Submission to the Senate Community Affairs References Committee Inquiry Into Aged Care

August 2004

EXECUTIVE SUMMARY

This submission has been jointly prepared by the Department of Ageing, Disability and Home Care (DADHC), and NSW Health. In NSW, both these Agencies are directly involved in planning, funding and delivery of aged care services. In the context of this submission, aged care is considered to mean the broad range of community-based, health and residential aged care services provided to support older people.

This submission covers a variety of issues, relevant to the Terms of Reference, including:

a) The need to increase the availability of trained staff for the aged care sector (including health and community services) to keep pace with the ageing of the population, together with mechanisms for matching staff with communities that experience acute workforce shortages;
b) Managing the overlap in Commonwealth and State-based quality management systems, linked with an overall shortfall in operational aged care places;
c) Meeting the care needs of particular target groups, including provision of appropriate, “mixed model” supports for young people with a disability (eg jointly funded from disability and aged care programs);
d) The adequacy of the community-based care system, particularly in meeting the needs of carers, people with a long term disability who are ageing and people from culturally and linguistically diverse (CALD) backgrounds, and
e) Improving the level of integration and “whole system” management, particularly at the interface of residential aged care and health services, but also including community-based care.

The adequacy of current proposals, including those in the 2004 budget, in overcoming aged care workforce shortages and training

Australia is currently facing two pressing and interrelated issues: the ageing of the population, which is placing increased pressure on our health system, coupled with a general shortage in all sections of the health workforce in nursing, medical and allied health.

To address the ageing population and shrinking workforce, actions need to reflect both demand and increasing consumer expectations. Critical issues to be addressed in this area include: the number and type of education and training places that are being established in the higher education sector; the workforce pressures in rural, regional and outer metropolitan regions; and existing or emerging shortages in certain specialities, such as geriatric medicine. These are issues that the State Government has little or no influence over, and to date collaboration between health and education sectors has not been a feature of the Commonwealth Government’s approach, as evidenced by the recent removal of the nursing undergraduate program at the University of Sydney without

consultation with the profession or the NSW government. The proposed COAG review of health and education is supported.

The performance and effectiveness of the Aged Care Standards and Accreditation Agency

While NSW supports a robust accreditation process such as that employed by the Commonwealth Government Aged Care Standards and Accreditation Agency, there is a concern about any overlap with existing health accreditation systems given the administrative impost that accreditation processes can involve. NSW would be pleased to work with the Commonwealth Government to resolve these concerns.

The appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs such as dementia, mental illness or specific conditions are met under current funding arrangements

While residential aged care may be the most appropriate service to meet care needs, it is acknowledged that nursing homes may not be suitable environments for younger people with a disability to reside in for several reasons.

An issue requiring particular consideration in the development of longer-term solutions is how the clinical care needs of younger people in residential aged care can be met and funded within alternative models. The CSTDA applies only to specialist disability services, while services with a specialist clinical focus are excluded and cannot be funded under the CSTDA. This issue will need to be addressed by the Commonwealth and State Governments when considering alternative models, as well as cooperation across both the disability and aged care sectors.

Current residential aged care funding arrangements do not adequately address the needs of people with dementia and/or mental illness, particularly those with behavioural disturbances related to these conditions. The NSW Government is substantially funding the residential care of this group of older people in around 22 State Government Residential Aged Care Facilities, even though this is a Commonwealth responsibility. The Commonwealth Government needs to make a commitment to, and develop a process for, negotiating joint funding arrangements with State Governments to address the accommodation and interim care needs of this target group.

There is recent evidence that some people with a disability acquire age-related conditions younger than the general population, however, the aged care system is generally not available to people with a disability who genuinely need age-related care. Some of the barriers are experienced at the point of assessment, but also arise because of lack of skills in staff in aged care facilities. NSW would

strongly encourage the Commonwealth Government to include people with a life-long disability in the definition of "special needs groups" under Section 11-3 of the Aged Care Act. This would ensure that appropriate allocations are made, that direct or indirect discrimination does not occur at the point of assessment or acceptance into a facility, and to ensure that staff are appropriately trained and resourced to provide high quality care.

The adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly

Demand for home and community care services is likely to increase significantly in the medium to long term as a result of:

- Increasing numbers of older people due to the ageing of the population and increased life expectancy.
- Increasing rates of 'core activity restriction' (a measure of frailty or disability) among older people – as a result of people living longer, and in particular people living longer with more long-term health conditions and frailties.
- Increasing preferences for community-based services over residential care services as older people seek to remain in their own homes for as long as possible before transferring to a residential aged care facility, resulting in demand for high level community care services.

There is a close relationship between residential aged care and community care and the demand for places in each system. It is the provision of community care services which often prevents or, at a minimum, delays entry to residential aged care. If residential aged care places do not keep pace with demand, added pressure is placed on the community care and health systems.

The extent to which this is already occurring is evident in the number of residential care places not operational in NSW (6,814 as at 30 June 2003). In the meantime there are those who have been assessed as requiring residential aged care services but who have been unable to access a residential aged care place, receiving State funded interim support arrangements (such as high levels of community care).

The aged care service system is dependent on carers to provide ongoing support to older people. However, many carers are also elderly themselves and can struggle to provide care for another person. Under these circumstances, the interfaces between community care, residential care and health care become a practical issue to manage.

People from CALD backgrounds around Australia continue to experience lower rates of access to HACC services than the general population. Anecdotal evidence indicates a potentially significant relationship between participation by CALD community organisations in funded service delivery and high rates of

HACC service use. Research is required to help identify the effectiveness of CALD access strategies employed, and to recommend national 'best practice'.

The effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care setting or back to the community

NSW Health figures show that: public hospitals accommodate up to 800 older people awaiting residential care places; the average stay while waiting is 27 days (compared to 3.31 days for an acute episode of hospitalisation); the cost of a hospital stay is more than double that of aged residential care; and the increased length of stay is estimated at a total cost to the NSW public hospital system of $87.3M per annum, putting further strain on the NSW health system.

The Commonwealth Government's recent announcement of jointly funding 2000 transitional care beds across Australia is welcomed, with approximately 680 beds for NSW. However, the proposed Commonwealth contribution of $87 per facility-based place per day is greatly below the real cost which is estimated to be in the range of $240- $325 per day.

Added to this is the considerable time lag between residential age care beds being approved and becoming operational. This time lag represents an estimated $142 million in aged care subsidies for older people of NSW.
The Commonwealth should not only work on reducing the lag time but also change the measure of need (70 years and over) that determines the number of residential aged care places available. For example, persons 85 and over currently occupies 52% of residential care places and is projected to grow to 80% by 2021.

The success of any transitional care program is dependent on the adequacy of the broader community care and residential aged care system to support older people and their carers. NSW health has consistently shown that access block in public hospitals is created largely by the lack of inappropriate care for older people no longer requiring acute care.

The number of residential aged care places and CACPs is clearly inadequate.

It is also obvious that services for people with higher levels of need, such as those with challenging behaviours or complex and multiple conditions, are not funded adequately and therefore not providing enough incentives to the private sector to provide care.

In recent years, NSW Health has, itself, introduced several initiatives aimed at addressing the transition of the elderly from acute hospital settings to aged care settings or back to the community. These include:

- The establishment of the Agedcare Services Emergency Teams to improve the care and management of older people presenting to NSW hospital emergency departments;
- A program called "ComPacks" to bridge and effectively manage the hospital-community service interface.

An additional strategy which would assist in this area would be for the allocation of funding for Aged Care Assessment Teams (ACAT) services to be made to Area Health Services. This minor administrative change would allow NSW Health to deliver a more locally responsive, integrated service.

Conclusion

In conclusion, there are multiple opportunities for the Commonwealth Government to work with the NSW Government to positively address the complex needs of older people. Given the ageing of the population, significant change must occur if respective service systems are to be better integrated to meet the needs of this important segment of the population. This will require a significant collaborative effort and commitment.

SUBMISSION

a) The adequacy of current proposals, including those in the 2004 budget, in overcoming aged care workforce shortages and training

The Australian population is getting older. In 2000, people aged over 65 years represented 12.3% of the population; by 2011 they will represent 14.3%.[1] The ageing population is placing increased pressure on our health system, with age alone being the greatest risk factor for physical dependency, multiple co-morbidities, need for community service support, admission to hospital or admission to residential care.

Australia is currently faced with a general shortage in all sections of the health workforce: nursing, medical and allied health. In Australia today, the national workforce grows at an annual rate of around 170,000 per year.[2] By 2020 this is predicted to be just 12,500 per year. What this means is that fewer and fewer staff will be available to provide health care services needed by more and more people.

To address the ageing population and shrinking workforce, actions need to reflect both demand and increasing consumer expectations. NSW Health is the largest health care employer in Australia and has drafted an action approach that addresses the issues of supply, distribution, culture and leadership as they impact on the sustainability of the health workforce. The NSW Health Workforce Action Plan translates the seven National Health Workforce Strategic Framework principles into action at a state level:

1. Achieve self sufficiency in workforce supply in Australia;
2. Ensure workforce distribution matches community need;
3. Become the industry and employer of choice through effective leadership and governance;
4. Develop innovative approaches to health education and training;
5. Develop flexible approaches to the way in which care is delivered;
6. Employ best practice in workforce assessment and planning, and
7. Work collaboratively at the state, national and international level.

The Plan highlights actions required now, and in the future, to overcome health workforce shortages. Current supply and distribution issues are addressed, together with areas for longer term action to challenge traditional practices: explore new workforce models: develop different skill mix within and across

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[1] Australian Bureau of Statistics, http://www.abs.gov.au/Ausstats/abs> Accessed 1/9/03

[2] Department of Health & aged Care (Australia) (2001), *Population Ageing and the economy*, Research prepared by the Access Economics, Canberra.

professions: and enhance collaboration between health, education and training sectors.

In relation to education and training, the NSW State Government has limited influence over the number and type of education and training places that are established in the higher education sector. It is critical that better linkages between the health, education and training sectors are established to ensure that we get the right number and type of health professionals to meet community need.

Our greatest workforce pressures are in rural, regional and outer metropolitan regions. Research has indicated that the location where a graduate chooses to practice is influenced by where they have been trained. The Commonwealth Government needs to establish extra undergraduate Higher Education Contribution Scheme (HECS) funded places for nurses, doctors, dentists and allied health staff in these workforce pressure areas, as well as incorporating more targeted rural clinical placements into curricula. Offering clinical placements in areas of workforce demand such as rural, regional and outer metropolitan areas is critical. The quality of the clinical placement experience impacts upon recruitment, particularly in areas such as aged care. The Commonwealth Government needs to acknowledge that clinical placements are significantly under-funded through the education sector and that this under-funding results in greater difficulties with recruitment and retention of the workforce.

Nationally based medical colleges influence the number of specialist training places for the medical professions. With the exception of pediatrics, NSW has existing or emerging shortages in 24 key medical workforce groups. Geriatric medicine is one of the specialties in shortage. To address all of these shortages, every state and territory government needs to negotiate training plans and numbers for medical specialty trainees based on workforce requirements. The NSW Government has already begun this process through their negotiation with the Royal Australian College of Physicians on basic physician training. This new system is based on a number of principles that ensure trainees are equitably distributed across the state at the same time as improving their training experience.

Greater collaboration between all parties involved in the training of our health workforce is critical to ensure it is truly patient focused. A team-based approach to learning, across and within professions, needs to be fostered in the education sector and reinforced in the workplace. This is particularly important in care of the aged where coordination of professional effort can result in significantly improved health outcomes.

Collaboration between health and education sectors has not been a feature of the Commonwealth Government's approach. The recent removal of the nursing undergraduate program at the University of Sydney without consultation with the

profession or the government is a clear example of the need for urgent review. COAG recently agreed to review health workforce issues.

The Commonwealth Government states that nursing numbers will not be lost. History would suggest that, without a closer connection between the sectors, there will ultimately be an impact on the total graduate numbers. A national review has highlighted that NSW needs to employ 1700 more nursing graduates by the end of 2004 than are expected to graduate (Johnson and Preston, 2002[3]).

The recent announcement of additional nursing undergraduate placements earmarked for aged care is welcome. It is unclear how these placements are to be implemented. As the target group is assistants in nursing and enrolled nurses there is a need to ensure that the perception of a "second class" cohort of students is not created as a result of this initiative. This would have the added negative effect of further reducing the attraction of a career in aged care.

As well as the need for trained staff within the health and residential components of the aged care sector there are staff shortages for community care services for older people, particularly for nurses and therapists. The impact is that older people may not receive appropriate community care services.

b) The performance and effectiveness of the Aged Care Standards and Accreditation Agency in
(i) assessing and monitoring care, health and safety
(ii) identifying best practice and providing information, education and training to aged care facilities, and
(iii) implementing and monitoring accreditation in a manner which reduces the administrative and paperwork demands on staff

- Accreditation is required in order for facilities to receive residential care subsidies from the Commonwealth Government. It involves a process of self-assessment and external auditing by assessors employed by the Commonwealth Government Aged Care Standards and Accreditation Agency. All 22 State Government Residential Aged Care Facilities (SGRACF) are accredited.

- The Accreditation standards are detailed in the Quality of Care Principles 1997 and encompass: management systems; staffing and organisational development; health and personal care; resident lifestyle; and physical environment and safe systems. There are 44 expected outcomes across these 4 standards. The period of accreditation generally awarded is for 3 years. Facilities that do not meet all or almost all of the expected outcomes or

[3] Johnson, Dick & Preston Barbara (2002), *"National Review of Nursing Education - the nursing workforce. Australia."* Department of Education, Science and Training (DEST) Australia. and Department of Health and Ageing.

have a history of significant non-compliance may be accredited for a lesser period. To continue to be accredited, a facility must comply with the standards and be able to demonstrate continuous improvement in performance.

- NSW supports a robust accreditation process such as that employed by the Commonwealth Government Aged Care Standards and Accreditation Agency. However, if there is a concern about any overlap with existing health accreditation systems given the administrative impost that accreditation processes can involve, NSW would be pleased to work with the Commonwealth Government to resolve any such concerns.

- Whilst NSW welcomes the recent one-off injection of Commonwealth Government funds to assist residential aged care facilities meet the space and privacy requirements required in all aged care homes by 2008, there will still be a significant delay between the allocation of aged care places by the Commonwealth Government and the actual building and operationalisation of these places in aged care homes. There will still be a large shortfall in the number of operational aged care places in NSW.

c) The appropriateness of young people with disabilities being accommodated in residential aged care facilities and the extent to which residents with special needs such as dementia, mental illness or specific conditions are met under current funding arrangements

(i) Younger people with a disability living in residential aged care

In NSW, 391 people under the age of 50 live in a residential aged care facility: 336 in high care (nursing home level); 52 in low care (hostel level), and 3 where the level of care is not specified[4]. This represents 0.78% of the total residential aged care population in NSW. Approximately a third of the 391 younger people in a residential aged care facility have a brain injury.

The Aged Care Act 1997 does not specify a minimum age for eligibility for aged care services. Younger people with a disability may enter residential care if they are assessed as meeting the residential care eligibility criteria and there are no other care facilities or care services more appropriate to meet the person's needs.

In practice this generally results in younger people moving into nursing homes following an objective professional assessment by Aged Care Assessment Teams (ACATs) that indicates that the person has significant care needs. Often these care needs, because of their intensity or clinical nature, are very difficult, if not impossible, to meet through alternative services.

[4] Source: Department of Heath and Ageing. Figures current at November 2003.

While residential aged care may be the most appropriate service to meet clinical care needs, it is acknowledged that nursing homes may not provide sufficient opportunities for social interaction with peers and for community integration are limited. The rehabilitative therapy needs of some younger people may also be difficult to meet within the current arrangements in residential aged care. The Residential Classification Scale assumes a model whereby funding levels decrease as independence increases. In the case of a younger person who has an acquired brain injury, for example, therapy needs may intensify as rehabilitation progresses, resulting in the need for greater funding levels, or at least maintenance of funding to meet therapy costs.

The development of long term and sustainable improvements to support services for younger people living in nursing homes will require close cooperation between the Commonwealth and NSW Governments, particularly, between the NSW Department of Ageing, Disability and Home Care (DADHC), and the Commonwealth Departments of Family and Community Services and Health and Ageing.

The need for collaborative action on this issue has been recognised in a Bilateral Agreement (which sits beneath the Commonwealth State/Territory Disability Agreement, "CSTDA") between the NSW and Commonwealth Governments. Under the Bilateral Agreement both Governments have agreed to work together on the intersections between the ageing and disability support systems as a priority area of action. In relation to younger people with a disability living in nursing homes, this will include work to better understand the characteristics and needs of this group to inform the development of alternative strategies and models for accommodation and support. Specifically, the Bilateral Agreement commits the NSW and Commonwealth Governments to:

- Document the number and characteristics of younger people (defined as under 50 years) with a disability living in residential aged care, public hospital beds or multi-purpose services in NSW;
- Develop an assessment model to assist agencies to identify and plan relevant services;
- Develop and cost strategies/models to provide disability services for younger people with a disability living in residential aged care.

An issue requiring particular consideration in the development of longer-term solutions is how the clinical care needs of younger people in residential aged care can be met and funded within alternative models.

While the CSTDA has been negotiated between NSW and the Commonwealth Department of Family and Community Services, it is clear that funding, policy and operational solutions will also need to be negotiated with the Department of Health and Ageing, particularly if joint models are to be developed.

The Bilateral Agreement is a significant and essential step to finding long lasting and effective solutions. However, the work required will take some time and will not result in immediate changes for individuals. It is, therefore, essential that younger people living in nursing homes are not disadvantaged in the interim. As an intermediate step, ways to improve access to additional support services for younger people living in nursing homes are being investigated by DADHC, including access to a range of services from mixed funding sources. This will require cooperation across both the disability and aged care sectors.

The Commonwealth Aged Care Innovative Pool flexible aged care places present a possible mechanism to develop alternative models for supporting younger people in nursing homes. However the current timing and funding restrictions applied to these places by the Commonwealth would first need to be reconsidered. As younger people living in nursing homes are a particularly vulnerable group, changes to their accommodation arrangements must be long term and sustainable. A commitment by the Commonwealth Government to provide ongoing funding beyond a fixed term period is therefore essential and has been requested by NSW.

Recent publicity in NSW has suggested that younger people in residential aged care facilities are "blocking" places and preventing older people from transferring from acute hospital settings to residential aged care. However, in light of the small proportion of younger people living in residential aged care (as noted above, only 0.78% of the total residential aged care population in NSW are aged under 50 years), little credence can be given to such an argument. Of greater significance is the number of unoccupied residential aged care places in NSW due to the considerable time lag between the allocation and approval of places and when these places become operational.

(ii) Residents with special needs, such as dementia, mental illness or specific conditions.

In terms of funding for the State Government Residential Aged Care Facilities (SGRACF), the Commonwealth Government provided approximately $27.9M and the NSW Government provided $20.8M in subsidies in 2002/03. The NSW contribution represents 43% of total Commonwealth Government /State subsidies. Thus the NSW Government provides substantial funding for the residential care of older people, even though this is a Commonwealth Government responsibility. Whilst NSW is moving towards transferring these facilities to the non-government and private sector, the residents in the SGRACF generally require higher level care due to complex conditions, multiple disabilities, advanced dementia and challenging behaviours, and can be more difficult to place in alternative settings.

Current residential aged care funding arrangements do not adequately address the needs of people with dementia and/or mental illness, particularly those with behavioural disturbances related to these conditions.

NSW Health is progressing work to examine models of care for people with severe and persistent challenging behaviours, including specialist residential aged care units and specialist interim care packages. The Commonwealth Government has funded a number of projects targeting people with dementia under the Aged Care Innovative Pool and has indicated that people with mental illness will be a target group for further Innovative Pool funding. However, the Commonwealth Government needs to make a commitment to, and develop a process for, negotiating joint funding arrangements with State Governments to address the accommodation and interim care needs of this target group.

This point also relates to the effectiveness of current arrangements for the transition from acute hospital settings (where people with dementia are at high risk of developing delirium and associated behavioural disturbance which may require intensive short-term intervention to settle) to residential aged care or community settings.

When developing longer-term solutions for this client group, any strategies need to consider meeting the full range of clinical, accommodation, family, transport and social needs.

(iii) Older people with a long term disability.

There is currently some debate throughout the ageing and disability sectors about the most appropriate environment in which to support people with a life-long disability who are also frail and aged: the disability support system or the mainstream aged care system. Despite there being no age-based criteria for entry into the aged care system, access by people with a disability is made more complicated by recent evidence confirming that some people with a disability acquire age-related conditions younger than the general population.

This is not to say that people with a disability who have age-related care needs should automatically be transferred to a residential aged care setting as they become more frail. In fact, the NSW CSTDA Bilateral Agreement negotiated between NSW and the Commonwealth Department of Family and Community Services includes “Intersections between the disability support and aged care systems” as a Key Result Area, and specifically aims at developing “mixed program” models of support (eg funded jointly from disability & aged care programs, or from Commonwealth & State governments) for people with a disability who have age-related care needs.

Currently, however, the aged care system is generally not available to people with a disability who genuinely need age-related care. Anecdotally, people with a disability - and disability service providers - report experiencing barriers at the point of assessment, but more particularly when being considered for an available place in an aged care facility. Aged care service providers also report

practical difficulties arising from staff in aged care facilities lacking relevant skills in supporting an older person with a lifelong disability, including behaviour management skills and appropriate communication skills. More work will be completed under the current NSW CSTDA Bilateral Agreement to document these issues, together with the impacts on older people with a disability, their families and carers, and on the system of disability support services.

These difficulties are mostly reported in relation to residential aged care, rather than community aged care packages. The Commonwealth Government's Innovative Pool flexible care places are noted, and there are four pilots occurring in NSW, targeted at people with a disability living in State-funded accommodation services who also have age-related care needs. While NSW welcomes the opportunity to advance aged-care provision to people with a disability through these pilots, the pilots cannot be used to support older people with a disability living in their own homes (with or without family or government-provided support) – an option which is available to other older people living in the community who are assessed as eligible for aged care.

Action that NSW would strongly encourage the Commonwealth Government to take to improve access to the mainstream aged care system, and the capacity for shared model development, would be to include people with a life-long disability in the definition of "special needs groups" under Section 11-3 of the Aged Care Act. Special needs groups currently identified are people from Aboriginal and Torres Strait Islander communities; people from non-English speaking backgrounds; people who live in rural or remote areas; and people who are financially or socially disadvantaged. People with a disability should be included to ensure that appropriate allocations are made, that direct or indirect discrimination does not occur at the point of assessment or acceptance into a facility, and to ensure that staff are appropriately trained and resourced to provide high quality care.

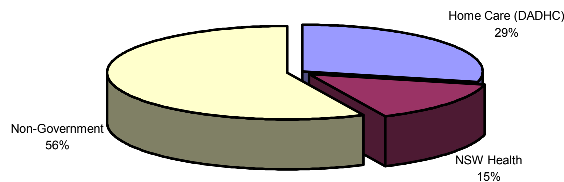
d) The adequacy of Home and Community Care programs in meeting the current and projected needs of the elderly;

The Home and Community Care (HACC) program is a key provider of community care services to frail aged people and younger people with a disability, and their carers. The overall objective of the HACC Program is to enhance the independence of people in these groups and to avoid their premature admission to long-term residential care.

The HACC Program is a joint Commonwealth Government, State and Territory initiative under the *Home and Community Care Act 1985*. In NSW, more than $414.095 million will be provided for home and community services in 2004-05, 60 per cent of funding coming from the Commonwealth Government and 40 per cent from the NSW Government.

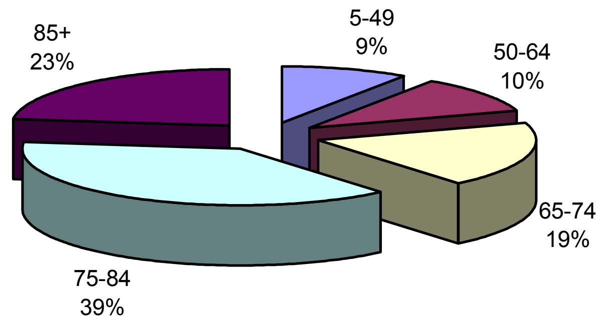
HACC services are provided by Government and non-Government organisations. The Home Care Service of NSW is a major provider of personal care and domestic assistance, and NSW Health is the primary provider of community nursing services. Non-Government organisations provide the entire range of HACC services, though focus mainly on services not provided by Government organisations. In 2003-04, $386 million was available for HACC services in NSW. The Home Care Service received $109 million in HACC funding, and NSW Health received nearly $60 million. The remaining $217 million was allocated to non-Government organisations.

Proportion of HACC Funding by Provider Type, 2003-04

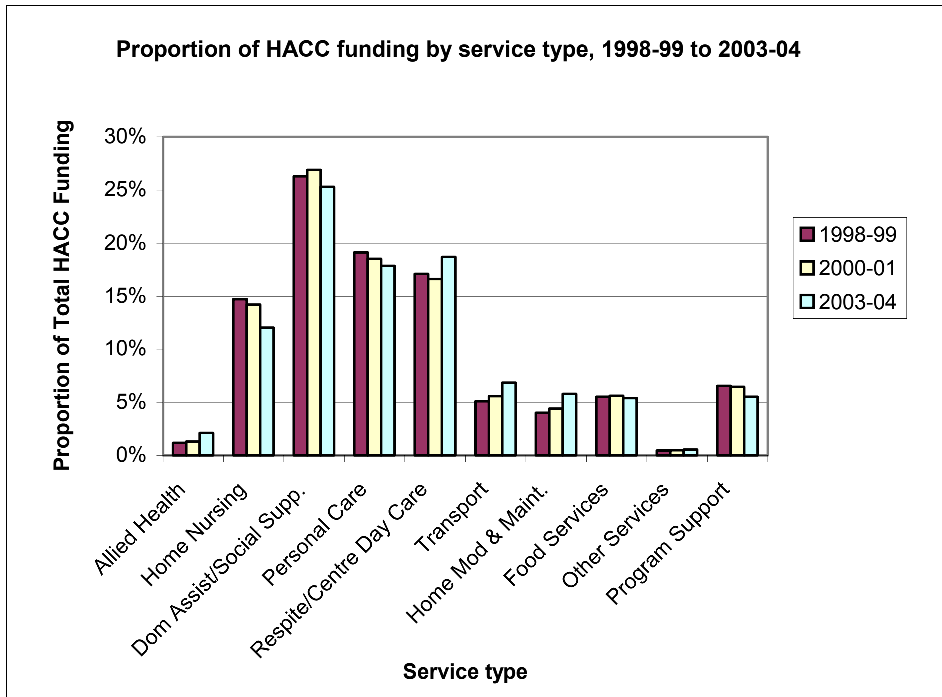


In 2002-03, there were approximately 178,000 clients who received HACC services. The most commonly accessed service types were domestic assistance (47,000 clients, 2 million hours of service), transport (44,000 clients, 1.4 million trips), meals (40,000 clients, 3.4 million meals), centre-based day care (13,000 clients, 1.6 million hours), personal care (16,000 clients, 1.4 million hours) (Source: Minimum Data Set Collection, 2002-03). The majority of HACC clients (81%) were aged 65 and over.

Proportion of HACC Clients, by age group (2002-03)



The graph below illustrates the proportion of HACC funding allocated to each HACC service type in 1998-99, 2000-01 and 2003-04. As the graph illustrates, the greatest proportion of funding is allocated to 'domestic assistance/social support' (previously known as 'home help'), 'personal care' and 'respite/centre-based day care'.



(i) Projected demand for services

Demand for home and community care services is likely to increase significantly in the medium to long term as a result of:

- Increasing numbers of older people due to the ageing of the population and increased life expectancy.
- Increasing rates of 'core activity restriction' (a measure of frailty or disability) among older people – as a result of people living longer, and in particular people living longer with more long-term health conditions and frailties.
- Increasing preferences for community-based services over residential care services as older people seek to remain in their own homes for as long as possible before transferring to a residential aged care facility, resulting in demand for high level community care services.

There is a close relationship between residential aged care and community care and the demand for places in each system. It is the provision of community care services which often prevents or, at a minimum, delays entry to residential aged care. If residential aged care places do not keep pace with demand, added pressure is placed on the community care and health systems.

The extent to which this is already occurring is evident in the number of residential care places not operational in NSW (6,814 as at 30 June 2003). As stated earlier, the reasons for this relate to the considerable time lag between the allocation and approval of places and when these places become operational. In the meantime, however, there are those who have been assessed as requiring residential aged care services but who have been unable to access a residential aged care place, receiving State funded interim support arrangements (such as high levels of community care).

The Commonwealth Government has recently published a national framework for community care[5], which seeks to better align the HACC Program with other community care programs, and the community care system more generally with the residential aged care system. The current structure can make it difficult for consumers and their carers to navigate between these systems and difficult for service providers to ensure continuity of care. There is potential for real benefits from improved linkages between the two systems through easier access, streamlined administration and assessment processes, and consistency and continuity in care programs.

While NSW sees potential benefits and opportunities in the National Framework, there is still substantial work that needs to be undertaken to improve system integration. It is essential that this work also consider the intersections with the health and disability systems.

[5] *A New Strategy for Community Care – The Way Forward*

NSW also does not endorse the Commonwealth using the proposed National Framework to abrogate its responsibilities for aged care such that there would be scope for shifting costs or generating down stream financial risks onto states orterritories.

Importance of Carer supports

There are more than 800,000 carers of older people and people with a disability in NSW, including more than 160,000 primary carers. Forty-three per cent of primary carers are aged 45-64, and 17 per cent are aged over 65. Most primary carers care for their partner (43 per cent), with 25 per cent caring for a child. For primary carers aged 65 and over, most care for their partner (75 per cent).

The aged care service system is dependent on these carers to provide ongoing support to older people. Without them, the costs of providing care and support to older people would be substantially higher. Lack of an informal carer (ie living alone) is the single most common trigger for an older person moving into residential aged care. Any changes to the balance of care for older people must therefore consider adequate carer supports, together with social changes (such as workforce participation) that impact on people's availability to fulfil the role of "carer".

The HACC program provides a range of supports directly to carers (including counseling and respite), although many other services provided under the HACC program (such as domestic assistance and personal care) directly relieve some of the responsibility of caring for an older person or person with a disability.

In addition to services provided under the HACC program, the NSW Government has established the NSW Carers Program with $12.9M over 4 years ($5.1M recurrent) to provide practical information, training and support. It also focuses on developing local and statewide services that address the needs of many of the various sub-groups of carers, including those caring for a person with intellectual disability, autism, the frail elderly, and chronic illnesses.

NSW has also established Carer Support Services in all Area Health Services to work in collaboration with other local service providers and progress initiatives to improve responses to the needs of carers by the health and community sectors. NSW Health has also funded the non-government sector to provide a range of local and statewide services.

Many carers are also elderly themselves and can struggle to provide care for another person. Under these circumstances, the interfaces between community care, residential care and health care become a practical issue to manage.

Given that they conduct in-home assessments for older people that identify individual needs and any available supports, ACATs become a valuable mechanism for identifying carers and linking them into appropriate supports.

(iv) Access to and provision of – HACC services which meet the needs of older people from culturally diverse communities

People from CALD backgrounds around Australia continue to experience lower rates of access to HACC services than the general population in all jurisdictions, as demonstrated in the *Report on Government Services 2004* which indicates HACC recipients from CALD backgrounds accounted for 16.3% of total clients, against a national target population of 23.6%. Research is required to help identify the effectiveness of CALD access strategies employed by all jurisdictions, and to recommend national 'best practice'. Findings of the research would enable greater focus on planning and funding the service delivery models that are preferred by people from CALD backgrounds.

National consultation is required to identify why disproportionably fewer CALD community organisations are funded to deliver HACC services and why they are funded for only a narrow range of service types. At issue is the under-utilisation of existing linguistic and cultural expertise and community resources. Anecdotal evidence indicates a potentially significant relationship between participation by CALD community organisations in funded service delivery and high rates of HACC service use.

The effectiveness of current arrangements for the transition of the elderly from acute hospital settings to aged care setting or back to the community

In 2003/04, NSW Health delivered health services at an estimated cost of $9.3 billion.

The ageing population is at the forefront for planning of NSW Health services. The NSW *Health Framework for Integrated Support and Management of Older People in the NSW Health Care System* (the Framework) presents a comprehensive strategy for addressing the support and management needs of the older person in the NSW health care system. The Framework aims to guide and coordinate necessary improvements in service delivery for older people in NSW and to achieve a level of consistency in approach across the State. NSW Health is currently implementing this framework.

The challenge of an ageing population also demands a more appropriate response from the Commonwealth Government on issues such as: demarcation of Federal/State responsibility; effective integration of the health and aged care systems; and the necessary flexibility to adapt residential aged and community care service models to support the growing needs of older people.

While NSW Health is planning for the future growth of the ageing population, it is already responding to the increased demands of older people. This is reflected in the increasing number of hospital admissions of people aged 65 years and over. In NSW hospitals in 2001/02, older people between the ages of 65-74 occupied 16% of all acute bed days and those over 75 years old occupied 29%.

Hospitals are also seeing an 8% annual increase in attendances by patients over the age of 80 years at emergency departments. For example, in Sydney metropolitan public hospital emergency departments more than 170 patients over the age of 80 years are being treated on a daily basis.

In addition, at any one time, in NSW alone, public hospitals are accommodating up to 800 older people awaiting a residential aged care place. NSW Health estimates this costs the public hospital system $87.3 million per annum. This includes the cost for those older people for whom the hospital has become a de-facto nursing home.

Factors such as an older person waiting in a public hospital for an average of 27 days (compared to the average length of stay for an acute episode of 3.31 days) for a residential aged care place, and the cost of a hospital stay under these circumstances being double that of residential aged care has put further strain on the NSW health system.

Avoidable days in hospital for older people unfortunately also result in a higher risk of falls, reduced mobility function, gastrointestinal problems, hospital-acquired infections, depression and increased worry and stress for the client and their families and carers.

The Commonwealth and State Governments need to work collaboratively to reduce waiting times for those in a public hospital needing a residential aged care place by improving the rate at which residential aged care places become operational.

In partnership with the Commonwealth Government, NSW Health continues to fund and develop the Multi Purpose Services (MPS) program. This program was introduced to improve the provision of health, community, and aged care in small rural and remote towns. State jurisdictions are responsible for planning the health and community services provided and capital costs for building and maintenance of MPS facilities. The Commonwealth Government is responsible for the cost of funding residential aged care places and CACPs, and jointly funds with States the cost of any Home and Community Care Program (HACC) services provided. The redevelopment of 36 rural hospital and health services is estimated to cost NSW Health $213 million.

Without the Commonwealth Government focusing on fundamental reforms at the health and aged care interface, the challenge to manage growth in demand

efficiently, service duplication and gaps, and ensuring older people have access to services in the right place and at the right time will continue. The cost shifting between jurisdictions, and the requirement to focus resources on managing program complexities and inefficiencies, will also continue.

What is required is an effective whole-systems approach to health and aged care. Although the terminology of “whole system” is widely used, the need to break down the health, community and aged care “silos” has been the subject of numerous submissions including those to the Commonwealth Government Review of Funding Arrangements in Residential Aged Care, and the Community Care Review. The progression in program and service integration across acute care, residential care and community care for older people has been slow and generally services and funding arrangements still remain inevitably fragmented, complex and inflexible.

Separating health and aged care public policy and planning has also acted as a constant barrier to coordinated and effective planning, and to a holistic, potentially cost-effective approach to service delivery.

Rather than aged care programs being able to fulfill clients’ requirements, older people often have to access funding from several sources to cover their care needs, each with their own eligibility criteria, service limits, geographical reach, financial contribution policies, reporting arrangements, and access points. From a client perspective, the service system can seem unnecessarily complex and not user-friendly.

The unique needs of older people with disabilities must be recognised. The current funding arrangements provide an effective disincentive to residential aged care facilities to provide services to those older people with complex needs. This often creates blockages in both the community and acute health care systems. In human terms, people are living in inappropriate settings by default, placing them and their families under unnecessary duress at a time when older people require special care and attention.

NSW Health and the Commonwealth Government are providing ongoing funding for a transitional care program for older people. The Commonwealth Government’s recent announcement of jointly funded 2000 transitional care beds across Australia is a start, with approximately 690 beds for NSW. NSW’s funding contribution to these services is, however, greater than that provided by the Commonwealth Government. NSW Health estimates that the real cost of providing facility-based transitional care is in the range of $240- $325 per facility-based place per day. The Commonwealth Government contribution of approximately $87 per facility-based place per day is clearly inadequate.

While the Commonwealth Government has increased its allocation of residential aged care beds to the States in the 2004 Budget, the inadequate growth in

funded residential aged care places and the considerable lag time between residential aged care beds being approved and becoming operational is problematic. At 30 June 2003, there were 67,653 allocated aged care places in NSW but only 60,839 were operational; that is, 6,814 places were non-operational.

At the same time, the demand for assessments of older people for aged care places has been increasing - from 59,965 in 1999-2000 to 67,475 in 2002-03. Put simply, there are insufficient aged care places to meet the demand.

The time lag between when places are approved and when they become operational represents an estimated loss of $142 million in aged care subsidies for the older people of NSW. The Commonwealth Government should not only work to reduce this time lag, it should also change the measure of need (70 years and over) that determines the number of residential aged care places available. People 85 years and over currently occupy 52% of residential care places and are projected to grow to 80% by 2021.

An example of an unnecessarily complex funding system is the funding of ACATs under the Commonwealth Government's Aged Care Assessment Program (ACAP). In NSW, there are 48 ACATs. Currently, each team is separately funded by the Commonwealth Government.

It is the position of the NSW Government that the funding should not be provided directly to individual ACATs but allocated at (larger) Area Health Service (AHS) level so they are able to plan individual ACAT services according to local need and population demand. This makes more sense given that the Area Health Services provide considerable top-up to the Commonwealth Government funding to meet deficiencies in funding based on assessed local needs and demands. For example, in 2001/02 NSW Health provided 48% of ACAT funding. Area-based funding would promote a regional system of ACAT assessment, reduce funding inequities, deliver real efficiencies to this over-subscribed and vital service, promote better cooperation between ACAT services, and promote equity of access across NSW. The reduction in numbers of Area Health Services in the current restructure of NSW Health would provide the much-needed impetus for rationalisation of ACAP service delivery. Put simply, this minor administrative change would allow NSW Health to deliver better ACAP services, in what is, in effect, a jointly funded program. It would also provide greater opportunities – and incentive – for integrated planning and service development with state-based community care services.

ACATs are under ever-increasing pressure as the proportion of older people grows and they find it more difficult to access appropriate services. The 'tyranny of distance' compounds the costs of service provision in rural Area Health Services (AHS). Metropolitan Area Health Services have to meet the challenge of demand outstripping the available supply of residential aged care places for

increasing numbers of frail older people, many with chronic and complex problems.

As one response, NSW Health has developed a special program to provide assisted discharge and post-discharge care to selected inpatients at risk of unnecessarily protracted hospital stays because of high community support needs. This program, called "ComPacks", received pilot funding approval from the Minister for Health In August 2003.

Under ComPacks, Community Options (COPs) case managers work with multidisciplinary hospital and community health teams prior to a patient's discharge to identify the patient's in-home care needs and to put in place a customised "community care package" comprising those community services which will allow the person to return home safely and with the support they require.

An innovative feature of ComPacks is its capacity to bridge and effectively manage the hospital-community service interface. Another strength is its flexibility, with the case manager having the capacity to move beyond mainstream services and negotiate alternative packages of care for people who would otherwise be on CACP waiting lists. An individual ComPacks can comprise a combination of informal, non-mainstream and mainstream services.

The ComPacks program also provides opportunities for people to take time to make decisions about the future care options for their elderly family members. In many instances, case managers have negotiated informal and service support options that have allowed the person to remain at home, sometimes with a CACP, sometimes on a CACP waiting list, and sometimes with other service choices. For a number of people in hospital, case management provided the necessary support for them to return home and put arrangements in place (eg preparing the home for sale) prior to moving into the nursing home placement. This type of service program ensures that individuals and their families are supported to make decisions that they believe are in their best interests.

In order to address access issues to Emergency Departments, in August 2002, the NSW Minister for Health announced the establishment of Agedcare Services Emergency Teams (ASETs) to improve the care and management of older people presenting to NSW hospital Emergency Departments. ASETs were established in 36 metropolitan and rural hospitals across NSW at a cost of $5.5 million.

The aims of these services are to identify and manage the unique needs of the older person presenting to Emergency Departments who may require a complex array of health, social, community and medical services, given the nature of their cognitive and/or chronic health conditions.

Conclusion

In conclusion, there are multiple opportunities for the Commonwealth Government to work with the NSW Government to positively address the complex needs of older people. Given the ageing of the population, significant change must occur if respective service systems are to be better integrated to meet the needs of this important segment of the population. This will require a significant collaborative effort and commitment.