PAPER 01/2022: Community Care in Australia: 2022 and beyond

What are the Zakumi Orange Papers?

Zakumi is an experienced organisation. We have worked with hundreds of organisations their communities, and the people they serve. We believe in reflecting on our work and the Orange Paper Series is a testament to that discipline. Through sharing our experiences, ideas and insights we aim to help build critical thinking across Australia's care sectors; we like to collect the evidence that helps us make sense of the complex "health and social care". This terrific sector that is focussed on solving Australia's wicked social problems. Please feel free to share this Orange Paper, and more importantly, let us know what you think.

Gary, Marika and the Zakumi Team

Community care, is a broad term used to describe the services, supports, advice and care that people access (or need to access) to continue to live in their chosen community. In Australia it is sometimes referred to as Home Care, Home Support Services, Care in the Community or In-Home Care. The truth is, that "community care" is the longest serving care and support system in Australia, with the person, their friends, family, neighbours, faith or social networks providing the bulk of the care and support. This type of care is commonly referred to as "informal" support**.** We call it, unpaid, critical care.

Since the 1980's policy shifts have progressively attempted to shift government funded-and-provided congregate (institutional) care, to community care. These "de-institutionalisation[1]" policies have continued to evolve over the past forty years, to a place that we (Zakumi) now call the ***"commarketisation"*** of care.

It is not all evil, but for people needing care there is a new way. For their providers, there will be different ways to access people that need care (customers), and the way services will be delivered will be different. This means the sector will, undoubtedly look and act differently.

So why are we seeing the "commarketisation" of care and what can we do about it?

Remember, that the evolution of community care will not happen overnight. But it will happen.

Understanding the drivers of policy and systemic shifts is a good place to start. Short government terms leading to an inability to plan systemic changes over a longer period; growing rights based, customer expectations; the growing population of older people; increased life expectancy; Australian's desire for lower taxes; the gendered nature of caring; Commonwealth and State government tensions on healthcare funding; the impact of primary care (GPs) and the Medicare system, and continued push for people to contribute to the costs of their own care. These are some of the drivers for change.

We know that given the choice, people overwhelmingly want to remain living in their own home and community. They do not want to enter residential care and they do not want to go to hospital (when they can avoid it). That is terrific, because institutionalised care (hospitals,

[1] Richmond Report- 1984

goals, aged care facilities, even group home models) are getting expensive for governments to fund. The need to shift the responsibility of care to the community and the “informal care sector” to keep people at home longer is more urgent.

We can better understand the impact of the reforms by understanding what has happened in recent years. The National Disability Insurance Scheme was introduced in 2016 (full rollout). It provides support to people with disability, their families and carers and is jointly governed and funded by the Commonwealth and participating States and Territories. The main component of the NDIS is individualised, long-term funding to provide support for people aged under 65-years with permanent and significant disability, or eligible for early intervention support. The NDIS also has a broader role in helping people with disability to access mainstream services and community services, and to maintain informal supports, and is not means tested, like many other Commonwealth social policy programs—such as Medicare, the Pharmaceutical Benefits Scheme and income support payments. The NDIS is an uncapped (demand-driven) scheme.

Individualism is at the core of the model; the notion that a person with a disability (supported or otherwise) is funded and can choose the services they need and want, based on a plan (Support Plan). Funding follows the person and provides them with assurance and flexibility. Government has significant control as well, importantly for them, they know and can manage demand; they largely determine eligibility and available funding, and critically, control the pricing. Customers (or Participants) also gain benefits; they can choose to manage their own affairs, select who they wish to receive services from and like true customers, pay for the services after they are received, and don’t have to negotiate prices. The providers of services for all intent and purpose operate as a ‘’market’’.

The Aged Care system is not the same. In this model, the providers of services still have a more direct role, in that they receive the funding for entry-level services (called Commonwealth Home Support),or are approved by the federal government to work and support the older person by managing their funding and care (Home Care Packages). The older person still has choice and some control over the services and support they receive, but the funding whilst able to be utilised by the individual, is determined by government (based on assessed need) and in most cases, managed by a provider.

That is all about to change.

The new Support at Home program will start in July 2023 and will bring all in home aged care providers under one funding model, replacing the Commonwealth Home Support Programme (CHSP) Home Care Packages (HCP) Program and Short-Term Restorative Care (STRC) Programs. These changes were driven by the Aged Care Royal Commission and will have impacts on all of the players (customers, government and providers). Looking at this more deeply, payments to providers will be made based on an agreed price; the older person will be assessed for the services they receive (by the “gatekeeper”) and these will be detailed in a plan (Care Plan), providers will be paid once services specified in the person’s support plan have been delivered.

There will no longer be an Approved Provider system, rather a ‘market’’ will operate and exist and to facilitate this, a “Point of Delivery Payment Platform” is being developed and will enable providers to receive payments in real time, from both government and “customers”. Government has control over demand that was made more impregnable when a few years ago they retained all surplus funding that was held by providers. In the new system, providers and senior Australians will not be able to accrue unspent funds because providers will be paid as services are delivered.

You could be mistaken for thinking you have read this somewhere before…..you did; in the previous paragraph where we talked about the NDIS. This paper is not seeking to comment or pass judgement on either system, merely to point out the alignment and the potential implications. This is the direction that community care is taking and once is starts, it will not be possible to change direction. The “commarketisation” of care has already begun.

This is as permanent a change as one could engineer, so it is important for those organisations who have a purpose related to community care, and values related to social inclusion, justice and equitable access, to be aware of the consequences and act as soon as possible.

Rather than speculate, we took a look outside of Australia and assessed what has happened in other countries. We started assessing the United Kingdom as almost all our social policy is informed, influenced and follows that of our original colonial master; then we looked closer afield to Japan and Korea as they are close neighbours with burgeoning populations of older people, and then briefly glanced at Denmark, seen universally as a benchmark for social care.

United Kingdom (England)

The UK does not have an NIDS, so the focus will be on the community aged care system and how this operates. Similar to Australia, depending on the person’s financial circumstances and their care needs, they may be entitled to social care funding UK from their local authority. This funding may meet the total cost of care or contribute to part of it and is provided to an individual that supports the tasks and activities of daily life. In almost identical style to Australia, social care funding is means tested, and different funding is applied on the basis of assessed need. Eligible customers can ask the local authority to manage their money (budget) and find suitable care (like Approved Providers in Australia), or they can opt to receive a personal budget with direct payment of funds for them to make their own care arrangements. Direct payments can be used to pay for care services, equipment or activities that meet the social care needs either from an individual or an organisation.

Relevance for Australia

The aged care reforms that followed the findings of the Royal Commission also followed the system that has operated in the UK for many years. The freeing up of certain constraints; the funding for individuals, the marketisation of the model with direct engagement with providers are all hallmarks of the UK model that will soon be the Australian Support at Home model. Looking ahead to what the UK sector believes are now issues for older people; better government collaboration to address the declining health of older people; disconnection from community and recognition of and support for the role that community services and the voluntary sector play in health and wellbeing of people as they grow older.

Japan and Korea

We have a lot to learn from our neighbours owing to the fact that they both (Japan and Korea) responded to a rapidly aging population, by introducing social insurance-based long-term care systems (LTCSs) in 2000 and 2008, respectively. Korea studied and took up key features of Japan's system while evolving along its own trajectory in line with its healthcare system. Given that in Australia, the aged care system is looking more and more like the NDIS, itself an insurance scheme, it was deemed beneficial to review these countries.

There are a number of studies that examine developments in the LTCSs of Japan and Korea, but almost none have done so with a view to the issue of system performance. Thus, we cannot say with any certainty if this insurance-based approach has been successful in aged care, however what we do know is that they all learned from somewhere…. Korea studied and took up key features of Japan's system in the design of its own *No-in Jang-gi Yo-yang Bo-heom*, and the Japanese LTCS, the *Kaigo Hoken*, was developed with reference to the German model, which had been introduced 3 years earlier in 1994.

As discussed above, these have been operational for decades so let's start with the design elements. Both are compulsory social LTCI's but in Japan it applies only to population over 40 years (Korea is for the entire population). Japan is decentralised with funding being sourced from insurance contributions: 45%, taxes: 45% and the balance through co-payments. Korea is centralised through the through the National Health Insurance Service with insurance contributions (60–65%), government subsidies (20%) and the remainder through co-payments, being the way it is resourced. Both have universal access based on a standardised care-need certification system.

A recent study[2] has been sourced and found that as both Japan and Korea shared similar socio-demographic challenges related to population aging, they both responded by adopting adopted a social insurance-based LTCS. The study noted that despite their shared reverence for social insurance, policy was impacted by local context and irrespective of the drivers, led to there being divergent performance results. In particular, the system differences between Korea with its centralised, single-payer LTCS and Japan with its decentralised, multi-payer LTCS are found in different roles and responsibilities of local governments in financing and governance of LTC which has enabled Japan to keep to its cost-containment policy relatively well, even as the number of people with care needs consistently increases.

Relevance for Australia

There is always going to be a natural tension between centralising and decentralising delivery in a social insurance scheme. Central control by government will likely enable demand and costs to be controlled but there may be continued upward pressure on sustainability.

What is a key learning is that in both cases where social insurance is the underlying philosophy, there has been a strong ''marketisation'' of the system, with traditional not-for-profits being significantly less dominant (in Japan, less than 40% are not-for-profit and in Korea, only 5% of the market comprises not-for-profits). The other noticeable commonality

[2] Hongsoo Kim,Boyoung Jeon,Lorraine Frisina Doetter,Nanako Tamiya,Hideki Hashimoto, Same same but different? Comparing institutional performance in the long-term care systems of Japan and South Korea, August 2021

and alignment with Australia is that there is a strong trend towards investment in community (as opposed to residential) care.

Denmark

Healthcare in Denmark sets a good example for elderly care in other countries. A large percentage of the population is ageing, as 19% of Danish citizens are above 65 years old. Danish senior citizens have the right to enjoy home care services at no cost (nothing is free, they paid their taxes), including practical help and personal care, if they are unable to live independently. Similarly, preventive measures and home visits can help citizens above 80 years old to plan their lives and care. In addition, the members of Senior Citizen Councils, which guarantee the healthcare rights of senior citizens, are citizens who are more than 60 years old.

LTC is financed through general taxation (90%) and predominately provided free of charge. Local authorities using block grants from the federal government, local taxes and transfers from other local authorities fund services. Most of the system is organised and financed at the local level, where municipalities adopt and deliver the bulk of LTC services. In contrast to where a social insurance scheme has been adopted for aged care, the majority of LTC providers are not-for-profits.

As with Australia and Japan and Korea, there is a trend towards community care and integration into home help, with the majority of services being provided as home care. However, there are contextual relevancies that need to be considered. Health care and LTC care care have always been regarded as public responsibilities; whereas long-term care financing and provision are the responsibility of the local municipality, health services are financed, planned and operated by the counties.

To ensure efficient and effective care giving, and to coordinate health and long-term care a case management system has been introduced (this is a comprehensive and systematic process of assessing, planning, arranging, coordinating and monitoring multiple long-term care services for the individual). It must be remembered however, that all citizens in Denmark enjoy universal, equal access to healthcare services, and tax revenue funds healthcare. The state government, regions and municipalities operate the healthcare system, and each sector has its own role (state government creates general healthcare plans and regulations and allocates funding, regions and municipalities are responsible for making specific plans according to socio-demographic criteria. Regions oversee hospital care, while municipalities are responsible for home care, prevention, rehabilitation and public health). They are thinking broadly and acting locally.

Relevance for Australia

Denmark is one the world's highest taxed nations. That is how they can afford to pay for a universal health and care system.

The Danish experience indicates that whilst vastly different welfare states and political regimes, as well as diverse economic and historical development of social policy exists, the economic and socio-demographic pressures faced by almost all countries is contributing to greater alignment of the social care system. There are similarities in the expectation of the role of the community (and civil society at large), and that the people will want to stay as long as possible in their own home. There is also expected pressure from demographic change,

and, especially, a possible pressure on women as they, more often than men, provide informal care and will have a higher risk of living alone when they age.

Also, integrated care and the use of re-enablement is a central parameter for a possible reduction in the pressure on spending as well as improving quality of life.

What can your organisation do to better prepare for the implications of social policy?

Here are eight things we think organisations should do to be at their best:

1. Stop thinking your organisation has a monopoly on providing community care. This is particularly the case for faith-based agencies and not-for-profits. We are seeing the grooming and development of hybrid organisations (for-profits with a social purpose) rise. They will be well placed in the new marketplace.

2. Get real about who does most of the caring. Friends, relatives and neighbours carry the overwhelming burden of care in the community. Find out how to make their life easier. This is not just about respite care. It is broader than that. Their life is more complicated than that.

3. Get informed. Your leaders and strategic thinkers and your frontline staff need to get what this “commarketisation” means for them and your organisation, but more importantly, for your customers.

4. Review your Purpose and stay true to it. Stop thinking about growing your organisation at the peril of Purpose.

5. Build new service models through a better understanding of technology in particular artificial intelligence, automation and analytics.

6. Build better, stronger and meaningful relationships with your customers.

7. Build connections with your primary health providers either directly or through the growing power holders, your local Primary Health Network.

8. Do not delay acting. This is the time to move.