SUBMISSION ~ DR MAHAJANI

(1)

Submission No. 181

History

My input to the committee will be based on my experience of working with age care services in NT for last 19 years that is since 1985. I have worked as a geriatrician in assessment team in NT from 1985 Ours being one of the first five teams started. It has always been different from other ACATS in a sense we were based in community verses the hospital based ACATS as in many other cities.

Emphasis was given to do multidisciplinary assessments with an aim of keeping people in community as long as possible. This noble goal was helped as we had few residential places available compared to the larger states and provided the challenge to keep people in community We were able to identify many services needed to keep people in community and subsequently were successful in getting these services through HAAC funding. As most of these services were co-located with ACAT to start with the working relationship between the services and ACATS has been very congenial.

Present situation

Work Load

At present the team consists of a 5 and half position with an addition of a locum nursing position for a year. The work load has increased many folds due to 1) **increased No. of referrals from eg 642 in 2002 compared to 498 in 2001 2)** The ACATS are required to do assessments for increasing No. of residential places ,care packages and nursing home packages. Geriatrician's position is half time only and the demand s of the job is much more than the time allows. No. of people with dementia have increased many folds The nature of dementia is complex in NT as the problem is multi faceted; alcohol and trauma adding to the other common issues. The need for diagnosing and treating dementia has eroded more in the available time.

The **profile** of the community has changed from the inception. Previously there was more demand on the male beds as there were many single men living a fast and hard life who were getting older and disabled now the profile looks more like other cities with people in their late 70 with dominance of female population. The no. of people presenting with dementia has increased greatly.

The **population** of older people in NT has increased due to people wanting to retire in Darwin. Other reason for the increased no. is older people migrating to Darwin from other states. To join their younger relatives. As the services in southern states get difficult to access the temptation to relocate the relatives to Darwin increases and often the relocation difficulties are not given enough considerations.

The plight of Aboriginal health

The situation of older aboriginal people is difficult and complex. Due to limited resources, funds and access to remote communities the assessments are not done by the multidisciplinary team having experience in age care. The information is gathered from the local expertise and assessments are based on this information. The problems in the bush are very different from the presentations in city. The disease load in aboriginal population is high

with many people having high blood pressure ,diabetes and renal problems and respiratory problems co-existing at early age and thus placing high demands on the health care. Gravity of these illnesses some how lessens the need for the care of older people and changes the focus of health Dept. from chronic care to acute care.

Ready or not, problems of age care are here now and most of the services needed to help elderly are getting stretched. There is a long waiting period for Haac subsidized hours. ,,for care packages. Guardianship boards, respite beds and so on

Issues for hospital services

Before the increase in the nursing home beds the **wait list** in the hospital for placement was long. Bed blockers do not fit in the acute hospitals. Now the people eligible for low care beds have to wait longer than the people needing high care beds.

Geriatric ward

Not having the a designated area in hospital for the elderly can be a problem as the demand of the nursing care from acutely ill people precedes the needs of elderly waiting to be placed. People end up becoming more dependant than when they entered the hospital. This can be worse when they have dementing conditions and they tend to wonder.

There is a minimal input by the psychiatric services to deal with psycho geriatric problems. Just this month we have been able to get limited assess to a psycho geriatrician for the opinion.

Assessment teams need to be working closely with hospital Most teams are based in hospital but if they are not then they have a problem However they should be placed outside the hospital system ,in the community where their main work belongs.

Some Positives

The advantages we have here are we are **well funded in community services.** We have total of 170 care packages and they have been very successful in keeping people in their own homes. The 20 nursing home packages have been a great help.

We have total no. of 38000+ haac hours .

The discharge planning and post acute services work closely with Acats

We work well with palliative services.

The waiting list for the subsidized Haac hours and packages is very long.

The liaison between the assessment services and all the agencies is good and being a small place this is easy and has a personal touch

Considering we started with an attitude that{ we do not have old people in NT and thus do not need any specialized services} we have done well.

Where to in next twenty years ?
I do not want to take it as far as as forty years because considering my age that will be irrelevant. There will be few local and central elections providing us with the opportunity to canvass our views and put forward our wish lists.

My Wish List

Centralizing the services

The demand for the age care grows rapidly . We need to work with many agencies to provide multidimential assessments and to work efficiently we will have to avoid duplications. Older people hate being assessed by multitude of people to provide the same information.

Legal issues

Need to improve the education amongst the elderly about their rights and give them the confidence and support to exercise them. The elder abuse is a traumatic and hidden problem. We have postponed dealing with end of life issues as being too difficult but increasingly healthy elders are coming forth wanting to ask questions and information.

Changes in Attitudes

The elders are very reluctant to spend money on themselves. The pleasure and duty in life is to pass on the assets to children. I can see the nursing home industry will be asking people to pay the bond moneys and this will be a very emotive issue. Hopefully the baby boomers generation will not be limited with the ideas of filial piety. Elders have to spend money on their own care and not to safe guard it for their children ; the thought not palatable even to me.

Health Promotion

Healthy aging needs to be promoted when ever possible as this will be a way to improve the quality of life of elders and reduce the huge health bills people seem to panic about. The issues of **multipharmacy** need to be explored in depth to save money spent on drugs

Geriatric care in residential places.

After the admission in the care facility the care of the residents is taken by their GPS with no input from the geriatricians. Once a year visit to check the immunization, skin care, to exclude depression and osteoporosis will be of a great benefit.

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