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National Aged Care Alliance

AHMAC and Beyond –
A Strategic Framework for Health Care for Older People:
At home, in residential care, in hospital and in transition between settings

A response to the Australian Health Ministers' Advisory Council national action plan, From Hospital to Home: Improving the outcomes for older people, July 2004

May 2006

National Aged Care Alliance

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Executive Summary

This Strategic Framework addresses the health care of older people within and across the three settings in which they receive their care: while living in the community, while living in residential care facilities and while staying in hospital. The Alliance's vision is for a system of health care for older Australians, that:

- provides access to planned, and properly resourced and integrated, quality health care;
- is flexible, equitable, accessible and affordable; and
- recognises diversity and promotes choice and respect for users and workers.

The Australian Health Ministers' Advisory Council (AHMAC) National Action Plan for Care of Older People, *From hospital to home: Improving the outcomes for older people* provides a plan through which government can establish and maintain world-class health care for older Australians. The plan however, while providing a framework that is fully supported by the Alliance, is focused on the transition of patients from hospital to home and provides limited direction in terms of methodologies for service delivery and little detail with respect to health care within the residential care setting or for those still living in the community. This Alliance paper provides a strategic framework and methodologies to assist implementation of the AHMAC Plan, identifying areas where further action plans need to be developed. It includes some new approaches, additional to the elements of the AHMAC Plan.

Firstly, the model recommends measures to integrate health services for older people across the three settings where they are delivered – the community, residential care, and hospitals – rather than the current approach of delivering health care separately in each setting. Integral to the approach is the recognition that a dynamic balance exists in service provision across these three settings, with any significant alteration in the service base of one setting impacting on the other two. Services at and across the interface between these settings are given particular attention.

Secondly, with the rapid expansion of the population aged 65 years and over, the Alliance calls for health care planners to review concepts and terminology used in discussing the health of older people and, in particular, to modify the use of population categories, which group together and homogenise older people over 65 years. The health care needs of those in the 65–74 years age group, 'the young old' where less than 10% have disabilities or are dependent, are widely different from the group 85 years and over, the 'very old' age group or 'frail aged', 80% of whom need assistance with some domestic tasks and more than 30% of whom are dependent for aspects of personal care.

Thirdly, while the Alliance recognises that the 'young old' are likely to be the major drivers of future health care costs in terms of high technology medical and surgical care, the model of health care outlined in this paper is primarily directed towards the needs of the two older age categories; in particular the 'frail aged' ie. those people 85 years and over and the 'older old' ie. people in the 75 to 84 age category, who are at high risk of needing health care.

At the core of the proposed model is:

- support for general practitioners as primary care providers for older people at the acute care interface – in residential care and community settings;
- development of multi-disciplinary teams responsive to the complex needs of 'frail older' people to assist the provision of chronic and complex care by general practitioners and the general practice teams;
- development of multi-disciplinary teams integrated with relevant acute, post acute and community health services, with specialist geriatric medical, nursing and allied health input, relating to local Divisions of General Practice;
- integration of hospital aged care services with elements of the health system at the interface between acute hospital care and return home, to provide seamless care across the acute/aged care/community care continuum.

Providing best possible care is not easy and will require contributions from a diverse range of professionals both within the public and private sector. Older people whether living in the community or in residential care need access to essential health services. Services must be coordinated and integrated to optimise the use of skilled staff and to maximise the health benefit for older Australians.

The fundamental requirements of quality health care for older Australians are:

- affordable and accessible 24 hour medical services delivered by general practitioners and the general practice team and other primary care providers, where disadvantage due to income and geography are minimised;
- access to quality nursing care and to the full range of essential specialist support and allied health professional services for those living in the community or in residential care. This must include access for those who have limited mobility and arrangements for back up specialist care especially the assistance of specialist geriatricians;
- provision of adequate services such as day care, respite care or hospice beds;
- access to a wide range of community health and support services will be essential. This must include adequate carer and home support services;
- appropriate rehabilitation and sub-acute care. Adequate provision for these services must be included in health services planning;

- sufficient well funded places in residential aged care facilities to cater for growth in the number of very old people who cannot be cared for in the community, especially the very frail or those with special needs associated with dementia;
- hospital services set up to cater for the increasing numbers of 'frail older' people with acute illness and complex care needs;
- hospital-home interface is an expanding area of service delivery and offers scope for avoiding and shortening unnecessary hospital stays as well as providing a seamless interface between systems and a genuine continuum of care;
- efficient client-centred assessment which minimizes the extent to which people are asked more than once for the same information and which makes the best use of the skills and knowledge of qualified staff;
- a system of health care that acknowledges the rights of health consumers to participate to the maximum extent possible in decisions about their own health care or treatment options.

The health care of 'frail older' people often requires complex multidisciplinary team care provided by specialist staff. The Alliance specifically recommends that this type of care should be accessible to those living in the community and in residential aged care facilities, as well as those in hospital where it is traditionally available.

The use of Extended ACATs is arguably the most effective model for effective delivery of such care over the next decade. This would build on and re-integrate the existing local sector Geriatric Medicine – ACAT framework and link this core sector system with divisions of general practice. ACAT teams now cover every local sector in Australia and provide an essential role in assessing specific support needs of older people and act as a resource to the general practitioner and other primary care providers. Many such teams are truly multidisciplinary and have the capacity to provide a wide range of supports for older people living in the community as well as the traditional role of client assessment. In addition to geriatric trained nursing staff and a diverse range of allied health care providers, a specialist geriatrician with a community focus should be added to each sector Geriatric Medicine – ACAT framework, to work with local divisions of general practice to support general practitioners and their practice teams in the provision of complex aged care and reduce the need for unnecessary access to multiple specialists. It would also refocus ACATs towards a more effective role in coordinating and providing services.

The Alliance stresses that while it may be easy to develop principles of care, implementation and ensuring adequate funding for the provision of care is more challenging. The way the health system is funded cannot be divorced from the overall health framework and the range, quality and accessibility of the services provided. Discussion about who pays or how much are of little value without first considering just what are the services which need to be delivered and who is best to deliver them.

Recommendations

- Funding for all elements of the health care service must be increased as the population ages, to cater for growth in the numbers of the 'very old' ie. those 85 and over and growth in the number of those at high risk of needing health care, generally in the 'older old' or 75–84 years age group.
- General practitioners and other members of the primary health care team are the backbone of health care for older people and the Alliance supports ongoing review of mechanisms that will ensure that such services are available, accessible and affordable. This should include a focus on workforce training, recruitment and re-entry and consideration of incentives that encourage quality care and outcomes across the aged care continuum.
- Actively aim at coordinating and integrating services across interface lines so that artificial barriers between care settings are removed or reduced and all elements of the health services are well integrated and coordinated.
- A model of care needs to be developed that ensures provision of specialised care and support is accessible and well coordinated. The use of Extended ACATs is arguably the most effective model able to deliver and support primary health care workers in the care of 'frail older' people over the next decade.
- Geriatric trained nursing staff and a diverse range of allied health care providers are needed in community assessment teams for older people and a specialist geriatrician with a community focus should be added to each sector Geriatric Medicine – ACAT framework to work with local divisions of general practice to support general practitioners and their practice teams in the provision of complex aged care and reduce the need for unnecessary access to multiple specialists. It would also refocus ACATs towards a more effective role in coordinating and providing services.
- Health planners should review concepts and terminology used in discussing the health care of older people and modify the use of population categories, which group together and homogenise older people over 65 years.
- Governments (both federal and state/territory) need to act urgently to introduce policies to achieve a system of services to which access is determined by the needs of older people, rather than the particular jurisdiction or service setting in which they may find themselves.
- Stream line assessment systems so that they do not duplicate information collection unnecessarily.

1. Introduction

The National Aged Care Alliance (the Alliance) is a representative body of 25 peak national organisations in aged care and includes consumer groups, providers, unions, and health professionals, working together to determine a more positive future for the aged care sector in Australia.

The Alliance was formed in April 2000, and has developed a united policy agenda to achieve better outcomes for the care of older people in Australia. At the February 2004 National Aged Care Summit, the Alliance recognised the importance of quality health care as a critical component of quality aged care. Alliance members are therefore keen to ensure the provision of world-class health care for older Australians.

As people age, they are more likely to require health care, not only acute care for sudden illnesses but ongoing care and monitoring of chronic conditions. The ageing of the baby boomers will significantly increase the number of people who are 65 years and over during the next two decades. Improved life expectancy will also see the numbers of people aged 80 years and over doubling during the following two decades. The majority of those over 65 years are well and independent, often providing services to families and communities. The majority of those aged over 80 years have complex health concerns and rapidly increasing levels of disability. Towards the end of life, for many older people health care and aged care need to become integrally linked.

The aim is to develop a model system of health care for the increasing numbers of older people in Australia, which gives the best care for the older person, in the best setting, using best practice to achieve maximum physical and mental capacity and minimum disability. This paper draws on Alliance Issues Paper No 1, which outlined an open model for provision of health services to residential care facilities but extends it to the provision of services across all sectors, including acute hospitals and older people living in the community.

The fundamental goals and principles, which underpin any strategic framework for health care of older Australians, have already been clearly outlined in The National Strategy for an Ageing Australia[1] and in the Australian Health Ministers' Advisory Council (AHMAC) National Action Plan for Care of Older People. Key supporting documents include *From hospital to home: Improving the outcomes for older people*[2] and *Age-friendly principles and practices: Managing older people in the health service environment*[3], developed on behalf of AHMAC by the Care of Older Australians

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[1] Commonwealth of Australia, National Strategy for an Ageing Australia, AGPS, Canberra 2001

[2] Australian Health Ministers' Advisory Council (AHMAC), From Hospital to Home: Improving the outcomes for older people, July 2004

[3] Australian Health Ministers' Advisory Council (AHMAC) Age-friendly principles and practices: Managing older people in the health service environment, July 2004

Working Group. The AHMAC National Action Plan provides a framework through which government can establish and maintain world-class health care for older Australians. The plan however, while providing a framework that is fully supported by the Alliance, provides limited direction in terms of methodology for service delivery. In addition it is focused on the transition of patients from hospital to home and while this is an essential element of sound health care, a strategic framework for health care needs to have a broader scope and to consider the wider needs of older people, whether living in the community, in residential care or having an episode of acute care.

This paper represents the Alliance response to the AHMAC National Action Plan. It proposes a methodology to assist implementation of the AHMAC Plan and identifies areas where further action plans need to be developed.

The AHMAC Action Plan provides little detail with respect to health care within the residential care setting or for those still living in the community, although this remains the largest component of health care for older people. The Alliance therefore has prepared this paper to outline a strategic framework for health care for older Australians, which addresses the needs of all older people across each of the settings in which services are provided. The majority of older people live in the community and will continue to do so. A growing number but still a minority will live in residential aged care, while most older people will have short episodic need for hospital care. These are the principal settings for health care that need to be addressed in a strategic plan. Transitions across these three settings also need to be considered in a comprehensive framework.

The Alliance accepts and supports the seven principles identified in the AHMAC National Action Plan (see Box 1).

Box 1. AHMAC National Action Plan principles

Principle 1 Older people have access to an appropriate level of health and aged care services that match their changing needs.

Principle 2 Services are shaped around the diverse needs of older people.

Principle 3 Avoidable admissions to hospitals or premature admissions to long term residential aged care are prevented where possible.

Principle 4 Older people have access to transition care services within the acute-aged care continuum.

Principle 5 The health and aged care sectors at both the service provider and government level operate to deliver an integrated suite of services and care for older people across the acute-aged care continuum.

Principle 6 The workforce involved in caring for older people is skilled, responsive and in sufficient numbers to meet older people's needs.

Principle 7 Informal carers and family members are well equipped to provide support and care.

The Alliance adds that there must be recognition of the right of older people to accurate diagnosis and to minimisation of disability. It is also recognised that the health care system should acknowledge the rights of health consumers to participate to the maximum extent possible in decisions about their own health care or treatment options.

In developing this response to AHMAC and a model for providing quality health care for older Australians, the Alliance recognises that there are some older people who do not fit easily into care models eg. those living in Indigenous communities, those in rural and remote settings and those who are homeless. Adjustments in care models will be needed for such groups but addressing these specific needs more in-depth consideration than can be included in this paper.

2. Vision

The challenge of a truly effective health care system is to promote a longer period of healthy active life, and the provision of world-class health care for 'frail aged' people, those with disabilities and with chronic and complex conditions.

Health services for older people are provided across three settings:

- hospitals (including sub-acute facilities);
- residential aged care facilities;
- within the community in the older person's home or that of a relative or carer.

The Alliance's vision for health care for older Australians is that all older people in Australia have access to planned and properly resourced, integrated quality health care that is flexible, equitable, accessible and affordable, that recognises diversity and promotes choice and respect for users and workers.

The elements of an effective health framework are:

- a comprehensive community health care program delivering services to the 'frail elderly' living in the community, with affordable and accessible primary care and ambulatory care services, which are well integrated with hospital, residential care and other community services;
- a quality residential aged care health system for those unable to remain at home or in the care of friends or relatives;
- an accessible public hospital system that caters for the 'frail aged' with multifactorial geriatric conditions; and
- a robust private health system which is well integrated with other elements of the health framework and which complements the public sector health services.

All elements of the care system; hospitals, residential aged care and community delivered support must be efficient, well funded, affordable, accessible and equitably distributed.

The Alliance recognises:

- that prevention is better than cure, treatment or management and there is need to stress 'healthy ageing' initiatives early in life;
- that the best setting for health care of older people is increasingly in their own homes, with appropriate supports, but that there will continue to be a need for residential care places for highly dependent older people or for those lacking alternative social support;

- that all health professionals will need to be skilled to practice aged and palliative care; and
- that there will always be a significant number of acutely ill older people who need the facilities of the modern acute hospital.

The Alliance supports the AHMAC principles included in the document, Age-friendly principles and practices: Managing older people in the health service environment (APP) (See Box 2).

Box 2. Age-friendly principles and practices: Managing older people in the health service environment

1. Health treatment and care delivered to older people will be based on strong evidence and have a focus on maintaining, improving and preventing deterioration in their health and quality of life.
2. Health services will recognise and address older people's complex needs.
3. Health treatment and care are respectful and recognise individual differences and specific needs, such as cultural, religious and sexual differences.
4. Health treatment and care are delivered in a coordinated and timely manner across care settings.
5. Unnecessary admission to hospital and extended hospital stays of the 'frail elderly' are avoided.
6. The care of older people is a primary focus for all health services.
7. Where safe and cost-effective to do so, older people receive health treatment and care in a setting that best meets their needs and preferences.

3. Context

Average life expectancy in Australia is now more than 80 years. As the population ages and the proportion of the population 80 years and over rises, barriers to the provision of health care to older people will become increasingly severe unless immediate action is taken. While the baby boomer bulge ages from 60 to 80 years, there is a window of opportunity over the next two decades to plan for a much older population. However it is important in discussing the health of older people that the outdated use of population categories which group together all older people over 65 years is modified. The health care needs of those in the 65 to 75 years age group are widely different from those in the 85+ years age group and planners must begin to readjust thinking and terminology to reflect the real demographic pattern today. A more appropriate and functional set of age categories are shown in Box 3. The appropriate use of an extended age structure (young old, older old and very old) and functional categories (healthy, at risk and frail) without imposing too rigid boundaries, can focus policy development and health care research and can improve the delivery of aged care and health care for older people.

Box 3. Redefining older age categories in Australia

Centenarians will soon be the fastest growing age group in Australia, however they now number some 3000 people and we have little evidence on which to assess their current functional status. Centenarians will come into their own around 2060 when average survival for women at birth reaches 100 years. A separate age category for this group is premature, although a separate research category is vital as they epitomise the large numbers of people growing 'seriously old' in developed countries.

The 'very old' age group (85 years and over) is of immediate importance to both service planners and researchers despite relatively small current numbers and slower growth, as they carry a disproportionate level of 'frailty'. From the 'Sydney Older Persons Study' it is known that 80% need assistance with some domestic tasks and more than 30% are dependent for aspects of personal care, due mainly to early impairments in cognition, capacity, gait and balance from neurodegenerative or brain disorders (of unknown cause or prevention).[4] We have a short planning window, two to three decades, to support age-related preventive research and develop age-related services, before we need to seriously consider the rapid rise to 1.3 million people aged 85 years and over we will have by 2051, in a total Australian population of around 26 million.

The 'older old' age group (75 to 84 years) will grow more rapidly over coming decades. They are generally active, mobile and independent, and often able to provide care and run businesses as well as care for themselves. However they carry high levels of physical ill health (22% lung disease, 46% heart disease, 68% painful hips and knees) and are 'at risk' of entering hospital (60% per annum).[5 6] Most importantly, as a group, they carry a rapidly rising burden of underlying (often symptom free) neurodegenerative brain changes. Moreover, these changes are largely responsible for their 'at risk of hospital' status, causing reduced mobility, loss of balance, or cognitive loss and delirium, which complicate acute reversible illness in this age group, but recover with appropriate multidisciplinary acute and sub-acute care.

The 'young old' (65 to 74 years) are the largest, fastest growing and by far the healthiest of the three age groups, even before the first baby boomers join them in 2010. As a group, they are healthy, mobile, independent and cognitively intact with good judgment and capacity. Their physical health is improving as levels of heart and lung disease and cancer continue to fall in the community. They are a potential economic and educational resource. 'Healthy Ageing' research is most appropriate to this group. Paradoxically, however, the young old, rather than their older compatriots, will drive future health costs with their expectations of a high technology health system largely designed to revitalise and renew their hearts, joints, kidneys etc.

[4] Waite LM, Broe GA, Grayson DA, Creasey H, Cullen JC, Casey B, Bennett HP, Brooks WS, Clinical diagnoses and disability among community dwellers aged 75 and over, Australian Journal of Ageing 2001, 20: 67–72

[5] Waite LM, Broe GA, Grayson DA, Creasey H, Cullen JC, Casey B, Bennett HP, Brooks WS, Clinical diagnoses and disability among community dwellers aged 75 and over, Australian Journal of Ageing, 2001, 20: 67–72

[6] Waite LM, Broe GA, Grayson DA, Creasey H, Cullen JC, Casey B, Bennett HP, Brooks WS, Clinical diagnoses and disability among community dwellers aged 75 and over, Australian Journal of Ageing, 2001, 20: 67–72

4. Impact on Services

Demand for general practitioners and general practice teams and specialist geriatric and palliative care services will certainly increase. Chronic non-communicable disorders (heart and lung diseases, bone and joint disease, cerebrovascular disease and diabetes) are now the major cause of both acute exacerbations of illness and chronic disability in Australia. It is expected these chronic disorders will remain at high levels, but to be overtaken by the neurodegenerative disorders as the major cause of severe disability and death in the rapidly growing numbers of 'older-old' – those 75 years and over.

With ageing of the aged, we will see an increasing number of 'older-old' people with neurodegenerative disorders, depression and mental health problems. The incidence of neurodegenerative conditions such as gait disorders with slowing and instability leading to Parkinson's disease, cognitive impairment leading to dementia, and sensory loss (vision and hearing) increases steeply as average survival increases beyond 75 years. This group of 'older-old' people, admitted to acute hospitals, are more likely to have significant co-morbidities, chronic and complex conditions, high dependency levels, vulnerability to adverse events, and needs for rehabilitation and post-hospital support, than are 'young-old' patients. A single illness model of care does not meet the medical or functional needs of this group. Rather, a broad multidisciplinary team approach that addresses the range of assessed needs is required. Such a multidisciplinary approach needs to embrace patients and their carers and it needs to make decisions in a truly collaborative manner between family and medical, nursing and allied health personnel.

The Geriatric Medicine system, which includes Aged Care Assessment Teams has good world standing, but it is increasingly under stress. It needs a funding upgrade to care for the burgeoning over 75s and coming over 85s. It also needs to expand and work closely with developing interdisciplinary teams such as palliative care, and community care teams. Cross training amongst related and overlapping disciplines is strongly supported – for example palliative care and geriatric care.

While developments in community and primary care may be expected to reduce the need for hospital care for the elderly, population ageing will still see large proportions of the acute hospital caseload made up of older Australians. There will be a growing need for multidisciplinary geriatric services to manage the sudden onset of acute illness in older people; management which is made more complex by falls, immobility, confusion, incontinence, sensory loss, depression etc.

Demand for elective surgery and high technology medicine will increase even more rapidly, largely driven by baby boomers in younger age groups (50 to 75 years of age). Such treatments are increasingly (and not unreasonably) expected to provide longer periods of healthy independent living. These include joint replacement, cardiovascular surgery, support or replacement of failing organs, surgery for treatable cancers and increasing use of pharmacological treatments. High technology health care, for the 'younger-old' will be the major driver of increased demand on an already stretched hospital capacity. Care should be taken that adequate capacity is maintained for health care of the rising numbers of 'older-old', the core group for specialist aged care health services.

Demand will increase with more pressure of 'frail older' people on community delivered health services. This will extend not just to primary health care providers, but also to the many community support services needed to maintain 'frail older' people living in their own homes. Shortages of primary health care workers may be expected and consequent pressure on rehabilitation services, residential care places and palliative care services will all increase. The impact on services may be heightened in rural and remote areas where rural general practice tends to transcend the three domains of aged care: community, residential aged care facilities, and acute in-hospital care. The demands on the on the already substantial volunteer workforce is also expected to grow rapidly and there will be a need to resource this workforce effectively.

5. Response to the AHMAC Principles

The overall Alliance approach is consistent with the seven principles underpinning the AHMAC National Action Plan for Care of Older people although it may need strengthening in some areas. Moreover, the Alliance stresses that while it may be easy to develop principles of care, implementation is more challenging.

Principle 1. Older people have access to an appropriate level of health and aged care services that match their changing needs

The AHMAC lists of basic services should include access to primary health care, including nursing, dental care, physiotherapy, occupational and speech therapy and dieticians as well as general practitioners and general practice teams. It should also acknowledge that there must be adequate access to acute hospital care when needed. Access to quality residential aged care and supported community care must also be accepted.

Principle 2. Services are shaped around the diverse needs of older people

The Alliance recognises the importance of this fundamental principle.

Principle 3: Avoidable admissions to hospitals or premature admissions to long term residential aged care are prevented where possible

It is anticipated that as the population ages the proportion of patients presenting with age related emergencies will increase. This is a priority area for action with expected benefits for patients, service providers and those funding health services.

Principle 4. Older people have access to transition care services within the acute-aged care continuum

The potential for patients who are suitable for residential care but fill hospital beds because places are not available is often highlighted as a prime area of concern offering potential for cost shifting between jurisdictions and service providers. Linked with this is a real need to provide adequate numbers of respite beds. These patients filling hospital beds are generally found in smaller rural hospitals rather than major metropolitan hospitals. While there will be an on-going need for transitional beds, the demand for transitional care beds and units should not distract the states and territories from the primary role of providing sufficient acute care and sub-acute rehabilitation for older people with complex needs.

The number of sub-acute and rehabilitation beds also needs to be increased to meet expected demand. To the extent that these beds promote discharge back home rather that to residential care, they will prove successful. While typically provided in hospitals there are many complementary models of service delivery for rehabilitation. However, where patients are cognitively impaired, changes of residential environment or surroundings should be minimised.

It must be recognised also that patients in interim care/transitional care beds also need occupational therapy and physiotherapy planning and care.

However, as a long term goal the need for transitional beds should remain modest. If there are adequate places in residential aged care facilities and enough community support packages, coupled with good rehabilitation and post acute services in the community or in residential aged care facilities, there should not be a need for a large numbers of transitional care places. In order to ensure that the aims of transition care are achieved and that patient outcomes are optimal, there is a need to define adequate funding and multidisciplinary staffing models for these new places in both residential facilities and the community. In addition to adequate resources and multidisciplinary staffing, the new transition care model should incorporate partnership arrangements between general practice, hospitals, geriatric services, residential facilities and community care providers. These should provide a structure that facilitates the overview by geriatricians throughout the processes of selection for, management within and discharge from, transition care.

Principle 5. The health and aged care sectors at both the service provider and government level operate to deliver an integrated suite of services and care for older people across the acute-aged care continuum

This AHMAC principle is fundamental but the paper provides only limited information on steps to achieve this outcome. It is the purpose of this Alliance paper to outline a care framework that gives a model through which services can be integrated.

Principle 6. The workforce involved in caring for older people is skilled, responsive and in sufficient numbers to meet older people's needs

AHMAC has highlighted perhaps one of the single biggest problems potentially facing the appropriate care for the ageing community, namely the decreasing supply of a well-trained workforce. Shortages of medical practitioners and nurses are already apparent and this shortage is expected to grow. This paper and the models outlined is predicated on there being available an effective and efficient workforce.

Possible shortage of trained workers is a growing area of concern and the Alliance calls for urgent government action to research, review and address this emerging issue.

The Alliance stresses however that the role of different health service providers should be clearly defined and well integrated to minimise interface problems.

Principle 7. Informal carers and family members are well equipped to provide support and care

Care by family and friends is the principal form of support given to older people and this need is likely to increase with time. As the ratio of older people to fit healthy younger people increases in parallel with a scarcity of health workers, pressure to use carers as a substitute for professional care may increase. This trend has the capacity to adversely affect the most disadvantaged in the community and should be resisted. While in many situations there will be families who have the time, skills, commitment and energy to perform such roles to a very high standard, this will not be universal and it is important that expectations of families to care for older people are reasonable and achievable and recognise that the carers sometimes may be disadvantaged on the basis of health, stress, time, finances and/or education.

The Alliance notes that the role of carers should not be confused with that of health workers.

6. Care Model

Providing a continuum of care requires effective integration of services and patient centred management that supports and tracks the movement of a patient between settings. This will require a structured framework so that 'frail elderly' get the services they need and do not 'fall between the cracks'. While options for providing this structure will vary between health services sectors, the cornerstone of care will be around general practitioners and general practice teams. It would be supported by a local geriatric medicine service, which includes ACATs, other multidisciplinary teams and outreach home care services.

Using the AHMAC National Action Plan as a foundation for more comprehensive models, the Alliance proposes a strategic framework for health care for older Australians that incorporates each of the essential elements of best practice health care but remains flexible to adapt to differing needs.

The aims of the health care model are to:

1. provide a continuum of care across the three settings where older people need and use health services – in the community, in the hospital and in residential care;
2. provide a dynamic model that allows the supply of places across the three settings to adjust to meet fluctuating demand;
3. provide a seamless service that integrates health promotion and prevention, primary health care and community health, acute, rehabilitation and sub-acute care, and health care in the residential aged care sector;
4. integrate health services within the broader systems of aged care provision.

The essential elements of the model are outlined below:

1. **An affordable and accessible primary health care service** which ensures that all older people have access to general practitioners and general practice teams and other service providers as required, without the need to rely on acute hospitals to fill gaps in service availability. This will require ensuring there are sufficient primary health care providers to meet growing needs, plus a system for ensuring that primary health care services can reach those with limited mobility. This primary health care service must incorporate preventative health and wellness programs.
2. **An effective system of secondary referrals** which ensures older people have access to specialists particularly geriatricians when required.
3. **Community and care centred services** which provide nursing, allied health and personal services to older people to assist them to stay at home as long as possible. Adjuncts to this service are carer support services, respite care and day care facilities, which could be provided through hospitals, residential aged care facilities, local government or independent providers.

4. **Hospital community interface programs** including as far as possible post acute care services, respite care and hospital in the home or the nursing home type services that may avoid unnecessary hospital admissions or reduce length of stay. It would include also a specialist support network, integrated with all care settings and able to provide support for general practitioners and patient review and assessment.

5. **Quality residential aged care facilities** for 'frail older' people who no longer are able to reside in the community. This should be integrated with hospital outreach services to prevent avoidable admissions. Residents should have access to primary care, rehabilitation, and palliative care as required.

6. **An acute hospital system** which has the capacity and skills to manage complex older patients. Adjuncts to the hospital service should include adequate sub-acute/ rehabilitation places. The acute system should adapt to the growing older population by integrating specialist gerontic and palliative care into hospital activity, initially at the point of entry (usually through emergency departments), but also by providing trained staff and/or specialist advisory services in other areas of the hospital.

7 **Efficient and client centred assessment** which minimises the extent to which people are asked more than once for the same information when moving between different parts of the care system and which makes the most efficient and effective use of the skills and knowledge of qualified staff within the respective care systems.

Making best use of specialists and multidisciplinary teams

Older people and the services, which care for them, are currently subject to duplicative administrative requirements. These have been designed in isolation from each other purely to meet the needs of specific funding programs. To eliminate duplicated requests for information and excessive compliance costs, a more streamlined and coordinated approach to business process engineering and information management across settings and programs is required. For example, the payments system for residential aged care is already under critical review. However, redesign needs to take into account how contribution from ACATs, general practitioners, other health professionals and aged care services can reduce the number of assessments of older people, avoiding needless intrusion and duplicated accountability which divert resources away from providing care.

There is also potential for information generated from a comprehensive medical assessment performed by a general practitioner to be shared with ACATs and residential aged care staff. This information, which would of course need to be subject to privacy considerations, is currently not generally available to these staff.

Box 4. Aged care assessment teams

An ACAT assessment and approval is required before people can access residential aged care, Community Aged Care Packages or Extended Aged Care at Home packages. Assessment teams are located around Australia and are usually based at a hospital, geriatric centre or community centre and can see people in their own home or in hospital. ACATs might include a doctor, nurse, social worker, occupational therapist or physiotherapist. ACATs help older people and their carers work out what kind of care will best meet their needs, provide information on suitable care options and can help arrange access or referral to appropriate residential or community care services such as Home and Community Care.

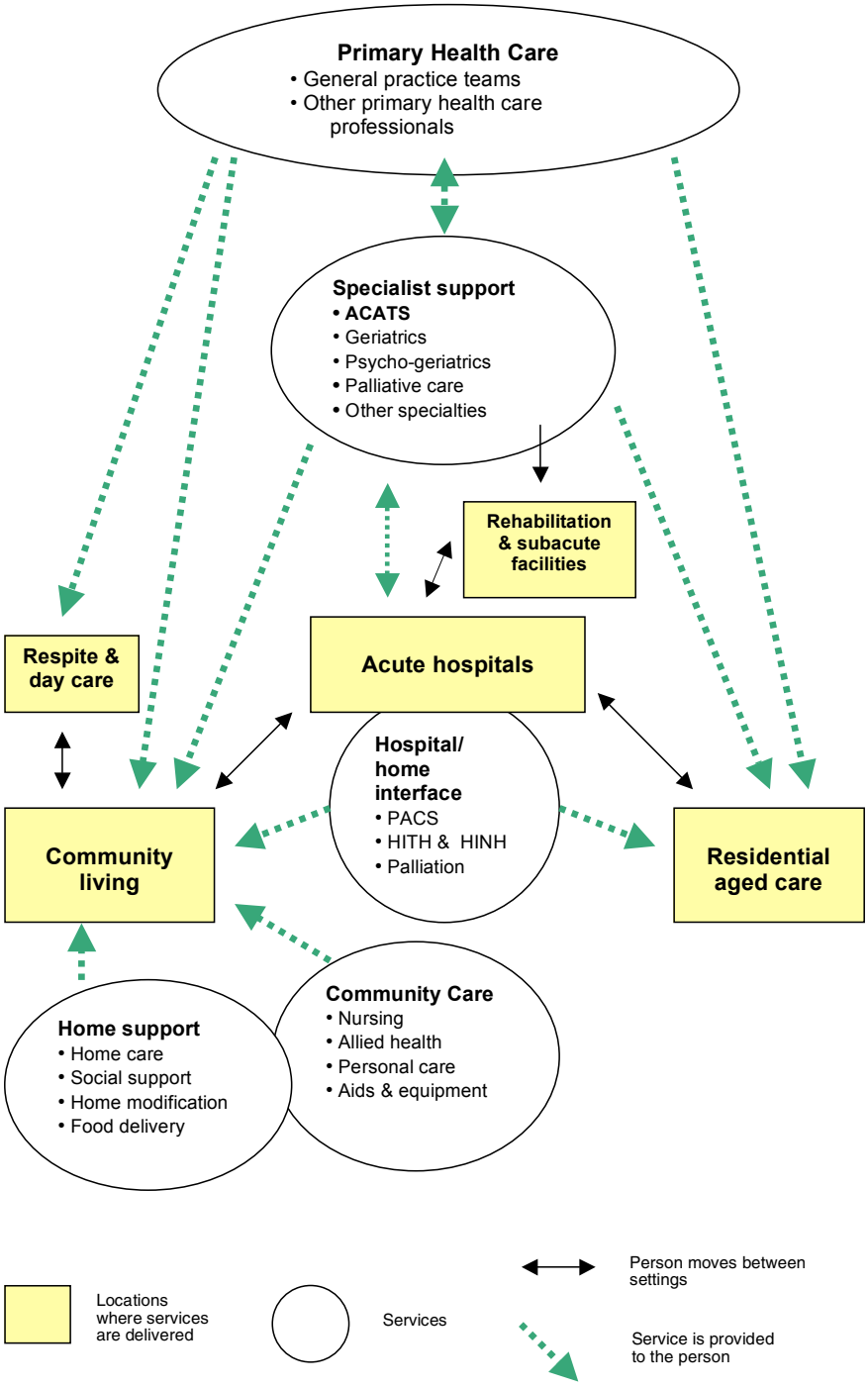
At the core of the proposed model is support for general practitioners as primary care providers for older people at the acute care interface, in residential care and community settings. This means better use of specialist geriatric and/or palliative care teams which ideally will be well integrated with the relevant acute or community health services and generic community service providers and residential aged care homes, as well as with the acute and rehabilitation hospitals. Frail or older people with complex care needs, whether living in residential care or in the community, with multiple pathology and impairments in cognition and gait, cannot access multiple specialists or private rooms and will all too readily find their way into unnecessary acute care. Specialist geriatric, psycho-geriatric and palliative services and improved access to the resources of multidisciplinary aged care teams, would support local general practitioners, general practice teams and the divisions of general practice to provide complex care for 'frail older' people, for older people in the community and in residential aged care.

ACAT teams now cover every local sector in Australia and provide an essential role in assessing the support needs of older people and as a resource for the general practitioner who is the central primary health care provider. Many such teams are truly multidisciplinary and have the capacity to provide a wide range of supports for older people living in the community. Frequently however their role is limited to client assessment, which is not the most effective use of well-trained professionals with specific training in geriatric care. Extended ACATs, which include a wider range of multidisciplinary professionals, and sometimes a community geriatrician working with acute hospitals and residential aged care facilities are able to provide a very wide range of services and support.

The most efficient and effective means of delivering this service would be to build on the existing ACATs and divisions of general practice network to develop an Extended ACATs model and is discussed in Box 5. ACATs include, or should include, specialist aged care nurses and a diversity of allied health professionals. Improved access to the extended multidisciplinary ACATs with a community geriatrician would be an invaluable support for general practitioners and would assist them to provide appropriate health care specific to the care needs of 'frail older' people. The Extended ACATs and community palliative care/home care models, should allow more referrals directly from general practitioners. However, these services need to work in an integrated manner to dovetail with, build and enhance general practitioner networks. Services that tend to disempower or compete could lead to fragmentation of the care continuum. Geriatrician Evaluation Models, which

allow assessment of patient needs, before entry into either acute or residential care and which focus on providing care, will avoid the need for institutional care, are strongly supported.

There are some older people who do not fit easily into any specific setting eg. homeless older people and older people in rural and remote and in Indigenous communities. It will be essential to develop services other than acute hospitals for providing for the needs of this group.



7. Quality Health Services for Those Living in the Community

An affordable accessible health care service

Availability of general medical services in particular general practitioners and general practice teams

The services, which are accessed directly by mobile patients, should also be available at home, when the patient is no longer mobile. General practitioners have traditionally provided this service, however increasing workloads and time demands have led to a decline in home visits by general practitioners in recent years. A more coordinated timely response from primary health care providers including general practitioners needs to be available 24 hours a day to avoid unnecessary emergency department presentations, hospital admissions and reliance on medical deputising services for routine care. This will require a change in the way primary health care is practised making better use of all health professionals, especially nurses, working in general practice teams. It will also require a move to preventative health care and wellness models of care. It will need models of care that bring patients to general practitioners as well as facilitating general practice home visits for frail or disabled elderly or at times and locations where public transport is not available. Governments and service providers will need to consider recruitment, retention and adequate financial incentives for providing these services.

Access to community nursing

The need for community nursing will increase as the population ages and as more people choose to stay living in the community. Management of chronic conditions at home will become more common and the need for basic nursing care at home will also grow. Ready access to such care at home will be essential if hospital visits are to be avoided. Community nurses already play a vital role in the provision of such services but it is important that they are adequately funded and easily accessed. Currently, in many states and territories, community nurses are backed up by, or are part of multidisciplinary teams and this model is strongly supported. The clinical service provided by community health services, including services through Extended ACATs, represents an alternative to services that would otherwise be provided in hospitals or residential care. It is generally accepted that community services are less costly than alternative service delivery options and also can have better clinical and social outcomes. It is therefore imperative that this type of service is strongly supported and encouraged to grow in line with the demands of the population. Furthermore community health in each local area has the capacity to support and coordinate the work of other health care providers especially private sector providers. However, with rapidly ageing population these services are going to face enormous pressures as the demand for community support increases.

Access to the full range of essential allied health professional services

Older people will have need for dental care, physiotherapy, podiatry, occupational therapy, speech therapy as well as social workers or counsellors. These allied health services are available to ambulatory older people but rarely are available to those with limited mobility. Home based physiotherapy, occupational therapy, nutrition, speech therapy, podiatry, psychology and counselling may be needed for many older patients to ensure continuity of care. Systems need to be put in place to ensure that home bound patients have access to the same types of services that they are eligible to receive (and need) whether living in residential care, at home or undergoing acute care or rehabilitation. Well-integrated community services programs may in part be able to deliver such services, but there may be scope also for a wider use of home delivered health care services. Innovative ways of delivering such services, including for example using nurses or other health professionals in a wider range of roles, needs research. Primary care coordination must form a component of primary care.

Access to specialist support and advice

Currently access to specialist geriatrician services, psycho-geriatricians or palliative care specialists is limited for those living in the community with diminished mobility or dependent on poor public transport. Access to other specialists is rarely available, except where admitted into acute care. Home visits by specialists are rare to non-existent.

Transport

Patients need to access services. An adequately funded system of transport that gets patients to general practitioners, specialists and allied health professionals or to outpatient services is essential. This needs to be available firstly to ambulatory patients able to travel to services but also to the growing number of mobility-limited people living in the community or in residential aged care facilities.

Box 5. Community geriatricians and the Extended ACAT Model

An effective focus for health service delivery for older people would be to build on and re-integrate the existing sector Geriatric Medicine – ACAT framework and to link this core sector system with divisions of general practice. An additional capacity for effective privately funded geriatric medicine will be essential because of variable and vulnerable funding commitments for public geriatric medicine. The most effective means of delivering this service would be to build on the existing ACATs and role of the divisions of general practice network.

- Most States have Geriatric Medicine Services funded on ACATs boundaries often on a local hospital base. Some States fund Extended ACATs.
- The Australian Government funds 118 general practice divisions (many on the same boundaries as ACATs). The number of solo or small general practice surgeries in each division varies, however this remains the commonest form of general practice.

- A specialist geriatrician with a community focus should be added to each regional Geriatric Medicine – ACAT framework, working with local divisions of general practice. This would provide essential back up to general practitioners and general practice teams and reduce the need for unnecessary access to multiple specialists.

- State, Territory and the Australian Governments should resolve funding boundaries to ensure that this service is available and that it is well integrated with the hospital, residential care, and community services programs and particularly with the local general practitioners and other local health professionals.

- Ensuring that a community geriatrician can also visit those in residential care, undertake periodic patient reviews (especially medication reviews) and work closely with general practitioners for ongoing care will reduce rather than increase overall costs, while at the same time enhancing the health and welfare of the older people that they see.

Provision of care and support services

There are some essential services that must be provided to those living in the community. These must be accessible, affordable and meet the needs of all patients from diverse backgrounds.

Access to continuing nursing management

Generally provided through community health services these must provide post-discharge care, and continuing care, with support programs in: rehabilitation, continence, heart and respiratory failure, dementia nursing and palliative care. Nursing services must be available 24 hours every day for specialised services such as palliative care or hospital in the home type services.

Access to multidisciplinary teams

Teams should include geriatricians, psycho geriatricians, palliative care specialists, general practice teams, pharmacists, physiotherapists, occupational therapists, podiatrists and other primary health care givers.

Day care centres

Day care centres for 'frail elderly' or those with dementia and non-terminal phase palliative care needs are a potential alternative to long-term residential care. Such centres allow carers to continue in the workforce while at the same time being assured that patients will receive necessary care. Such centres need to be integrated with wider health services (through Extended ACATs, community care services, community health centres, day therapy centres or outpatient services) providing access to primary health care providers.

Respite centres and/or opportunity for short-term placement in residential aged care facilities

The use of such centres to give carers a break, to provide for periods of short term intensive rehabilitation or stabilisation will grow and such centres are an essential component of an effective community support.

Community hospice beds

These will need to be adequately staffed to provide for the 24 hour care needs of palliative care patients who are unable to die at home or choose to die in this type of environment.

Carer and home support services

The clinical side of community health should be supplemented by a well-resourced community services component, providing necessary domestic support and personal care. Partnerships with community providers should be established to ensure an integrated service approach. There are some essential components of a home support network that need to be provided in parallel with clinical services. Packages for domestic and personal support need to be expanded to meet growing needs. The packages and or services provided should include essentials such as food, cleaning, and shopping and should also include provision for transportation to appointments and to social activities.

8. A World Class System of Residential Health Care

A world class system of residential health care is required, particularly for those frail or older people with dementia and conditions that render them immobile and unable to care for themselves. Longer stay residentail aged care facility populations are, by their nature, at high risk of (often preventable) illness and injury; and inadequate medical management, rehabilitation, and symptom control as a result of medical conditions. These conditions require residential care-based multidisciplinary health services with specialist inputs. However, people in residential care are currently in receipt of sub-optimal internal health services, as well as having sub-optimal exposure to external health service inputs. This unacceptable state of affairs also inhibits optimum levels of medical, behavioural and palliative health care within residential aged care services. The essential elements of a health framework for those in residential care are outlined below.

Access to quality nursing care

This should include access to sufficient numbers of appropriately trained nursing staff when needed. If admissions to hospital are to be avoided then there should be access to adequately trained nursing staff able to manage acute care needs such as intravenous therapy and injections etc. The range of nursing services should prevent unnecessary or inappropriate hospital visits. It must include access to specialist nursing care for dementia and palliative care etc.

Access to quality personal care

High standards of nutrition, accommodation and personal care and hygiene are essential to quality residential care. When people live in a residential aged care facility it is stressed that the care and services are not just health care nor are they simply basic services such as food cleaning or shelter. People actually live in these facilities and as such their care should extend not just to the basic services and/or health care but should include aspects of daily life that make like meaningful. Diversion therapies and social interaction should be an integral part of the services provided.

Access to quality of life services

The care in residential aged care facilities must not be just about the medicalisation of ageing but must also incorporate the essential services that give quality of life to residents. Communication with others, access to meaningful activities and opportunity to participate as far as possible in daily life are also fundamental components in the provision of quality residential aged care.

Availability of general medical services

Just as for those living in the community, access of residents in residential aged care facilities to general practitioner services is essential, however general practitioner participation in residential aged care facilities has declined sharply. Only 16% of general practitioners visit residential aged care facilities on more than 50 occasions per year (ie. more than one per week). If admissions to acute care facilities are to be avoided, access to appropriate clinical care for residential care patients is essential. Incentives for support of general practitioners to visit residential aged care facilities are needed, including MBS consultation items, which provide incentive for members of the general practice team to visit aged care facilities. Purpose-built consulting rooms within aged care homes, with adequate examination facilities, modern clinical equipment, and access to electronic prescribing, records and billing services, are needed if aged care residents are to get the health care they deserve.

Access to specialist support and advice

Just as for those living in the community, access to specialised services is needed for residents of residential aged care facilities for the management of complex multifactorial geriatric conditions including behavioural disorders and palliative care. Currently access to specialist geriatrician services, psycho-geriatricians or palliative care specialists is limited for most residential aged care facility residents. Access to other specialists is rarely available, except where admitted into acute care. Home visits by specialists are rare to non-existent and where there are community geriatricians or palliative care physicians, funding barriers mean these typically are not available to residents in aged care facilities. An Extended ACATs Model as outlined in Box 5 can also be used for those living in residential aged care facilities.

Access to the full range of essential allied health professional services

Just as for those living in the community, residents in residential aged care facilities have need for dental care, physiotherapy, podiatry, occupational therapy speech therapy as well as social workers or counsellors, while living in residential aged care facilities.

9. The Hospital/Home Interface

Hospitals should be fully integrated with other elements of the health system and will supply services at the interface between acute episodes and return home to provide truly seamless care across the acute/aged care/community care continuum. There is a wide range of potential 'hospital outreach' programs which may provide a seamless interface between care settings. These include, but are not limited to, the services described in Box 6.

The principles of such hospital outreach programs are:

- the service is integrated with the acute hospital system and has access to the expertise of the hospital;
- the service provides a quality of care that is similar to that of a hospital but in a setting that minimises disruption for the person;
- the service is flexible and able to go to the person where appropriate; and
- the service provides a cost effective intermediate service which keeps older people out of hospital and/or care as long as possible.

Box 6. Models for providing support to general practitioners caring for older people in the community or in residential aged care facilities

- General practitioner emergency clinics to support local general practitioners who have older patients living in the community and requiring a complex assessment (often including imaging, blood count, micro-urine and other pathology) that would otherwise be directed to emergency departments. These clinics could provide an emergency department alternative through a 'quick response' clinic for general practitioners, providing acute assessment, investigations, diagnosis and a management plan with necessary community supports and would support, not replace, general practitioners in chronic and complex care.
- A hospital based ambulatory care unit would complement domiciliary based and primary health care services in the home, by providing a hospital site for the ambulatory management of suitable conditions through hospital transport and/or taxi voucher service for patient attendance for intravenous antibiotics, blood transfusions, anticoagulant therapy, investigations and complex dressings. Ambulatory services should not be limited to just hospital services but should connect patients with the full range of community delivered health services. Given the importance of fitness (both in mind and body), ambulatory services, to get older people to health, welfare, fitness or educational activities should also be established.
- Post acute care services provide acute and post acute care outside the confines of the acute hospital. The service should operate 7 days per week with evening and on-call services included. It can provide medical co-management, pre-admission, discharge planning, rehabilitation of older patients with fractures or joint replacement surgery and home based rehabilitation of older people with complex care needs.

- Hospital in the home or residential aged care facilities may be a continuation of inpatient treatment at the residence or avoidance of admission to hospital. It may include, for example, intravenous antibiotics, or management of anticoagulation therapy.

- Rapid outreach programs that would include multidisciplinary squads able to undertake home visits. This type of service is currently largely limited to general practitioners or community health teams but could also be provided by a wider range of health professionals if a different system of payment were developed.

10. Quality Care in Acute Hospitals

Emergency departments

The emergency department is the first point of entry into the acute hospital system for many older people. An essential element of an emergency department system needed to cater for older people is integration of geriatric specialists into routine emergency department activities. Depending on community profile and emergency department activity, this could involve including specialist geriatric trained medical and nursing staff in the emergency department or close integration with specialist geriatric hospital staff through rapid response advisory services. However, this service should be available 24 hours per day. As the population ages, the proportion of 'frail older' people presenting at emergency departments will reach 20 percent or more. In this scenario staff should also have the skills to identify patients with cognitive and mobility disorders and be able to instigate appropriate early management and discharge/transfer procedures.

The Alliance stresses that adequate well-staffed emergency rooms capable of coping with the expected patient load without excessive waiting times or multiple ambulance diversions is a fundamental requirement of world class health care and should in no way be compromised. In the face of an ageing community and expected growth in demand for emergency services, there is an urgent need to plan for these expected emergency department needs.

In-patient care

The AHMAC National Action Plan restricted its focus to areas of interface between the acute care sector and the patient's home environment. However, a comprehensive health care model needs to include consideration of the acute hospital system, which is required to achieve best outcomes for older people. The Alliance therefore stresses that while emergency departments and effective discharge planning are essential, there will also be an ongoing and increasing need for multidisciplinary care of a of 'frail older' people. General practitioners are often the primary care interface between the acute care and community environment and are an integral part of providing seamless care as part of a multidisciplinary team. This will require:

- An adequate (and slowly increasing) number of specialist geriatric beds available to care for a core group of patients who do not reach criteria for initial admission to another specialised service or program, and require the care of a multi-disciplinary aged care team. These should include acute in-patient geriatric units, well resourced and staffed by geriatricians and multidisciplinary teams. Current provision of such units is inadequate for the current population and should be expanded substantially as the population ages. Once established, such units would become a model for education and training for other hospital staff, and provide essential hands on experience.

- An adequate number of beds and services available in disciplines that are essential to the care of 'frail older' people including psychogeriatric services and palliative care.
- Hospital staffing set up to manage patients with age related conditions such as dementia induced wandering, delirium (exacerbated by the hospital environment), continence issues, and communication issues due to combination of sensory loss and cognitive impairment. It will be essential that staff move from the mindset that focuses on a specific organ problem ignoring the complications of age and sometimes relegating the elderly to lower priority. The hospital staff should be capable of assessment and management of medication use, cognition, delirium and acute behaviour disorder and of preventing deconditioning and functional decline. This will require training of ALL acute care staff in general hospitals in the basics of geriatric care. This is expected to best be achieved through education and exposure to best practice in multidisciplinary geriatric units.
- Specialist geriatric advice throughout all parts of the hospital. Because older people will be the majority of patients in hospitals, and many will have some geriatric conditions, there will be a need for specialist geriatric advice throughout all parts of the hospital. This advice requires a geriatric advisory service which would allow consultations to support specialist physicians and surgeons with aged care services for older people with complex care needs through a consultative or shared care model. Specialist medical and surgical care would continue to be provided by the sub-specialty physicians, surgeons, and nursing staff but geriatric teams would provide advice, additional resources, and education in aged care.

Box 7. Options for ensuring geriatric care in acute hospitals

- Acute geriatric medicine units and/or acute care of the elderly units, which provide specialist, interdisciplinary care of older people coordinated by geriatric specialists. These should be well resourced and staffed by multidisciplinary teams including geriatricians.
- Effective liaison between acute geriatric units and other specialists, general practitioners and other health professionals, when needed and particularly prior to patient discharge.
- Admission under specialist physicians on acute roster with geriatrician consultation and subsequent transfer for sub-acute rehabilitation.
- Geriatric rehabilitation units in the acute hospitals.
- Geriatric rehabilitation in a sub-acute hospital on a separate campus.
- Aged care emergency teams in emergency departments.

Rehabilitation and sub-acute care

Access to multi-disciplinary services is essential for rehabilitation care. 'Frail older' patients whether in general wards or geriatric units need access to multi-disciplinary services essential for rehabilitation and/or palliative care. All older hospital patients should have access to physiotherapists and occupational therapists for prevention of deconditioning and for mobilisation and restoration of function, rehabilitation, discharge and pre-discharge home visits. These should not exclude those in the last months of life who have a right to and enhanced quality of life.

Also there should be access to speech pathologists and dieticians (to address nutrition and swallowing) and clinical neuro-psychologists with expertise in assessment and setting up behaviour management programs for demented and delirious patients and with expertise in mental capacity and guardianship.

General practitioners are often the primary care interface between the acute care and community environment and are an integral part of providing seamless care as part of a multidisciplinary team. This role encompasses in particular rehabilitation and sub-acute care after discharge but also being part of multidisciplinary care teams within a hospital environment.

11. Challenges

The model outlined sets up a framework for what will provide quality health care for older people in Australia. This paper outlines strategic health care objective which will meet our stated aim to 'develop a model system of health care for the increasing numbers of older people in Australia, which gives the best care for the older person, in the best setting, using best practice to achieve maximum physical and mental capacity and minimum disability.'

There are serious barriers to the delivery of appropriate health care for older people including:

- separation of responsibilities (particularly between Australian, State and Territory governments) and the development of silos for service types often with inflexibility in health funding programs;
- inadequate integration of health services for older people across community, hospital and residential care settings on a local geographic sector base;
- lack of sub-acute rehabilitation and options for transitional care between settings;
- limited availability of acute and post acute care services delivered at home in the community or residential care setting;
- shortage of community care and community supports;
- shortage or mal-distribution of residential aged care facility beds;
- inadequate development of multidisciplinary and palliative geriatric medicine acute hospital services for frail complex older people in the 'older-old' age group;
- consequent public hospital access block and emergency department overcrowding.

It is recognised that these challenges are small, relative to the potential for scarcity of trained clinical staff such as nurses, general practitioners and specialists, which is expected to intensify in coming years. This important issue is being addressed by the Alliance in other forums and is only briefly acknowledged in this paper.

There are major structural impediments to effective and equitable service delivery to older people in Australia. Governments at all levels need to act urgently to introduce policies to achieve a system of services to which access is determined by the needs of older people, rather than the particular point of contact or service setting in which they may find themselves. It is now acknowledged that current service models, across the three settings, fail to meet the needs of older people who require a level of health care that falls between current community, hospital and residential care provision. This includes components of care variously described as sub-acute rehabilitation/restoration of function, and sub-acute, transitional or interim care. These issues have been addressed by AHMAC, which calls for a more collaborative approach to planning and delivery of services by different government levels.

The final challenge is ensuring adequate funding for health services. The way the health system is funded cannot be divorced from the overall health framework and the range, quality and accessibility of the services provided. The current Australian, State and Territory government divide discourages good use of services since funding source depends upon condition classification rather than patient need. State/Territory funded hospitals have incentive to discharge patients to Australian Government funded residential care facilities, while residential care facilities have an incentive to place ill residents in acute hospital care if additional staffing or care is needed. In an ideal world, there would be a single funding source and these allocation issues would not arise. Both levels of government have an incentive to send people back into the community where care is expected to be provided to people with complex and palliative care needs by voluntary carers or poorly paid workers.

However discussion about who pays or how much are of little value without first considering just what are the services which need to be delivered and who is best to deliver them.

12. Conclusion

The Alliance proposes an integrated framework for health care of older Australians, which addresses the particular needs in the three settings in which they are delivered – in the community, in residential aged care and in hospitals. Services at and across the interface between these settings are given particular attention.

Living in the community

Increasing the proportion of older people living in the community is strongly encouraged but it must be recognised that this will only remain viable if there is easy access to essential health services. This must include 24 hour per day general practice and other primary care services, access to allied health professionals including for those who have limited mobility and arrangements for back up specialist care especially the assistance of specialist geriatricians. Access to a wide range of community health and support services will be essential. Governments need to avoid false economies that limit community based services but increase cost in other areas of the health service. Clinical services provided by community health services represent an alternative to services that would otherwise be provided by hospitals or residential aged care facilities. The temptation that governments will face to control expenditure on these services needs to be balanced against the outcomes of inadequate care, resulting in more costly hospitalisation, premature admission to residential aged care facilities or excessive levels of family/carer burden that will impact on society as a whole.

Residential aged care facilities

Growth in the number of very old people means that additional places in residential aged care facilities will be needed and funding must be available to cater for those who cannot be cared for in the community, especially the very frail or those with special dementia needs. Quality health care requires that those living in residential aged care facilities have equal access to essential health services such as general practitioners, allied health professionals and geriatricians.

Hospital care

The number of 'frail older' people needing acute care will increase as the population ages. Governments must plan for increased numbers of 'frail older' people needing acute health care. Hospitals will need management systems and staff to cater for increased numbers of 'frail aged'. Older people will benefit from appropriate rehabilitation and sub-acute care and adequate provision for these services must be included in health services planning.

Hospital home interface

This is an expanding area of service delivery and options of safely providing services to older people living in the community or in residential aged care facilities should be promoted wherever practical. These services offer scope for avoiding (or shortening) unnecessary hospital stays as well as offering a seamless interface between systems and a genuine continuum of care.

Review terminology

The Alliance also calls for all health planners to review concepts and terminology used in discussing the health of older people and, in particular, to modify the use of population categories, which group together and homogenise older people over 65 years. The health care needs of those in the 65–74 years age group, 'the young old' with less than 10% disabled or dependent, are widely different from the group 85 years and over, the 'very old' age group or 'frail aged', 80% of whom need assistance with some domestic tasks and more than 30% of whom are dependent for aspects of personal care.

Integrating care services

Providing best possible care is not easy and will require contributions from a diverse range of professionals both within the public and private sector. Services must be coordinated and integrated to optimise the use of skilled trained staff and to maximise the health benefit for older Australians.

Multidisciplinary care

Care of the 'frail elderly' requires complex care, often with rapidly changing needs that can best be provided through multidisciplinary teams. Specialist geriatric clinical care is needed and should be accessible to those living in residential aged care facilities or in the community. A model of care needs to be developed that ensures provision of such specialist care and is accessible and well coordinated. The use of Extended ACATs is arguably the most effective model for rapid delivery of such care over the next decade. In addition to geriatric trained nursing staff and a diverse range of allied health care providers, a specialist geriatrician with a community focus should be added to each sector Geriatric Medicine – ACAT framework, to work with local divisions of general practice to support general practitioners and general practice teams in the provision of complex aged care and reduce the need for unnecessary access to multiple specialists. It would also refocus ACATs towards a more effective role in coordinating and providing services.

Efficient and client centred assessment

This minimises the extent to which people are asked more than once for the same information when moving between different parts of the care system and which makes the most efficient and effective use of the skills and knowledge of qualified staff within the respective care systems.

This framework of health care for older Australians is consistent with the seven principles underpinning the AHMAC National Action Plan for Care of Older People. The plan however, provides limited direction in terms of methodologies for service delivery. The Alliance stresses that while it may be easy to develop principles of care, implementation and ensuring adequate funding is more challenging. Discussion about who pays or how much are of little value without first considering just what are the services which need to be delivered and who is best to deliver them.

Appendix One
Roles of Care Providers

General practitioners and general practice teams

General practice is the basic building block of Australia's aged care health services and is an integral component of any strategic health care framework. General practitioners are responsible for much acute episodic care and for most of the management of chronic conditions. General practitioners should also take a leading role in disease prevention and health promotion. Increasingly, multidisciplinary general practice teams are central to the delivery of comprehensive and continuous care and wellness services to older Australians.

General practice nurses are increasingly becoming core members of the general practice team. They provide valuable support to general practitioners in the provision of primary care services to patients. Evidence indicates that nurses working in general practice can improve health outcomes in chronic disease[7], assist in primary-acute integration, better coordinate care and enhance the range of services available in the general practice[8].

General practice nurses are already involved in the provision of a range services to older people including wound management, immunisation and assisting general practitioners with chronic disease management through initiatives such as Comprehensive Medical Assessment, home health assessments, GP Management Plans, Team Care Arrangements, Diabetes Cycles of Care and Asthma 3+ Plans.

As the population ages, general practice teams will increasingly be required to manage chronic and complex conditions. General practice teams need to be adequately trained and supported with access to allied health and community services to assist in the management of complex co-morbidities in older people. This will involve facilitating the establishment of ongoing training programs to ensure general practitioners, nurses in general practice and allied health professionals, have the skills and knowledge needed for management of complex chronic illnesses, supported by robust systems for referral and collaborative care.

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[7] Wagner E, Austin B, Von Korff M, Organizing Care for Patients with Chronic Illness, The Millbank Quarterly, 1996 (74) 511–534

[8] Watts I, Foley E, Hutchinson R, Pascoe T, Whitecross L, Snowden T, General Practice Nursing in Australia, 2004, RACGP/RCNA

General practice teams are more likely than other health professionals (excluding community care workers) to build up an on-going personal relationship with older people and their families/carers and therefore should have a major role in the management of the increasingly 'frail elderly'. In particular, general practice teams should be actively involved in discharge planning and rehabilitation and palliative care programs so that they are kept fully informed of patient needs, particularly after a period of acute hospital care.

If general practitioners are to adequately provide care to older people, there will need to be incentives for general practitioners to handle complex chronic cases. The current fee structure in general practice is having some success in attracting general practitioners to increase their role in the management of chronically ill elderly. Although a number of government initiatives, including the *Strengthening Medicare*, Aged Care GP Panels, General Practice Evaluation Program, Shared Care, Enhanced Primary Care and the Practice Nurse initiative, have gone some way towards addressing this they have not fully resolved the financial disincentive to provide in depth complex aged care. A model where general practice nurses work with general practitioners as part of a general practice team, supported by appropriate MBS consultation items has the potential to improve service delivery to both community and residential aged care settings.

An effective general practice service in Australia will have sufficient general practitioners and there will be practice teams available in all areas including outer suburban and regional areas, available 24 hours a day and the service will be accessible and affordable to all Australians. To be able to adequately coordinate interdisciplinary teams for the management of their patients, general practitioners will need to be financed to attend meetings to discuss and plan for the integrated care of their patients and also to adequately coordinate care for their patients' families/carers. There is a well-recognised shortage in the number of general practitioners especially in rural and outer suburban areas. Overcoming this shortfall will require a range of actions including consideration of innovative models of care (eg. general practice nurses working with the general practitioners as part of a general practice teams), as well as improved training, recruitment, retention and re-entry strategies for older general practitioners.

Accessing specialist support

However general practitioners in solo or small group practices will not be able to access the full range of multidisciplinary services needed or to provide 24 hour a day service and cannot be expected to work alone in the complex care of 'frail older' people. To assist general practitioners to provide complex disease management planning, general practitioners and their patients require improved access to the resources of the multidisciplinary teams, including Extended ACATs. Nurses and other health professionals in these teams provide specialised advice and management for at risk older clients. The model could assist general practitioners access to an Extended ACATs service with adequately resourced intake system, community geriatrician consultations and other essential specialists such as psycho-geriatricians or palliative care specialists (See Box 5).

Equity and effectiveness of service provision for older people require entitlement to access the expertise of geriatricians in settings outside public hospital services. Key initiatives include the following:

1. Training
Increased numbers of geriatricians need to be trained to cater for the expected increase in the number of 'frail aged'.

2. Incentives
If geriatrician training places are to be filled, incentives should be in place to encourage medical practitioners to choose geriatrics as a specialty. In addition appropriate forms of remuneration will be needed to ensure geriatricians are able to undertake the home and community visits which are required of this specialty, given the poor mobility of most of the patients. The augmentation of existing fee for service payments including payments for home visits or visits to residential care facilities, private hospitals and community centres, coupled with new fee structures for core geriatrician activities such as complex cognitive assessments, is likely to prove the most effective means of increasing the number and penetration of trained geriatricians in the medium term.

3. Extended ACATs
The appointment of community geriatricians in association with each ACATs would provide much wider access of older people to the full range of essential community based services. The skills of the whole ACATs team would be used more effectively and in a role that went well beyond the basic task of assessing eligibility for residential care or home support. This model is outlined in Box 5. As with all areas of clinical practice there is currently a shortage of geriatricians, however there are positive signs of growing interest in specialist training places and, if complemented by the use of other well trained clinicians, access to geriatrician specialists may not prove a major barrier to quality care for older people. The cost of such a model would be relatively small and could be off-set by reduced use of other services especially hospital services. It will require a 10-year forward plan if it is to be achieved before the baby boomer generation start becoming seriously old.

In parallel with the increasing need for specialist geriatricians there will be a need for an increase in the number of specialist psycho-geriatricians to cater for the subset of older people with dementia who display severe behavioural disorders and for the projected ageing of people who currently have psychiatric disorders. Access to psycho-geriatricians is currently restricted and many mainstream psychiatrists are unwilling to take on older patients. As is the case for geriatrician access to psycho-geriatricians should not be restricted to hospital only patients. In fact, the need for the services of psycho-geriatricians will be greatest where challenging behaviours will be most disruptive ie. when clients are living in the community or in residential care.

Many terminally ill patients are appropriately cared for by their primary care physicians (mostly general practitioners but also other non-palliative health care specialists) in the community (14–20%) or hospital (>50%). However, these practitioners need to be able to refer patients for specialist services where necessary. For many patients this will be for assessment and periodic review, with

responsibility for ongoing care remaining with the primary health practitioner. For patients with more complex care needs, ongoing care may involve a specialist palliative care service in conjunction with the primary health care service. Guaranteed 24-hour access to support is vital for primary care doctors, the patients and their families or carers. Early 'Active Living' models of care dovetail with care from geriatricians, oncologists and other chronic disease management specialists. See Box 8.

Providing nursing and personal care

The increasingly important role of nurses as part of general practice teams has been discussed above.

Access to generalist nurses will also be essential to treat older people in hospitals, in residential aged care facilities and in community nursing services. For people opting to 'age in place', ready access to community nurses will be essential for age related problems such as wound and medicine management.

A range of specialist nursing services should be available to assist nurses providing care to older people living at home and in residential aged care facilities. Gerontological nurses, dementia care and palliative care nurses should to be included in multidisciplinary teams and need to be available in hospitals, in residential aged care facilities, in community services and in hospital outreach services. Gerontological nurses should be encouraged to take on a wider role either as nurse practitioners or as expert nurses, integrated into general practice teams and while this will partially address shortages in some areas it may further reduce the availability of skilled nurses for general patient care in other sectors. Specialist nurses would also play an important role in developing the knowledge and skills of their generalist nursing colleagues. This is vital for professional development and empowerment, providing quality care and for attracting nurses into aged care.

As with so much of the health workforce, access to skilled nurses is becoming increasingly difficult and there is an urgent need to expand the nursing workforce at all levels from care and support workers through to specialist nurses. As the rest of the world ages, access to a pool of skilled nurses will also become more restricted. Addressing this workforce issue is a priority and requires urgent action by the Australian and State and Territory governments. Action includes increasing places in both the higher and the vocational education sector, improving wages and conditions so that retention rates increase and more nurses are encouraged to return to nursing or increase the hours that they work as nurses.

Personal care services are another essential component of gerontological nursing care. Bathing, dressing, toileting and feeding the 'frail aged' and people with complex care needs require skilled nursing care and/or supervision.

Other personal support services are also an indispensable component of care for many older people, and a skilled workforce is required. Maintaining this workforce will also be a challenge as the demand for support services is very likely to increase.

The role of volunteers and carers is also of very great importance in providing personal care services. The demand on such volunteers and carers is expected to increase rapidly as the number of older people needing care and support increases. Traditionally most of this support has been provided by older women or newly retired men, however as pressure on older people to remain longer in the paid workforce increases, the demands on this volunteer and carer workforce will also increase considerably and will need to be addressed in long term workforce planning.

Access to allied health services

Allied health professionals should be encouraged to visit patients at home and in residential aged care facilities and models of care need to incorporate the right mix of incentives to ensure services are provided. Not all residential aged care facilities provide extensive multidisciplinary care and residents may not get access to physiotherapy, podiatry or other primary health care.

Older people will access an increasing range of clinical services including podiatrists, physiotherapists, occupational therapists, speech therapists, psychologists, nutritionists, dentists, optometrists, pharmacists, pathologists, social workers and counsellors. Most of these services are provided privately and are a crucial component of the health system. However, as people age and become frail, accessing these services will become more difficult. Co-location of services, easy access by public transport and communication between providers will be essential if these services are to meet the demands of an ageing population.

The role of all health professionals needs to be examined to determine what is a sensible contribution to care for the 'frail aged'. Integration with community health services, increased role in patient advocacy or in medications review are all areas where a very wide range of health professionals might expand their role.

Funding the provision of such services is also an issue of some concern. Levels of government subsidy for allied health services are quite limited and private funding of access to these services typical. For those with limited retirement income some funding support to access these services may be needed. Australian, State/Territory and local government and the private sector should all co-operate to ensure these services interact seamlessly and are affordable and accessible to older Australians.

Box 8. Specialist palliative care

These services augment general practice or other specialist care with focused, intermittent, specific input as required. Some examples are listed below.

- Help with assessment and treatment of complex symptoms (physical, psychological, social, cultural and spiritual) experienced by the resident.
- Provide information and advice on such challenging issues as the ethical dilemmas of nutrition and hydration; management of depression and existential issues and many other relevant issues for the resident and their family/carers at the end-of-life.
- Facilitate access to a broadly based interdisciplinary team which often includes: doctors, nurses, physiotherapists, occupational therapists, social workers, clinical pharmacists, dieticians, speech therapists and pastoral care workers.
- Be available to discuss issues with the individual resident and family members.
- Proactive provision of information, advice and education of residential aged care facility staff in evidence-based management of distressing symptoms that may be troubling to the resident or family.
- Assistance in maintaining a sense of therapeutic partnership with residents and their families, especially when there are difficult family relationships or a lot of complex 'unfinished business' exists.
- Facilitate discussions about the goals of care and advance care planning, prognosis, when to recruit the help of other specialists for more effective symptom control or when to admit a terminally ill patient to hospital to further investigate symptoms for more efficacious symptom management and improvement in quality of life for patients and their families/carers, and facilitate this admission in a seamless and non-traumatic manner.
- Provide advice on resources available for bereavement management and facilitate appropriate referrals.
- Early 'active living' models of a palliative approach to care instituted in the last 6–12 months of life allow for integration of a seamless and continuous system of symptom control and advanced care planning that are patient rather than disease focused and are family/carer supportive all the way to the end-of-life. This model of early palliative care intervention can be easily integrated with any patient requested 'life prolonging medical care' and geriatric practice, it provides for the best outcome for patients' quality of life and sets in place arrangements for support of family and carers that continue on seamlessly into the bereavement period.[9]

[9] Guidelines for a Palliative Approach in Residential Aged Care: http://www.health.gov.au/internet/wcms/publishing.nsf/Content/palliativecare-pubs-workf-guide.htm