://www.health.gov.au/sites/default/files/legislated-review-of-aged-care-2017-report.pdf Accessed July 2022.
[9] It should be noted that some people used multiple programs more than once during the year. Australian Institute of Health and Welfare (AIHW), "Aged Care Snapshot", 16 September 2021. https://www.aihw.gov.au/reports/australias-welfare/aged-care Accessed August 2022.
[10] AIHW, "Aged Care Snapshot", 16 September 2021. https://www.aihw.gov.au/reports/australias-welfare/aged-care Accessed August 2022.
[11] AIHW, "GEN – People using aged care", 29 April 2022. https://gen-agedcaredata.gov.au/Topics/People-using-aged-care Accessed August 2022.

- be able to contact a simplified 'gateway' for: easily understood information; an assessment of their care needs and their financial capacity to contribute to the cost of their care; an entitlement to approved aged care services; and for care coordination — all in their region
- receive aged care services that address their individual needs, with an emphasis on reablement where feasible…";[12]

- The *Living Longer Living Better* reforms that, in 2012, committed that:

"Additional functionality will be gradually added to the My Aged Care website and work will commence to standardise assessment processes for basic home support and comprehensive assessment services delivered by Aged Care Assessment Teams (ACATs), both of which vary significantly across states";[13] and,

- The Tune Review that, in 2017, clearly established assessment as one of the key element that would enable uncapped supply:

"The third condition that supports access on the basis of assessed need, is robust assessment. This is required to ensure effectiveness, sustainability, and equity. Without robust assessment, there will be a mismatch between the intended scope of the care system, and the care actually delivered, potentially resulting in inappropriate exclusion of people who need care, or people being directed to the wrong kind of care, wasting resources and time. If assessment is weak it may incorrectly provide access to people who do not meet the eligibility criteria, or direct them to care that is beyond what is needed. Such outcomes increase costs, threatening the system's sustainability. Assessment that is fragmented, poorly guided or conducted by staff without sufficient skills will undermine equity."

The Review also noted that: "further improvement is needed to the existing assessment framework".[14]

It is clear from these reports that assessment and reablement are critical components of a better aged care system, and an ongoing focus on these is required in order to achieve access, equity and efficiency while maximising the positive outcomes that can be achieved by and for older Australians.

Assessment in the context of today's Australia's aged care system[15]

Two assessment programs exist in Australia to perform aged care assessments – Regional Assessment Services (RAS) and Aged Care Assessment Program (ACAP). Both programs train, manage and support those individuals who perform the aged care assessments with organisations across Australia being funded

[12] Productivity Commission, *Caring for Older Australians,* Report No. 53, Final Inquiry Report, 2011. https://agedcare.royalcommission.gov.au/system/files/2020-06/RCD.9999.0011.1031.pdf Accessed August 2022.
[13] The Department of Health, *Living Longer, Living Better*, Aged Care Reform Package, April 2012. https://www.health.gov.au/sites/default/files/documents/2019/10/foi-request-1295-extra-service-fees-living-longer-living-better-aged-care-reform-package-april-2012_0.pdf Accessed August 2022.
[14] David Tune AO PSM, *Legislated Review of Aged Care 2017,* 31 July 2017. https://www.health.gov.au/sites/default/files/legislated-review-of-aged-care-2017-report.pdf Accessed July 2022.
[15] Information taken from Department of Health and Aged Care, "About the aged care assessment programs", 13 October 2021. https://www.health.gov.au/initiatives-and-programs/aged-care-assessment-programs/about-the-aged-care-assessment-programs and Department of Health and Aged Care, *My Aged Care Assessment Manual,* version 3.1, December 2021 https://www.health.gov.au/resources/publications/my-aged-care-assessment-manual Accessed July 2022.

by the Federal Government to undertake RAS assessments and the Federal Government funding the states and territories to deliver the ACAP.

The type of assessment that senior Australians receive depends on the level of support they are likely to require. For those individuals who require low-level support to remain independent and at home, a Regional Assessment Service (RAS) assessor will usually perform their assessment by visiting the home and assessing the person in place. The RAS assessor will determine if the individual is eligible for Commonwealth Home Support Programme services.

Where an individual has more complex needs, an Aged Care Assessment Team (ACAT) will perform a more detailed assessment. These assessments may also occur in an individual's home but, given the complexity of some people's needs or the timing of their assessment, they may also take place in a hospital.

Aligned with the greater complexity of the needs of the people they assessed, each ACAT is multidisciplinary and includes a range of health-related disciplines such as medical practitioners, registered nurses, social workers, physiotherapists, occupational therapist and psychologists. Likewise, rather than requiring the low-level support traditionally identified by RAS, ACAT assessments are designed for people who may need:

- a higher level of home care through the Home Care Packages Program;
- residential aged care, including respite;
- short-term restorative care; and/or
- transition care.

Sometimes a RAS assessor will determine that a higher level of support is required for an individual than the entry level services anticipated. When this occurs, a RAS assessor will refer onto the ACAT to ensure that the individual involved receives the more comprehensive assessment they require.

Reablement in today's Australia's aged care system

The Commonwealth Home Support Program (CHSP) Manual requires CHSP service providers to embrace a wellness and reablement approach to service delivery.[16] In addition the My Aged Care Assessment Manual for Regional Assessment Services and Aged Care Assessment Teams identifies that reablement approaches should be embedded in the home support assessment. Wellness and reablement approaches build on people's strengths and promote greater autonomy and independence for people in performing the

[16] Department of Health and Aged Care, Commonwealth Home Support Programme (CHSP) Manual 2022-23, 2022. https://www.health.gov.au/resources/publications/commonwealth-home-support-programme-chsp-manual Accessed August 2022.

daily tasks of living. Reablement approaches avoid "'doing for' when a 'doing with' approach can assist individuals to undertake a task or activity themselves (or with less assistance)".[17]

Evidence around Reablement

Definitions

There is no universally accepted definition of reablement. Definitions =differ based on the perspective of the viewer, whether funder, provider or consumer, and upon jurisdiction. Three illustrative examples follow, the first being:

"Reablement involves time-limited interventions that are targeted towards a person's specific goal or desired outcome to adapt to some functional loss or regain confidence and capacity to resume activities. If a client is suitable and agrees that short-term reablement support is appropriate, the assessor should include service solutions within the support plan which:

- Promote their independence;
- Assist them to maintain and/or strengthen their capacity to undertake daily activities;
- Maintain social and community connections.

Supports could include training in a new skill, modification to a client's home environment or having access to equipment or assistive technology."[18]

An interesting feature of this Commonwealth definition is the insistence on **time-limited interventions** and **short-term reablement support**, which are consistent with the Short-term Restorative Care (STRC) program but may not be included in a universal understanding of reablement.

Next, from the United Kingdom:

"Reablement is an outcome-focused service that helps people to return and stay in their own home or community setting. Reablement services focus on user-defined goals aimed at promoting independence and choice whilst at the same time helping to reduce the need for future services.

Reablement is an ongoing process of assessment which aims to ensure positive change and movement towards the user's goals. In addition, it is strengths-based and builds on what people currently can do whilst building their confidence and independence within other areas of their lives."[19]

What stands out here are the phrases **outcome-focused** and **ongoing process of assessment**. While these are not excluded by the Commonwealth definition, neither are they central to it. These principles are

[17] Department of Health, My Aged Care Assessment Manual For Regional Assessment Services And Aged Care Assessment Teams, 2021. https://www.health.gov.au/sites/default/files/documents/2021/12/my-aged-care-assessment-manual_0.pdf Accessed August 2022.
[18] Australian Government, My Aged Care: "Linking Support and Reablement".
[19] Social Care Institute for Excellence. https://www.scie.org.uk/prevention/independence/reablement Accessed August 2022.

critical to understanding reablement as a preventive and stabilising measure rather than a short-term intervention.

Third, from the NSW Government:

"Wellness and reablement practice with older people within NSW Health is based on the following set of principles:

- supporting older people living at home to live as independently as possible for as long as possible;
- treating each older person as a unique individual with their own strengths, abilities, life experiences, preferences, choices, and needs.
- assessing an older person in a holistic, strength–based way, promoting wellness, considering dignity of risk and encouraging active participation in the development of appropriate support plans.
- ensuring an older person's aspirations and needs are best met when assessment, support planning, and service provision is a partnership between the older person, their informal support network, the assessor and service providers."[20]

Here language such as **partnership**, **holistic assessment** and **active participation** is used. Again, this adds to the Commonwealth definition and more closely approximates the ethos and design of the ACNA active assessment method.

Finally, moving from these local examples, there is a definition built through four rounds of consultation with 82 reablement experts from 11 countries, including Australia and New Zealand and similar cultures such as the UK and Canada. The final definition from this group is:

"Reablement is a person-centred, holistic approach that aims to enhance an individual's physical and/or other functioning, to increase or maintain their independence in meaningful activities of daily living at their place of residence and to reduce their need for long-term services. Reablement consists of multiple visits and is delivered by a trained and coordinated interdisciplinary team. The approach includes an initial comprehensive assessment followed by regular reassessments and the development of goal-oriented support plans. Reablement supports an individual to achieve their goals, if applicable, through participation in daily activities, home modifications and assistive devices as well as involvement of their social network. Reablement is an inclusive approach irrespective of age, capacity, diagnosis or setting."[21]

Importantly, **ongoing assessment** is part of this expansive and optimistic approach and are the key to savings as well as benefits to the consumer. Some of this is reflected in the definitions above, particularly that from NSW Health, and it is proposed as an optimal definition for this paper. It is further recommended as a common definition across Australian regulators and services providers.

[20] Secretary, NSW Health Department: "Guideline: Wellness and Reablement in Aged Care".
[21] Silke F Metzelthin et al, "Development of an internationally accepted definition of reablement: a Delphi study", *Ageing and Society* (42) 2022, p.713

Nonetheless, it is understood that, throughout the world – and taking into account the need for fiscal restraint – reablement is almost always time-limited, typically in the range of 8-12 weeks. This is the period of formal intervention which is likely to offer the greatest return on investment. Noting this, Evaluate is of the view that there is a broader philosophical shift necessary to make care more productive, by regular review of care allocation, permitting innovation at each stage of care delivery.

Experience of delivery

There is a plethora of literature on the design and delivery of reablement, some of which is reviewed here. This section is focused on understanding *what* is delivered and *which* benefits are sought or expected. Much of this comes from Scandinavia, where there is a particular focus on reablement within very developed health and social service systems.

However first, from Western Australia, there is an observation that because reablement is strongly focused on functionality – which may be the most readily and usefully measurable aspect of outcomes – it is mainly delivered by allied health practitioners such as occupational therapists and physiotherapists.[22]

It is noted that this departs from the optimal definition above in which multidisciplinary teams are proposed. The authors of the WA study note this and further note the importance of targeting, starting with active assessment to determine optimal support strategies. Further, they note the importance in complementing functionality as a measure with other significant goals, particularly social connectivity.[23]

However, even with the principal emphasis on what might be termed rehabilitation rather than true reablement, there is evidence from qualitative reviews that understanding of individual motivation and integration of user goals into the support plan dominates standard training approaches.[24]

This view of reablement is supported by international evidence which notes that, despite the evolution in language over recent years from 'restorative care' to 'reablement', the emphasis on time limitation has translated reablement from being a goal-oriented or socially focused to more commonly resembling traditional models of physical rehabilitation.[25] Again, it is understood that this is a consequence of fiscal pressure, but more expansive and innovative approaches should be permitted, and will be driven by active assessment models.

Other than the focus on functionality, there are other pressures which have impeded the delivery of true reablement as per the definition preferred in this paper. Five of these are:

1. The cooperative nature of active assessment and true reablement – described here as "the transition from 'doing for' users to 'doing with'" – is resource-intensive;

[22] Daniel Doh et al, "Reviewing the reablement approach to caring for older people", *Ageing and Society* (40) 2020.
[23] Daniel Doh et al, "Reviewing the reablement approach to caring for older people", *Ageing and Society* (40) 2020.
[24] Marianne Eliassen and Andreas Lahelle, "Enhancing functional improvement in reablement – a qualitative study", *European Journal of Physiotherapy* (23:6) 2020, p.358.
[25] Amy Clotworthy et al, "Reablement through time and space: a scoping review of how the concept of 'reablement' for older people has been defined and operationalised", *BMC Geriatrics*, (21:61) 2021, p.10.

2. Self-determination and cooperation are ultimately ideals and, in some cases, may raise unrealistic expectations;

3. There is significant variation in older people's ability to commit to cooperation in reablement;

4. Cooperation needs to be continuous, which again has resource implications; and,

5. Limited time, resources and the variability of consumer capacity may lead to defaulting back to more traditional approaches, which have delivered less cooperative strategies. [26]

In short, this is a complex and demanding process compared to traditional assessment and service allocation approaches, and requires significant commitment from all assessors, support providers and consumers.

The particular problem of heterogeneity in client capacity, understanding and attitude does not erode the expected value of reablement, but rather underscores the importance of proper assessment and engagement in finding the path which best involves the older person. Three key elements of any effective solution are noted here as follows:

1. First, establishing shared understanding and acknowledgement of the need for help should be the initial step in the active assessment process. Without engagement, reablement cannot be effective;

2. Next, ongoing commitment and motivation are essential to productive and successful reablement. Much of this is grounded in understanding of purpose together with goal-oriented plans; and,

3. Finally, homecare helpers are critical team players. They will have the greatest contact with the older person and must be equally motivated to make the extra effort required to deliver authentic reablement.[27]

To some extent, these may be regarded as filters within the active assessment method. In the absence of these factors – or the capacity of active assessors to develop engagement and commitment from all participants – the return on investment in reablement will be limited. The active assessment approach therefore seeks to take into account each factor, to ensure both that what is recommended can be practically delivered, and that there will be dedicated cooperations from the consumer.

Consequently, it should be part of the active assessment protocol to identify where *continuing* active assessment and associated reablement intervention will *not* be productive and, in particular, is unlikely to affect the older person's future care demand trajectory. It is understood that this recognition is built into the active assessment method, although seeking to break through resistance is a prior step. Importantly, it

[26] This list is based on Karl Jokstad et al, "Ideal and reality; Community healthcare professionals' experience of user involvement in reablement", *Health and Social Care in the Community*, December 2018, pp.4-7.
[27] Adapted from Mads Nibe Stausholm et al, "Reablement professionals' perspectives on client characteristics and factors associated with successful home-based reablement: a qualitative study", *BMC Health Services Research* (21:665) 2021, pp.5-7.

should be noted that that *initial* active assessment will always be productive, as it remains the optimal method of classifying future needs, with or without reablement.

A useful observation as part of this filtering process is that there are two species of motivation: intrinsic motivation which might be regarded as innate, and depending on each individual's willpower and sense of self-responsibility; whereas extrinsic motivation comes from those around the older person. In relation to the latter, this is enhanced in the home environment where there are known and trusted voices to motivate the person.[28]

Moving from the observed default of physical functionality to true interdisciplinary reablement relies on a number of features. These include:

- Using the older person's individual goals as the foundation of a common interdisciplinary platform. This may seem obvious, but it requires recognising that different disciplines must adapt to the consumer's goal-setting rather than simply offer their own services;
- Establishment of a positive professional community, with a common commitment to the definition and principles of reablement;
- Learning from others' skills and competencies, to develop the sense that reablement allows for sharing of knowledge and requires a new paradigm of intersecting support provision; and,
- Potential changes in roles and responsibilities to recognise that true reablement may not fit with traditional lines of demarcation.[29]

This will require substantial goodwill and cooperation between different contributors to the reablement process but should add to the knowledge base and skillset of all participants. Importantly, it will transcend the problem of heterogeneity in reablement itself. While creating a common approach starts with agreement on definition, even with that acceptance, a great deal of variance in design stems from grounding in single disciplines. This has been observed by Australian researchers to limit the integration of reablement within community service providers in primary care settings.[30]

This approach also accords with the experience of reablement in recent years with the recognition that while it is an *individual* approach, it requires *systemic* roots. This means that it needs to be built into the aged care system, not simply be the domain of individual providers and their clients. This is in part why the adoption of a more optimal and common definition of reablement across jurisdictions is crucial.

Drawing on literature, the path to systemic provision may be understood in three phases as follows:

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[28] Kari Margrete Hjelle et al, "Driving forces for home-based reablement; a qualitative study of older adults' experiences", *Health and Social Care in the Community* (25:5) 2016.
[29] Based on: Arvid Birkeland et al, "Interdisciplinary collaboration in reablement – a qualitative study", *Journal of Multidisciplinary Healthcare* (10) 2017, pp.198-199.
[30] Marguerite Bramble et al, "A scoping review exploring reablement models of training and client assessment for older people in primary health care", *Primary Health Care Research & Development* 2022.

1. The replicating phase, in which professionals tasked with supporting a person through a reablement phase are educated within a common model to understand the philosophy and requirements of cooperative reablement;

2. The adapting phase, which involves tailoring what is learnt in the initial phase to the local network and expanding the number of participants who understand what is expected. This would also include educating older Australians as to what reablement means; and,

3. The establishing phase, in which reablement becomes modal within the aged care assessment and service system.[31]

It is noted in this model that, in the final phase, filtering of the type described above occurs to identify those who will benefit from reablement and those who will not. This does not affect the initial active assessment but it will ensure minimal resources are allocated to reablement where they are not expected to deliver meaningful outcomes.

The benefits of this type of systemic change are powerfully summed up in a testimonial from a regional Australian worker in community-based care as follows:

"Since the teaching … I have been more mindful of encouraging independence and I am very much a doer and I'm very much look, I can just do that for you … So, I had to be really aware of stepping back, and if it takes my client ten minutes to do something and it takes me half a minute to do something, I really do consciously have to step back and allow that ten minutes, rather than get it done in half a minute yourself and it's done."[32]

Within this, the understanding of the fundamental ethos of reablement can be observed – it is individual; it is client-centred; and it is about independence and the confidence that flows from it.

That this can work in regional Australia is an important piece of evidence because, other than defraying increased care costs, the capacity to age in place in parts of the country where there are fewer formal services available, due to thin markets and workforce shortages, will be dependent upon innovation in care management. In turn, reablement for one older person in such areas means freeing up scarce services to others who need them.

The key takeouts from all this evidence are:

1. There must be a common preference for active assessment;

2. This and associated programs for reablement should be standardised across the Australian health and ageing system; and,

[31] Adapted from Catherine Moe and Berit Støre Brinchmann, "Tailoring reablement: A grounded theory study of establishing reablement in a community setting in Norway", *Health and Social Care in the Community* (26) 2018, pp.116-118.
[32] Hazel Maxwell et al, "Staff experiences of a reablement approach to care for older people in a regional Australian community: A qualitative study", *Health and Social Care in the Community* (29) 2021, p.688.

3. These must be embedded with deep roots in health and aged care if both patient experiential benefits and potential fiscal savings are to be realised.

Future changes

In responding to the recommendations of the Royal Commission into Aged Care and Quality, in November 2019, the Government announced its intention to establish a Single In-Home Care Program. This program is designed to replace various aged care programs, including the Home Care Packages Program and the CHSP, with the goal of delivering timely and flexible care services that meet individual consumers' needs.

There are two key elements of change relevant to aged care assessments – the new Support at Home Program and the Single Aged Care Assessment.

Support at Home

The new Support at Home Program will reform all elements of how in-home aged care is delivered including assessment, reablement and restorative care as well as more individualised support plans, changes to funding of providers, clarity on service inclusions and market regulation.

Individualised approvals for services will be granted to senior Australians depending on their assessed needs instead of the current situation where they are placed in one of the four home care package levels. A new program will mean that senior Australians can access the goods, equipment, assistive technologies, and home modifications they need to live safely and independently and that will support the delay of their functional decline.[33]

This new Program will be supported by a single assessment workforce that is designed to provide a better experience for senior Australians within the aged care system or as they enter it while simultaneously improve the consistency and quality of assessments.[34]

Single Aged Care Assessment

The foundations for Single Aged Care Assessment were established by recommendations of the 2017 Tune Review that specifically considered the RAS and ACAT assessments; the integration of these and their workforces; and the need to focus on reablement and restorative care.

The specific recommendations included:

- Recommendation 27 that recommended that the Government integrate the RAS and ACAT assessment workforces;

[33] Department of Health, "Support At Home Program Overview", January 2022. https://www.health.gov.au/sites/default/files/documents/2022/01/support-at-home-program-overview.pdf Accessed July 2022.
[34] Department of Health, "Workforce (Pillar 4 of the Royal Commission response) – Single assessment workforce for aged care", Budget 2021-22. https://www.health.gov.au/sites/default/files/documents/2021/05/workforce-pillar-4-of-the-royal-commission-response-single-assessment-workforce-for-aged-care.pdf Accessed July 2022.

- Recommendation 28 that, following review of ACFI, the Government integrate residential aged care funding assessment with the combined RAS and ACAT functions, independent of aged care providers; and

- Recommendation 29 that Government and providers work to improve access to wellness and reablement activities to provide greater choice and better support for consumers to live independently, including by increasing access to short-term reablement supports and/or episodic care and supporting staff and consumers to better understand and access information about wellness, reablement and restorative care providing aged care assessors with training on wellness, reablement and restorative care.[35]

Public consultation undertaken by the Department of Health following the release of the Tune Review demonstrated support for Recommendations 27 to 29 with key messages from the consultation including:

- Broad support for an integrated assessment model, including a combined Aged Care Assessment Team (ACAT) and Regional Assessment Services (RAS) workforce; and

- Strong support for a greater focus on short-term restorative care and reablement approaches.[36]

The Active Assessment Method

Traditionally, an assessment consists of a person, often a clinician, sitting with a person at their hospital bed or kitchen table asking a series of questions, usually about what a person 'can't do'. This traditional approach, by focusing on what people believe they can't achieve, increases costs for governments and undermines the sustainability of social services. Further, for the older person, it reinforces the sense of a downward slope of decreasing ability, rather than seeking a pathway to stability.

Under the active assessment method, people are asked to show the assessor how they manage their everyday living activities. This allows the assessor to both identify an individual's strengths and capabilities and also reinforce these. In addition, this method enables the assessor to identify specific aspects of a task or activity with which the individual may be having difficulty.

Observing how each component of an activity is completed or not also allows the assessor to identify what type of support or intervention a person requires or, in some cases, what strategies the individual might try that could help them overcome the difficulty.

In addition to allowing a deeper understanding, and therefore more detailed identification of the types of support or intervention might be required to meet the individual's needs, the picture gained by the

[35] David Tune AO PSM, *Legislated Review of Aged Care 2017,* 31 July 2017. https://www.health.gov.au/sites/default/files/legislated-review-of-aged-care-2017-report.pdf Accessed July 2022.
[36] Department of Health, *Summary Report – Key insights from future care at home reform consultation*", 2017. https://webarchive.nla.gov.au/awa/20190208034748/https://agedcare.health.gov.au/reform/future-care-at-home-reform-summary-report-of-consultation-feedback Accessed August 2022.

assessor is more likely to be accurate and more comprehensive. Multiple researchers have found that there are low to weak relationships between self-reporting and observed quality of ADL task performance.[37]

Given this, it is thought that self-reporting and observation are essentially measuring different things and that it is necessary for a full understanding of an individual's needs to collect both types of information.

Across more than 400,000 assessments, the Active Assessment Method's unique features that have proven to deliver better outcomes for both older people and those funding the services they receive. These features, as highlighted above, include:

- An active 'show me' component that involves a person demonstrating what they can do to the assessor;
- The assessor taking the time to show a person how tasks might be managed more easily or more safely; and
- A discussion of reablement strategies to help a person understand how they can achieve their goals and maintain or, in many instances, regain their independence.

The key difference here is that active assessment leads to individual engagement with the consumer, to understand whether their reported limitations are accurate, and whether they can be transcended. Demonstration and individual strategies to manage deteriorating capacity are critical next steps before allocating care.

The benefits here lie not only in deeper investigation of what older people truly can and cannot do but in the joint assessor-client examination of *strategies and options* aimed at stable solutions to those limits, rather than simple service allocation.

This method deliberately shifts the focus from what people can't do rather to what they can. Instead of answering questions, people are asked to demonstrate daily tasks and the assessor can then offer practical advice and also provide encouragement as a follow-up to the initial assessment. It introduces a priority based on capability and sustainable solutions, rather than external services.

In ACNA's words:

> "The best reablement outcomes result when the assessor and person 'connect' – there is no substitute for taking the time to get to know the person and their aspirations. However, the time it takes to connect is also one of the biggest obstacles organisations face when attempting to embed reablement in their practices. We needed to find ways to truly listen and see things differently, we needed tool/s that would help us get underneath a person's defence barriers, to understand the full story – and quickly.

[37] Anne G. Fisher, Lou Ann Griswold, Michaela Munkholm; Anders Kottorp(2017) Evaluating domains of everyday functioning in people with developmental disabilities, *Scandinavian Journal of Occupational Therapy*, 24:1, 1-9.

In spending over 884,472 hours in the homes of people we discovered something. If the subject was difficult, personal or perhaps shameful the conversation was likely to be much more honest if people didn't have to look directly at each other and have something to do while they talked. This was the basis for the mechanism that sits at the heart of ACNA's Active Assessment Method: the 'show me' approach."[38]

Case Study: Supporting Martin in his role as carer – active assessment at work

Over two to three years, Adam has visited Martin and Marion a number of times to undertake a face to face assessment. Martin is Marion's carer and the assessment is designed to provide him with the confidence that he can continue in that role and that he is linked to the appropriate supports to help Marion stay at home.

The active assessment that Adam undertakes has a number of elements. He always checks the for consent – identification, – despite the fact that he has now known the couple for a long while. After that, he will observe how they move around, walking through the house, looking at the veggie garden and outdoor area. He also checks how Martin gets in and out of the car, onto the bed and how easily he can manage the shower and toilet, how they complete the household tasks.

In addition, Adam has subtle means of checking Martin's memory, even just asking for his identification, asking him to show him the microwave and or the remote control for the television.

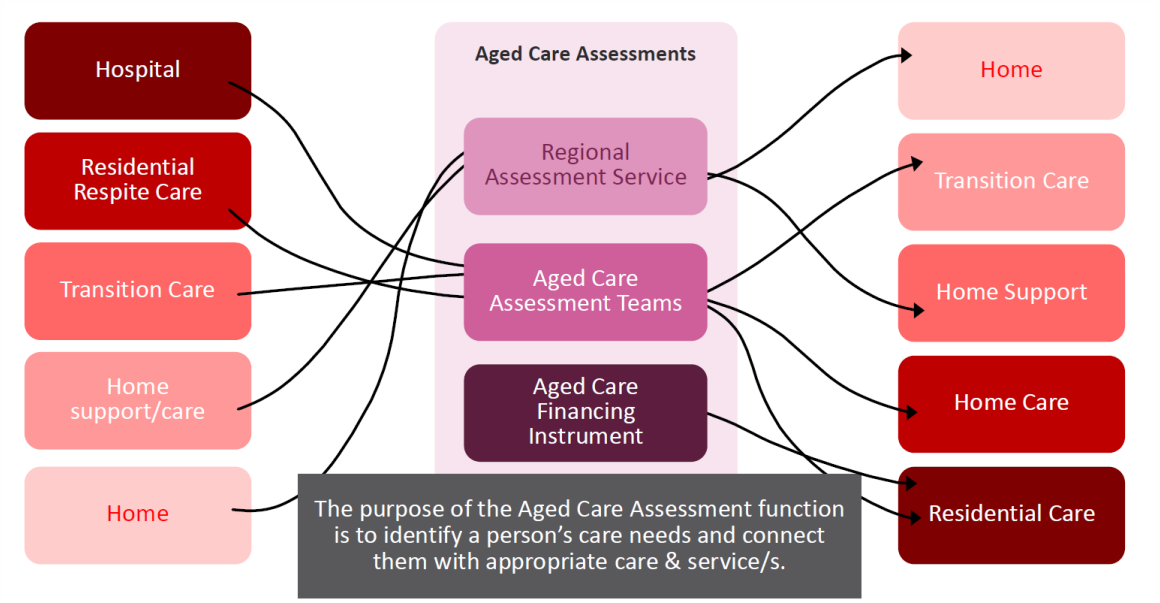
Once Adam has undertaken the assessment, he writes it all up in the MyAgedCare portal so that next time he has a benchmark for Martin's capabilities and a record of how he performs day to day tasks. Reporting to Martin that there has been no change since the last assessment provides Martin the confidence that he can continue to look after Marion and the two of them can live at home together safely a while longer.

Sources of Benefits[39]

Figure One illustrates the complex role of assessment in both meeting consumer needs and preferences and efficiently allocating ageing support services, both in the home and in a variety of residential care environments.

[38] Supplied by client.
[39] Much of this section draws upon: ACNA, "The importance of an independent assessment function to the future aged care system", 23 February 2021. Supplied by client.

Figure One: Assessment Entry and Exit Points[40]



To meet both Government's and consumers' goals, assessment would ideally:

- Build independence, delaying and in some cases avoiding the need for higher levels of home care;
- Reduce avoidable demand for hospital care, by ensuring older Australians are safe and well-supported in their preferred/appropriate environment;
- As a corollary, support ageing in place to the extent it is both preferred and does not require more expensive hospital services as a support mechanism; and,
- Associated with this, delay and in some cases avoidance of residential care, which saves accommodation costs.

From an economic perspective, there are three sources of savings – less home care, less hospital care and less residential care – and one source of costs – the cost of care services as ageing in place becomes more demanding.

The first source of savings is well-illustrated by a 2012 Australian study which shows the benefits of active assessment. Critically, this study showed that:

- Groups with similar reductions in ADL capacity can receive radically different rates of care intervention if actively assessed and encouraged -and educated – to be more self-reliant, without differences in healthcare or QoL outcomes;

[40] Supplied by client.

- As a core measure of this effect, at 12 months:
    - The traditionally-assessed group showed only 18.0% of consumer where no ongoing care was required;
    - Whereas, for the actively assessed group which resulted in a period of intensive reablement support, 49.3% required no ongoing care.[41]

This is powerful evidence of the economic savings of active assessment coupled with home-based reablement. Though the savings themselves were not quantified in the paper, one can conclude the benefits of a significantly larger cohort of older Australians not requiring ongoing services would have a positive economic benefit. As an example of the real savings associated with such outcomes, it is estimated by industry that reducing support for three showers per week would mean reduced expenditure of over $9,000 per person annually.

Next, the comparison between savings from constrained progression in the aged care system, and the cost of hospital avoidance is considered. The observation is that progression in the aged care system, as a question of economic efficiency, only makes sense where it defrays substantial hospital costs. Otherwise, better ageing in the home is most efficient.

The logic is that hospital admissions, at a mean National Efficient Price of $5,797 per national weighted activity unit (NWAU),[42] are by far the most expensive solution to ageing/chronic care needs. This is followed by residential care and then home care services. What follows is that it is most fiscally efficient to keep people ageing at home until hospital savings outweigh the savings from avoiding residential care.

A simple calculation is offered to summarise this relationship as follows:

- If compared to a mid-level HCP (3) package, this has a daily base subsidy of $96.27, leading to an annualised cost of $35,138.55;[43]
- Compared to an indicative average cost for residential aged care – assuming quartile 2 in a small facility – of $97,521.75,[44] the avoidance of residential care for one year, instead remaining on a mid-level HCP subsidy, would represent a saving of $62,383.20 [$97,521.75 *less* $35,138.55]; but,
- This is only efficient to the point where staying at home does not lead to more than 10.7 average hospital admissions compared to a year of relocation to residential care [$62,383.20 *divided by* $5,797].

[41] Gill Lewin et al, "A randomised controlled trial of the Home Independence Program, an Australian restorative home-care program for active adults", *Health and Social Care in the community*, 2013 (21:1)
[42] Independent Hospital Pricing Authority, "National Efficient Price Determination 2022-23", March 2022.
[43] This and other HCP pricing in this document are from the 1 July 2022 schedule: https://www.health.gov.au/resources/publications/schedule-of-subsidies-and-supplements-for-aged-care Accessed August 2022.
[44] Royal Commission Research Paper No.9 (University of Queensland), "The cost of residential aged care", August 2020.

This requires a note of caution, in that these are theoretical, rather than demonstrated savings. Nonetheless, there is no question of the relationship between better assessment of aged care needs, and the rate of hospitalisation. A recent study on this subject noted:

- One in five older Australians had an unplanned hospitalisation or emergency department visit within 90 days of an ACAP assessment; and,
- Consequently, that identifying predictors of hospitalisation during assessment is a core task of the assessor, and an important initiative in reducing avoidable hospital presentations.[45]

What is clear is that there is a significant gap between home and residential care in terms of the benefits of avoided hospital admissions. While this is, for example, lower for HCP4 at 7.6 admissions and higher for HCP2 and 1 at 14.0 and 15.3 admissions respectively, it represents a significant measure of the difference between residential and home care.

This indicates that the type of health conditions and limitations which lead to this level of frequency in hospital emergency departments are not marginal questions. It should be very obvious where home care is inappropriate, well before such regular admission levels are reached.

Consequently, most of the economic benefits of the Active Assessment method and reablement are likely to be found in constraining progression between CHSP to HCP levels and, in turn, from the HCP system to residential care.[46] This is the focus of the economic calculations undertaken later in this paper.[47]

Case Study: Ensuring people don't access services inappropriately

In talking with assessors, it becomes clear that it's not just in helping people access the right services that they deliver value; they also help ensure the right allocation of services and avoid people accessing services when there is an alternative.

Sally, who is a RAS assessor, reports numerous instances of older people reporting challenges with day-to-day tasks, especially those such as laundry or cleaning. Often though, she says, these people don't need external help with these tasks, they simply need to change how they approach them.

'Using long handled tongs to get clothing out of a top loading washing machine rather bending over, having portable drying racks available so they don't need to stretch to the washing line and lower shelves are often changes we recommend', she says. Simple changes like this or getting a robovac or stick vacuum can mean that these tasks can continue to be performed without outside help, maintaining independence whilst, at the same time, freeing up those limited cleaning or other services for those who need them more.

[45] Maria C Inacio et al, "Predictors of short-term hospitalization and emergency department presentations in aged care", *Journal of the American Geriatric Society*, 2021 (1:15)

[46] in an academic trial of their method, 16.4% of clients did not require ongoing government-funded services with no deterioration in quality of life measures – despite a significant proportion of people not receiving ongoing support.

[47] These outcomes may vary with the move to a more continuous system of aged care funding, but average savings from more appropriate allocation of care should be similar

Case Study: Returning Alex to full independence after hospitalisation

Alex had been in hospital where often he was told what not to do rather than helped to do as much as he could. Returning home, he was really disengaged and was assessed as requiring short-term domestic help and physiotherapy. He found himself lacking confidence though and second-guessing what he could and could not do.

Together with his assessor and his physiotherapist, a plan was devised to support Alex to return to full independence. A lot of physiotherapy and a few setbacks later, Alex's confidence was rebuilt and he did regain his independence, something that, without help, he is sure would not have occurred.

Economic Evidence

One of the challenges of assessing the economic impact of active assessment and reablement is that it is a relatively recent phenomenon. This is particularly true of the migration from more traditional restorative care to true reablement under the preferred definition.

As evidence of this, as recently as 2016, a Cochrane Collaboration publication was only able to review two completed eligible studies – from Norway and Western Australia – and could only conclude:

"There was very low quality evidence from one study to indicate that the reablement intervention may reduce need for either ongoing home-care, or a new episode of personal care at 12-month follow-up, and may slightly reduce the likelihood of being assessed as needing a higher level of care … Neither study measured user satisfaction, which is possibly an important factor in ensuring uptake and adherence related to such interventions."[48]

Since then, further work has been undertaken to better define reablement along with various recommendations on how to embed reablement across community care, including the emphasis on multidisciplinary team approaches.

Nonetheless, there have only been a few studies in recent years which build on the experience of active assessment and reablement in the Australian context. It is therefore recommended that the Commonwealth Government should fund a longitudinal tracking study into the differences in outcomes between those individuals who are assessed using traditional methods compared to those experiencing active assessment and reablement. This would build on the Government's 2021 review of the 2018 budget measure discussed above as well as the effects of ACNA's training across the various community care organisations.

In 2017, the care provider Silver Chain[49] undertook a comparison of traditional restorative care with active assessment and reablement focusing on demand for HACC services, noting that the expected benefits may

[48] Andy Cochrane et al, "Time-limited home-care reablement services for maintaining and improving the functional independence. of older adults (Review), *Cochrane Database of Systematic Reviews*, 2016, p.16.
[49] Please note that SilverChain is ACNA's parent company.

flow because "By helping people to improve their level of independence, services provided through a reablement approach aim to minimise the level of need for ongoing formal supports."[50]

This study found slightly improved outcomes for reablement against EQ-5D-5L and ICECAP-0 measures.[51] However, the more significant observation was that, of those individuals who received short-term intensive assistance as part of their reablement strategy, around half did not require further external support for that activity over the following six months.[52]

The economic analysis which accompanied this study showed that utilising the active assessment and reablement methods with 10,000 new HACC care recipients would save some $2.87 million or 7.4% of program costs. This leads to a willingness to pay measure of around $3,000 per consumer *per annum* which means that, if the annual costs of active assessment and reablement are below this number, then the additional work is cost-effective.[53]Looking to UK and European analyses, further evidence shows:

- In a British study:
    - Significant reductions in hospital visits following reablement;
    - Reductions in demand for care services;
    - Substantial reduction in costs, particularly from hospital overnight stays.[54]

This is consistent with the highest cost services sought for avoidance, discussed earlier in this paper; and,

- A Norwegian study which suggests, particularly on ADL performance, reablement dominates other home-based services over the first 12 months after implementation.[55]

At this time, more data is required to better understand the economic benefits of reablement, both for the older person and for funders.

Economic Assessment

Broadly speaking, the benefits of active assessment are both the efficiencies gained from more appropriate service allocation and the particular benefits of reablement. What flows from both sources is consumer stability, reducing progression to higher-cost services and freeing up budgets to support individuals in greater need.

[50] SilverChain, "Measuring the Impact of Community Care: Project Report", February 2017, p.17.
[51] SilverChain, "Measuring the Impact of Community Care: Project Report", February 2017, p.40.
[52] SilverChain, "Measuring the Impact of Community Care: Project Report", February 2017, p.49.
[53] SilverChain, "Measuring the Impact of Community Care: Project Report", February 2017, pp.52-3.
[54] Bryony Beresford et al, "Outcomes of reablement and their measurement: Findings from an evaluation of English reablement services", *Health and Social Care in the Community* (27) 2019.
[55] Though there is convergence in effects following this period. E. Langeland et al, "A multicenter investigation of reablement in Norway: a clinical controlled trial.

Underpinning this view is the calculation that the longer-term funder's cost of active assessment compared to traditional assessment is $451.31 compared to a mean of $400,[56] which is only a 13% increment. Alongside this, it is reported within the sector that active assessors typically complete 12 assessments per week compared to 13 for traditional assessors.[57] This is a slightly slower process, but it does not add to direct costs to the Commonwealth as funder.[58]

The impact of this is that any cost-benefit analysis in the longer-term can be expressed as:

$$Return = Savings - \$51.31 - Additional\ Cost\ of\ Reablement$$

Within this equation, the incremental cost is a negligible effect. Equally, where there is no reablement, but there is a more appropriate allocation of services, this will be reflected in the nett Savings figure.

The next issue to note is that, drawing on the Silver Chain study noted earlier, reablement for HACC-type interventions will not be economically efficient if the solution has costs similar to STRC, as costs would dominate potential savings. However, Evaluate understands that core reablement in the HACC/CHSP environment is much more home-focused, and the $3000 willingness to pay measure is more than adequate.

With a current daily subsidy for STRC of some $214.39,[59] either there is:

- A current eight-week (seven-days a week) cost of $12,005.84; or
- The projected twelve-week cost of $18,008.76.

Clearly either of these is substantially higher than the assessed willingness to pay measure of $3,000.

While – as per discussion earlier in this paper – reablement is ideally more than restorative care, the 12-week STRC figure may be regarded as a current willingness to pay threshold from the Commonwealth in order to reduce progression within the aged care system. Taking this figure, it is further noted that:

- Compared to the $44,253.65 incremental cost of progressing from an HCP4 package to modal residential care, the STRC threshold would require a delay of 0.41 years or around 5 months to be cost-effective;[60]
- Compared to the $18,129.55 incremental cost of progressing from an HCP3 to an HCP4 package, the STRC threshold would need to hold back progression by 0.99 years in order to be cost-effective;

[56] Australian Healthcare Associates, "Evaluation of the Promoting Better Ageing: Independent Living budget measure for the Australian Government Department of Health", May 2021, p.47.
[57] Data from consultation.
[58] The slightly lower number of active v. traditional assessments is due to greater follow-up time for each assessment.
[59] https://www.health.gov.au/initiatives-and-programs/short-term-restorative-care-strc-programme/funding-for-the-short-term-restorative-care-strc-programme/flexible-care-subsidy-for-the-short-term-restorative-care-strc-programme#calculating-the-subsidy Accessed August 2022.
[60] Noting the Royal Commission recommendations which would effectively deliver residential-level care in the home, if these were adopted, this would be the equivalent saving.

- Similarly, with an increment of $18,990.95 between HCP2 and HCP3, it requires a 1.12 year or around 13 months delay to be cost-effective; and,
- With the step from HCP1 to HCP2 only costing $6,967.85 *per annum*, the threshold would need to delay progression by 2.58 years to be cost-effective.

For the higher levels of care, beyond HCP1, active assessment and reablement at this expenditure allocation look credible. And, while its use for HCP1 consumers looks superficially less cost-effective, if use at this stage holds back future progression to higher levels, it is still likely to be cost-effective.

Further, the use of active assessment can still be cost-effective in the CHSP, which replaced HACC, if the incremental costs are much lower. The 2021 review of the 2018 reablement budget initiative differs from STRC, in that it used a more expansive reablement schedule of:

- Active assessment;
- SMART goal-setting;
- Broad reablement strategies, only part of which was time-limited CHSP services; and,
- Follow-up over the 8-12 week period of the trial.[61]

What this demonstrated in terms of outcomes was:

1. First, the active assessment method led to substantially higher levels of reablement implementation, from 13% before commencement to 30% at the end, in the trial group.[62] This is principal evidence that active assessment is not only the path to greater use of productive reablement, but that it is also an effective filter as still only a minority of participants were offered and accepted reablement;
2. There was both a decline in reablement uptake with age; and significant variance in uptake rates between different regions of Australia. One explanation for this is different levels of managerial commitment to active assessment and reablement in different organisations.[63] This illustrates the problem of heterogeneity, which will hopefully be solved through more training and better embedding following the strategies outlined earlier. Again, this commences with a common definition;
3. There were some savings observed in referral for CHSP services, both by percentage of clients. Here:
    a. Active assessment increased the percentage of actively assessed clients against a traditional RAS with no CHSP service recommendation: from <1% to 5% for those diverted

[61] Australian Healthcare Associates, 2021, p.12.
[62] Australian Healthcare Associates, 2021, p.21.
[63] Australian Healthcare Associates, 2021, pp.22-25.

to reablement and; from 7% to 11% for those with no reablement recommendation or uptake;

b. Numbers of services were also fewer, moving at the mean from 3.0 for RAS to 2.7 for active assessment amongst reablement clients, which is a 10% reduction on average;[64]

4. More significant reductions in use of particular services were observed, with:

   a. Actively assessed persons receiving allied health services at a slightly higher rate – 34% v. 32% – which likely reflects the higher rate of reablement; but,

   b. A reduction in demand for basic ADL support:

      i. To 33% from 44% for domestic assistance (a 25% saving); and,

      ii. To 28% v. 34% for transport (a 17% reduction);

      iii. These are consistent with the fundamental goal of active assessment, to maintain independence;[65] and,

5. Strong evidence that individual customisation goals are being met, with an increase in unique general (non-CHSP) recommendations from 39% to 70% of reablement clients and from 28% to 67% for non-reablement clients. This shows active assessment in practice.[66]

Alongside these, the report shows evidence of marginal improvements in self-assessed wellbeing but not statistically significant differences in health-related quality of life (HRQOL) and independence for actively-assessed clients.[67] This is in part contrary to expectations and likely reflects the heterogeneity of commitment and experience observed in the sample.

This is consistent with some international studies which show improvements in ADL capacity as a source of savings, but less clarity with respect to HRQOL.[68] Other studies though claim there are clear benefits in HRQOL as well as ADLs.[69]

On the cost-benefit analysis front – and while the trial model was expensive in the first instance – it is concluded that:

- In subsequent years, the incremental cost of active assessment will be $51; whereas
- Savings on CHSP services per client are around $100 at the mean, which is a 2:1 ROI ratio.

[64] Australian Healthcare Associates, 2021,pp.25-6.
[65] Australian Healthcare Associates, 2021, p.27.
[66] Australian Healthcare Associates, 2021, p.31.
[67] Australian Healthcare Associates, 2021, pp.34-37.
[68] Hanne Tuntland et al, "Reablement in community-dwelling adults: a randomised controlled trial", *BMC Geriatrics* (15:145) 2015.
[69] Annie Tessier et al, "Effectiveness of Reablement: A Systematic Review", *Healthcare Policy* (11:4) 2016.

In practice, this equates to $6.2 million in expenditure annually which delivers savings of $6.7 million in the second year and $6.9 million in the third year. The report notes, that within an annual CHSP budget exceeding $2.5 billion, the additional cost is negligible.[70] Active assessment is therefore recommended in the CHSP environment.

These savings cases differ from historical cost-effectiveness analyses of restorative care in Australia, though they concur with earlier evidence that there are savings from such investments across both 5-year[71] and 2-year periods.[72]

Overall, the evidence for savings cases is strong, even if the evidence for other gains is less clear at this time.

Conclusions and Recommendations

Three important recommendations emerging from this paper are restated here. These are:

- When compared to the traditional approach, the incremental cost of $51 or 13% associated with the Active Assessment is negligible and so endorsed in all circumstances;
- Active assessment has value whether or not coupled with reablement, because it will both:
    - Give the consumer the care they need, rather than the services they claim they need, which will lead to savings; and,
    - Done properly, will also lead to savings elsewhere in the health system, by early identification of risks contributing to avoidable hospital use;
- While the evidence is incomplete, the value of active assessment and reablement will remain ambiguous in many settings. Accordingly, further implementation should be accompanied by an appropriately scoped longitudinal study to measure both the:
    - Benefits and costs of the model; and,
    - Consistency of application; noting that,
- This starts with the common definition formulated by the expert group on reablement which is included earlier in this paper.

[70] Australian Healthcare Associates, 2021, p.45.
[71] Gill F Lewin et al, "Evidence for the long term cost effectiveness of home care reablement programs", *Clinical Interventions in Aging* (8) 2013.
[72] Gill F Lewin et al, "A comparison of the home-care and healthcare service use and costs of older Australians randomised to receive a restorative or a conventional home-care service", *Health and Social Care in the Community* (22:3) 2014.

Beyond this, from an ethical perspective, increasing self-reliance is a more worthy objective than simply funding support services, so reablement remains the right thing to do. No evidence exists to suggest that active assessment delivers worse outcomes, and there are savings cases, so it should be utilised in all cases.

Better Data to Permit an Incentive-based Approach

Maximising both benefits and cost-efficiency in aged care assessment will – as with all endeavours – improve with competition and effective incentives.

Further, as noted above, there is good evidence of savings cases in CHSP and credible expectations of saving funds in HCP and residential care. Unfortunately, what is currently lacking here is an adequate dataset to properly show the benefits of active assessment, in terms of client experience, better care allocation, and effective reablement.

As a priority, it is recommended that:

- Data collection be instituted to identify differential outcomes and costs; and,
- As a prelude to this, there should be further interrogation of existing datasets to identify historical evidence and project potential benefits.

This would then permit an incentive model which would maximise the value of assessments going forward, and would clearly emphasise the need for universal active assessment.

To introduce incentives which would lead to better standardisation and implementation of active assessment, the following are further recommended for consideration:

1. The various savings targets associated with holding back progression for different levels of care should be recognised as goals for assessors;
2. While the mean price of assessment would only increase by the expected increment of around $51 with indexation, costs for any reablement would also need to be included;
3. A microsimulation model would be developed which allows genuine direct comparison between:
    a. Expected rates of progression between aged care funding levels depending on different demographics;
    b. Actual rates of progression amongst the cohort assessed, with reference to their specific demographics;
    c. Typical rates of hospital attendance;
    d. Allowing for an assessment of savings annually attributable to that assessment firm;
4. From here, the nett savings would be given by $attributable\ savings - total\ reablement$ with total reablement expenditure further attributed by assessment firm; and,

5. This would permit an incentive which might be set, say, at 10% of nett savings as an annual bonus.

This model would also allow for the data collection for the proposed longitudinal study.

The benefits of the model, other than direct savings, are that it provides incentives to:

- Allocate optimal care without wastage;
- Deliver effective reablement;
- Identify risks which may contribute to higher than average levels of avoidable hospitalisation and ED presentation;
- Adopt innovations from those demonstrating comparative success in maximising nett savings.

It is noted that this will require ethical consideration to ensure savings cases do not displace consumer outcomes.

Finally, it is recommended that this general model description be approved for further expansion and detailed design.