Submission 160

Parliament of Australia
House of Representatives Standing Committee on Ageing

Inquiry into long-term strategies to address the ageing of the Australian population over the next 40 years

Submission by NSW Health

June 2003

Summary

In common with all other developed countries, older people are major users of the NSW health care system. Their usage will continue to have a major impact as the baby boomers age. Older people 75 years and over will increase from 6.1181M in 2001 to 7.098M in 2026. The peak growth of those people aged over 85 years will occur a decade later.

The NSW Chief Health Officer's Report 2002 indicates that there has been a life expectancy gain of 3.3 years for males and 2.9 years for females between 1985 and 2000. Males born last year will live on average to 77.2 years and females to 82.2 years.

Generally, we will see an increasing proportion of the population living a long time, they will be healthier, ageing well and continue to live in our community. At the same time we will also see an increase in neuro-degenerative diseases leaving some older people frailer, much slower, with greater loss of balance, vision and memory.

Supporting the theory of "compression of morbidity[1]" it is expected that there will be intensive use of health services during the last year of life by a factor of about six times those of the general population of the same age.

Obtaining the right balance in service delivery to ensure healthy people remain independent, living at home with minimal support and those more vulnerable older people with chronic and complex needs get the specialised services they require, is a significant challenge and cannot only be addressed through health service improvements.

Thus challenge demands a more appropriate response from the Commonwealth on issues such as demarcation of Commonwealth/State responsibility and effective integration of the health and aged care system and the necessary flexibility to adapt residential aged and community care service models to support the growing needs of the older community.

At any one time, in NSW alone, public hospitals are accommodating up to 800 older people waiting for residential aged care and a significant number of older people waiting for Commonwealth funded community care. NSW Health estimates this costs the public hospital system $87.3M per annum including the cost for those older people for whom the hospital has become a de-facto nursing home.

Factors such as an older person waiting in a public hospital for an average of 27 days for residential aged care and the cost of a hospital stay under these circumstances being double that of aged residential care has put further strain on the NSW health system. the Commonwealth has to support more significant reforms than it has been prepared to do to date.

NSW Health has called for the Commonwealth to fund interim and transitional care solutions for older people waiting inappropriately in hospital for aged care services.

[1] The theory is increasing years of life may not lead to a corresponding rise in years of poor health and may even reduce the time between failing morbidity and death (Fries J (1980) *Aging, Natural Death and the Compression of Morbidity* New England Journal of Medicine 303: 130-135)

Transitional care needs to be flexibly funded so that the interim care offered by public hospitals reflects individual circumstances as older people wait for the appropriate community or residential aged care service.

In NSW there are about 49,000 beds operating in aged care homes to provide care to elderly residents. This is less than the number operating last year (about 51,000) and is not enough to meet demand. Compounding the problem is that many beds although approved by the Commonwealth for funding remain non operational for a considerable length of time.

The Commonwealth should not only work on reducing the lag time, which is estimated to be a loss of $147 million of aged care subsidies for the older people of NSW, but also change the measure of need (70 years and over) that determines the number of residential aged care places available. For example, persons 85 and over currently occupies 52% of residential care places and is projected to grow to 80% by 2021.

The demand for public hospital services will increase with the increase in the number of older people continuing to live in the community with chronic and complex needs. As a result the Commonwealth has to address the need for proper/adequate indexation of grants delivered to the States and Territories so that they can enhance community aged care services.

In terms of the *burden of disease* – dementia, a measure reflecting both mortality and disability data, is projected to become in 2016 the leading cause of disease burden in women (all ages) and the fifth highest in men (all ages).

Addressing dementia care and support services are central to health and aged care service systems.

It is, therefore, disappointing to see that the Commonwealth has made a decision not develop a second national dementia plan.

The division of responsibility between levels of government for health and aged care services is at the forefront and a major impediment to reform of service delivery. Most recently the *Productivity Commission Submission to the Review of Pricing Arrangements in Residential Aged Care* (June 2003) reiterated that this division results in incentives to cost shift, create gaps in care and poor coordination of planning of residential and community care and lack of integration across programs.

To date the Commonwealth has refused to address this issue. For example, the Commonwealth has not used the current Australian Health Care Agreement negotiations to bridge the gaps between health and community care services or to progress significant reforms that would have ensured better outcomes for older people.

Similarly, the Commonwealth may argue that its recently released *New Strategy for Community Care* is working towards partially address program boundary issues.

However, NSW Health does not believe that this Commonwealth response has gone far enough.

Introduction

The Parliament of Australia House of Representatives Standing Committee on Ageing terms of reference provides an opportunity to comment on a broad range of ageing issues. However, the purpose of this submission is firstly, to outline the most significant medium to long term challenges facing the Commonwealth that, if left ignored, will add to the fiscal pressures already looming alongside the effects of an aging population and shift responsibility to the States and Territories without appropriate funds. Its second purpose is to highlight recent NSW health system reforms and initiatives.

Transitional care

A key factor in ensuring older people maintain optimal health outcomes following an acute stay in hospital is the availability of a range of non acute services including community services, transitional care and residential aged care.

While there may be considerable uncertainty associated with projecting long-term future demand for residential and community aged care, at the moment demand is outstripping supply.

In NSW alone, at any one time 800 older people are waiting in public hospitals for residential aged care and an estimated 150 are waiting for Commonwealth funded community care. The average length of stay in NSW public hospitals for those older people needing residential aged care is 27 days compared to the average length of stay for an acute episode of 3.31 days. This is particularly noticeable in rural NSW, where public hospitals are accommodating a significant number of older people should be living at home or in residential aged care facilities.

The cost to the hospital system of the delay has been highlighted in the recent Productivity Commission report[2] which estimated that of a bed day in a hospital is double that a bed day in an aged residential care facility.

NSW Health estimates that it costs a total of $87.3M per annum to care for these older people while they wait for aged care, including the cost for those older people for whom the hospital has become a de-facto nursing home.

The inappropriately waits undermines an older persons confidence, increases their dependency, increases their chances of contracting hospital acquired infections and will result in deterioration of their functioning and cognitive ability. The effect on the hospital system is increase delays for other patients getting through the hospital system, increase risk of cancellation of elective surgery, increase waiting times for admissions and inappropriate use of acute care resources and expertise.

NSW has repeatedly asked the Commonwealth for permanent, interim and transitional care solutions for older people waiting for aged care services. Flexible health and aged care funding and service arrangements at the acute-aged care interface have been shown to work to provide better and more efficient outcomes for older people.

[2] Productivity Commission (June 2003) page 55

A model of transitional care trialled at Newcastle hospital with Commonwealth and State funding found that, compared to hospital patients, those in transitional care:

- improved their functional status;
- were placed in a facility of their choice;
- required a lower level of residential care than initially anticipated;
- were more likely to be discharged home; and
- were less likely to die.

In spite of these findings, the Commonwealth insists on trialling the same service concept over and over to postpone making a real commitment.

Rather than seeking some yet to be discovered innovation that would sweep large numbers of older people waiting for aged care out of hospitals, the Commonwealth needs to work with state jurisdictions on short term reforms that provide flexible *transitional care* for older people and longer term strategic reforms that allow for more effective roles and responsibilities for the States and Federal Government in the delivery of health and aged care services.

It is particularly disappointing that the Australian Health Care Agreement negotiations were not used by the Commonwealth to support health and aged care system reforms that would ensure better service outcomes for older people.

The Commonwealth may argue that the offer of $253 million nationally over 5 years, under the Australian Health Care Agreement (AHCA), is about working towards better provision of step-down and rehabilitative care services. However this is not new money nor is it for recurrent service provision. Nor is it being offered in the context of reform that bridges the gaps between health and community care services.

The Commonwealth has ignored the fact that the cause of older people waiting inappropriately in public hospitals is because of a lack of Commonwealth aged care services not hospital beds. A national survey found that "patients recommended for another form of hospital based care flow through the system quicker than patients recommended for residential aged care".

The Commonwealth has also ignored the calls from States and Territories and experts in aged care for flexible aged care funding to provide a better transition from hospital to community and residential aged care services.

Recommendation

The Commonwealth supports the development of transitional care with the intent of maximising older people's return to the community and the appropriate provision of this type of care across Australia.

Residential aged care places operational and non-operational places

In NSW there are about 49,000 beds operating in aged care homes to provide care to elderly residents. This is less than the number operating last year (about 51,000) and is not enough to meet the needs of NSW's older community.

There continues to be a serious lag between the time the Commonwealth approves residential aged care beds and when they become operational.

According to the Commonwealth's planning ratios for NSW, at December 2002 an estimated 7,209 (12%) residential aged care places were allocated but not operating.

This is a loss of $147 million per year in Commonwealth aged care subsidies for the older people of NSW.

Compounding the problem, is the significant slow down in hostel bed turnovers. Figures indicate that in 1996-97 the yield turnover was an estimated 30% compared to 18%[3] in 2002.

The Commonwealth has tried to work with the aged care industry to increase the number of operating age care places. But these places are not coming on line fast enough and the Commonwealth is not prepared to discuss alternative funding and service options even though its benchmarks are not being met.

At the same time, there is a growing demand for aged care services. Assessments for entry into aged care have increased from 59,965 in 1999-2000 to 64,457 in 2001-02. And the time spent waiting for assessments in metropolitan areas has increased.

Areas such as Central Coast, Illawarra and South Western Sydney are seeing a significant gap between operational and non operational beds with over 500 residential places still not operating.

As a result Area Health Services are having to come up with expensive, stop-gap measures to maintain patient flow during periods of high demand for acute care. Winter is a particularly difficult time as the demand for aged care placement increases and a significant number of patients experience delays in transferring from acute facilities to aged care homes.

Last winter, Commonwealth inflexibility meant that it would not support a plan to operate approximately 150 interim residential aged places in metropolitan Sydney for six months to provide appropriate accommodation and care for older people in public hospital who were waiting for residential aged care.

Aged Residential and Community Care funding

Further compounding the problem is the Commonwealth Department of Health and Ageing standard for "age" in the planning formula for residential aged care and Community Aged Care Packages (CACP). The Commonwealth uses a planning

[3] Source: *Informing Policy And Service Development At The Interface Between Acute And Aged Care*", Australian Health Review, Anna Howe, Vol 25 No 6 2002

indicator aged 70 years even though people aged 85 years and over take up 52% of residential care places with projected growth to 80% by 2021.

The Commonwealth is looking more towards community care as a preferred option to residential aged care demonstrated by its rapid increases in CACP.

Providing services that maintain older people in the community is supported. However the due factors of the inadequacy of funding provided under CACP and the expectation that States will play a greater (as yet unfounded) role in community aged care services and be able to meet the increase demand for public hospital services generated by older people remaining in the community has not been adequately addressed in the current Commonwealth funding to the States. These problems will result in a major cost shift to States.

Recommendation

The Commonwealth

- meets residential aged care benchmarks and use flexibilities associated with non-operational places to support community based care and transitional care.
- Reviews its planning benchmarks and formulas in consultation with States and Territories

More flexible community and residential aged care

Growth in community care is important to the future of ageing in Australia: encouraging independent living has been and should continue to be a major goal for aged care policy.

However this cannot occur at the expense of growth in the residential aged care sector. If it does, then the cost of community care will rise dramatically in order to meet the high support needs of people ageing at home and there will be continued blockages in acute care beds due to inappropriate utilization by older people.

While there has been some growth in programs such as the Home and Community Care Program and the Commonwealth Aged Care Packages, further growth and flexibility in funding is required if we are to prevent the premature movement of older people into the less preferred and sometimes more costly option of institutional care.

Recently the Commonwealth increased the use of *flexible care arrangements* provided for under the *Aged Care Act (Act) 1997* including the funding of Multipurpose Services (MPS), Extended Aged Care at Home (EACH) and Innovative Pool Places (IPP).

In 1996 there were an estimated 400 flexible places increasing to 2,063 by June 2001 [4]. In 2002/03 with two rounds of *Innovative Pool Places* and the recent introduction of the *Retirement Villages Care Pilots* a further 1,200 places were released.

[4] Report on the operations of the Aged Care Act 1997 1 July 01-30 June 02, page 11

Anecdotal evidence suggests that initiatives such as EACH, have gone some way to supporting older people with a very high care to remain at home. However, need is currently outstripping supply. Other initiatives such as the IPP, unfortunately is trapped by the funding rules of the Commonwealth *Aged Care Act 1997,* thereby preventing any real flexibility in the delivery of services that support people following an acute episode in hospital.

The MPS initiative developed to improve access for older people living in rural and remote areas to aged care including residential aged care services has been impeded by the lack of Commonwealth capital funding to build and maintain these purpose build centres, leaving State governments solely accountable for renovating or rebuilding deteriorating infrastructure.

There are other small-scale initiatives/pilots being developed to fill service gaps created by the lack of capacity in existing community care programs or at times, to pay premium prices to gain priority access. Rather then paying this premium or developing discrete initiatives the Commonwealth would be better off to use new funds to expand existing programs and services.

Recommendation

The Commonwealth

- supports flexible use of some resources from residential care and community packages to support aged care and intermediate care in non-traditional settings.
- identifies new funds to expand the range and volume of existing community care programs.

Older people with more complex and special needs

In terms of the *burden of disease* – a measure reflecting both mortality and disability data – dementia was the third highest cause of disease burden among older Australian women and the fifth highest in men in 1996. In 2016, dementia is projected to become the leading cause of disease burden in women (all ages) and the fifth highest in men (all ages). The number of people with dementia in NSW is expected to increase from an estimated 54,720 in 2001 to 91,200 in 2020

Dementia care and support services are central to health and aged care service systems, and the increasing prevalence of dementia will impact on government-funded health, aged and community care services.

Both the Commonwealth and States have a role in funding dementia support and there are a number of boundary issues that impact on continuity of care and access to services.

The Commonwealth has provided funding for special services, such as Psycho-Geriatric Units (PGU) and dementia specific places in residential aged care. However, the funding and services provided are limited and Commonwealth funding parameters

prevent initiatives such as the PGU from being integrated into the broader dementia care system.

The decision not to develop a second national dementia plan to follow the *National Action Plan on Dementia Care 1992-1997* has demonstrated the Commonwealth lack of commitment to a coordinated State-Commonwealth approach to dementia care.

Another growing health care issue is the increasing number of older people with dementia and/or mental illness with complex behavioural disturbance and older people suffering from depression.

Epidemiological evidence indicates that there is a fourfold increase in the death rate for individuals over the age of 55 with a major depressive disorder. Suicide rates are greater in elderly men than in the general population. There is also an emerging cohort of older people who have had a lifelong mental illness, who develop health problems associated with ageing.

The cognitive impairments associated with dementia are commonly accompanied by deterioration in emotional control, social behaviour or motivation, often referred to as 'Behavioural and Psychological Symptoms of Dementia' (BPSD). Prevalence estimates for BPSD vary widely, however some evidence suggests dementia is complicated by behavioural/psychiatric symptoms in over 90% of cases during the course of the disease (Final Report of the Select Committee for Mental Health, December 2002, p.204).

The lack of support and accommodation options for this group, their difficulties in accessing residential aged care facilities and specialist mental health facilities and services, and the lack of coordination between key services and case management services to ensure continuity of care is a major concern.

Recommendation

The Commonwealth

- develops a national dementia strategy that provides for a coordinated approach to dementia policy, planning and research, workforce development and training, particularly with the Divisions of General Practice to address the lack of GP involvement in the medical care of people with dementia in aged care facilities;
- ensures adequate funding, staffing and design, in residential aged care facilities, and ongoing education and training initiatives for the residential aged care workforce.
- works with State Governments to develop funding and service provision arrangements for:
  - specialist residential facilities for older people with dementia and/or mental health problems and severe behavioural disturbances
  - increase capacity to provide consultation/liaison to residential aged care facilities, and
  - increase capacity to manage older people with behavioural disturbance in the community.

Other aged related demands on the health system

The *Intergenerational Report* suggests that health spending will increase mainly through rises in the cost of the Pharmaceutical Benefits Scheme and the impact of new technologies.

However, the Report remains silent on the increased demand for and cost of health care services such as acute, sub acute and primary health care. There is an apparent assumption that the present level of health service delivery for older people is adequate, in that projections for the future are based on existing expenditure with no consideration of unmet need.

Consider a single demographic change in the health status of older people, such as loss of mobility leading to falls (this is currently the top diagnosis for older people entering acute care). Over the next 50 years resource requirements are expected to double if there are no changes in the rate, severity or treatment of falls. This will place increased pressure on the health system in an area that is already creating significant demand for treatment and preventative services.

Major advances in medical technology have resulted in the ability to effectively treat a significantly wider range of illnesses and disease processes. As new technologies are refined and become more specialised an increasing amount of health funding will be required to purchase, maintain and replace major equipment items. Consumer driven demand will also influence the uptake of emerging technologies.

The ability of a health system to meet these needs and keep pace with science and technology is a measure of its quality. State public hospital expenditure on these costs has grown at an annual average rate of 3 percent. Overall State health expenditure (public hospitals, mental health, public health, community health and residential aged care facilities) has grown at a similar rate.

The last Australian Health Care Agreement (AHCA) contained indexation of 2.1 percent to account for growth in non-demographic pressures on demand.

The *Intergenerational Report* reviewed the future growth in Commonwealth-funded health expenditure and projected a real (adjusted for inflation) growth rate for factors unrelated to demographics of 2.6 per cent per annum over the next four decades.

However even after this assessment, the Commonwealth has reduced the growth rate for this factor for the 2003-08 AHCA to 1.7% and applied it to the component of the AHCA grants meant for patients admitted to hospital wards (75% of the grant). Therefore growth in the costs of technology, for instance, for patients treated in settings such as emergency departments went unfunded by the Commonwealth.

This is an outmoded arrangement. Increases in non-demographic costs do and will affect services for patients treated outside wards.

Recommendation

The Commonwealth applies a growth rate for non-demographic costs of 2.6 percent to the entire AHCA grant.

Demarcation of governments' role and function in health and aged care programs and services

Separating health and aged care policy and the responsibilities of different levels of government and boundaries between different programs, has acted as a barrier to coordinated and effective planning and a holistic, potentially cost-effective approach to service delivery.

Overcoming boundary issues is further complicated by concerns of 'cost shifting' between levels of government or a poor fit of programs to clients. Rather than a program fulfilling the client's requirements, clients rely on funding from several sources (such as Community Aged Care Packages and Community Nursing) to cover their care needs, in the community. In NSW, there are currently some 20 programs or initiatives in the community care system, rather then a streamlined and integrated system. Interagency approaches, engaging agencies in cooperative and complementary service provision and streamlining funding could address these issues.

The greatest impact of ineffective links and lack of integration of services and programs is on the primary health care and community care sectors. Responsibility for primary health care and community care crosses boundaries between health and aged care services, between levels of government, and between government-funded programs.

The Commonwealth may argue that its recent release of the *New Strategy for Community Care* partially addresses program boundary issues.

While NSW Health supports the principles of integration and reduction of duplication offered through this review, the Commonwealth reform has limited coverage. For example, there are no links with the community care system (defined as programs within the Minister for Ageing's portfolio) to the health care, residential and supported accommodation systems. Furthermore, the Commonwealth has made it quite clear that it will not consider consolidating funding streams for community care, or administration to one level of government or implement reforms that would mean broad banding programs.

The recent Productivity Commission submission says administrative reforms are essential if we are to obtain any real gains in planning and delivery of services.

Recommendation

The Commonwealth

- supports the establishment of a joint planning mechanism for all services for older people covering acute, transition care (including rehabilitation and step-down) community and residential care.
- supports pooling of Federal, State and Territory money for new programs that use services and professions that span Federal, State and Territory responsibilities.

Workforce Issues

By 2021, a lower dependency ratio and a probable increase in numbers in full time education will lead to stress on many occupations. Since there will be greater health activity and expenditure as a proportion of GDP, the health professions are likely to be under greater pressure than other sectors of the economy.

In consequence, the workforce implications are immense. New skills will be required especially for social support and in-home therapy. Discussions with educational authorities on training sufficient people with those skills need to take effect at an early date given the long time lags for those skills to be effectively secured in the workforce. The proportion of the workforce in some health professions is concentrated towards older practitioners who will have retired by 2021. The percentage of practitioners aged 45 and over in 2001 was 61.8% (general practitioners), 54.5% (pharmacists), 42.2% (registered nurses), 54.9% (psychologists) and 49.0% (dentists). The situation for general practitioners, registered nurses and pharmacists would appear to be most urgent given the probability of increasing call on these professions.

Responsibility for education of a workforce able to supply expert aged care services in a flexible way rests with the Commonwealth.

NSW Health is improving services for older people

NSW health system has been focusing on the needs of older people through its preventative strategies (such as fall provision programs) and refocusing the public hospitals so an older person's journey through the hospital is more appropriate and effective. Since 1998 NSW has committed at least an additional $90M to aged care service delivery.

Resources have also been identified to prevent admission and to improve access to health care following an acute health episode. Some highlights include:

- *Multi-disciplinary teams in emergency.* In response to 8% annual increase in attendance by patients over the age of 80 years at emergency departments, with some metropolitan public hospital treating more than 170 patients over the age of 80 years on a daily basis the NSW Government establishment 36 Aged Care Services Emergency Teams in Emergency Department of public hospitals at an additional cost of $5.5 million per annum. Research shows that this initiative has the potential to reduce admissions for older people by 17%.

- *Telehealth facilities* to support the provision of both secondary and tertiary services across a wide geographical area. This service allows older patients to access

services closer to home thereby reducing their need to travel to major metropolitan facilities. There may also be a reduced demand for the provision of in-patient beds.

- *NSW dementia strategy.* $11.043 million has been allocated over 4 years to implement the 2001-2006 NSW dementia strategy jointly sponsored by NSW Health and the Department of Ageing, Disability and Home Care. This strategy represents a planned response at the State level to the expected increase in the prevalence of dementia over the next 5 years. $800,000 per annum has been allocated to specialist dementia nursing positions to improve acute hospital care for people with dementia

- *Funding for capital works.* Since the mid 1990s, $230M has also been committed for capital works to increase access to residential care, particularly for those living in rural and remote area.

- *Falls prevention strategy* following a study which conservatively estimated fall injuries among older people in NSW costs the health system $325 million per annum with fall injury set to escalate by more than 5 times in the next 8 years, the NSW government released $325,000 over three years to develop fall prevention strategies such as home safety checklist, guidelines for health staff, Fall Injury Prevention Program targeting ten rural AHS.

- *A Care of Older People Committee* has been recently established to implement other report recommendations and to integrate developing policy and initiatives to ensure that NSW Health improves the care it provides for older people. The Committee will be co-chaired by Ms Wendy McCarthy AO and Dr Jeff Rowland and includes Commonwealth representation. This Committee will develop a comprehensive work program that will examine and implement health care reforms that will result in better outcomes for vulnerable older people who access the health and associated care system.

- *Research and development* to inform the heath care needs of older people a total of $1 million has been allocated over 5 years to establish an academic chair to conduct research into geriatric medicine. A further $600,000 over 3 years has been allocated to the Centre for Education and Research on Ageing to research neuro-degenerative disorders which in an ageing population are most likely to cause disability, dependency and carer stress.

- *Chronic and Complex Care.* Through the Government Action Plan, at a total cost of $45m over 3 years is being spent on new service models which
  - over 16,000 patients with cardiovascular disease, respiratory illness, and cancer accessing 60 local programs across NSW have benefited;
  - 12,000 patients were provided 24 Hour telephone service; and
  - an anticipated 30,000 patient within 12 months will be able to use a single point of reference to obtain their medical history

Recommendation

The Standing Committee notes that NSW Health will:

- work on improving care pathways for older people moving through the health

and aged care system, with a focus on joint venturing;

- implement initiatives to facilitate and encourage sharing of assessment information across professions to deliver more effective recovery and rehabilitation process; and
- implement initiatives to improve primary health care services, particularly general practice, to reduce inappropriate presentations and admissions into acute hospitals from the community and residential aged care facilities.