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STANDING COMMITTEE
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ON AGEING

Our Ref –
Your Ref –

HUNTER HEALTH
Improving Health in the Hunter

30 October 2002

Dr M Kerley
Committee Secretary
Standing Committee on Ageing
House of Representatives
Parliament House
CANBERRA 2600

Dear Dr Kerley

Professor Katherine McGrath has asked me to resend this submission from Hunter Health to you as she has been informed by the Committee Deputy Chair, Ms Jill Hall, that our submission has not been received.

Yours sincerely

Dr John Ward
Director
Aged Care and Rehabilitation Services

Copy to – Ms J Hall, MP

AGED CARE AND REHABILITATION SERVICES

LONG TERM STRATEGIES TO ADDRESS THE AGEING OF THE AUSTRALIAN POPULATION OVER NEXT 40 YEARS

1. Introduction

Over the next 40 years, the number of Australians over age 70 will more than double. This presents a number of challenges with potentially serious impacts on the health care system:

1.1 Falls injuries and hip fractures

If we do not implement proactive measures to reduce the rate of falls injuries and hip fractures, it has been estimated than an additional 800 acute beds and 2,000 nursing home places will be required in New South Wales by the year 2050.

1.2 Dementia

The prevalence of dementia will more than double, placing great strains on families, community health services, Home and Community Care Services (HACC) services and residential aged care facilities.

1.3 Prevalence of disability

If we do not act now to promote healthy ageing, the increasing numbers of people living into the older ages will carry with them high levels of disability, placing stress on all aspects of the health system, including general practice, the Pharmaceutical Benefits Scheme (PBS) system, HACC services, hospital services and aged care facilities. These disabilities will be predominantly related to arthritis, neuro-degenerative diseases (dementia, stroke, Parkinson's disease, etc) and impairments of vision and hearing.

1.4 Depression and loneliness

The prevalence of depression increases with older age and is related to bereavements and other losses, social isolation and neuro-degenerative diseases. This prevalence will increase dramatically unless social changes aimed to reduce isolation and to encourage social participation are pursued.

2. STRATEGIES TO REDUCE THE PREVLENCE OF ILL-HEALTH AND DISABILITY IN OLDER AGE

2.1 Increase Physical Activity Levels

Participation by older people in regular physical activity would have many benefits, including:

- improved balance, reducing falls injuries
- increased bone strength, reducing falls related fractures
- improved diabetes, blood pressure and lipid control
- reduced loneliness and depression.

The strategies required to increase physical activity levels, include:

- including physical activity advice in retirement planning
- Local Government ensuring the availability of accessible and safe facilities for physical activity of older people, including:
    - safe walking tracks (with toilets)
    - cycle paths
    - heated pools
- clubs providing facilities for physical activity by older people, including:
    - exercise groups
    - supervised strength training
    - dance groups
    - aquarobics.

To facilitate the promotion of safe physical activity by older people, special funds need to be made available for:

- the training and accreditation of fitness leaders
- home-based exercise supervision for isolated older people.

2.2 Osteoporosis Prevention

A national program to increase bone strength in older age should be developed and funded, to include:

- increasing physical activity and calcium intake in childhood and adolescence
- minimising cigarette smoking and excessive alcohol intake
- introducing a MBS Item for bone densitometry at:
    - peri-menopausal age
    - age 60
- educating health professionals to protect bone strength when prescribing corticosteroids
- educating health professionals to refer all older people suffering minimal trauma fractures for bone densitometry
- promotion of physical activity in older age, as outlined in Strategy 1 above.

2.3 Life-Long Learning

The availability of life-long learning, through accessible educational facilities/programs, should be a national goal. Its benefits include:

- the promotion of tolerance and civil society
- delaying the onset and rate of progress of dementia
- reduction of social isolation, loneliness and depression.

Community education programs for older adults should be made accessible in terms of physical location and cost. The TAFE, Community College, WEA and other education providers for older people should be supported as part of a major national goal to promote civil society and to prevent disability.

Models, such as the University of the Third Age and the Coast Centre for Seniors at Prince Henry Hospital, Sydney, should be supported by the provision of suitable physical facilities at no or low cost.

2.4 Dementia Care

The current and forthcoming endemic of chronic neuro-degenerative diseases, particularly dementia, are placing an unacceptable burden on families and carers because of the inadequacy of funding. This, in turn, is related to the confusion between levels of government and departments within the same level as to responsibility for dementia.

Most funding for dementia services has come from the Commonwealth Department of Health and Ageing but it has been allocated through the Home and Community care (HACC) program, meaning that services in the community are fragmented and not provided according to any co-ordinated plan. An adequate community service for dementia must include:

- diagnosis and assessment
- education and information
- carer support
- assessment and management of difficult behaviours
- residential care

and must be provided in accordance with a community plan that avoids duplications and gaps.

At the moment we have National and New South Wales Policies for dementia but the two do not seem integrated to an extent that is reflected in co-ordinated funding for adequate community programs.

2.5 Home and Community Care (HACC) Program

This joint Commonwealth and State funded program has provided unprecedented funds into community services over the last 20 years. Two problems have now arisen:

2.5.1 The HACC program is excessively fragmented and unco-ordinated to the extent that almost no one in the community understands the various service providers. The lack of any co-ordinated referral or assessment system makes it impossible to set service priorities to ensure that the most needy people in the community are receiving services. It has also allowed some people to access services from multiple providers up to levels of $3,000.00 per week or more.

2.5.2 The lack of other services for younger people with disabilities has forced them onto the HACC program. Their need for large amounts of personal care support to stay at home and the long-term nature of their state of disability has led to the situation where the bulk of personal care hours of organisations like Home Care Service of New South Wales now go to younger people with disabilities. This has made it difficult for older people to access personal care, forcing them to turn to expensive private agencies.

In addition, the encouragement given to older people with high levels of disability to remain at home, has further strained HACC programs, such as Home Care, that were not designed to service large numbers of such people.

A national solution to the provision of community support services to high need clients is urgently required so that Home Care Service can provide for the needs of frail older people, the majority of whom need only small amounts of service to remain in their own home. The national release of

Extended Aged Care at Home (EACH) packages would be one way to provide community care for high need older people.

2.6 Residential Aged Care

There are several issues, with regard to residential aged care, that need addressing urgently:

2.6.1 The inadequacy of RCS funding to allow facilities to provide high quality dementia care.

The care of people with dementia, particularly those with behavioural difficulties, is complex and demanding. High levels of skill are required, necessitating considerable staff education, given that most staff in aged care facilities are untrained. Modern dementia care, is person-centred, utilising strategies such as Dementia Care Mapping and non-pharmacological therapies.

Reasonable dementia care, particularly in units prepared to manage people with challenging behaviours (20%-50% of people with dementia) is not possible with the staffing levels provided by RCS funding. Staffing supplementation for facilities prepared to care for such people is mandatory.

2.6.2 The need for supportive housing.

Over the last 20 years the level of dependency and dementia of residents in both nursing homes and hostels has risen steadily. Most residents in hostels are now quite elderly or have some degree of dementia.

This makes the hostel environment an unattractive one for mentally alert older people. These people are now 'forced' to remain at home even if they are socially isolated, lonely and frightened.

Independent living units in a retirement village will meet the needs of some of those more independent people but they are expensive and only available for people able to sell a reasonably valuable home. They also often do not resolve the loneliness and anxiety of living alone.

Supportive housing, along the lines of those developed by the Abbeyfield Society, would meet the needs of the more independent older person who finds living alone unpleasant. It would also meet the needs of some younger disabled people in the age group of 50 to 70.

2.6.3 Medical care in large aged care facilities.

General practitioners do not find aged care facilities an attractive environment in which to work. The needs of the residents are complex and time-consuming, remuneration is relatively poor for the time required and the environment of the aged care facilities is not designed to meet the needs of general practitioners. Small nursing homes and nursing homes in areas with high general practitioner densities, can attract adequate numbers of appropriately skilled general practitioners but this is difficult, or often impossible, in large aged care facilities, especially those in areas of general practitioner shortage.

One approach being successfully trialed at Allandale Aged Care Facility, Cessnock, is the employment of a full-time primary care nurse and a half-time general practitioner. Unfortunately, there is no RCS funding to cover the salary of the primary care nurse.

In addition, most general practitioners prepared to accept such appointments, are not likely to be vocationally registered. Non-vocationally registered payments for work in aged care facilities is very low – about 50% of the vocationally registered remuneration. A Level B consultation (up to 25 minutes, involving examination) receives a direct billing return of $14.20. No doctor will remain in this type of employment for such remuneration, especially when the environment does not facilitate efficient service.

2.6.4 Guidelines for allocation of aged care places.

Aged care places are allocated according to a target ratio based on the population over age 70. This is not a relevant age group on which to base the increasing demand for aged care facilities.

The majority of people over age 70 in the community are between the ages of 70 and 80. On the other hand, 70% of people in aged care facilities are over 80.

The rate of growth of the 80 plus population is currently about twice that of the 70 plus population. This means that the community demand for aged care facilities is growing much faster than the increased allocation, even despite the increasing trend to remain in the community with support services.

2.6.5 Accommodation for younger people requiring high level care.

The absence of other suitable accommodation for younger people with disabilities has forced them into aged care facilities if they require institutional care. The inappropriateness of this is now generally accepted but alternative accommodation is not available.

The reluctance of the Commonwealth Department of Health and Ageing to approve the admission of younger people into aged care facilities and the lack of alternatives, either domiciliary care or institutional care, means that many remain unnecessarily in acute or rehabilitation hospitals blocking beds required for more appropriate needs.

A Commonwealth-State program to provide high level care for younger people with severe disabilities is required urgently.