BALLARAT DISTRICT NURSING & HEALTHCARE INC.
A0017116M

Submission to
Senate Community Affairs references Committee

Inquiry into Aged Care

Our submission is relevant to only two parts of the Terms of Reference:

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

(e) the effectiveness of current arrangements for transition of the elderly from acute hospital settings to aged care settings or back to the community

BDNH provides district nursing, occupational therapy and podiatry services to over 1600 clients per year in the Ballarat and Golden Plains LGA's.

Issue: Case Management

There is evidence that the complexity of our clients is increasing. They are requiring a greater number of services and more often. District nurses are trained to assess and in collaboration with other care providers develop a holistic plan of care however increasingly clients require some sort of aged care package which means that the client then has a case manager from another agency. In many instances the nurse is still doing pseudo case management, their role is to assess the individual needs of the client and effectively plan, arrange, coordinate and deliver care. In many instances our clients who are under the care of a Primary Care Nurse are referred to a brokerage service for a package because their complex needs cannot be sustained by HACC funding alone. The client then has a case manager who manages the funding and a Primary Care Nurse who plans, coordinates and implements the care. Nurses are important players in this process as they have unique skills that understand a person's health care situation as well as their health care needs.

Proposal: Services like BDNH who provide a range of services including personal care and home care services should be funded to provide Case Management for some clients rather than bringing in a new player.

Issue: Flexible funding

We are aware of the projected increase in the ageing population over the next half century but does an ageing population mean a sicker population? HACC services are funded in a manner which encourages a reactive rather than a proactive service. Funding through various programs to separate agencies encourages delineated services which tend to deal with only specific needs rather than a whole plan of care for each client. Community funding needs to be more flexible so that it can respond to individual needs case by case and this would allow service providers to meet the challenge of promoting healthy and productive ageing.

Commitment Quality and Care

Community care needs more funding so that a person's assessed level of need can be aligned with the appropriate level of funding. This includes recognition that other things such as equipment and carer support also needs to be provided. There is often a huge strain placed on carers and families of people with complex care needs as the community services are not able to provide the quantity and flexibility of care that is required

Proposal – there should be changes to community health funding and HACC funding programs to reduce fragmentation of services and provide a holistic service which is proactive as well as reactive.

Issue: Social isolation

Whilst increasing numbers of people with increasing needs are maintained and supported at home, in many instances they are becoming increasingly isolated. Social connectivity is an important aspect of a person's health.

Adjustment of the societal parameters needs to occur to include older people, just because they are older does not mean they are not productive and cannot continue to contribute to society

Proposal – Aged Care Standards require social programs for clients in residential care. A strategy to ensure social connectivity and psychological wellbeing is also required for clients who are isolated in the community due to their care needs.

Issue: Integrated Care

State funded programs such as the Hospital Admission Risk Program have demonstrated the benefits of collaboration between acute and community care services. The outcomes have been good for clients in many ways, including significantly reduced or eliminated admissions to hospital. Staff who have been involved in these programs feel that they are really making a difference in people's lives and this leads to increased job satisfaction. The broader view of the system is that decreasing peoples need for acute care decreases the overall cost of healthcare. Prevention and proactive care is much more cost effective for a society than reactive care which has been evidenced by many health promotion strategies.
Educating people to be in control of their destinies and to be proactive in the management of their illnesses, can achieve great outcomes for people with chronic conditions.

Proposal - Programs which have been piloted such as Hospital Admission Risk Programs which ensure collaboration between acute and community service providers need to continue. Ultimately that ensures that clients have holistic proactive care plans in place. There is evidence that it gives control back to clients and that health care services work together better with better outcomes.

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