Structural reform of aged care in Australia

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Abstract

This paper discusses the recent reform of the aged care system in Australia. The reform has provided better accessibility of care services and a more impartial care assessment system. The reform also boosted industry confidence in investing for accommodation facilities. However, the increasingly aged population will require continuous improvement and expansion of the service system.

1. Introduction

A new aged care insurance system has been introduced this year in Japan and it has been one of the most discussed issues in mass media.

One of the features of the new system lies in the emphasis of home and community care. Australia introduced the home and community care service system in 1985 and it has grown to be one of the two major schemes

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of aged care systems in Australia. The other scheme is of course the traditional residential care services provided through hostels or nursing homes.

This paper aims to review the recent trend of the Australian aged care system after Howard's government started in 1996. Howard's government policy concerning the aged care remains in principle in line with the previous government's strong initiative to encourage people to stay at home rather than to be accommodated in residential facilities.

However, Howard accelerated the Community Aged Care Packages (CACPs) and tackled other problems such as funding inequity.

Aged population is one of the unavoidable policy issues in many developed countries. Australia and Japan are not the exception.

Commonwealth Department of Health and Aged Care (2000) estimates that the number of people aged over 65 years will increase by 48 per cent over the next 20 years. By the year 2019, around 3.5 million people (16 percent of the population) will be aged over 65 years. At present, Australia has six people aged between 18 and 65 years for every older person (those aged over 65 years). In 2025, this ratio will have halved to three. In 2045, there will be only two people aged between 18 and 65 years for every older person. These statistics tell us the growing importance of aged care for sustainable social management in the near future. Although Australia is not necessarily a more aged society than Japan (1), it has always been an innovative country in social welfare system in human history. Australian aged care system in the light of an international perspective may provide some insights into other countries' policy planning.

2. Options for aged care

The Australian aged care system provides two options for the older

people needing a variety of care and help. One is moving to residential facilities (hostels and nursing homes) and the other option is staying at home with care and help provided by professional people visiting home. The latter system originates from Home and Community Care (HACC) which started in 1985 and it has been supplemented by Community Aged Care Packages (CACPs) which started in 1993. CACPs is the most recent innovation which aims to replace hostel arrangement with home and community care for those who wish to stay home but need external help.

The contents of these services are summarized in the following Sections 2.1 and 2.2 (Australian Pensioners' and Superannuants' Federation 1994; Phillips 1996).

2.1 Residential facilities

(1) Hostels

A hostel is used by older people who need assistance with domestic tasks and personal care. Some hostels are part of a retirement village complex and others are modified homes or purpose-built accommodation within the community. Meals, laundry and various recreational services are usually provided, and a resident can also receive assistance with showering, dressing and medication. Hostel residents usually have their own room, some with an en suite and some with shared facilities. Also provided are common areas such as a dining room, lounge and other recreational space.

(2) Nursing Homes

A nursing home is used by people who need either long-term or respite nursing care. The services offered include; assistance with bathing, toileting, dressing and moving around; meals and laundry

services; full-time nursing care; and recreational and therapy services. The nursing care provided is continual and a nursing home has a range of staff including; an executive officer or manager, a director of nursing, registered nurses, enrolled nurses, nurse assistants/personal care assistants, physiotherapists, occupational therapists/activities officers, and domestic staff. Doctors are not part of the staff but are called in when needed. If a resident needs urgent medical attention, the person may be moved to a hospital.

2.2 Home and Community Care (HACC) and Community Aged Care Packages (CACPs)

(1) Home and Community Care (HACC)

Home and Community Care (HACC) is a program of care services for older adults and anyone with a disability living at home. The aim of the program is to support these people so that quality of life is maintained and the need for residential care is lessened. The services provided under this program are broad and not limited to aged people, although most of the users are older than 65.

The services include the following;

(a) Transport services
(b) Home help services
(c) Personal care services
(d) Community Nursing Services
(e) Food services
(f) Respite care
(g) Home maintenance and modification

Each consumer should have a Delivery/Care Plan which outlines the services provided, the person providing these services, and details of any coordinated services with other service providers. Often this Care Plan will be part of the original assessment. This Plan should be developed in consultation with the consumer so that the consumer is actively involved in this process and understands the services that are being provided.

(2) Community Aged Care Packages (CACPs)

Community Aged Care Packages (CACPs) are packages of care services in a person's home. This scheme was introduced nationally in 1993 designed as an alternative to residential care. The services provided under this program are similar to the services provided in hostels, that is,

(a) assistance with dressing, meals, washing, laundry,
(b) assistance with maintaining health,
(c) some maintenance/gardening services; and
(d) temporary respite care.

A Care Plan is prepared in a similar way to HACC. Service providers must assess each consumer's care needs and develop a suitable Delivery/Care Plan. The Plan must clearly describe the services that are being provided, including details of who will provide the service and when it will be provided. There should also be regular monitoring of the Plan to take into account changes in the consumer's needs.

2.3 How are options chosen and used

(1) Demographic profile of service recipients

Australian Institute of Health and Welfare (1999) reports that, in June 1998, there were 3,015 residential aged care facilities in Australia providing a total of 139,917 places, of which about 56% is in nursing homes and 44% in hostels. The occupancy rate is computed to be 95.6% from the number of residents, i.e., 133,807. The supply of residential aged care service in 1998 increased by 0.6% compared to the previous year 1997 when there were 139,058 places.

The Australian government has a target of providing 90 residential care places for every 1000 Australians aged 70 and over (Commonwealth Department of Health and Aged Care, 2000). This target was almost reached in June 1998 when the ratio was 87.4 to 1000. Given the target ratio, the absolute number of supply needs to be increased in the future as the aged population grows.

The demographic profile of recipients of home and community aged care service is estimated separately for HACC and CACPs. As for HACC, the Department of Health and Family Services estimates that there are 220,000 clients on the basis of the 1993/4 HACC User Characteristics Survey (Cited in Mathur, 1996, p. 12). The clients are counted on a service for a person basis in this survey, thus, the actual number of users is much less than 220,000, since about two thirds of the recipients use two or more kinds of services. According to the same survey, the total number of HACC users is estimated to be 41,653, of which 33,708 were over 65 years old (81%).

On the other hand, the supply of CACPs is increasing rapidly. As at 30 June 1999, 13,723 care packages were provided across Australia through 611 care providers. This number includes 4,169 packages

advertised in 1999 and 2,996 packages in 1998 (Commonwealth Department of Health and Aged Care, 2000).

As discussed later, this trend is expected to continue because of Howard government's strong initiative.

Thus, the total population who are under residential care service and home and community aged care service is estimated to be 181,238 or more in 1999 (the sum of 133,807 and 33,708 and 13,723), which is approximately equivalent to 1% of the total population of Australia.

(2) Aged Care Assessment Team (ACAT)

When a decision needs to be made by older people, whether to move to a place with facilities or stay home with external help, Aged Care Assessment Team (ACAT) will discuss care options available with them. At the same time, the older people's needs for care are assessed by the team. Admission to a residential facility is in principle subject to referral by the team (Banks, 1994).

Home and Community aged care service is also subject to the referral (The English at Work Unit of SBS, 1996).

The assessment system by the team was introduced in 1986 and has been operational since then all over Australia. The team consists of doctors, nurses, social workers and occupational therapists. They are well trained to discuss and assess different needs and requirements with the aged people. The professional functions of occupational therapists in Australia are quite broad, butare typically exposed in therapeutic roles for the physically disabled, psychosocial dysfunctions and pediatrics.

One of the instruments they use for the assessment is Residents Classification Instrument (RCI). A new RCI which applies to both

hostels and nursing homes has recently been introduced. Its introduction is one of the reforms which the Howard government launched and it will be discussed in the next section.

3. Review of recent reform

The Liberal Party led by John Howard took power following the general election in 1996 after the Labor party's 13 years rule. His government undertook a reform in the aged care system and his policy was legislated in the Aged Care Act 1997. The new act came into effect on 1 October 1997.

The implementation of the act was reviewed by the government, and the result of the review was recently published in the paper titled Commonwealth Department of Health and Aged Care Report on the Operation of the Aged Care Act 1997/October 1997 - 30 June 1999.

The Aged Care Act 1997 was aimed to secure greater choice for aged care services and continuous improvements in the quality of care and accommodation services. The paper concludes that the new act has delivered major improvements to access and quality of care for older Australians needing residential aged care and home and community care service. The major contents of the reform are as follows;

(1) A new unified Residential Classification Instrument (RCI)
(2) A new accreditation system launched by Aged Care Standards and Accreditation Agency (ACSAA)
(3) Financial safeguards for the fee standard
(4) Increasing trend of CACPs
(5) Trial of extending CACPs to nursing home level care

The above (1) to (3) are regarded as reform of residential care, while (4) and (5) as reform of home and community care.

(1) A new unified Residential Classification Instrument (RCI)

This instrument was introduced to solve the funding inequity problem recognized by hostel residents. There were increasing assessments that led to inequities in funding, particularly for hostel residents with higher care needs. An overlap was emerging between the higher levels of hostel dependency and lower levels of nursing home dependency with a significant funding differential based solely on the type of facility in which the care was provided. This problem was caused by the previous assessment instruments which were designed separately for hostel and nursing home care. Therefore, the inequity problem could be well addressed by the development of a single system of funding based on a unified scale for both of them. The new Residential Classification Instrument (RCI) has provided the basis for the unification of the hostel and nursing home systems into a single care system and ensured that people are funded according to their care needs by a more appropriate assessment method. The new system is more responsive to individual needs and allows residents to remain in one facility as they age even if their care needs change.

(2) A new accreditation system launched by Aged Care Standards and Accreditation Agency (ACSAA)

ACSAA was introduced to improve quality assurance of residential facilities, thereby allowing the industry to invest in accommodation facilities and providing care recipients with better quality

service.

The new system measures the quality of care and services provided for aged care recipients and it will apply to all residential aged care services and facilities. Accreditation will ensure residents receive higher quality accommodation and care. Facilities that provide poor quality care and services will not be accredited and from 2001 will not be funded by the government.

The reform replaces the previous intrusive system of standards monitoring with a cooperative system of quality assurance through a new accreditation assessment managed by the independent Aged Care Standards and Accreditation Agency (ACSAA).

ACSAA performs the following;

(a) manages the accreditation process
(b) assists facilities to improve quality through education and training
(c) refers poor quality facilities to the Department of Health and Aged Care to ensure action is taken
(d) assesses the quality of care in facilities not yet accredited

(3) Financial safeguards for the fee standard

The Aged Care Act 1997 reassured that older people's access to care will continue to be based on need, not capacity to pay. This strong safeguard did not exist under the previous system. A key objective of the act is to ensure that access to aged care services is according to need and regardless of race, culture, language, gender, economic circumstances or geographic location. Underlying this objective is the need to ensure that services are targeted towards the

people with the greatest need for these services, and to ensure that access to care is affordable. The government ensured that for the purpose of paying accommodation bond or charge, the family home is not counted as an asset if the resident's spouse or dependent child is still living there when the resident enters care. The government has also ensured that residents who cannot afford to pay an accommodation bond or charge cannot be asked to do so.

The fee standard of residential care is set to be affordable for all income groups. The basic ongoing charge for hostel residents generally covers meals, laundry, power and the room. Personal items such as medication, hairdressing, toiletries, private transport, etc. are not included. For those whose only income is the pension, this charge in most cases will be no more than 85% of the pension plus rent assistance (Hostel residents who receive a full pension are eligible for rent assistance). Many hostels also charge an entry fee (bond or charge), but it is refunded when the resident dies or leaves the place.

Nursing homes receive a large subsidy from the Commonwealth government. Except for a handful of exempt homes, they can not charge residents more than 87.5% of the pension plus rent assistance (2).

Fees for the home and community care vary according to the services provided, however, they are worked out under the assumption that aged people are on pension (The English at Work Unit of SBS, 1996). It is noted that the Australian pension is an unconditional allowance by the government for the aged who are in need, unlike superannuation which is run by financial institutions based on individuals' contribution for the fund.

(4) Increasing trend of CACPs

CACPs are a key element in ensuring that the staying at home rather than entering residential care is a real option for those older Australians who choose to do so. They offer an integrated package of services and enable the care recipient to deal with one person who arranges all their care. Because of the Government's staying at home initiative, the number of CACPs is to be increased significantly. Approval of new CACPs will be speeded up to reach the target of 10 places per 1000 people aged 70 and over shortly. The level of care package provision is estimated to reach about 12 places per 1000 people aged 70 and over by 2002 to 2003. This will involve an extra 3400 places being allocated. In the future, up to five percent of existing hostel places may be converted into care packages.

(5) Trial of extending CACPs to nursing home level care

The government is investigating the possibility of extending CACPs service to nursing home level care. The program called the Extended Aged Care at Home Packages Pilot Program aims to test the feasibility and cost effectiveness of providing nursing home level care to people in their own homes. In total, approval so far has been given for 299 packages. Of 299, 179 were operational in early 2000. The trial period extends from 1 July 1998 to 30 June 2001. Pilot projects operate in South Australia, Western Australia, New South Wales, Victoria and the Australian Capital Territory.

Delivering nursing home level care in the home is resource intensive and staff needs to visit clients up to six or seven times a

day to undertake feeding, toileting and medication. Coordination of care is more complex and challenging than in a residential setting and it requires dedication and commitment by the service provider.

The pilot program will be evaluated by the following criteria;

(a) the quality of care provided - both in terms of client satisfaction and clinical practice

(b) whether the care can be delivered at the same cost as in a residential care facility

(c) what types of clients are, and are not, suitable for the program

4. Conclusion

This paper aimed to review the Howard government's reform of the aged care system. Although it is too early to discuss the long-term effectiveness, there are some observable improvements in the system.

(1) Greater accessibility and choice

The demand for the aged care service has been always greater than the supply. The 1999 application rounds for both residential and community aged care places were substantially oversubscribed. The 1998 residential and community rounds were also oversubscribed. In order to meet the increasing demand, the government has boosted growth in the provision of community aged care places, while a large number of services are catering for both nursing home level care and hostel level care. The government has set a benchmark of providing 90 residential and 10 community aged care places for every 1000 Australians aged 70 and over. HACC does not have a particular target number, probably because, (i) HACC is not restricted for aged persons but for any

disabled person in need, and (ii) HACC is based on a different legislation (Home and Community Care Act) while CACPs is based on Aged or Disabled Persons Care Act which also regulates hostel services.

The target ratios set by the government have almost been reached or are being reached with increasing supply of care packages. However, there is no doubt that further expansion of service will be required for the increasingly aged population.

(2) Effect of new accreditation system on industry confidence and quality of accommodation

The reform in the accreditation system has already brought much needed capital investment and major improvement to the quality of residential care accommodation. The proportion of services passing certification has risen steadily to its current level of 98%. Other facilities, which have not yet achieved certification, have been working hard to restructure, and the government has quickly provided help and practical assistance where needed. The industry demonstrates confidence about its future and is engaged in extensive building, upgrading and refurbishment work. Over 870 million dollar projects are estimated to have been in progress or completed during the fiscal year 1998/1999.

(3) Fair funding and financial assurance

The new unified Residential Classification Instruments have provided more appropriate and fair funding system for the recipients of residential care service. With the new system, the aged people who may need the same level of care are assessed equally, whether they stay at hostels or nursing homes.

Before the new system, there were two separate scales for hostels and nursing homes.

It would mean very much for the people in need in Australia that the Australian government confirmed a policy that entry into residential care continues to be based on need and not capacity to pay. The operational possibility of this policy is supported by empirical evidence that people with urgent needs are promptly allowed to enter residential care. Recent data indicates that over 18 percent of those who require nursing home level care were placed within 2 days and 60 percent were placed within 30 days (Commonwealth Department of Health and Aged Care Report, 2000). The people in most urgent needs are treated in most prompt procedures.

Design and implementation of new aged care systems will be of increasingly importance for many countries. The Australian case discussed in this paper may suggest some alternative approaches for quality of service, service mix and financial set up.

Notes

(1) Miyahara (1998) reports that Japanese population over 65 years has already reached 16 percent of the total population. It implies that Japanese population structure is much more aged than that of Australia.

(2) Miyahara (1998) reports a case study of a nursing home in Queensland where the maximum care fee ($21.52/day) charged by the nursing home is still within the reach of the pensioner.

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