CARING FOR AN AGEING POPULATION

Submission to the National Health and Hospitals Reform Commission

June 2008

CARING FOR AN AGEING POPULATION

Aged and Community Services Australia (ACSA) is pleased to make this submission to the National Health and Hospitals Reform Commission.

ACSA represents over 1,200 church, charitable and community-based organisations providing housing, supported accommodation and community care services to around 700,000 older Australians, people with a disability and their carers. Many of our members are also involved in the provision of 'crossover' services for older people, bridging the gap between hospitals and the community. All have a keen interest in the work of the Health and Hospitals Reform Commission and the potential to improve the delivery of services to our growing population of older people.

ACSA would be pleased to discuss this submission and any other matters relating to the work of the Commission as it relates to aged and community care.

Aged Care and Health

With an ageing population, consideration of health reform must include aged and community care. Caring effectively for older people involves good services in both the health and aged care sectors and requires good links between them. If we get aged care wrong, we will not get the best results from our overall system of health care.

Aged and community care services include home care, residential care, respite care and specialised housing for older people. Up to one million Australians receive home or community care services each year and there are currently 170,000 older people in Commonwealth-funded residential care. Specialised housing is provided for at least 50,000 older people.

Aged care is about more than health care. However aged care services have a number of important functions in terms of the overall system of care, not all of which are able to be fully realised at their present stage of development and resourcing. They can preserve older people's capacity for independent, active and healthy living. Appropriate, barrier free housing, in age-friendly communities, is important in this regard. A powerful, effective and well-resourced community care system is essential to maintaining people in their own homes as they age. Caring for older people in residential care acts to stabilise their condition and reduces the need for hospital care.

Aged care services are already involved, and could play a larger part, in the recovery and rehabilitation of older people following episodes of illness involving hospitalisation, in palliative care and other shorter term interventions though they would need to be specifically resourced to do this. This is true both for community and residential care services. This should not be seen simply as saving money, it is about providing a choice of appropriate settings for different levels of care.

The potential to support older people's health and well-being in their own homes, or in residential care, through the use of technology is only beginning to be explored but is seen, worldwide, as one part of the response required to caring for ageing populations with constrained resources and a finite or declining workforce. We face a shortage of nurses, allied health professionals and certificate-trained care workers as well as the medical workforce (doctors) and using technology to support self management, and care provision, is one of a number of strategies that we believe must be pursued.

For the aged care system to play its key role in the care of older people it must be well-resourced in a sustainable fashion. Funding from a combination of government subsidies and user payments has,

over the past ten years, failed to keep pace with rising costs. This has meant a steady, measurable erosion in hours of care per resident in residential care and in hours of care per client in community or home based care. This is compounded in residential care by a shortfall in capital raising capacity for high level care.

If our aged care services are to realise their potential as part of our overall system of care, we must invest more resources in them. A failure to invest will result in higher costs elsewhere in that system.

Aged Care is not Simply Health Care

The distinctive feature of the aged care paradigm is that it combines care and treatment, in various ways, with housing and social support services. Residential aged care is where 170,000 older Australians *live* and involves all three of these services. Community care supports up to a million more to live in their own homes with various combinations of care and support. In many countries this system is referred to as 'long term care' to distinguish it from the short term or episodic care that more typically characterises the health system. People go to health services to 'get something done' and then leave. By contrast many older people live in, or live supported by, aged care. Their health needs are supported in those settings.

This distinction between short and long term care is an important one. It should inform the training of our staff, the design of our buildings and services and underpin the ethos or culture of aged care. We do not want residential aged care homes to resemble hospital wards in their design or operation and if we are to accommodate 'treatment rooms' for GPs to use on their visits or more space for therapy this should not be at the expense of creating an appropriate living environment.

Health and aged care are inter-related, even co-dependent, but they are not the same.

Comments on the Commission's Terms of Reference

Our submission has grouped these to avoid repetition.

a) System Coordination (ToR a, b, and d)

When service failures occur at the point of handovers from one part of the system to another, both parties share the responsibility. The explanation that whatever has gone wrong is the fault of someone else has never been good enough. Consumers of care services, providers and funders would all benefit from a focus on solutions rather than attribution of blame. The aged care and health systems have long common borders with many points of crossing.

While residential aged care falls mainly under the Commonwealth Government, both the Commonwealth and State Territory governments are involved in the funding and management of home care with significant levels of local government involvement too in some jurisdictions. Program rules have been created to control cost shifting and program expenditure and these often stand in the way of flexible and responsive client care. Areas to focus on for improvement include:

Transfers Between Aged Care and Hospitals and Back Again

These are more difficult than they should be with both parties blaming each other for real or perceived shortcomings in care and information transfer. Most of the rules and procedures governing such transfers have been developed to control local expenditure rather than to provide client (or patient) centred care.

Examples which illustrate this point include:

- Restrictions on providing home care under the Home and Community Care program, Australia's largest funding program for home care, to people who have recently been discharged from hospital. While these restrictions were relaxed to a degree in the mid 1990s, barriers still exist, Resource constraints in home care services, stretched ever more thinly by costs rising faster than subsidy levels mean that the full potential of such services to support people on discharge from hospital is not realised.
- Pilot or localised programs under which hospitals purchase after care services from experienced home care providers enjoy a good reputation but the availability of such services is far from universal.
- Sometimes people do not need new services on discharge, they need to be reconnected to previously used services and supports and these arrangements need to be confirmed before they arrive home.
- Residential aged care funding rules act as an impediment to the smooth transfer of older people from hospital. A new funding system introduced in March 2008 appropriately contained an incentive for providers to maximise the capacity for independent functioning of residents by not withdrawing funds where this is achieved. This new incentive structure does not apply to residents transferred from hospital whose funding must be reviewed after six months. Aged care providers stand to lose funding and incur an additional administrative load for residents admitted from this source. Whatever else this mechanism may do, it acts as a barrier to the smooth access of hospital patients on discharge to residential care.
- Hospital funding systems contain strong incentives for patient throughput and a change of setting can be beneficial for older patients for a range of reasons. However this pressure to discharge creates tensions between hospitals and aged care facilities with inadequate handovers, incompletely treated conditions and transfers at inconvenient times being all too common.
- Hospital staff also report difficulties with patients transferred from residential aged care and sometimes do not seem to appreciate the level of care that residential aged care facilities are funded, and able to provide.

Hospital to aged care transfers also involve GPs, compounding handover issues.

Transition Care Services

This year's budget contained a further investment in services specifically designed to bridge the gap between hospital and residential aged care. ACSA members in different parts of Australia have experience and expertise in providing such services but are concerned that State Health departments may overlook this and seek to replicate infrastructure we already have. While it is ACSA's view that the Government's estimates of the relative costs of hospital and residential aged care underestimate the true costs of aged care it still remains a more economical, often safer and more supportive environment for older people recovering from an acute episode.

We should not overlook existing services such as the network of Day Therapy Centres funded under the aged care program and focus only on new initiatives. Building on existing, successful models is a sound strategy. ACSA has prepared a discussion paper on *Day Therapy Centres: The Forgotten Services* which may be found on our web site agedcare.org.au (under Policies and Papers)

Aged Care and Primary Care Services

A key issue in this area is the lack of access to GP services by residents of aged care homes. There have been several initiatives adopted over the past decade to redress this, however one of these, the aged care panels initiative, has just been abandoned as a result of Budget savings. ACSA is not convinced that financial incentives, such as those which are to replace the panels, will be sufficient on their own to address this issue since relationships still need to be built and protocols developed.

Issues in this area include:

- GPs perceive that the remuneration they receive for seeing patients in residential care facilities is inadequate to cover their costs. Recent initiatives in this area have yet to be evaluated.
- Aged care facilities are not funded to provide consulting rooms or equipment for GPs and tend to regard GP visits as 'home visits'.
- Aged care staff are not able to readily drop other tasks to meet the needs of visiting GPs
- Some GPs assign a low priority to completing the paperwork required by the Department of Health and Ageing to substantiate funding claims. This results in less funding being received by the aged care service meaning that less care can be provided to its residents.

b) Focus on prevention and early Intervention (c and e)

This is supported however ACSA notes that many discussions of prevention are not cognisant of the fact that effective preventative services and practices can be valuable at any age. It's not too late for older people to benefit from exercise programs, a good diet or ceasing substance abuse. There is a growing level of support for home care services which act to restore levels of functioning rather than compensating for their loss and good evidence to support their effectiveness.

ACSA is also concerned that the new funding system for residential aged care, known as the ACFI, will act as a disincentive to admit older people with low level needs but whose condition is likely to seriously deteriorate if they remain at home, even if supported by home care services. It cannot simply be assumed that additional community care services will be available or suitable to meet these needs. A failure to provide preventative services is very likely to lead to more serious, and expensive, health issues. ACSA and our members are currently monitoring this situation.

c) Rural Services (f)

Rural aged care services face many of the same challenges as rural health services with the additional challenge that they are not providing episodic care. ASCA and the National Rural Health Alliance issued a joint policy on these challenges in late 2005 - *Older People and Aged Care in Rural, Regional and Remote Australia.* This may be obtained from ACSA's web site agedcare.org.au. Key areas for improvement include funding, workforce and transport with an emphasis on solutions which fit the needs of specific local circumstances rather than a 'one size fits all' approach.

ACSA and NRHA argue that aged care services should be available locally for all Australians; and that governments should recognise the real costs of providing rural and remote aged care services, Including the fact that these services cannot benefit from economies of scale.

d) Indigenous Services (g)

Australia has not had a comprehensive strategy for providing aged care services to indigenous people for some time. ACSA has prepared a strategy paper on this which can also be found on our web site. A stronger focus is required on an overall policy framework; organisational viability and service support; workforce issues in remote communities; the cultural responsiveness of 'mainstream services'; and the creation of an 'indigenous voice' on aged care issues.

e) Workforce (h)

All health and care services face a double challenge from the ageing of our population which will simultaneously increase the demand for care services and reduce the growth in the national workforce to minimal levels. Aged care and health services operate in the same, or at least an overlapping, labour market and a holistic view needs to be taken. Aged care services are particularly severely affected in terms of their ability to compete in this restricted labour market with capped funding levels making it impossible for aged care services to compete with remuneration levels offered by State-funded health services for all levels of care staff. This labour market distortion does not act in the best interest of the overall system of care or its efficacy in caring for older people.

ACSA supports initiatives to make more flexible use of scarce workforce resources and to remove barriers to this which, often in the name of safety or quality, in fact act to protect professional territory.

Suggestions:

The following avenues are suggested as ways of improving the care of older people by improving the functioning of our overall system of care.

1. **Eliminate arbitrary administrative barriers to flexible client centred care by conducting a systematic audit of aged care and hospital program funding rules from the standpoint of smoothing the path of older people between different care settings.**
2. **Fund more aged and community care providers to provide step down care for older people on discharge from hospital.**
3. **Develop a stronger focus on wellness and preventative programs for older people and evaluate their effectiveness.**
4. **Develop a stronger focus on the use of assistive technology to promote self reliance and self management of chronic conditions.**
5. **Promote and resource partnerships between hospitals and aged and community care providers to end blame games and facilitate client centred care.**
6. **Recognise and resource existing services, such as Day Therapy Centres as well as inventing and developing new ones.**
7. **Develop new mechanisms to improve coordination between aged care services and General Practitioners.**
8. **Evaluate the incentives provided to encourage GPs to provide services to residents in aged care facilities.**
9. **Invest in systems and protocols to facilitate the exchange of health information between services across the health and aged care spectrum.**