SUBMISSION TO THE SENATE INQUIRY INTO AGED CARE AUGUST 2004

"FRAGMENTS OF CARE"

Overview

About Us

The Victorian Healthcare Association (VHA) and its members welcome the opportunity to provide comments to the Senate Inquiry on Aged Care as the issues under consideration are of great importance to our members. VHA represents public healthcare providers in Victoria including hospitals, aged cared facilities and community health centres. As such we represent 74 providers of residential aged care with a total of 5,281 beds in metropolitan, regional and remote locations.

As public providers, our members represent the full spectrum of aged care ranging from the very complex, high care services (including aged mental health) to low care, hostel services throughout the state. In addition, many of our members represent healthcare services that provide a range of community based services including HACC, CACPS and EACH packages.

Our members are also unique in that they represent the largest group of public aged care facilities in Australia. This brings with it a unique mix of issues that highlight the complexity of the industry. In particular, our providers are generally not in the position to turn away older people requiring care – regardless of the complexity of their conditions or their ability to pay accommodation bonds. As a result we represent some of the most difficult and challenging aged care provider situations, as well as representing providers who are integrated with other healthcare services.

New initiatives – a good start

We acknowledge that recent initiatives announced in the 2004 budget and following the "Review of Pricing Arrangements in Residential Aged Care" by Professor Warren Hogan, have been positive and have provided a much needed boost to the industry. In particular, VHA congratulates the Government on its decision to:

- Increase the aged care provision ratio to 108 operational places for every 1,000 people over 70
- Strengthen the ability of ACAT teams to improve the timeliness of assessments and improve links between residential and community-based care
- Allow providers to hold new accommodation bonds for more than five years
- Significantly increase funding for patients with dementia
- Increase opportunities for training of nurses and aged care workers

However, there is still much that needs to be done to ensure the ongoing financial viability of our member organisations.

Fragmentation and the need to focus on the continuum of care

We believe that the issues addressed in this inquiry are all of vital importance to the sector. However, none of the solutions will be possible unless the Commonwealth, States and providers work collaboratively to minimize the extreme levels of fragmentation that affect this industry. The system has failed to act on the principles of equity of access and provision of care because only the most articulate and self-sufficient clients can navigate their way through the process of accessing resources.

While providers continue to report to multiple accreditation bodies and multiple funding sources, it will not be possible to focus adequately on the needs of older Australians.

We concur with the Myer Foundation report when it states that,

"*Bluntly, it is very difficult for many older Australians who need care to get access to the advice, support and care services they need. Our aged care system is fragmented, with no easy points of access and in many regions, too few resources to meet needs. The same older person might need community and residential care at different stages of their life, but to get it they have to negotiate with different organizations and tiers of government, with different rules and protocols. Where and how each older person lives has a significant impact on their health and the level of care they need - but there is no systematic coordination of health and housing policy and planning which would address the varying needs of older people*.[1]

Our Priorities

In making this submission, we acknowledge that a number of recent reports and inquiries have already provided a great deal of valuable information and recommendations. We will make reference to these reports. Our objectives with this submission are to:

1. **call on the Government to act** on recommendations from previous reports that have not yet been addressed

2. **provide insights** into the perspectives of aged care providers in Victoria and recommend further solutions.

3. **highlight the serious viability issues** faced by providers of aged care because of an acute lack of funding.

In response to the Inquiry, we will be focusing on the following issues:

[1] Myer Foundation (2002) The Financial Implications of Caring for the Aged to 2020. Melbourne. P.14

A dedicated workforce … but we can't take it for granted.

The strength of our care system lies with those who work in this sector as nurses, personal carers, allied health workers and medical practitioners who genuinely care about the people they look after.

"*Aged Care facilities are fortunate in that staff are generally strongly committed to care of the aged. They have to be. Conditions of work are difficult, and their commitment is a big a factor,"* one of the Directors of Care at a VHA member agency recently said.

The recent report on "Care of Older Australians" (2004)[2] notes that "*Most workers are content with their jobs… staff are strongly motivated by the intrinsic satisfaction of providing good care to the elderly who cannot look after themselves*."

But while we acknowledge the role and commitment of this dedicated workforce, we cannot take it for granted – in fact to ignore its unique set of challenges would be to devalue the contribution it makes.

Staff shortages

We are facing increasingly serious workforce shortages in the aged care industry. Providers, particularly in rural areas, already find it difficult to recruit sufficient staff for their current needs – let alone increased future needs. Aged Care and Community Services estimated in 2001 that there are as many as 4,500 vacant shifts in residential care homes per fortnight in Victoria. [3] Given more recent developments with nursing EBAs, there is little to suggest that this situation has improved. In 2001-02 the West Wimmera Health Service was required to spend $178,000 on agency nurses in high care residential services alone in order to meet staffing needs.[4]

A competitive and challenging market

The aged care sector is part of a very competitive market in which providers compete within the different parts of the health sector as well as competing with an increasingly diverse labour market outside the health sector. Sixty years ago, a young woman had the choice of becoming a teacher, a secretary or a nurse. Today young women have endless choices and the aged care sector has to be able to compete. For men, the choices have been greater for decades, but increased competition from other sectors has seen a further decline in the proportion of male nurses.

To add to the problem, we know that demand for aged care workers will outstrip the growth of the workforce. Professor Hogan points out that the demand for aged care workers is likely to increase by 35 per cent in the next decade while the entire Australian workforce will only increase by 8 percent.[5]

We also know that the wages growth will be greater for the aged care industry. Increased demand for skilled nurses is likely to rise faster than the average wage as providers are forced to pay a premium to attract staff to fill vacancies.[6]

2 National Institute of Labour Studies (2004) The Care of Older Australians. Adelaide. P 4
[3] Aged and Community Services Australia (2001) Submission to Senate Inquiry into Nursing. P1
[4] Providers of Aged Residential Care for small rural communities in the Grampians Region, Victoria.(2003) Joint submission to the Commonwealth Government Review of Pricing arrangements in Residential Aged Care. P17
[5]Hogan, W P (2004) Summary of the Review of Pricing Arrangements in Residential Aged Care. Commonwealth Government of Australia. P24
[6] Hogan, W P (2004) Review of Pricing Arrangements in Residential Aged Care (full report). Commonwealth Government of Australia. P136

Planning for the future workforce

The aged cared industry will not be able to continue to provide appropriate care unless the Government and providers work together to address the poor image of the industry, the lack of pay parity and the lack of career opportunities that currently make the industry unattractive to employees.

Image and pay parity
It is vital for the maintenance of standards and for the image of the aged care industry that qualified nurses are paid at the same level in an aged care setting as in the acute sector. In Victoria, aged care nurses are subject to a different EBA to acute sector. The ANF estimates the difference to amount to about 18.6%.[7] Although some nurses will make the choice to work in aged care, the lack of wage parity will represent a barrier for many.

In particular, those working in community care and those working as Personal Care Assistants suffer from lack of recognition and a poor image. Craig Thomson, National Secretary of the National Services Union recently described the problems of aged care workers by saying "*It is an industry with no minimum staff numbers, no minimum training standards and where personal care workers, who do the bulk of the work, earn less than supermarket staff*.[8]"

The image of aged care nursing also suffers because at present aged care nursing does not attract a great deal of attention in either undergraduate or postgraduate University courses. While inclusion in Undergraduate and Postgraduate courses does not necessarily create status for aged care as a profession, it certainly does increase its credibility.

Innovative solutions for an aging workforce
It is ironic, but not surprising, that the workforce that cares for our aging population is aging to such an extent that we can expect a significant shortfall of carers in the near future. We know that nationally the age of the nursing workforce in aged care is 47 years as compared with 41.8 in other clinical areas. When surveyed, 40% of nurses indicated they would retire in the next 10-15 years.[9]

Some of our members report that the average age of their nursing workforce in aged care settings lies between 48 and 54 years. While there is no doubt that this mature workforce provides excellent care, we also need to plan for the retirement of these nurses.

Recommendations:

We urge the government to give further consideration to the recommendations in Chapter 7 of the "The Patient Profession: Time for Action" released in June 2002 and Recommendations 68-75 and Recommendation 8 by Professor Hogan. In particular, we urge the Government to:

1. **Review its funding commitment in response to the Hogan Report *(Recommendation 8)*. The response to date has been very significantly short of the recommendations.**

2. **Give serious consideration to the Inquiry into nursing *(Recommendation 70 and 71)* that universities review clinical placements, undergraduate and postgraduate university programs and courses and the possibility of more distance education.**

3. **To review funding formulas to account for the cost of providing nursing staff with pay parity between the acute and aged care sector.**

4. **Give serious consideration to a range of strategies to deal with an aging workforce including finding ways of enabling and encouraging existing staff to work past traditional retirement age in a part-time or advisory capacity.**

5. **That the Government commissions a thorough review of workforce needs in the aged care sector which enables a more realistic projection of needs for all aged care workers including home carers, personal care assistants and nursing staff.**

7 Australian Nursing Federation. Nurses Paycheck, Vol.2. No.4 September – November 2003.
8 Quoted in The Age Newspaper (7 August 2004) "Its time to boost the status of care workers". Melbourne p.27
9 Australian Nursing Federation Website.(May 2004) www.anf.org.au

Models of care – one way to better solutions

Current models of care can be significant contributors to the problems that threaten the viability of providers. As always, viability depends on the ability to control costs, or alternatively, to attract more appropriate levels of funding.

We believe that if providers and the Government were to work together to agree on an appropriate model of care, we could provide better care without significant additional costs

Without a unified approach to models of care and the corresponding workforce skill mix, the decisions will be driven by parties whose mandate it is to promote their own interests. In Victoria, the result is that decisions are made in an industrial setting. This is entirely inappropriate, and more leadership from the Commonwealth would enable a more consistent approach across the sector.

Challenging the "hospital centric" model of care

The basic premise of aged care - whether it is in a residential or community setting – should be elderly people need to be cared for in a home setting. If an elderly person cannot be accommodated at home anymore, then the residential care they receive should mirror a home, not a hospital.

A major international survey found that:

Many of today's senior residential/long-term care facilities are task-orientated, driven by schedules, rules regulations, and of course, the bottom line. Elders often are forced to surrender their freedom and control in order to get the fundamental human support and services they need to live.

By moving away from the medical model of care and embracing a more social model that is person-centered, we can create a culture of aging that is life affirming, satisfying, humane and meaningful.[10]

The Royal Australian and New Zealand College of Psychiatrists points out that " … *we have a legacy of a medical model approach in nursing home care, frequently carried out in buildings that resemble small hospitals. This approach and these environments are frequently ineffective or even counterproductive to manage behavioral issues*."[11]

Challenging these traditions will be difficult. We require leadership from the Government and a less fragmented approach by the industry on the whole.

Models of care and cost control

We believe that the only appropriate way of reviewing and adjusting the cost structure is to gain agreement on a model of care that is determined by factors other than traditions based around hospital care with hospital ratios and skill mixes.

Even a small adjustment to the costs for labour will have a significant impact on the financial viability of aged care providers, as labour costs make up 50% of the total costs for low care and 79% of for high care. [12]

Funding formulas need to recognise that better care may be more expensive. For example, the Western District Health Service in Victoria found that using Division 2 nurses instead of personal carers provided improved documentation, wound care and overall resident care, thus justifying an increase in costs.[13].

10 Press Ganey Associates Pty Ltd. "The Satisfaction Snapshot Electronic Newsletter" June 2004, P.5

[11] The Royal Australian and New Zealand College of Psychiatrists, NSW Branch (2003) Submission to the Review of Pricing Arrangements in Residential Aged Care. P 5

12 Allen Consulting Group (2002) The Financial Implications of Caring for the Aged to 2020. A report commissioned in conjunction with the Myer Foundation Project 2020: A Vision for Aged Care in Australia. P.59

13 Western Districts Health Service. (2003) Submission to the Commonwealth Government Review of Pricing Arrangements in Residential Aged Care.

However in other cases, substantial savings may be possible if the industry works collaboratively with the professions to consider new solutions. Some of the solutions may be found by looking at other successes in changing models of care.

For example, a regional health service in Victoria recently decided to axe 12 mental health beds and provide care within the community instead. As result, they were able to increase the number of staff working in community settings from 5 to 45 FTEs.

Recommendation:

We concur with Recommendation 68 of Inquiry into Nursing (2002): [14]

That the outcomes of reviews and research be used to establish appropriate benchmarks for resources and skills mix in aged care nursing so as to support improved care for residents, workforce management, organizational outcomes and best practice and that Commonwealth funding guidelines be reviewed in light of this research.

We also urge the Government to give serious consideration to other models of care such as those proposed by Professor Rhonda Nay and Dr Susan Koch at La Trobe University.

People not Paper – The role of the Aged Care Standards and Accreditation Agency

An industry buried in paper

After funding, the biggest concern for our members is the multiplicity of administrative and accreditation systems that dominate the management of aged care operations. Most of our members are faced with 3 or 4 separate accreditations. The excessive burden generated by regulatory frameworks and reporting systems has grown to the point where is it a serious threat to the industry. Apart from the impost on providers, the multiplicity of systems is the major cause for fragmentation.

Because quality reporting is linked to funding, we increasingly observe that senior staff in aged care facilities are focusing their attention on paperwork. The complexity of the system means that less experienced, more junior staff cannot handle the work. Mistakes are costly. When mistakes are made, it can take up to two years to correct the mistake at the Agency level that often means a loss in funding.

We acknowledge that monitoring of standards by funding agencies, with corresponding accountability from services providers, will always be necessary, but it should not dominate operational agendas to the point where it becomes an obstacle to effective care and efficient operations.

VHA Member responses:

When asked to describe their key challenges, our members gave responses as follows:

"There is a constant tension between providing appropriate care and documenting the same. At this stage, due to the nature of the current system, it appears that more time is required for the documentation than for the care."

"Accreditation impost as a result of having to undertake four different accreditation processes - Aged care,EQuIP, HACC and DVA for community nursing"

[14] Report into the Inquiry into Nursing: "The Patient Profession: a Time for Action" (2002) Commonwealth of Australia, Canberra. P 158

"The cost of meeting the Accreditation standards with not enough funding to be viable"

"The cumbersome, over-regulated nature of the quality framework for aged care appears to require more time in justification than in provision."

"The cumbersome, over-regulated nature of the quality framework for aged care appears to require more time in justification than in provision. There is little, if any, appreciation in the current system of Clinical Governance and Risk Management, and the approach of the Surveyors in our most recent survey did nothing to enhance the capacity or understanding of the staff in the benefits of quality and how it impacts on care."

"Accreditation documentation is duplicative and labour intensive. Pre-admission documentation is also labour intensive and families usually require a great deal of assistance to complete it. Initial and ongoing resident assessments and daily recording is duplicative and minimises one on one time with residents."

"Our training budgets are spent on training staff on how to make sure they complete documentation correctly, and so there is neither time or money to train for better patient care"

The role of Government

We concur with Professor Hogan who emphasizes that one of the most important roles of government is to control quality and access to services because those who most require the services are least able to ensure the protection of their own rights and needs. Hogan (2004) states:

The Government's intervention in aged care to promote quality and protect consumer interests is justified, because providers and aged care recipients have unequal access to relevant information and the frailty of residents can make them vulnerable to exploitation. The tight supply of places, the reinforcement this constraint on supply has on provider's market power and the inability of residents to exercise choice, necessitate regulatory provisions on quality assurance and conditions of entry. [15]

The Role of Providers

We also agree with Professor Hogan that providers need to be held accountable for their roles. We agree that Government agencies have a role to ensure that providers:

- take more responsibility for business decisions,
- focus more sharply on resident needs, and
- respond more flexibly to residents and their families.

Regulation versus innovation

While it is relatively easy to estimate the cost of compliance reporting and auditing of standards, it is almost impossible to measure the impact this impost has on the industry's ability to be innovative and find new and better ways of providing services. We concur with Professor Hogan when he states that:

The degree of regulation and control exercised must be balanced with the need to encourage an efficient and innovative service sector…. Only with more flexibility in arrangements can improved strategies be pursued… allowing providers to make independent decisions about pricing and investment and thereby contributing to the maturing of the industry.

Although this problem was highlighted by Professor Hogan as well as being highlighted in all the other reports mentioned in this submission, this is an area where there is little progress to report.

[15] Hogan, W P (2004) Summary of the Review of Pricing Arrangements in Residential Aged Care. Commonwealth Government of Australia. P 27

Recommendation

We recommend that the Government:

1. **Urgently reviews current reporting systems and the role of its Agencies to achieve more streamlined reporting mechanisms which will enable providers to focus more clearly on provision of care and improved methods of providing that service.**
2. **Implements Recommendation 7 (a) and 7 (b) by Professor Hogan to ensure that consumers – especially those who are frail and disadvantaged, can access the most appropriate care.**
3. **Implements Recommendation 5 by Professor Hogan to simplify the RCS classification scale and thus remove perverse incentives and the need for repeated assessments as needs change.**

Lack of Flexibility

As stated in the Quality Care Principles, the Accreditation Standards "… ***do not provide an instruction or recipe for satisfying expectations but, rather, opportunities to pursue quality in ways that best suit the characteristics of each individual residential care service and the needs of its residents. It is not expected that all residential care services should respond to a standard in the same way*****"*** (emphasis supplied)[16]

The current complex funding mechanisms also severely impact on the flexibility that providers have in arranging for care of consumers.

As an example, the Western District Health Service runs a low care facility that was registered after 1997. Whilst this facility is committed to aging in place, it cannot admit any high care residents. Ironically, this facility operates under the same roof as a high care facility providing the only residential aged care facilities in that township. [17]

Other rural providers report that patients have to be transported to facilities 1-2 hours travelling distance away because the funding for a bed cannot be shifted between facilities.

Recommendation

1. **That the review of reporting and assessment systems recommended above also includes consideration of ways in which consumers can exercise more choice in the way they receive care while providers are given more flexibility and the ability to respond to various needs.**

2. **Further that the Government give serious consideration to the voucher system proposed by Professor Hogan in his recommendations for longer term solutions (Option 1) which would enable prospective residents and their families to exercise more choice in the provision of their care**.

16 Hogan, W P (2004) Review of Pricing Arrangements in Residential Aged Care (full report). Commonwealth Government of Australia. P 237
17 Western District Health Services (2003) Submission to the Pricing Review of Residential Aged Care. P 1.

Complex Needs = Complex and Expensive Care

As public sector providers, our members are particularly affected by the lack of funding for complex needs – particularly those with mental health problems. Unlike other providers, our members cannot exercise much choice as to who will be admitted to either residential or community based services.

Serious operational deficits

Our members, as providers within the public healthcare system are generally not prepared to take the risks associated with inappropriate care and so complex care needs are subsidized by other parts of the organization – or contribute to their deficits.

This is particularly noticeable in smaller, rural health services where access to specialist care can be much more expensive than in metropolitan centres. Increasingly our members are finding that provision of aged care is responsible for their deficit.

The following statistics from our members for the 2003/04 financial-year are of concern:

Rural and Regional Aged Care Services Deficits for 2003/04

- *A rural healthcare service that provides 60 high care and 30 low care beds reported this year that 21% or $540,000 of their $2.479m deficit was due to under funding of aged care*
- *A smaller rural health service reported a deficit of $316,000 for 35 high care beds*
- *A rural facility with 77 high care beds, reported a deficit of $1.7m which represents deficit funding to 25% of revenue*
- *A regional healthcare service reported that their 30 bed facility has a deficit of over $300,000*[18]

There is significant evidence to suggest that current RCS funding does not sufficiently recognise the cost of this type of care and may result in a lower quality of care. For example, evidence compiled by the Royal Australian and New Zealand College of Psychiatrists (2003) suggests:

Management of severe behaviour is staff intensive. Anecdotal evidence available to members of the committee suggests that funding based on the current RCS scale better meets the care needs of physically dependent and frail residents than the needs of residents with disturbed behaviour. Inappropriately small staff to resident ratios lead to interventions of desperation. These include the use of medication as a chemical restraint or the use of physical restraints. These interventions have been demonstrated to produce negative side effects including social isolation, falls, injury, emotional distress, further behavioral complications and even death.[19]

Sicker patients with more complex care needs

There is considerable evidence to suggest that aged care providers are dealing with patients who require higher levels of care than was the case a few years ago. The RANZCP states that "*The core nature of the business of residential care is changing from essentially frail aged care to management of people with complex cognitive decline. Behavioral distance requires a qualitatively different approach to management than frail aged care, conducted by skilled staff and supported by prosthetic environments and appropriate geriatric medical and psycho geriatric services."* [20]

It also needs to be recognized that "*ageing in place*" places considerable burdens on residential care facilities as residents become progressively more in need of care. While there is general acceptance that aging in place is an appropriate principle, the cost is not always recognized in funding levels.

18 Names and further details of financial reports for the 2003/04 financial year will be publicly available by the end of August.
19 The Royal Australian and New Zealand College of Psychiatrists, NSW Branch (2003) Submission to the Review of Pricing Arrangements in Residential Aged Care. P 7
20 The Royal Australian and New Zealand College of Psychiatrists, NSW Branch (2003) Submission to the Review of Pricing Arrangements in Residential Aged Care. P 5

The following statistics produced by AIHW (2002)[21] show the dramatic increase of residents who have aged in place.

High Care Residents	**1998**	**2001**
Admitted as High Care	961	4,141
"Aged in place"	4,993	8,874
Total	5,954	13,015

Funding supplements as recommended by Prof Hogan

In Recommendation 6, Hogan (2004) suggests that supplements should be extended to cover specific care needs for palliative care, dementia patients and other challenging behaviours and short-term medical conditions such as IV therapy, wound management, intensive pain management, tracheostomy etc.

We believe that the Government response to this recommendation has been very inadequate.

1. We do not accept the response of the Government when it says it "*considers that extending supplements to other conditions or circumstances would add unnecessary complexity to the payment system and administration*."[22]
2. We also do not accept that the 1.75% increase to the basic subsidy is sufficient to account for these complex and special needs.
3. While we welcome the injection of $4.6m over 5 years for dementia, this is totally inadequate to provide appropriate care for the burden of disease that follows the increase in dementia.

Recommendation

We call on the Government to review its position on the payment of funding supplements or provide an alternative means by which to recognise the cost of caring for complex care needs as recommended by Professor Hogan.

Rural and remote needs

Our rural and remote members face particular challenges in accessing appropriate support for dealing with patients with complex needs.

A recent VHA survey of problems faced by members providing aged care services contained comments such as:

"Huge Demand for Allied Health Services"
"Lack of access to GP's, Bulk Billing, Chronic Illness and Depression"
"We need improved funding allocations toward continuous quality improvement for residents through increased activity / diversional therapist hours".
"We have advertised repeatedly and cannot find a physiotherapist – even though we are down to no other requirement than a 'warm body' with a registration certificate."

Professor Hogan's research (2004) supports these comments when he states that "*rural and remote services may have more difficulty in providing appropriate support for residents with special needs such as dementia, psychiatric disabilities, intellectual disabilities and acquired brain injury. Access to allied health care professionals such as physiotherapists, occupational therapists, podiatrists, GPs and chemists may also be more limited*."[23]

Recommendation

That the additional costs incurred by regional and rural providers who care for patients with complex needs are recognised in funding formulas linked to RCS supplements.

21 Australian Institute of Health and Welfare (2002) "Aging in Place" Bulletin Issue 1 June 2002. P 4.
22 Commonwealth of Australia, Response to Review of Pricing Arrangements in Residential Aged Care
23 Hogan, W P (2004) (full report). Commonwealth Government of Australia. P 191

More Psychiatric Patients in Residential Aged Care

Increasingly, aged care providers are taking on the responsibility of caring for people suffering serious psychiatric conditions. The ABS reports (2003) that "*from 1981 to 2001, the number of people in psychiatric hospitals or psychiatric institutions decreased from 21,700 to 6,100 while the number in accommodations for the retired or aged increased from 27,400 to 147,700*"[24]. This represents an additional 120,000 people, many with serious mental illness, being cared for by aged care institutions.

In Victoria, we know that the majority of those patients are being cared for by our member organizations, as private providers (particularly those in the for-profit sector) are less likely to choose to admit such patients.

Dementia and associated costs

The increase in the prevalence of dementia in aged care facilities requires urgent attention. The AIHW estimates that 40% of older people in residential care settings have dementia and that for about 33% of longer-term residents, dementia is the condition that causes the majority of their problems.[25]

The RANZCP states that:

The prevalence and continued increase of dementia in the Australian population is well documented. The increase has been reflected in resident characteristics of Australian aged care facilities that now predominantly care for people with dementia. What is less well documented is that up to 90% of residents with dementia may develop behavioural and psychological symptoms as part of their disease process. A smaller portion of residents will go on to develop severe symptoms.[26]

Aged care providers are faced with increasing costs as a direct result of increasing levels of dementia. The impost on high care providers is likely to be greater than on any other providers of residential aged care as 97% of patients in the two highest RCS classification levels have probable dementia or possible dementia.[27]

Our members also point out "*in the provision of psychiatric residential facilities, there are additional costs resulting from compliance to State Safety legislation and guidelines such as the need for review by a chief psychiatrist. These costs are not recognised in the current funding arrangements. In addition maintenance and repairs is higher in facilities that care for those residents with challenging behaviours*."[28]

The RANZCP also points out to other serious consequences and costs of managing patients with dementia. These include:

- Distress to residents and their fellow residents
- Risk of injury
- Burn-out of residential care staff
- Injuries to staff and associated worker's compensation claims[29]

The cost of these effects is difficult to estimate and is most likely being absorbed in the deficits and funding shortfalls cited earlier.

24 Australian Bureau of Statistics (2003) Australian Social Trends. "People in Institutional Settings". Canberra.
25 Australian Institute of Health and Welfare (2004). Press Release 11 June 2004, Canberra.
26 The Royal Australian and New Zealand College of Psychiatrists, NSW Branch (2003) Submission to the Review of Pricing Arrangements in Residential Aged Care. P 4
27 Australian Institute of Health and Welfare 2004. The impact of dementia on the health and aged care systems. AIHW Cat.No. AGE 37. Canberra: AIHW. P xiii – xiv.
28 Eastern Health (2003) Submission to the Review of Pricing Arrangements in Residential Aged Care.
29 The Royal Australian and New Zealand College of Psychiatrists, NSW Branch (2003) Submission to the Review of Pricing Arrangements in Residential Aged Care. P 4

Working toward strategic solutions for dementia

Given the complexity of the problems associated with caring for dementia and other complex care needs, it is imperative that Government, peak bodies and providers work to develop a strategic approach to:

1. Ensure that more providers will see it as financially feasible to provide care for patients with dementia.
2. Enable equity of access for people with special needs – especially dementia.

Recommendation

That the Government give further serious consideration to the recommendations previously put forward by the National Aged Care Alliance [30]as summarized below:

1. **That the Government adopt dementia as a national health priority for research[31]**
2. **That care staff receive additional training and support to facilitate early diagnosis**
3. **That community and respite care be increased to allow dementia sufferers to remain at home as long as possible**
4. **That greater incentives are provided to residential aged care providers through an improved mix of capital and recurrent funding for people with dementia and challenging behaviours.**

Allied Health

With the added complexity and higher levels of care required, it is no longer appropriate that the RCS funding system allows claims for only one allied health service.

One of our members, the Western District Health Service with 76 high care beds, comments
"*Under the current RCS funding system, only one allied health service can be claimed, when in fact quite often a resident will require a mix of allied health services such as a dietician, physiotherapist and diversional therapist. Higher resident classification mixes over recent years have had significant impact on this and future funding mechanisms will need to address the issues of allied health funding.*"

It needs to be recognized that relatively simple interventions by allied health professionals can avoid more complex and costly problems at a later stage. For example, more access to podiatrists can mean significantly improved levels of mobility that can prevent other health problems.

Recommendation

That the Government reviews its funding of allied health services for RCS classifications 1-4 to allow for more than one service to be provided and claimed.

Disabled younger persons

We agree that it is not appropriate for younger people with neurological diseases, serious head injuries or disabilities to be accommodated in aged care facilities. However, at present our providers do not have any other means by which they can accommodate such specialized needs. As we know that about three times (18%) as many people with a disability live alone as compared with the general population (6%),[32] these people will require higher levels of support as they grow older. With improved support in the community, disabled people can continue to live at home rather than transferring to an aged care facility.

We acknowledge that significant progress has been made in this regard with numbers of institutionalized disabled persons dropping from 11,800 to 9,300 between 1991 and 2001 in spite of a 40% increase in the number of Australian under 65 years with a disability.[33] However, there is still room for further improvement in order to provide more appropriate care for this group.

We welcome and support any initiative to fund new solutions for disabled people requiring specialized, longer-term care who are currently accommodated in aged care facilities.

30 National Aged Care Alliance (2004) "Get Aged Care Right", Canberra. P.5
31 Professor Hogan supports such a priority for national research in Recommendation 20
32 Australian Bureau of Statistics (2002) Year Book Australia: Income and Welfare. "There's no place like home". Canberra. P 1.
33 Australian Bureau of Statistics (2003) Australian Social Trends: People in Institutional Settings. Canberra

Turning Fragments of Care into a Continuum of Care

"Fragments of Care" at its worst

The level of collaboration and co-ordination between the acute, residential and community based setting is variable at best, and in many cases almost non-existent. We require a system response that allows care to be provided holistically.

Due to Government purchasing policies, the funding of care is given to a large number of smaller providers – some of which have been set up specifically to respond to the availability of a particular type of funding. It is not in the interests of such agencies to provide integrated care as there is no incentive to work with other providers. There also may not be sufficient understanding of other types of care available.

However, even in integrated health services, where the level of co-operation and understanding between acute and non-acute services is better than in other parts of the industry, the diversity of funding streams makes effective co-operation and planning difficult and, at times, impossible.

More importantly, this system does not build capacity to deliver care. Much of the funding at present is given to providers who are essentially "brokers" of funding for care. For example, our members may be called upon to deliver home nursing or allied health services, but they do not have access to secure funding streams. As a result, they cannot employ permanent staff or establish good systems to deliver the care.

The impact of this level of fragmentation is of great concern to our members because the current system:

1. Does not ensure that patient needs are viewed in a continuum of care
2. Does not deliver efficiencies and economies of scale that would be possible in a more co-coordinated approach.
3. Is based on narrow eligibility criteria which fragment care, exclude many who need care, and may cause the needs of some to be overlooked.
4. Diverts scarce health funding into multiple administrative hierarchies set up to manage the services.
5. Does not build capacity to deliver care.

Fragmentation between levels of government

It is difficult to estimate the impact of the fragmentation of a system that is provided by Commonwealth, State and Local government jurisdictions. The Productivity Commission (2003) describes the various levels of government resulting in:

- Incentives for cost-shifting between State governments and the Commonwealth;
- Gaps in care for older people such as in rehabilitation and convalescent care; and
- Poor coordination of planning of residential and community care, and a lock of integration across programs.

The Productivity Commission concludes "*The mix of Commonwealth state and local government responsibilities has resulted in a 'patchwork' or around 30 different aged care programs, with a range of eligibility criteria, user charges, access points and reporting requirements. This situation also results in high administrative costs for providers*." [34]

The report further quotes Aged Care and Community Services Australia that claims:
"*The underlying dynamics of cost-shifting between different levels of government creates a pressure to provide services, or referrals, on the basis of who pays rather than what might be in the interests of clients and patients*."[35]

It is important that all the stakeholders in the aged care industry work together to reduce the perverse incentives created by the different levels of government and the resulting fragmentation.

34 The Productivity Commission (2003). Submission to the Review of Pricing Arrangements in Residential Aged Care. Canberra (2003) p. 53.
35 The Productivity Commission (2003). Submission to the Review of Pricing Arrangements in Residential Aged Care. Canberra. P.51

The cost of fragmentation

The ultimate cost of fragmentation of services between the various sectors providing care is borne by those who should be the recipients of care. But the cost also is borne by providers.

The following example, quoted by The Productivity Commission, very aptly describes the weaknesses of the system.

A hypothetical *case where rehabilitation services would result in a very different outcome*

Differences in the financial responsibilities of the Commonwealth and State governments give rise to gaps in the provision of step-down, convalescent and rehabilitation services for older people. Consequently, older people may be prematurely placed into residential care.

This example covers a situation where, under the current arrangement, Mr Smith would be placed into residential care when this would not be necessary if appropriate step-down care was available.

> *Mr Smith, aged 89 years, had a stroke two years ago. He can manage his own basic personal care, but relies on his frail wife for most other activities. When he has a fall and injures his back, he is referred by his GP for admission to the local hospital. X-rays do not show any fracture, but with the 'good news' that there is 'nothing wrong'; his wife expresses concern that, as he cannot walk, she cannot look after him. After a variety of attempts to find a way to send him home, he is begrudgingly admitted to hospital after a 36-hour period on a trolley. He has become slightly confused and incontinent. The staff mention that he is taking up an expensive hospital bed and that a good solution would be to find a residential care place.*
>
> *But if step-down care was available the situation could be quite different.*
>
> *For example, it could be that after careful assessment in the emergency department, Mr Smith is directly admitted to an aged care unit. With adequate pain relief, support and encouragement to remobilize and take care of himself, after 12 days he has recovered almost to his usual level of health and independence. Additional assistance is offered to his wife in bathing her husband for two weeks after discharge, with visits by a physiotherapist every second day. The situation returns to normal after four weeks.*[36]

Recommendations

1. **We concur with the recommendations of the National Aged Care Alliance[37] when it calls for:**
   a) **the introduction of a national strategic framework covering all settings where care is provided (including prevention, health promotion community and residential care, acute and sub-acute care)**
   b) **the development of best practice guidelines that provide linkages across the range of care services**
   c) **a common assessment process for the entire continuum of care**

2. **We recommend that public health services in Victoria are included in any pilot programs for the provision of a better continuum of care, as it is likely that this is one of the settings where such programs are most likely to be successful.[38]**
3. **We call for greater integration with ACAT and provision for short- term "step down" facilities.**

36 The Productivity Commission (2003). Submission to the Review of Pricing Arrangements in Residential Aged Care. Canberra (2003) p. 52.
37 National Aged Care Alliance (2004) Getting the link between Aged Care and Health Right. P.6
38 See West Gippsland Healthcare Group (2003) Submission to the Review of Pricing Arrangements.

Conclusion:

We call on the Government to provide leadership in finding and funding solutions for the challenges of providing quality aged care. The ongoing viability of the sector and the willingness of providers to continue to provide quality care is under threat unless the sector and Government work collaboratively to find better solutions.

In a wealthy, industrialized country like Australia it is not acceptable that we provide care that is either inappropriate or inaccessible to those who need it most. The solutions are complex, but not necessarily expensive.

We need to work together to provide a continuum of quality of holistic care – not fragments or disjointed episodes of care.