PAPER 1: The State of Aged Care in Australia: Are we heading back to the United Kingdom?

What are the Zakumi Orange Papers?

Zakumi has a long and successful history in the social care sector and produces quarterly opinion papers on topics and issues of relevance to the sector. These are intended to provide insights that may stimulate further conversations or actions. Please feel free to share them with others in the hope they will spark new thinking and discussion.

We hear a lot about the model of social care in the United Kingdom and how what we have in Australia mirrors that model. There are certainly many other areas that if we track back will notice that they too are based on historical policies emanating from the United Kingdom so it seems like a good place to start. The paper will attempt to assess the differences and/or similarities between the UK and Australian model of aged care.

The governing act in the United Kingdom in the Care Act (2014), which followed on from a series of reviews and reforms, replacing a number of previous laws. The purpose was to provide a coherent approach to social care in the United Kingdom (UK). The first part of the reforms were introduced in April 2015 and the second part was due for introduction in July 2015, however this has been delayed until 2020.

The underpinning principle of the Act is that of wellbeing – physical, mental and emotional, both of the person needing care and their carer. It is centred on two further principles; the prevention and delay of the need for care and support and, putting people in control of their care.

Sound familiar….. In Australia, the Commonwealth Home Support Program (CHSP) followed a series of reviews, reforms and consolidations of different programs under one single banner with a centralised point of access. The objective was to provide a single entry point for entry into the aged care market which comprises people aged 65 years and older, or aged 50 years an older for Indigenous Australians. The program was intended to commence in earnest in July 2015 and whilst some aspects have occurred, funding for most of the original (HACC) services has been extended by a further two (2) years.

The underpinning philosophy is that of ''reablement'' and the delay or prevention of entry into more formal care, like residential or higher levels of community care through the delivery of a range of services designed to keep people in their homes for longer. Whilst progressive in implementation, the strong shift is towards person or consumer directed care which will see the person having their own money and in doing so, exercising their own choice about the services they access.

Both the Care Act (which relates to England only, not the UK) and the Commonwealth Home Support Program, based on the Aged Care Act 1997 (CHSP) have a centralised, needs based assessment entry point. In the Care Act, a person has the right to receive a free needs assessment from their local council if they believe they have a need for care and support. A needs assessment looks at how they are managing everyday activities, household tasks and getting out and about. A needs assessment is where the person discusses what support might be best for them and also the time that local council decides if they can get support from them.

Sound familiar …….the Regional Assessment Service (RAS) is the front end of the CHSP for older Australians where a face-to-face assessment occurs to determine eligibility for services that were the traditional HACC services (domestic assistance, social support, etc.). The funding is from a different source in that it is funded centrally by the Federal government but the principle is the same.

In the United Kingdom, prior to the Care Act, Councils could decide at which level people would get support from them. For example, they could decide to only support people with critical needs, or to support people with critical or substantial needs. This meant that someone might qualify for support from one council, but not from another somewhere else in England. Following the introduction of the Care Act, there is now national eligibility criteria which all councils must use. There is one threshold over which people qualify for support from their council, rather than there being four 'bands' of eligibility. When using this new national criteria, councils cannot just prioritise people's personal care needs (such as needing help with getting washed and dressed), but also have to look at their general wellbeing and any other sorts of help that they might need, such as help with housework or any housing needs they have .

Sound familiar……..under the original HACC program, organisations were funded and they made the determination. It is a very similar system that which applied in England, but councils have replaced separately constituted organisations like we have in Australia. However, following the advent of the CHSP, the criteria for eligibility have changed and there is also a national and standardised assessment process which is the mechanism through which support is assessed.

Both the Care Act and the CHSP require the creation of a Care Plan, however, the former is more ''advanced'' in their concept of consumer directed care and budgeting. The Care Act refers to as a personal budget which is a statement of the amount of money needed to meet the person's eligible social care needs. As of 1 April 2015, the person has a legal right to a personal budget from the council. If the person funds all of their own care, it is called an independent personal budget. However, the ''value '' of the personal budget is essential as from April 2020, the amount will be 'tallied up' in their care account and this will count towards their care cap. This applies whoever ends up paying the amount needed for their personal budget.

The determination of who pays the amount stated in the persons personal budget is decided after a financial assessment is undertaken. The financial assessment is a way of deciding what the person can afford to contribute towards their own care costs (your personal budget).

Sound familiar………it will when it occurs here.

So…..what does this all mean?

Clearly, the model we are adopting in Australia is a mirror image of that in England (and the broader UK) and whilst the Care Act has only just been incepted, some of the fundamentals have been in place for some time. What has arisen in their model will likely manifest here too and these include the entry of new players into the market; higher cost contributions from people and a shifting of responsibility for care onto the person. Evidence from the personal budgeting or consumer directed care philosophy is mixed and there is evidence that it has been successful and almost the same evidence to suggest otherwise. Other changes that have been noted are those impacting on the labour market which has seen a scarcity of

resources and the integration with health. The shortfall in funding to local councils was meant to be ''minimised'' with a transfer of funds from National Health Service (NHS) for services that should be covered by local councils, but reports suggest that this has not met the funding gap. Other notable trends include the fact that councils are making new contracts with people and communities so that individuals can take more responsibility for their own care and families and communities are supported to help those individuals to be as independent as possible; there are changed models of care and increasingly there are those that promote independence and manage risk in collaboration with service recipients. There is a stronger focus on reablement for older people or recovery models in mental health services which help a person to maximise their potential for independence before putting in longer-term services; there is significantly more use of volunteer and local community labour and, councils have embraced the opportunity to integrate services with other public or independent provider services, most notably with the health system. Evidence from a number of councils suggests that savings from personal health budgets have been realised when operating within an integrated model of care. Others found that an integrated reablement model avoids duplication, brings together a range of intermediate care services to support hospital discharge, avoids admissions to residential care and helps older people in the community.

There have been other positive impacts as well that are worth noting[1] including that the proportion of people who say they have control over their daily life is increasing, the proportion of people using social care who receive self-directed support and those who receive direct payments is increasing, the rate of delayed transfers of care from hospital per 100,000 population attributable to social care has continued to decrease and overall satisfaction of people who use care and support services has continued to improve.

So………..what can you do?

It is too early to tell whether or not the changes noted above will arise here in our market or indeed whether they will manifestly change the social care landscape for the better. What we do know is that over the next decade people will pay and pay more for their own services; governments will continue to contract out this level of care as they grapple with an ageing nation. The market is still tightly regulated but one can see a time in the not too distant future when it will be deregulated and that is when we will really see the new entrants into the market. Many are sitting, ready and poised but are reluctant to fully enter the market whilst it is still controlled by government.

It is essential that organisations do not remain idle, do not sit and wait and worse still, don't wait for government to make the next move and tell them what to do. There are opportunities out there.

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[1] Abstracted from Towards Excellence in Adult Social Care programme, part of its work on the National Progress Report, 2014.