Rearranging The Compartments: The Financing And Delivery Of Care For Australia's Elderly

Recent changes to Australia's scheme of funding care for the elderly have added some compartments while removing others, in an attempt to integrate services and funding.

by Anna L. Howe

PROLOGUE: When Australian prime minister John Howard and his conservative Liberal coalition government took office in March 1996, the change ushered out the Labor government and ushered in new policy directions throughout Australian society. Underlying the reform in health and social services for the elderly were the broader themes of deregulation, containing the public purse, and increased contribution for health and welfare services by those who could afford to pay. The most notable change for aged care came with the implementation of a Residential Care Restructuring Package, which was intended to achieve two goals: (1) to separate the costs of care and of accommodation in residential care, and (2) to target services in community-based care. As this paper by Anna Howe demonstrates, the goals were not achieved overnight, and their relative merits have been the subject of intense debate.

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ABSTRACT: Aged care policy in Australia underwent rapid change following the 1996 change of federal government, although continuing to emphasize changing the balance of aged care away from residential care toward community-based care and improving quality of care. This paper examines these policy directions with reference to two specific areas: the differentiation of funding arrangements for the care and accommodation components of residential care, and the targeting of services in community care. In both cases, funding arrangements have been used as a prime mechanism for redrawing the boundaries between different components and levels of care. This process of compartmentalization appears likely to increase the diversity of the Australian aged care system in the future.

AUSTRALIA, A NATION WHOSE COMMITMENT to universal coverage has solidified only recently, has always provided care for its elderly citizens. Under the Labor government, which held office from 1983 to 1996, Australia's system of care for the aged underwent reforms that were rapid at first, then slowed to a sustained pace, through a series of measures that came to form a coherent Aged Care Reform Strategy.[1] By 1996 the momentum of reform had slowed, and the margins for further change appeared modest.[2] Neither demographic nor spending trends, nor the scale and nature of some specific problems recognized in the mid-1990s, signaled cause for radical change.

Demographic trends present few challenges in Australia, which is now and will remain one of the youngest of the Organization for Economic Cooperation and Development (OECD) countries. Australia's age structure is similar to that of the United States: 12 percent of the population was age sixty-five or older in 1996, a figure projected to reach 22 percent by 2041. Total outlays on aged care increased only slightly ahead of the growth of the aged population from the early 1980s to mid-1990s, and total health care spending as a proportion of gross domestic product (GDP) has remained stable over the past twenty-five years, at around 8.5 percent.[3] This has been achieved by purposeful federal policy decisions, and most analysts agree that there seems little reason for concern about aging's impact on health care costs on demographic grounds alone.[4]

A new government took office in March 1996, bringing changes in political objectives in aged care. These changes were the main driving force behind the Residential Care Structural Reform Package, implemented following the change of federal government in early 1996, and the new Aged Care Act of June 1997.

The new policy climate emphasized deregulation, containment of public outlays, and greater contributions to the cost of health and welfare services by those with the capacity to pay. These were given added impetus through a review of public expenditure undertaken

by the National Commission of Audit as soon as the new government took office.[5] The audit specifically considered the impact of demographic change on Commonwealth finances, identifying aged care as a prime area for policy attention, and a number of savings measures were set out in the 1996–1997 federal budget.[6]

While decisions regarding the range of financing and other measures were shaped by the circumstances in which they were to be implemented, and the nature and extent of the changes made varied across the aged care program, several lessons have emerged. Here I examine two areas that demonstrate approaches taken to manage cost pressures: separating the costs of care and of accommodations in the funding of residential care, and targeting of services in community care.

■ **The program context.** The balance of care in Australia has been shifting away from residential care toward community care, and within residential care, from nursing homes to hostels (which provide accommodation and a range of social support and personal care services but are not required to provide nursing care). The share of total aged care funding going to residential care fell from 87 percent in the early 1980s to 75 percent in the late 1990s, and community care rose inversely; nursing homes now account for 61 percent of residential care, and hostels, 14 percent. Total spending on aged care is now just over US$2.5 billion.[7]

For the most part, the shift in the balance of care came not from savings in residential care but from new funding. While growth in residential care services has been controlled, more resources were devoted to improving quality of care.[8] A strict needs-based planning process sought to reverse the ratios of nursing home and hostel use per thousand persons age seventy and older from 60:40 in the mid-1980s to 40:60 by around 2005. Given a shortfall in hostel places into the early 1990s, the initial hostel target ratio was lowered and the equivalent funds transferred to provide twelve community aged care packages (CACPs) per thousand elderly. This "saving" is the only direct transfer from residential care to community care, but rather than being directed through the Home and Community Care (HACC) program, planning and funding of CACPs remain within the federal residential care framework.

Several other factors that limited the federal government's ability to change the balance of care also have a considerable bearing on financing decisions. First, the federal government has almost total responsibility for residential care, and the major share of resources comes from general tax revenues. In contrast, costs of HACC are split sixty-forty between the federal and state governments.

A second factor is the uneven involvement of for-profit and not-

for-profit providers in residential and community care. The federal government has no role in direct service delivery, and state governments have only a limited one. Nursing home care is dominated by the for-profit sector, which has half of the beds, followed by some 40 percent in the not-for-profit sector and the remainder in the state government sector. Almost all hostels are in the not-for-profit sector, with state governments and the private sector each accounting for some 5 percent of places.[9] In community care, half of all funds go to nonprofit providers, with local government accounting for another 20 percent and 30 percent going to quasi-nongovernment organizations that have statutory status under state legislation (mostly large community nursing services). The HACC program has only a very small private sector.[10] Each sector responds differently to different funding options, ranging from strong profit motivation among some private-sector nursing homes to reliance on a large volunteer input in some community services.

Separating Care And Accommodation Costs

Until 1997 residential care in Australia had two distinct tiers: hostels and nursing homes. While the Aged Care Reform Strategy brought both tiers into an integrated planning framework as a means of changing the balance of provision in favor of hostels, modifications to funding arrangements actually reinforced their distinct roles.

The structure of nursing home funding was reviewed in 1993–1994 to address a number of problems, particularly with regard to capital funding for upgrading aging facilities.[11] A range of options was proposed, and the 1996–1997 restructuring adopted those most consistent with the new government's wider policy goals. Some measures met with great resistance, and several modifications were made in the course of rapid implementation of a complex set of measures. To restore stability and address lingering problems, a two-year review was initiated.[12]

Funding was to be integrated by aligning the separate arrangements in nursing homes and hostels vertically in a common system covering both levels of care, rather than merging the components horizontally into a single payment at each level of care (Exhibit 1). Maintaining and, indeed, strengthening the separation of the cost components enabled government savings while generating additional income for providers by extending user charges for both components. Government achieves a direct saving from increases in care fees as providers' fee income is offset against benefits. The savings from accommodation charges are indirect, as retention of this income by providers enables government to reduce capital grants.

■ **Care costs.** The core common element in all residential care

EXHIBIT 1
Integration Of Funding For Residential Care, Before And After The 1997 Restructuring

	Before 1997				
	Accommodation costs		Care costs	Benefits	
Site of care	Entry payments	Capital grants	Resident contribution	Dependency related	Acquittal required
Hostel	Yes	Yes, matching funds raised by approved organizations, and for special-needs groups	Standard resident contriibution plus variable income-related fees	4 levels, determined by Personal Care Assessment Instrument, not subject to validation	Not required
Nursing home	No	Yes, for rebuilding and upgrading, and for special-needs groups	Standard resident contribution only	5 levels, determined by Resident Classification Instrument, subject to validation	Required
	After 1997				
Hostel	Entry payments Concessional Resident Subsidy	Limited to special-needs groups and small homes viability	Basic care fee Income-tested care fees	8 levels, determined by single Resident Classification Scale, subject to validation	Not required
Nursing home	Accommodation charge Concessional Resident Subsidy	Limited to special-needs groups and small homes viability	Basic care fee Income-tested care fees	8 levels, determined by single Resident Classification Scale, subject to validation	Not required

SOURCE: Compiled by author.

funding is the basic care fee, set at 85 percent of the age pension. This amount covers 25 percent of the cost of nursing home care, on average. From 1989 to 1997 nursing home residents paid only this standard contribution, mainly on the grounds that universal access to free care in public hospitals under Australia's Medicare scheme limited the scope for charging for nursing care. The standard contribution also protected access for low-income persons by effectively neutralizing ability to pay as a factor in admission.

These considerations were less relevant to hostel care, which is more focused on social support and personal care, and there is more scope for provision of other amenities because the resident population is less dependent. Hostel care benefits were not means-tested, but providers could charge fees in return for higher amenities, while allowing for certain protections of residents' finances.

With integration, means-tested care fees were applied to both tiers of care. Care fees are capped at the full reimbursable cost of care, except in 3 percent of nursing homes that are exempt from fee control. Together with about 10 percent of hostels that also charge fees in excess of reimbursable levels, these homes now operate as extra-services facilities. At the same time, all facilities must admit a certain number of financially disadvantaged residents, and offsetting of fee income against reimbursements curbs providers' incentive to admit those who can pay higher care fees.

In the second integration measure, the two separate instruments used to determine the level of dependency-related care benefits were replaced with one instrument, and the associated case-mix systems were unified. The main rationale for this single Resident Classification Scale (RCS) was to address a discrepancy in funding for residents with similar dependency in the two settings. Residents' dependency profiles had shifted over time, and while hostel funding had risen to meet higher care needs, there was an overlap between a residual group of relatively less dependent residents remaining in nursing homes and the most dependent residents in hostels. It was also envisaged that giving hostels access to higher levels of funding would enable residents to "age in place" rather than having to transfer to a nursing home as they became more needy.

The third change was the removal of the distinction made in nursing home funding between the costs of nursing and personal care vis-à-vis other operating costs. Funding of the former was based on validated ratings of residents' dependency and care needs and had to be accounted for against rostered hours for care staff, to ensure that funds were used for care purposes (a process known as "acquittal"). The latter costs were funded at a flat rate to drive efficiency.

In submissions to the 1993–1994 funding review, nursing home operators argued that accounting for staff hours imposed unnecessary administrative burdens and limited flexibility in use of funds. These objections resonated with the wider climate of deregulation and microeconomic reform, and integration saw the dual funding system dropped and the nonacquitted hostel system applied across all residential care.

Explanations for not requiring accounting for care staff hours in hostels are found in several factors, including its less intensive nature and lower cost, fewer concerns about risks to quality of care for less dependent residents, and the lower overall level of hostel funding. Further, with some 90 percent of hostel places in the not-for-profit sector, providers were seen to be less driven by profit motives and less likely to skimp on care. Hostels were otherwise subject to outcome standards and monitoring similar to nursing homes.

■ **Accommodation charges.** Hostel funding has always included provision for persons to make a capital contribution toward the cost of their accommodation. While spending down is not required, realization of housing assets is the most common source of these contributions. This arrangement can be traced to the emergence of hostels from a housing program for elderly persons established in the 1950s, with funding for personal care introduced in 1969.[13] As the Aged Care Reform Strategy sought to expand hostel provision, entry payments were kept as an important source of capi-

tal alongside grants to not-for-profit providers. Hostel provision also was opened to the private sector, but take-up remained low.

To generate a similar capital flow for nursing homes, the restructuring package proposed "accommodation bonds," the amount of which would be set by income and asset testing; unlike the age pension asset test, the family home was to be included. The bonds were to be paid in the form of an interest-free loan, and this source of capital was especially keenly sought by for-profit providers, which, having half of all nursing home beds, stood to gain a major inflow of new capital. Following a very hostile reception, these proposals were abandoned in favor of a means-tested accommodation charge.[14] This is paid as a daily fee rather than a lump sum at admission, capped at U.S.$2,600 per year; as of early 1999 one-third of residents paid some accommodation charge. Entry payments by way of accommodation bonds remain for hostels, and two-thirds of hostel residents make some entry payment.[15]

Finally, to compensate providers for financially disadvantaged residents, a concessional resident subsidy is paid. Just over half of all nursing home residents and just under half of all hostel residents qualify for this subsidy.

■ **Effects on spending.** On balance, increases in federal outlays have exceeded savings to date. A primary goal of the changes in funding arrangements was to generate additional capital inflow, so the Aged Care Act requires an annual survey of capital expenditure.[16] Figures reported in the first of these surveys are in line with estimates, but the lack of prior data makes it difficult to judge how much funding has come directly from the new payments or how much this income has leveraged additional market capital, compared with the amount of capital already coming into the industry. Now as in the past, the rate at which licenses for new nursing home beds are sought and the price paid when existing beds come on the market indicate ready capital availability.

The extent of capital savings to government is evident in the reduction of the capital grants program to around one-third of the annual levels that were seen in the early 1990s. However, the cost of the concessional resident subsidy has to be taken into account; unlike a grant program, which can be adjusted annually, the commitment to this subsidy is ongoing.

In recurrent expenditure, there has been considerable growth as more residents have been classified in higher dependency categories under the RCS system. Whereas the number of places funded at each tier under the separate classifications was tied to the levels of provision set by the planning ratios, this control mechanism has been overridden by the single RCS. Further, the shift in classifica-

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tions was not confined to the margins between the two tiers of care but rolled out across the whole system. This movement amplified a longer-term trend of increasing dependency and may be associated with introduction of the RCS and hence a one-time adjustment, but it is not yet clear how far it reflects real changes in dependency, more consistent measurement of dependency and care needs across the whole residential-care population, changing norms regarding standards of care, and some possible gaming.

■ **Effects on quality.** A two-stage process has been adopted to ensure the quality of facilities and accommodations.[17] As of late 1997 all facilities had to meet new certification standards as a condition for levying accommodation charges or bonds and to receive the concessional resident subsidy; fully 98 percent of facilities have now met those standards.[18] Continuous quality improvement is built into the certification process, and beginning in January 2001 all facilities will have to meet higher physical standards and accreditation standards to continue to receive federal funding.

The establishment of an independent Aged Care Standards and Accreditation Agency reflects the government's philosophy of greater industry self-regulation. The agency's functions have evolved from the standards monitoring process previously carried out by federal officers, and the single set of standards has built on the separate standards that already covered nursing homes and hostels. Extensive evaluations of the previous quality assurance process reported high levels of acceptance and widespread improvements in quality of care, at least as measured by compliance with the standards.[19]

The accreditation process retains the validation of the RCS to control cost escalation associated with possible overstating of dependency, and quality of care is further pursued through facility visits, documentation requirements, compliance checks, and complaints procedures for consumers. The requirement to account for care funds was a powerful and continual adjunct to standards monitoring, and its removal has been seen to raise the potential for skimping on services, particularly by reducing skilled nursing staff.

Overall, when the additional costs borne by residents by way of means-tested care fees and accommodation charges are added to the additional government outlays, the cost of residential care to the community overall has risen. New capital investment has seen improvements in facilities, and while quality continues to improve, it is

less clear that quality outcomes have been commensurate with the scale and spread of resources.

Targeting Of Community Services

■ **Emergence of the debate.** In contrast to the long-standing and continuing policy focus on funding of residential care, the Home and Community Care program has long remained without clear guidelines for resource allocation. When it was established in 1984, HACC brought together a number of separate programs that provided different community care services and unified their funding, and also expanded the range of services funded. HACC services are now funded by way of grants to providers, on the basis of agreed-upon service outputs and unit costs, and through user fees, which now account for something under 20 percent of all program funds. Resources are distributed among regions on the basis of various population-based formulae, but these are far less consistent and less rigorous than the residential care planning process.

The population eligible for HACC is defined only in broad terms and estimated as persons with moderate and severe disabilities as reported in surveys of the Australian Bureau of Statistics.[20] Coverage of HACC services extends to about one in three of the frail aged segment of this total target population, and fewer younger persons with disabilities, who also are covered by a range of programs operating under Commonwealth State Disability Agreements. While the Aged Care Assessment Teams refer more of the clients they assess to community services than to residential care, formal assessment is not required for admission to HACC services, and providers apply a range of assessment methods and priority criteria.[21]

The tension as to whether community-based services should be spread across a wide target population or concentrated on a smaller group of more dependent clients was present from the start.[22] Early growth of the program, however, brought growing recognition of the role of community-based care in its own right—that is, helping persons with some level of disability to maintain their independence, rather than just preventing admission to residential care. By the early 1990s the initial rapid growth of HACC funding had tapered off, and as demand continued to grow, a debate emerged about how community-based services should best be targeted.

A trend toward concentrating resources on persons seen to be in greatest need was advanced by several developments. The population effect of shifting more-dependent persons to community-based care as a result of controls over residential care has been gradual and at the margin, with some of the displacement being absorbed by other forms of supported housing. There has been a more pro-

nounced "standards effect," driven by rising expectations about the nature of community-based care, combined with two changes that enabled higher levels of service provision.

The Commonwealth began a pilot program of Community Options Projects (COPs) within HACC in the late 1980s when states failed to take up all the funds available for matching under the cost-sharing arrangements. These projects, which continue as part of HACC, provided the model for the Community Aged Care Packages. The provision of case management and brokerage funds gave funding to a small group of clients that is up to ten times the average level of funding for other HACC clients.

As part of the ongoing development of community care, case management practices were adopted more widely, and there were other effects in HACC, especially as growing demands for postacute community care added to competition for HACC services. Although the combined effects of these developments were in line with directing resources to those most in need, "greatest need" was variously interpreted. There was growing concern about the effects of reducing or withdrawing services from low-use clients to provide more resources to high-need clients. The debate over targeting came to be framed in terms of the effectiveness of more-intensive levels of service use vis-à-vis more basic support, in the course of two policy reviews undertaken in the mid-1990s.[23] Given the dearth of clear evidence, research to investigate targeting strategies was commissioned in late 1995.[24]

■ **Relationships between resource use and outcomes.** The research began with a review of evaluations of Australian case management and other intensive community care projects, and found only ambivalent evidence of their effectiveness.[25] This is consistent with international findings. The second part of the research, which investigated patterns of service use among clients in several large community care providers, confirmed that the main outcome of HACC was the spread of basic services. Typically, half to two-thirds of clients receiving low levels of service accounted for only 20–30 percent of resources. However, targeting had seen small groups of clients absorb a disproportionate share of service resources; with some 5–10 percent of clients using as much as half of all service hours, the implications of further concentration were obvious.

The view of targeting as a trade-off between more services for fewer clients or fewer services for more clients was found to be overly simplistic. A much wider mix of strategies was found to be operating, to some extent simultaneously. "High-risk" strategies aiming to reduce use of residential care or prevent premature admission were found to be problematic, because it was very difficult to

predict likelihood of entry and subsequent length-of-stay. More support was found for strategies that aimed to maintain high-need clients in the community, to improve functioning and independence across a wider target group, and to support caregivers.

Findings from an analysis of large-scale databases on clients of Aged Care Assessment Teams proved to be particularly informative in clarifying how use of community-based services mediated use of residential care. First, compared with clients using no services at the time of assessment, those using a single service were significantly less likely to be recommended for nursing home care. Second, while no low-dependency clients used high levels of service, service use among high-dependency clients was very variable; a large group of high-dependency clients who were not using any formal services were identified as the prime target for support. Third, where dependent clients were already using high levels of service, there appeared to be diminishing returns to further inputs.

Taken together, these findings pointed to a need to moderate strategies that concentrate resources in favor of a wider range of clients. This conclusion is in line with an early U.S. analysis of the effectiveness of community-based care and accords with Walter Leutz's recent review of integrated care programs—namely, that while such programs may be very effective for a few, they should not come at the cost of good "usual care" for many.[26]

■ **Measures for refining resource allocation.** Measures intended to achieve more consistent and equitable resource allocation in HACC have been the subject of policy discussion for some time now, but implementation has proceeded slowly. The cumulative effects of three sets of measures that are now in progress will be important not only in clarifying financing arrangements within community care, but also in securing the funding of community-based care in the overall balance of care.

Parallel to the targeting research, a consultancy was carried out into possible models for assessment in HACC.[27] A two-tier system now being implemented is designed to maintain initial open entry to basic services while requiring comprehensive assessment for all clients who have complex needs and who reach a defined level of resource use. This approach is consistent with proposals set out in the targeting research study, which sought to align funding arrangements for COPs, CACPs, and HACC in general.

The quality assurance process that is also now being implemented in HACC includes standards relating to priority of access guidelines and resource allocation, both for individual clients and for agency performance overall.[28] The third measure is the development of a classification system for clients in community-based care.

Only preliminary work has been carried out to date, and the way in which such classifications might interface with those used in residential care has been identified as one area for resolution.[29]

Conclusion

The recent changes in financing and delivery of aged care services in Australia might usefully be seen as a process in which the "compartments" of care, made up of various service components, providers, and associated funding arrangements, have been redrawn. Adjustments in the boundaries between compartments, defined by funding and other conditions governing service provision as well as the settings in which care is provided, have sought to direct flows of funding to different compartments, in line with policy objectives.

In residential care, the new compartmentalization has achieved a vertical integration of care funding but not of capital funding and has drawn in new sources of user funding. But the removal of some of the boundaries that previously set limits on cost escalation between and within the previously separate compartments has generated increased government outlays. In community-based care, in contrast, new compartments are now being drawn by aligning funding arrangements, assessment processes, and levels of service provision across the three main community-based care programs, to achieve a more consistent horizontal division between clients at different levels of service use and the share of all funds to be allocated to each level. Taken together, these measures are expected to moderate rising cost pressures in HACC.

The debates that have arisen in the course of making these changes have not only highlighted the varying balances between different cost components and how they can and should be funded, but also brought into focus many fundamental differences between the choices available in making a decision to remain in the community with support services, enter a hostel, or be admitted to a nursing home. There are many indicators of the need for nursing home admission, which most often occurs on discharge from acute care, and the compressed decision-making time frames and short subsequent length-of-stay for many, as well as differences in individual decision-making capacity, present far fewer choices than for those remaining at home or entering a hostel. The same wider range of choices that underlies the feasibility of funding of care packages that can be delivered at varying intensity in a variety of settings offers prospects for a range of financing options that could drive service provision in new directions.[30]

Three channels of ongoing policy development present different opportunities for discussion of these options. The two-year review,

due to report in mid-2000, is focused on resolving several problem areas in the current arrangements; at this point, no wider changes are anticipated. In the medium term, the objectives set for an audit of the HACC program by the Australian National Audit Office (a quite separate body to the National Commission of Audit) indicate some potential for opening up broader developments: In addition to examining financing arrangements within community-based care, the audit extends to canvassing the boundaries between community-based and residential care.[31]

In the longer term, a National Strategy for an Ageing Australia that was initiated for the International Year of Older Persons offers the broadest prospects for change.[32] The scope of this strategy is very wide, having been framed in accordance with the principles identified by the OECD for reforms to deal with the social and economic implications of population aging. Two Discussion Papers, on healthy aging and independence and self-provision in retirement, were released during 1999, but the priority accorded to further development, including the release of Discussion Papers on world-class care and attitude, lifestyle, and community support, appears to have waned.

It is not easy to predict exactly what would renew policy interest in aged care. However, changes that are already under way at a number of critical margins in community-based and residential care are continuing to reshape the field. Recent Australian experience has shown that a range of funding arrangements can be devised that protect quality of care and access to health, nursing, and personal care services, while allowing for more variation in the cost of other components and more varied combinations of public and private funding, and in turn fostering even greater diversity in forms of service delivery. The emerging options point to an increasing mix of types of accommodation and environmental, amenity, and social support services, and more rather than less separation of the associated cost components as new compartments of care are devised.

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NOTES

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