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# Aged care and health services

> Older people receive care services across acute, aged, primary and community care sectors. Wherever older people interact with these systems and associated interfaces there is a risk of harm to the older person, a risk of functional decline and altered quality of life. It is no longer possible to consider one sector without the impact of the other.[1]

8.1 While there is growing awareness of the need for longer-term strategies to foster health ageing, much of the evidence the Committee received focussed on concerns about current aged care and health service. Wide ranging evidence was received from individuals, service providers, professional associations, peak bodies, researchers and research institutions, state and local governments, and lobby groups.

8.2 Projections in the *Intergenerational Report* identified health and aged care as accounting for much of the expected rise in Australian Government spending over the next four decades. Not surprisingly, subsequent debate has largely focussed on who should pay for health and aged care services.

8.3 This chapter surveys evidence received by the Committee providing on-the-ground perspectives on aspects of aged care and health services and related policies. The Committee notes that in relation to residential aged care, the evidence is consistent with that in submissions to the Hogan Review.

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1 Australian Nursing Federation (SA Branch), sub 93, p 4, citing DHS SA, *Moving Ahead*, 1999.

8.4 The chapter is rather lengthy. The scope is broad covering: services to maintain healthy functioning; community care; care in diverse setting for people with dementia or other mental health problems, respite and palliative care; residential care; the need for age friendly hospitals; GPs and older people; fragmentation and lack of cooperation; and workforce shortages.

8.5 A consistent thread throughout the chapter is the need for more flexible, integrated policies and services delivered through far greater collaboration and team work than is demonstrated by today's workforce. Hence, the Committee has resisted the obvious approach of shorter chapters reinforcing traditional fiefdoms.

## Funding for aged care and health services

8.6 Funding for aged care and health services comes from governments at all levels, private individuals, health insurance funds and other non-government institutions.

8.7 The Australian Government provides the majority of funding for aged care services overall: $5.6 billion in 2002-02, expected to rise to $6.5 billion in 2003-4 and $6.7 in 2004-05. The bulk of this funding is directed to residential aged care.[2] The states and territories make a substantial contribution to the funding of Home and Community Care providing $434.1 million of the total $1.1 billion in 2002-03. They also provide some funding for public sector residential care beds and for Aged Care Assessment Teams.[3]

8.8 Older Australians who can afford it pay fees for community care services and residential aged care, and accommodation bonds or charges for residential aged care. Reliable data on the total contribution older Australians make to community care services and residential aged care fees is not readily available. In relation to accommodation bonds and charges, the Pricing Review of Residential Aged Care found that, as at June 2003, an estimated $2.7 billion in

2 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997,* 1 July 2002 to 30 June 2003, pp 21, 23, viewed 5/07/2004, <http://www.ageing.health.gov.au/reports/ acareps/rep2003.pdf>. This includes $4.6 billion in the Health and Ageing Portfolio and $630 million for the residential care of veterans funded through the Department of Veterans' Affairs. The expectation for 2003-04 does not include expenditure announced in the 2004-05 Budget but to be paid to residential aged care providers before 30 June 2004.

3 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004*, vol. 2, p 12.11

bonds was held by the industry. In addition, residents had paid providers approximately $124 million in accommodation charges. In 2002-03, providers deducted around

8.9 $90 million in retention amounts form bond holdings and refunded bonds to the value of some $733 million. [4]

8.10 The *Report on the Operation of the Aged Care Act 1997* for the period 1 July 2002 to 30 June 2003 provides details of the numbers of older Australians (including Indigenous people aged 50 years and over) who received assistance from aged care services:

- 184,095 people received permanent residential care;
- 34,025 people received residential respite care, of whom 14,792 were later admitted to permanent care;
- 31,186 received care through a Community Aged Care Package, including some who also received permanent or respite residential care during the year; and
- an estimated 700,000 people received services through the Home and Community Care program.[5]

8.11 The proportions of people from the targeted special needs groups receiving aged care services may be summarised as follows:

- 0.5% of Indigenous people aged 50 years and over received residential care;
- 3.9% of Indigenous people aged 50 years and over received CACP services;
- 2.5% of Indigenous people aged 50 years and over received HACC services;
- 12.7% of residents from a non-English speaking country aged 70 years and over received residential care;
- 19.5% of residents from a non-English speaking country aged 70 years and over received CACP services; and
- 16.3% of residents from a non-English speaking country aged 70 years and over received HACC services.[6]

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4 WP Hogan, *Review of Pricing Arrangements in Residential Aged Care, Final Report,* 2004, p 161. Information based on, Department of Health and Ageing, *Census of Aged Care Homes 2003,* Commonwealth of Australia, 2003.

5 Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 1 July 2002 to 30 June 2003, p 3, viewed 5/0/2004, <http://www.ageing.health.gov.au/reports/acareps/rep2003.pdf>.

6 Steering Committee for the Review of Government Service Provision, *Report on Government Services 2004*, Supporting Table 12A.18, Aged care recipients from special

8.12 Comparable information on the proportion of health funding directed to the care of older Australians is not available. Some information relating to the high cost areas of acute care, Medicare and pharmaceutical benefits was provided to the Committee by the Department of Health and Ageing.

- In 2000-01, people aged 65 years and over accounted for approximately one third of all hospital separations but accounted for approximately 41 per cent of the cost. This was attributed to the complexity of health issues for older people and the compression of morbidity into the last few years of life.
- In 2001-02, expenditure on the Pharmaceutical Benefits Scheme was $4.2 billion of which people aged 65 years and over accounted for 47 per cent. This was attributed in part to the fact that over 90% of these people have a concession card and therefore pay only the concessional co-payment.
- In 2001-02, expenditure on the Medicare Benefits Schedule was $7.8 billion. People aged 65 years and over accounted for 26.4% of services and 27.4% of cost but comprise only 13% of the total population. [7]

8.13 The Australian Government has introduced a range of health measures specifically designed to focus on the health of older people, such as enhanced primary care multidisciplinary case planning, access to medical care for residents of aged care homes, and promotion of the wise use of medicines. Experiences with some of these initiatives were raised with the Committee.

## Issues raised in evidence

8.14 The issues raised, sometimes passionately, were many and varied reflecting the scope of the services accessed by older Australians and the concerns of service providers and other stakeholders. Several broad themes emerged, demonstrating that there are areas of common concern in aged care and health services:

needs groups, June 2003. Indigenous data includes only people who identify as Indigenous.

7 Department of Health and Ageing, sub 119, pp 34-35.

- inadequate focus on services aimed at maintaining healthy functioning: physiotherapy; podiatry; nutrition advice; speech pathology; oral health services; and podiatry;
- confusion caused by multiple community care services, and issues around the quality of community care services;
- need for further development of the potential enabled under flexible care funding;
- the availability and quality of care for people with dementia or mental health problems, and for those needing respite or palliative care – care which may be provided at home, in the community or in an institutional setting;
- the availability, quality and viability of residential care;
- hospitals that are seen as becoming increasingly unfriendly to older people and poorly integrated with other care services for older people;
- the need for changes in general practice and the ways GPs work with other health professionals to provide better care for people as they grow older; and
- workforce shortages, especially nurses and other residential care staff.

8.15 The evidence also made clear that three overarching matters are seen as critical to addressing these issues, together with related funding issues:

- a workforce more attuned to the needs of older people and more appropriately skilled to provide services: not just solving the shortage of nurses, but changing the attitudes and work practices of the other health professionals and better utilising services to maintain functioning;
- increased focus on research to gain a better understanding of ageing and the care of the aged; and
- better integration of services at all levels: from genuine cooperation between the states, territories and the Australian Government, to a far greater willingness by health and care professionals to work together to provide person-centred care.

8.16 These concerns are not inconsistent with containment of costs that was the primary concern of the *Intergenerational Report* – especially costs driven by the demand for new technologies and treatments. Indeed the Committee considers them critical to achieving cost containment even though some ongoing investment will be needed.

8.17 This chapter discusses, at some length, the concerns presented to the Committee. Proposals for addressing the overarching issues are covered in Chapter 9, Aged Care and Health Services: Looking to the Future.

## Services to maintain healthy functioning

> The main emphasis in aged care needs to shift from providing care towards the end of life, to providing better health programs before mobility and independence begin to deteriorate….[8]

### Maintaining physical function

8.18 Ageing and the diseases associated with age are, for example, contributing to an increasing number of older people experiencing swallowing and communication difficulties. Swallowing difficulties can arise from stroke, Parkinson's disease, dementia and respiratory conditions resulting in difficulty organising and coordinating muscles for swallowing.[9] The Committee heard of the distress swallowing problems caused one resident:

> … the difficulty [he] was experiencing in swallowing tablets ... he could not manage to swallow a large antibiotic tablet unless it was crushed…[10]

8.19 Factors seen as contributing to poor access include workforce shortages (physiotherapists, podiatrists) and the limited number of health professionals in rural areas. In Broken Hill, for example, the hospital's rehabilitation facilities (including a hydrotherapy pool and gymnasium) are not fully utilised because rehabilitation staff numbers are down 'at least one in every department'; nor are there enough staff and funding to keep up with the need for rehabilitation services in people's homes.[11]

8.20 Overall the evidence put to the Committee makes clear that these services tend to 'fall into the cracks' at the interfaces between acute

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8 Australian Physiotherapy Association, sub 118, p 7.

9 Speech Pathology Australia, sub, 52, pp 1-2

10 Warn P, sub 26, p 20.

11 Australian Physiotherapy Association, sub 118, p 16; The Aged Care Rights Service, sub 87, p 35; National Rural Health Alliance, sub 131, p 131; Speech Pathology Australia, sub 52, p 4; Peck M, transcript 19/05/2003, p 480; Kennedy M, transcript 23/02/2004, p 823; Flecknoe-Brown S, transcript 24/02/2004, p 844

care and community and residential aged care or between Australian Government and state/territory responsibilities. These health professionals may not be included in Aged Care Assessment Teams and while it could be assumed their services (such as assistance with communication and swallowing difficulties) are provided in aged care homes this is not necessarily be standard practice.[12]

8.21 The services are also at the interface of various funding mechanisms where professional groups protect their access to funding streams. It was suggested to the Committee that hospitals attuned to casemix funding place higher priority on early discharge than rehabilitation.[13]

8.22 Under the *Health Legislation (Private Health Insurance Reform) Amendment Act 1995*, health funds are required to cover private psychiatric, palliative care and 'rehabilitation services' under hospital tables. The National Private Rehabilitation Group suggested to the Committee that these arrangements are not working well, in part because health funds compliance with this requirement is variable.[14] Services not related to hospital care may be covered by private health ancillary tables. Consequently, older Australians who do not have private health insurance may not be able afford access to support of the sort that could significantly assist them to maintain healthy functioning.

8.23 In addition, there is growing use of purchasing contracts between health funds (or organisations such as the Department of Veterans' Affairs) and service providers. The National Private Rehabilitation Group noted that these are premised on a medical model – 'episode of illness' – which does not necessarily assist with preventative maintenance of functioning. Further, payment is made to the acute care provider or general practitioner with flow on distribution of payments to other providers being dependent on the acute provider.[15]

8.24 The National Private Rehabilitation Group and the Australian Physiotherapy Association stressed the need for more suitable and consistently applied funding models: '… governments need to untangle funding…' and develop transparent patient-centred funding models. Options put forward include:

12 Speech Pathology Australia, sub 52, pp 3, 4.

13 Australian Physiotherapy Association, sub 118, p 9

14 It should be noted, however that the Private Health Insurance Ombudsman has received no complaints on this matter.

15 National Private Rehabilitation Group, sub 53, executive summary pp 3-4; Australian Physiotherapy Association, sub 118, p 9.

- restricted coverage through Medicare for targeted groups such as Enhanced Primary Care patients;
- implementing blended payments as a single industry-wide model for private medical rehabilitation services; and
- replacing 'episode of illness' contracts with a single level of purchasing for private medical rehabilitation services.[16]

8.25 The Committee notes that a new health initiative allows chronically ill people who are being managed by their GP under an Enhanced Primary Care (EPC) plan, access to Medicare rebates for allied health services. Five services per patient per year may be claimed for services provided by an eligible allied health professional following referral by a GP as part of care provided under a multi-disciplinary care plan. Allied health professionals covered are Aboriginal health workers, audiologists, chiropodists, chiropractors, dieticians, mental health workers, physiotherapists, occupational therapists, osteopaths, podiatrists, psychologists and speech pathologists.[17]

8.26 The Committee sees this as a positive step towards involving allied health professionals in care that will potentially contribute to maintaining health functioning. However, the Committee considers that the actual contribution will be limited as the initiative is still premised on waiting until the patient is significantly affected by one or more chronic conditions.

8.27 The Committee also notes that further consideration is needed of how best to find increased access to preventive allied health services.

## Oral health

8.28 Oral health continues to be a concern with the cost of services being seen as far beyond the means of many pensioners. COTA stated that:

> One of the worst examples of poor health policy is in divorcing the oral health of individuals from all other aspects of their health care. … Many older people are missing out on basic dental care and are subject to long delays in receiving treatment.
>
> Poor dental health can contribute to deterioration in overall health and can lead to premature admission to a nursing

16 National Private Rehabilitation Group, sub 53, p 7.

17 'Expanded Medicare services for the chronically ill', Joint Media Release, The Hon Tony Abbott MHR, Minister for Health and Ageing, and Senator Meg Lees, Senator for South Australia, 24 June 2004.

> home or death. Early intervention for dental problems is important in preventing further deterioration…[18]

8.29 The National Rural Health Alliance stressed that poor dental health is sometimes seen as a 'relatively trivial issue' yet it is closely linked with such major health problems as cardiovascular disease, stroke, diabetes, endocarditis, and nutritional deficiencies in older people. In remote Aboriginal communities, there is a strong link between oral health and diabetes.[19]

8.30 As with other services for maintaining functioning, evidence to the Committee indicated that funding is inadequate and affected by being at the interface of various funding arrangements. Evidence suggested the need for a national dental policy, with increased funding provided by the Australian Government and greater cooperation between the Australian Government and the states and territories. Funding mechanisms suggested included inclusion of oral health in the Australian Health Care (Medicare) Agreements, or a jointly funded program managed in a similar way to HAAC, with the mechanism to include innovative approaches to funding for rural areas and remote Aboriginal communities.[20]

8.31 The Committee notes that in the 2004-05 Budget, funding was confirmed for an MBS item to cover:

> … up to three dental consultations each year where dental problems are significantly exacerbating chronic medical conditions being treated under a Multidisciplinary Care Plan.[21]

While this initiative is a welcome step, the Committee considers that it falls short of providing access to preventive dental care to maintain good oral health for older people.

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18 COTA, sub 91, p 21.

19 National Rural Health Alliance, sub 131, p 33.

20 National Seniors Association, sub 81, pp 10-11; Superannuated Commonwealth Officers' Association, p 57, p 18; COTA, sub 91, p 21, National Rural Health Alliance, sub, 131, p 33; The Aged-care Rights Service, sub 87, p 35.

21 *Budget Measures 2004-05*, Budget Paper No. 2, p 208. For conditions of access, see <http://www.health.gov.au/pubs/mbs/mbsjul04/MBS_Updated_July_2004_HTML/MBS_Updated_July_2004_755.htm>, viewed 30 July 2004.

## Community care services: coordination and quality

8.32 Quality community care is a critical factor in a positive experience of ageing for the 93% of those over aged 65 years of age who live in the community and want the choice of remaining at home.[22]

8.33 While there is wide acknowledgement of the significant contribution community care programs make to enabling older people to live at home, evidence to the Committee indicates concerns about the adequacy of some aspects of current arrangements.

8.34 Mrs Sneesby, a member of the ACAT team for the Mid-North Coast Area Health Service informed the Committee:

> Some of the concerns we have in relation to services at home are that older people generally are unaware of them, quite often support is not initiated early enough, the guidelines for entry leave some people ineligible, some services have extended waiting times, some older people find it too difficult to negotiate their way through the system and some older people have the capacity to pay for private services but there is no way of ensuring their safety.[23]

8.35 Consistent with this, lack of coordination resulting in fragmentation and confusion, quality and safety, access to respite and palliative care, and funding were the most frequently raised issues. While the need for better coordination between community services and health services was also raised, especially in relation to hospitals, this is covered in the section on 'The need for age-friendly hospitals' below.

### Confusion or coordination?

8.36 The Committee heard that fragmentation and confusion are caused by:

- all levels of government having policy and funding responsibilities;[24]
- an absence of coordinated planning across levels of government and across services; [25]
- multiple funding, eligibility and accountability requirements;[26]

22 National Aged Care Alliance, sub 88, p 6.

23 Sneesby A, transcript 19/05/2003

24 Aged and Community Services Australia, sub 101, p 2

25 Lgov NSW, sub 89, pp 17-18; Moreland City Council, sub 37, p 4; Aged and Community Services Australia, sub 101, p 2;

- multiple entry points making it difficult for older people to locate the services the need;[27]
- in some locations HACC services are targeting those with high support needs, diverting funding from basic support services such as home maintenance and gardening; and[28]
- a proliferation of new, small programs – whether funded by the Australian Government or by states or local government.[29]

8.37 The Committee also received suggestions for improving integration so that services focus on client needs rather than on funding streams and associated administrative structures: a single national community services program, a single entry point, and coordinated planning of funding and assessment.

8.38 The Myer Foundation suggested establishing a national program integrating the full range of community care services. The Foundation considered that this, together with encouragement of comprehensive care providers, would improve efficiency and help ensure equity of access to similar services based on assessed need across all regions. A single national program was also suggested by the Moreland City Council, but achieved by merging Australian Government programs (including those funded through the Department of Veterans' Affairs) with HACC. The merged national program would target both high and low levels of need and have clearer goals and strategic directions.[30]

8.39 A single point of entry together with case management was suggested to ensure easier access for older people and continuity of care as their needs increase. Ms McClean stated that:

> …we would need service providers to have some form of central point where someone is actively managing a particular person and facilitating the actual levels of care with different service providers. If you like, one organisation is contracted, perhaps on a regional basis, to manage a person's care … guide the client and the family all the way …[31]

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26 Lgov NSW, sub 89, pp 17-18; National Aged Care Alliance, Sub 88, p 6; Moreland City Council, sub 37, p 3;

27 Waddington B, transcript 28/04/2003, p 374; McClean C, transcript 31/03/2003, p 340

28 Lgov NSW, sub 89, pp 17-18.

29 Moreland Council, sub 37, p 4; McGuiness M, sub 60, p 642

30 Myer Foundation, sub 80, p 3; Moreland City Council, sub 37, p 5.

31 McClean C, transcript 31/03/2003, p 340. See also, Waddington B, transcript 28/04/2003, p 374. Waddington B, transcript 28/04/2003, p 374

8.40 Regardless of the structure used to improve integration, Mr Mundy of Aged and Community Services Australia pointed to level of planning involved for CACPs (within the overall 40:50:10 ratio) when those places result in only a small proportion of all community services:

> Most of [the services are] in the HACC program, which of course the states run, and it does not really make sense to spend a lot of time carefully planning the CACPs when the bulk of the system is done separately. It should be looked at slightly more broadly.[32]

8.41 Differing requirements for assessment for CACPs and HACC also make planning less effective than it should be and more confusing for older people needing to access care services.[33]

## Quality and safety in community care

8.42 In addition to the negative impacts of fragmentation on older people's experiences of community care services, the Committee heard that greater attention should be paid to the training and qualifications of staff, standards and accountability, and the safety of the environments in which service providers work.

8.43 The Older Women's Network suggested that community care services must have the safeguards of quality management principles, standards and accountability. Mrs Sneesby saw the increase in private provision of community care services as an additional reason for introducing more robust standards. ANHECA drew a sharp contrast between community care and the level of Australian government supervision in residential care where meeting standards is mandatory. Other evidence conveyed the frustration carers feel when the community services providers sent to support them lack the training needed to provided a quality service, or behave in an unprofessional manner.[34]

8.44 Equal importance was placed on ensuring that homes are safe – both for older people receiving care and those providing care.[35] As more older people continue to live at home (and until they become more frail) the issue of safety must become a higher priority especially as many older people live in older homes. Inadequate home safety could

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32 Mundy G, transcript 7/02/2003, p 74.

33 Mundy G, transcript 7/02/2003, p 74.

34 Older Women's Network, sub 58, p 9; See also Sneesby A, transcript 19/05/04, p 468; ANHECA, sub 111, p 7. Halliday G, transcript 3/02/2004, p 768; Foreman R, sub 38, p 4.

35 Australian Nurses Federation, sub 97, p 7; Waddington B, transcript 28/03/03, p 374.

also limit access to Extend Aged Care at Home or to hospital in the home programs (See further, chapter 4, 'Housing and transport').

8.45 The Committee notes that in the 2004-05 Budget, the Government committed $13.7 million over four years for development and implementation of a quality assurance framework. It is intended that framework apply to CACPs, EACH and the National Respite for Carers programs.

## The community care review

8.46 The Committee notes that the Department of Health and Ageing conducted a review of community aged care with a view to delivering community care in a more consistent manner across all programs. Input was sought from the community through a consultation paper, *A new strategy for community care*. This paper acknowledged the types of problems identified in evidence to the Committee:

> Many of these Programs provide similar services to similar people but have different administrative arrangements, which can be confusing to care recipients. Additionally, these differing arrangements mean that there is limited continuity of care when care recipient needs change in a way that necessitates a move from one program to another. [36]

8.47 Ms Margrie informed the Committee that the discussion paper:

> …seems to be getting a very good response on the ground. … Quite often the policy comes down from on high … This paper is quite different in that it looks at trying to lead the discussion forward and being interested in what is coming from the ground and in the innovation. So I think that new strategy is a really good first step; it is long overdue and it is very refreshing to see it.[37]

8.48 The consultation paper proposed a set of guiding principles and a National Framework for community care to enable 'Programs, regardless of the funding source, to be planned, funded and delivered in a cohesive and coordinated way and to make the most effective use of finite resources'. The proposed elements for the Framework were:

- The reorganisation of community care service provision to better align with three distinct levels of need, incorporating three service provision tiers:

36 Department of Health and Ageing, *A New Strategy for Community Aged Care*, Consultation paper, March 2003.

37 Margrie L, transcript 4/07/03, pp 677-68.

- ⇒ Access, Information and Support Tier;
- ⇒ Basic Community Care Tier; and
- ⇒ Packaged Community Care Tier;

- The development of a Regional Access Centre network to make it easier for care recipients and carers who require community care information and services;
- The standardisation of assessment and information management mechanisms to reduce unnecessary duplication in assessment and data collection; and
- The streamlining of administrative requirements so that more resources can be redirected into service provision.[38]

8.49 The Committee notes that the Minister for Ageing has recently announced a blueprint for work to be done to move towards greater cooperation and integration in the planing and delivery of community services. The blueprint envisages consistent approaches across Australian Government funded services, and working with the states and territories to extend consistent approaches to HACC services.[39]

8.50 The Committee commends the blueprint's intent to make access easier for people needing care, to enable a continuum of care as care needs increase and to work through a collaborative partnership with the states and territories. The blueprint also indicates that guidance will be sought from a National Reference Group. The Committee notes that funding for the developmental stage will come from within the $47.9 million provided in the 2004-05 Budget. Implementation of common arrangements is envisaged from 2005, once a new HACC agreement with the state and territory governments is in place.[40]

## Flexible care

8.51 Evidence to the Committee indicated support for existing flexible care initiatives and stressed that more could be achieved through further realising the potential of flexible care.

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38 Department of Health and Ageing, *A New Strategy for Community Aged Care*, Consultation paper, March 2003, pp 17, 6.

39 Department of Health and Ageing, *A New Strategy for Community Aged Care: The Way Forward, 2004,* pp 7-9, 23-44.

40 Department of Health and Ageing, *A New Strategy for Community Aged Care: The Way Forward, 2004,* pp 11-12.

8.52 The *Aged Care Act 1997*(Part 3.3) enables the provision of flexible care in community or residential settings funded by the flexible care subsidy. (s49-1 to 49-3). Current flexible care initiatives include extended aged care at home packages (EACH), time limited initiatives under the Aged Care Innovative Pool, and multipurpose services. The scope of flexibility enabled by the *Aged Care Principles* (s15.24) is wide-reaching and encourages coordination and integration of care, addressing short term needs such as those following hospitalisation, and exploration of new care arrangements through pilots and projects.

## Extended aged care in the home

> People on our [EACH] packages are very pleased to be able to get those added services coming in, delaying their admission to an aged care facility.[41]

8.53 Since the Northern Territory Salvation Army EACH program – 'With Care' – began operation in July 2003 its flexibility has suited the mixed ethnic population in Darwin and the needs of older people without family. There has been a 10% participation rate for both Indigenous older people and for older people without carers. The program has also been successful in maintaining people at home until 24 hours from death. [42] Services provided by With Care include: personal hygiene; domestic assistance; nursing services; meal preparation; medication management; respite care; social contact; transport accompanying to medical consultations; gardening; pet care; provision of mobility equipment; light maintenance; occupational therapy and physiotherapy; and care management.'[43]

8.54 Mrs Poole noted that a lack of set up funding made the first few months difficult:

> One of the difficulties that we experienced with the program was that there was no start-up funding for the program and therefore it was initially difficult to purchase equipment to commence the program.[44]

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41 Poole J, transcript 3/02/2004, p 797-798; NSW Department of Health, sub 160, p 7-8; Community Care Options Inc, part of ASLARC, sub 151, p1; Department of Health and Ageing, sub 119, p 43-45. See also: Community Care Options Inc., part of ASLaRC sub 151, p 1; Australian Nursing Homes and Extended Care Association Ltd (ANHECA), sub 111, p 12-13; Ward J, transcript 25/02/2003, p 143; Anglican Aged Care Services Group, sub 99, p 1

42 Poole J, transcript 3/02/2004, p 797.

43 Poole J, transcript 3/02/2004, p 797.

44 Poole J, transcript 3/02/2004, p 797.

8.55 Since 1998, more than 900 older Australians who would have otherwise had to enter residential care, now receive high level care at home by using the EACH program. As at the 30 June 2003 there were 450 allocated places through 19 service providers, with an additional 550 EACH places to be allocated in 2003. Following increases in provision for CACPs in the 2004-05 Budget, over 3,224 EACH places are expected to be available by 2006.[45]

8.56 Evidence presented to the Committee highlighted growing demand for EACH places and the need for further resources to increase the number of EACH packages to enable people to have the chance of receiving high care at home.[46]

8.57 The Committee considers that while the EACH program must continue to grow, expansion should be timed to proceed within the proposed quality assurance framework for community care programs.

## The Aged Care Innovative Pool

8.58 The Aged Care Innovative Pool provides flexible care subsidies to enable the testing of new approaches to aged care, not to provide ongoing aged care services. Projects are operated in partnership with other stakeholders including state and territory governments. At 30 June 2003 there were 865 innovative care places allocated to 30 projects. A further 400 places were to be made available in 2003-04.[47]

8.59 It was suggested to the Committee that innovative service models may provide a future basis for improving access to a range of specialised services for the elderly in rural and remote areas.[48]

8.60 Professor Byles pointed to the worth of these pilots in exploring problems such as how best to ensure older people have enough time to recover following a stay in hospital:

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45 ANHECA, sub 111, p 12-13; Hogan W, Pricing Review of Residential Aged Care, 2004, p 16; Department of Health and Ageing, Extended Aged Care at Home, viewed 19/08/2004, <http://www.health.gov.au/acc/commcare/each.htm>; Minister for Ageing, the Hon Julie Bishop MP, *Investing in Australia's aged care: More places, better care*, May 2004, p 8. Department of Health and Ageing, *A New Strategy for Community Care: The Way Forward,* p 14.

46 NSW Department of Health, sub 160, p 7-8; COTA, sub 157, p 7; Carers Australia, sub 77, p 13; National Aged Care Alliance, sub 88, p 2;

47 Department of Health and Ageing, *Investing in Australia's aged care: more places, better care,* May 2004, p 11; Department of Health and Ageing, *550 aged care places for transitional and dementia care*, media release, 8 July 2002.

48 National Rural Health Alliance Inc, sub 131, p 5.

> Many people are admitted to long-term residential care following acute admission to hospital. There needs to be effective programs for enabling people to rehabilitate and return to their own homes. Transitional Care projects are beginning to shed light on these opportunities and indicate that such approaches can be effective and cost-effective.[49]

8.61 Since 2002, pilot projects to trial transitional care have been jointly funded by the Australian and State/Territory Governments. The pilots combine personal and nursing care and rehabilitation, with the aim of:

- increasing the number of older Australians able to return to their own homes, or to enter residential care from the pilot with a higher level of functional and cognitive ability and independence than would otherwise have been possible;
- reducing the rate or readmission to hospital of recently discharged older people; and
- improving the quality of life of participating frail older people.[50]

8.62 Mrs Thorn informed the Committee of three models of interim/ transitional care being explored in Victoria which 'seem to be working quite well': a hospital based model; a residential care facility model using unfunded beds and hospital projects funding; and a community based model providing extra support to the family.[51]

## Transitional care and Pathways Home

8.63 The need for immediate investment in some form of transitional care was raised in evidence to the Committee in relation the importance of services to maintain healthy functioning, the interfaces between acute care and residential and community care, residential care, and older people's experiences of care during a stay in hospital – as is discussed in other sections of this report.

8.64 The Committee notes that the Hogan Review recommended the creation of a strategic pool of up to 3,000 additional places each year for the next four years to be used (among other things) flexibly and to support innovative care models.[52]

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49 Byles, J, sub 103, pp 8-9. See also, National Aged Care Alliance, sub 11, p 6.

50 Department of Health and Ageing, sub 119, p 45-46; Thomann M, transcript 7/02/2003, p 9.

51 Thorn J, transcript 31/02/2003, p 306.

52 Hogan W, Pricing Review of Residential Aged Care, 2004, p 16

8.65 In response, the Australian Government agreed to provide up to 2,000 new transition care places (from within the increased ratio) to:

> … help older people after a stay in hospital. This will allow them to receive rehabilitation services and support to increase their independence and confidence, and give them time to assess whether they can return home with additional support from community services or need to consider the level of care provided in an aged care home.[53]

8.66 The program will continue to be funded via flexible care subsidy, and costs will be shared with the States and Territories.

8.67 The Committee welcomes the intent of this initiative. Giving older people time to regain confidence after acute care and time to make decisions about future care without undue pressure is essential. The details of joint funding and program implementation arrangements are yet to be finalised.

8.68 The Committee is concerned that there is potential for duplication and overlap with the Pathways Home program, funded under the Australian Health Care Agreements 2003-08. A collaborative initiative between the Australian Government and the States and Territories, Pathways Home is designed to increase the rehabilitation and step down (convalescent) services provided to patients leaving hospital, particularly patients who are older or who have some form of mental disability. Projects agreed under State and Territory work plans include home and community based care as well as transitional care in hospital related sub-acute facilities.[54]

## The Multipurpose Services Program

8.69 The Multipurpose Services Program (MPS) is a joint Australian and state/territory government funded initiative. It is designed to provide a range of health and aged care services to rural and remote communities. At 30 June 2003, the MPS program consisted of 1,810 flexible aged care places in 83 locations.[55]

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53 Minister for Ageing, the Hon Julie Bishop MP, *Investing in Australia's aged care: more places, better care*, p 17

54 Department of Health and Ageing, 'Pathways Home Projects (Schedule B of the ACHAs)', viewed 24/08/2004, <http://www.health.gov.au/ahca/agreements.htm>. Links at this site lead to lists of projects approved for each State and Territory.

55 Department of Health and Ageing, *Investing in Australia's aged care: more places, better care*. May 2004, p 11.

8.70 Evidence to the Committee affirmed that the MPS program has worked well a in many areas and that the pooling of Australian government and state/territory funds has enabled a greater number and variety of services to be available in rural and regional areas.[56] Mrs Jeffrey from Uniting Church Frontier Services, however, reminded the Committee that the MPS model was not designed – and does not work – for remote areas such as most of the Northern Territory:

> Multipurpose schemes have worked quite well in lots of areas but, because of the spread of our population, it is not the way to go all the time…[57]

8.71 The Committee heard that there is some confusion around the roles of and arrangements for MPSs and Regional Health Services.[58] Both programs are designed to enable flexible and integrated solutions for communities that are too small to support a range of stand-alone services. Because they are funded under the flexible care subsidy provisions of the *Aged Care Act 1997* (Part 3.3) and *Flexible Care Subsidy Principles 1997* (s15.13 – s15.14), MPSs must have the capacity to provide residential care whereas Regional Health Services are not required to do so. Otherwise the services provided can be very similar.

8.72 The Committee questions whether continuing two separate programs is sensible. Perpetuating silos around two programs which both have the goals of encouraging flexibility and integration is not desirable.

8.73 Further, the Committee considers that ongoing consideration must be given to how the flexible care subsidy may be used to better provide care in remote areas.

## Care services in diverse settings

8.74 Wide-spread concerns were put to the Committee about the availability and quality of care for people with dementia or mental health problems, and for those needing respite or palliative care. Such care may be provided at home, in the community or in an

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56 Gregory G, transcript 7/03/2003, p 240; Jeffrey R, transcript 3/02/2004, p 777; North R, transcript 23/02/2004, p 814.

57 Jeffrey R, transcript 3/02/2004, p 777.

58 Gregory G, transcript 7/03/2003, pp 240-41.

institutional setting – or a mix of these settings – raising questions about continuity and integration of care.

## Care for people with dementia or other mental health problems

> Dementia is an insidious disease and Alzheimer's accounts for up to 70% of all dementia cases. The disease by its very nature changes the lives of those with dementia and their relationship with family members and friends, often to a critical degree.[59]

8.75 Evidence to the Committee suggested that while the impacts of dementia are beginning to be more fully recognised and addressed, the extent of depression and other mental health problems are yet to be acknowledged.

### Incidence and costs of dementia

8.76 Alzheimer's Australia suggested to the Committee that a potential impact of the ageing of the Australian population will be a rapid increase in the numbers affected by dementia. Dementia is already the fourth biggest cause of death among older Australians; it is the third largest cause of disability burden among women and the fifth among men. Projections indicate that by 2041 the number of people affected will increase by three and a half time to around 460,000. More recent studies by Access Economics (commissioned by Alzheimer's Australia) and the Australian Institute of Health and Welfare (AIHW) suggest similar increases. However, the AIHW counsels that the figures should be treated with some caution. There are no Australian incidence studies: all estimates have been based on information derived from overseas epidemiological studies.[60]

8.77 Dr Michael Lowe drew the Committee's attention to the fact that in the Northern Territory Aboriginal people with dementia are likely to be just middle-aged. There is also a growing number of people in their thirties with dementia caused by substance abuse, diabetes or vascular disease. People with alcohol related brain damage live longer

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59 Alzheimer's Australia, sub 79, p 6.

60 Alzheimer's Australia, sub 79, p 6; Access Economics, *The Dementia Epidemic*, p 32; AIHW, *The Impact of Dementia*, pp 13-14; NSW Health, sub 160, p 8; Australian Medical Association, sub 86, pp 4-5; The Aged Care Rights Service, sub 87, p 33. The Review of Pricing Arrangements in Residential Aged Care, p 296, recommended that future research should include comprehensive prevalence studies to provide more robust data for future planning and policy development (Recommendation 20).

than an 85 year old with Alzheimer's so that they may spend much longer in residential care.[61]

8.78 Dementia results in a heavy financial burden on individuals and their carers, health and aged care services, and the economy. These direct and indirect costs are summarised in Table 8.1 (below). They are projected to rise from 0.91% of GDP in 2002 to 3.3% by 2051.[62]

8.79 Equally heavy are the non-financial burdens on individuals and their families and carers including loss of income, isolation and poor mental health.[63]

Table 8.1: Summary of direct and indirect financial costs of dementia, 2002

| | Real cost $ million | Transfer payments $ million | Total $ million | Per person with dementia | % GDP 2002 | % GDP 2051 |
|---|---|---|---|---|---|---|
| *Direct Health Costs* | 3,235.9 | | 3,235.9 | 19,938 | 0.45 | |
| Including Residential care | 2,847.1 | | 2,847.1 | 17,542* | | |
| Home and community care | 174.8 | | 174.8 | 1,077* | | |
| *Indirect financial costs* | | | | | | |
| Lost earnings (patients) | 355.3 | | 355.3 | | | |
| Morality burden | 8.8 | | 8.8 | | | |
| Tax Foregone (patients) | | 102.2 | 102.2 | | | |
| Value of carers | 1713.2 | 324.4 | 2,037.6 | 12,555 | 0.28 | 1.0 |
| Tax foregone (carers) | | 489.7 | 489.7 | | | |
| Welfare payments | | 52.0 | 52.0 | | | |
| Aids and modifications | 119.8 | | 119.8 | | | |
| Subtotal indirect financial costs | 2,197.2 | 968.3 | 3,165.4 | 19,504 | 0.44 | 1.6 |
| **Total financial costs** | **5,607.9** | **968.3** | **6,576.1** | **40,519** | **0.91** | **3.3** |

*Notes: The averages, per person, with dementia is residential care and per person with dementia at home receiving formal services are $36 547 and $2 554, respectively.

*Source: Access Economic, Dementia Epidemic, p 50.*

## Diagnosis and care

8.80 In all cases, dementia is a progressive disease with changing care needs as it progresses:

61 Lowe P, transcript 3/02/2004, pp 787-8; Wintringham, sub 42, pp 6-7.

62 Access Economics, *The Dementia Epidemic*, p 50.

63 Access Economics, *The Dementia Epidemic,* p 24.

> For each of these stages a person moves through with that illness[,] they require a different skill set, possibly even require a different type of environment with various levels of expertise … depending on the level and difficulty of that challenging behaviour.[64]

8.81 Dementia may be accompanied by challenging behaviours – referred to as behavioural and psychological symptoms of dementia (BPSD) – which may range from wandering to episodes of increased anxiety and bouts of aggression. Such behaviours can be disruptive to carers and other residents and may result in physical injury to the individual themselves or to care staff.[65]

8.82 Dr Susan Richardson explained to the Committee that not all people with dementia exhibit challenging behaviours: however, a significant number have moderately challenging behaviour and a few have extreme behaviours. According to Brodaty's model of management of BPSD, only 1% of all dementia sufferers (some 1,700 people) have 'very severe' BPSD, and a very small number have 'extreme' challenging behaviours. Brodaty considers that those with 'very severe' BPSD should be cared for in psychogeriatric facilities and those with 'extreme' behaviours require a high security specialist care unit.[66]

8.83 The Committee heard, however, that it is not always easy to find a place for people with dementia, especially when there are challenging behaviours. The small numbers of people with severe and extreme behaviours means that in many localities there are no facilities suited to their needs.[67]

8.84 The diagnosis of dementia is not straightforward and the Committee heard that many GPs are not well informed about its diagnosis and treatment. As Dr Menzies stated:

> Dementia is a complex health problem, and often GPs do not have the skills to give optimum care to these patients.[68]

8.85 This may result in people receiving inappropriate care, forgetting to take their medications for other conditions, and not being in a

64 Richardson S, AMA, transcript 7/03/2003, p 214.

65 NSW Health, sub 160, p 9.

66 Richardson S, transcript 7/03/2003, p 214; Gegg S, sub 48, p 1; Burfoot C, transcript 19/05/2003, p 470; Henry Brodaty, Brian M Draper and Lee-Fay Low, 'Behavioural and psychological symptoms of dementia', *MJA, 2003* 178 (5): 231-234.

67 Richardson S, transcript 7/03/2003, pp 214-15; The Aged Care Rights Service, sub 87, p 34; K Burfoot, transcript 19/05/2003, p 470; Ward J, transcript 24/02/2003; p 142.

68 Menzies R, transcript 24/02/2004, p 841.

position to start planning for how their care, financial and legal matters will be handled when they can no longer take responsibility.[69] Central Coast Health, NSW, referred the Committee to a CD-ROM called, *Its time to think about dementia,* distributed to GPs to assist them to improve diagnosis. While such products provide useful support, the Federation of Ethnic Communities Councils of Australia emphasised that there is an urgent need to develop culturally and linguistically appropriate assessment tools for the diagnosis of dementia. [70]

8.86 Dr Mahajani stressed that the need to develop dementia skills is an even greater challenge when working with Indigenous people, especially those in remote areas.[71]

8.87 The New South Wales Department of Health suggests the implementation of a 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…[72]

8.88 The need for community care and residential care staff to improve their knowledge and care skills relating to dementia was repeatedly raised. Constant TV, a small fish tank, and a weekly keyboard rendering of WWI songs scarcely constitute appropriate care.[73]

8.89 Views were put that dementia care education and training should be compulsory for all care staff in residential aged care and for management and support staff. This is in keeping with the requirement under the Accreditation Standards that management and staff have appropriate skills to perform their roles effectively. While the assistance of the Psychogeriatric Units in assessing difficult behaviours is valued, these are few and far between so that many areas lack access to their support.[74]

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69 The Aged Care Rights Service, sub 87, p 33; Blackwell J, transcript 24/02/2003, p 90; Council on the Ageing, NSW, sub 157, p 5; Richardson S, transcript 7/03/2003, pp 215, 220; Flecknoe-Brown S, transcript 24/02/2004, p 841.

70 Blackwell J, Central Coast Health, transcript, 24/02/2003, p 90; Federation of Ethnic Communities Councils of Australia, sub 140, p 2.

71 Mahajani S, transcript 3/02/2004, pp 795-796.

72 New South Wales Department of Health, sub 160, p 9.

73 Warn P, sub 26, p 10.

74 Council on the Ageing, NSW, sub 157, p 5; NSW Health, sub 160, p 9; The Aged Care Rights Service, sub 87, p 32; AMA, sub 86, p 2; Accreditation Standards, viewed

8.90 The Committee heard that facility design plays a significant role in successful dementia care. Architects KLCK Woodhead International explained that:

> Designing for people with dementia requires a particular understanding of the impact of the disorder on residents and their families. … it is essential to provide an environment that enables residents to use their remaining cognitive abilities and skills to the highest possible level. To achieve this, we believe key design principles, such as redundant cueing, design for wayfinding and orientation, familiarity, appropriate scale and security, need to be applied.[75]

Australia now has a growing body of experience in design for dementia care.[76]

8.91 To act as an incentive for residential care providers to take dementia care more seriously, the Council on the Ageing, NSW, suggested:

> Making accreditation reports publicly available to potential residents and their families and carers to know whether the facility has the staff and environment to provide quality dementia care.[77]

8.92 The Committee notes that in the 2004-05 Budget, a new supplement for the care for people with dementia and challenging behaviours recognises the more intensive staff time needed for this care. Details of the rates and eligibility for the supplement have yet to be announced.

## Depression and other mental health problems

8.93 Evidence to the Committee indicated inadequate provision of mental health services in the community and in residential care, and a lack of access to skilled staff to call on for support. The National Rural Health Alliance pointed to the limited capacity in small towns to provide either effective diagnosis or ongoing care for people with mental

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13/07/2004, <http://www.accreditation.aust.com/accreditation/ standards.html#1>; Ward J, transcript 25/02/2003, p 141.

75 KLCK Woodhead International, sub 96, p 2.

76 Review of Pricing Arrangements in residential aged care, pp 183-84

77 Council on the Ageing, NSW, sub 157, p 6

health disorders (such as schizophrenia, delirium, mood disorders or mania) or to provide respite for their carers. [78]

8.94 Many older migrants who suffered trauma in their earlier lives are in need of mental health services attuned to their particular circumstances. In this context, the importance of careful assessment to distinguish between dementia and other mental health conditions was stressed by the Blacktown Migrant Resource Centre.[79]

8.95 According to the findings of the 'Challenge Depression 'project, approximately 51% of residents in high care homes and 30% in low care homes score above the cut-off point for depression on the Geriatric Depression Scale. Other studies suggest that up to 20% of older people in the community are also subject to depression. [80] The project identified factors that best explained the depression experienced by residents as follows (in order of importance):

- Grief over loss of opportunities and abilities to take part in valued activities
- Described by a relative as being depressed prior to admission
- Not involved in helping others
- Attending but not taking part in activities
- Having problems settling in, particularly with establishing good relationships
- Experiencing chronic pain
- Having had a stroke
- Not having a weekly visit.[81]

8.96 Other research concludes that:

> Depression is commonest among those living in nursing homes or hostels, and is especially prevalent in those who suffer chronic illness or disability, especially conditions that produce pain, urinary incontinence, or significant activity limitation. … depression among the elderly is under-recognised, under-treated, and associated with a poor

78 Australian Nursing Federation (SA Branch), sub 93, p 12; Aged Services Learning and Research Collaboration, sub 151, p 12; National Rural Health Alliance, sub 131, p 32-3; FECCA, sub 140, p 2; Department of Veterans' Affairs, transcript 7/02/2003, p 33.

79 Malak A, transcript 7/03/2003, p 260; Agyepong B, transcript 4/07/2003, p 660.

80 Flemming R, 'Challenging Depression in the Elderly: making a determined start'. A project commissioned by the Department of Health and Ageing, viewed 4/07/2004, <http://www.hammond.com.au/resources/intro.pdf>.

81 Flemming R, 'Challenging Depression in the Elderly: making a determined start', p 3.

prognosis, including being an independent risk factor for premature death.[82]

8.97 The Committee also heard that in part the inadequacy of services stems from poor understanding of mental health disorders in older people, and hence how to best provide support and services. As Professor McCallum stated, 'We do not know what to do at the moment'.[83]

8.98 Building on the 'Challenge Depression' project, the Department of Health and Ageing has developed a resource package and is promoting seminars to assist residential aged care staff to recognise and manage depression in residents.[84]

8.99 The Committee welcomes the assistance that will be provided through the resource package but concludes that there is a long way to go before depression in residential aged care is properly understood and managed.

## Respite care

8.100 Alzheimer's Australia, among others, welcomed the expansion of respite services in recent years through the National Respite for Carers Program and the Home and Community Care Program. Australian Government funding subsidised 47,716 admissions to residential respite, (around 985,000 days) in 2002-03. The Committee notes that funding for the National Respite for Carers Program was expected to be almost $99 million in 2003-04.[85]

8.101 Even so, a number of concerns were raised. These were echoed by Mr Chodziesner, of Carers Australia, in light of his personal experiences caring for his wife:

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82 Ritchie C and Ames D, 'Disorders of old age in Australia', in Meadows G and Singh B (eds), *Mental Health in Australia: collaborative community practice*, Oxford University Press, 2001, p 418.

83 McCallum J, transcript 4/07/2003, p 674.

84 Department of Health and Ageing, *Challenge Depression: Reducing Depression in Aged Care Homes,* viewed 4/08/2004, <http://www.ageing.health.gov.au/workforce/chaldepr.htm>

85 Alzheimer's Australia, sub 79, p 13; Lgov NSW, sub 89, p 19; Sneesby A, transcript 19/05/2003, p 468; The Hon Julie Bishop MP, *Investing in Australia's Aged Care: More Places, Better Care,* May 2004, p 10; Department of Health and Ageing, *Report on the Operation of the Aged Care Act 1997*, 1 July 2002 to 30 June 2003, p xi.

- insufficient respite places to cover demand, in part because funding incentives for aged care homes to provide respite care are lacking – and quality residential respite care is difficult to find,[86]
- insufficient home respite resulting in long waiting lists or, in some locations, no access at all;
- limited choice in respite arrangements: short term residential care or occasional home care – and in a few locations, day care, but this may cater only for people with relatively low care needs, and not for people with dementia; and
- weekend and overnight respite is very scarce and very hard to organise.[87]

8.102 A further disincentive identified by representatives of the Aged Care Assessment Services in Victoria, is the paperwork burden involved in admitting people to residential care respite, especially for high care. Despite the desperate need to respite care, Mrs Thorn stated that some providers seem willing to not fill respite beds rather than complete the necessary paperwork. She also noted the success of Carer Respite Centres in helping to maximise access:

> We have about 2,500 respite bed days in the north-east region and we use about 500 of those a year. The only ones that are being fully utilised are being managed through the care and respite centre, where they do a lot of the paperwork and provide extra dollars for settling in … If the bed is not filled for some reason, the facility does not miss out.[88]

8.103 Other evidence indicated there are very good respite services operating, including dementia respite services, day care services and innovative approaches similar to family day care for children. Lake Macquarie City Council's single assessment service makes it easier for people seeking respite by referring them to providers that could meet their particular needs. [89]

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86 A further disincentive identified for residential respite was the paperwork burden involved: see Harvey D, transcript 31/03/2003, p 298.

87 Chodziesner B, transcript 7/03/2003, p 246; Burfoot C, transcript 19/05/2003, p 470; Sneesby A, transcript 19/05/2003, p 468; Barrand P, transcript 3/02/2004, p 759; Bogaerts J, transcript 25/02/2003. A further disincentive identified for residential respite was the paperwork burden involved: see Harvey D, transcript 31/03/2003, p 298.

88 Houghton P, Harvey D and Thorn J, transcript 31/03/2003, pp 297-98; Sneesby A, transcript 19/05/2003, p 468.

89 Burfoot C, transcript 19/05/2003, p 470; Iliffe J, transcript 7/03/2002, pp 252-53; Bogaerts J, transcript 25//03/2003, p 153-54

8.104 In addition to more funding for services under the National Respite for Carers Program, proposals put to the Committee included improving funding incentives for offering respite care, and incentives for developing specialisation and diversification of models of respite care to encourage greater flexibility and responsiveness and give carers more choice.[90]

8.105 As part of the allocation of new places, providers nominate the proportion of place days that will be used to provide respite care. Once approved, providers are then limited to their specified allocation of residential respite place days, regardless of the demand and whether they are willing to provide more respite days.[91]

8.106 At present for each respite care resident, aged care homes receive:

- respite care subsidy, paid at RCS level 3 for high care and RCS level 6 for low care; and
- respite care supplement. This supplement was increased in the 2004-05 Budget by $2.75 to $16.25 per day in line with the concessional resident supplement to assist providers with capital requirements.[92]

8.107 The Committee considers that while the increased respite care supplement is welcome it is unlikely to improve access to residential respite care. In the 2004-05 Budget context, the Australian Government announced that the RCS (residential classification scale) will be streamlined from eight categories to three. This provides an opportunity to establish respite care subsidy rates that will provide a better incentive for aged care homes to provide respite care, including care for people with complex high care needs.

8.108 A more comprehensive reassessment of residential respite care arrangements is needed.

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90 Moreland City Council, sub 37, p 3; National Aged Care Alliance, sub 88, p 6.

91 Department of Health and Ageing, *Residential Care Manual,* Appendix 1, Residential Respite Care, viewed 16/07/2004, <http://www.ageing.health.gov.au/manuals/rcm/contents/append1_b.htm>.

92 Department of Health and Ageing, *Residential Care Manual,* Appendix 1, Residential Respite Care, viewed 16/07/2004, <http://www.ageing.health.gov.au/manuals/rcm/contents/ append1_b.htm>; *Budget Measures 2004-05*, Budget Paper No. 2, p 187.

## Palliative care

8.109 Quality palliative care is essential to the person and their family in the final stages of an older person's life. Palliative Care must be easily available to people who are terminally ill. Caring staff and adequate resources are necessary to ensure the comfort of those in need of care.[93]

8.110 In evidence to the Committee many organisations and individuals emphasised the importance of access to quality palliative care.[94] Palliative care refers not just to caring for people who are very sick or dying, it involves supporting patients and their families in dealing with the physical, psychological, emotion and spiritual aspects of their condition.[95]

8.111 Palliative care can be provided in community settings, designated palliative care beds in hospices, acute hospitals or living environments such as an aged or supported care facility environment of the patient's choice.[96] Evidence to the Committee showed that people are opting for all of these settings. By the very nature of aged care homes, the incapacity to provide quality palliative care will grow in importance.[97]

8.112 Mrs Sneesby of the Mid North Coast Area Health Service explained that many people wish to remain in their own homes and in the Coffs Harbour area there are approximately 150 patients seeking palliative care each year, with 50 per cent of people electing to die in their homes.[98]

8.113 People in rural and remote areas should also be able to benefit from palliative care. Limited resources in rural and remote areas mean people often miss out or travel long distances to major centres for

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93 Australian Lung Foundation, sub 173, p 36

94 Country Women's Association, sub 121, p 2; Otomancek G, sub 169, p 4; Australian Physiotherapy Association, sub 118, p 18; Anglican Dioceses of Sydney, sub 67, p 3-4; Australian Nursing Foundation, sub 97, pp 1, 14.

95 Palliative Care Australia, sub 139, p 4; Australian Lung Foundation, sub 173, p 36.

96 Palliative Care, *Service Provision in Australia: A Planning Guide*, viewed 28/07/2004, <http://www.pallcare.org.au/publications/Planning%20guide2003.pdf>, p 17; Barrand P, transcript 3/02/2004, p 760.

97 Baptist Community Care Ltd, sub 56, p 2; Maddocks I, Medical Journal of Australia, *Palliative Care in the 21st Century,* 15/09/2003, volume 6, supplement, viewed 28/07/2004, p 1-2, <http://www.mja.com.au/public/issues/179_06_150903/mad10519_fm.html>.

98 Sneesby D, transcript 19/5/2003, p 468.

palliative care.[99] Very few palliative care services are available in Indigenous communities, however, the Central Australian Aboriginal Congress informed the Committee of their innovative primary health care service for older indigenous people including palliative care through its Frail, Aged and Disabled (FAAD) program.[100]

8.114 Australia is earning a high reputation in the development of palliative care. It has been suggested that this is due in part to the increasing focus by governments on palliative care over the past twenty years.[101] This focus is reflected by endorsement in 2000 by the Australian Health Ministers' Advisory Council (AHMC) of the National Palliative Care Strategy. The strategy represents the commitment by governments, together with key stakeholders, to the development and implementation of consistent policies and quality palliative care services across Australia. Under the 2003-08 Australian Health Care Agreements, the Australian Government is providing $201.2 million for palliative care. Of this, $188 million it to be allocated on a per capita basis to states and territories for palliative care provision, and $13.2 million for the implementation of national initiatives.[102]

8.115 Other recent initiatives include: a scoping study to determine palliative research priorities;[103] funding for palliative care in the community;[104] a national study of the palliative needs of Indigenous communities;[105] and funding for the Divisions of General Practice to develop multi-disciplinary palliative care suited to the needs of rural communities.[106] The NHMRC is providing specific funding for palliative care research through PhD scholarships, post-doctoral fellowships and research grants. A recently completed NHMRC

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99 DeBono S, transcript 24/02/2004, p 875; Millman D, transcript 24/02/2004, p 859; Smith M, transcript 2/02/2004, p 743.

100 Central Australian Aboriginal Congress Inc, sub 176, p 5; Boffa J, transcript 2/02/2004, p 730.

101 Maddocks I, Medical Journal of Australia, *Palliative Care in the 21st Century,* 15/09/2003, volume 6, supplement, viewed 28/07/2004, p 1, <http://www.mja.com.au/public/issues/179_06_150903/mad10519_fm.html>

102 Department of Health and Ageing, The National Palliative Care Strategy, viewed 27/07/2004, <http://www.palliativecare.gov.au/strategy.htm>.

103 NHMRC, research, viewed 30/07/2004, <http://www.nhmrc.gov.au/research/srdc/pallcare.htm>

104 Department of Health and Ageing, Budget Measures 2002-03, Budget Paper No. 2, 2002, http://www.health.gov.au/budget2002/fact/hfact2.htm

105 National Indigenous Palliative Care Needs Study, viewed 28/07/2004, <http://member.telpacific.com.au/ksa/>.

106 Australian Divisions of General Practice, Rural Palliative Care Program, viewed 28/07/2004, <http://www.adgp.com.au/site/index.cfm?display=683>.

funded project indicates there is still much work to be done before older people in Indigenous communities can access palliative care that also respects Indigenous cultural practices.[107]

8.116 The 2004-05 Budget saw the introduction of a new care supplement for residents with complex palliative care needs. The supplement recognises that palliative care requires more intense care time. The supplement will help ensure that aged care homes are adequately funded to provide residents with high quality palliative care.[108]

8.117 A further step to national cooperation was taken in July 2004 with the release of guidelines for a palliative approach in residential aged care and an associated framework for education and training.[109]

8.118 The Committee welcomes the increasing focus on palliative care across levels of government. Even so, it is clear that the potential benefits are yet to be widely accessible in the community. Eligibility criteria and access arrangements for the new palliative supplement are yet to be announced by the Australian Government. It is essential that eligibility and the level of funding reflect all facets of a palliative approach, including the person's physical, cultural, psychological, social and spiritual needs.

## Residential care

8.119 In 2002-03, 184,095 people received permanent residential care - just 10% of Australians aged 70 or more years. Some 34,025 people received residential respite care, of whom 14,792 were later admitted to permanent care.

8.120 Of residents in care as at 30 June 2003:

- just over 50% were over the age of 85;
- 72% were female;
- 56% of all female residents were over the age of 85;

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107 NHMRC Palliative Care Research, viewed 30/07/2004, <www.nhmrc.gov.au/research/train/ palgrant.htm>, <www.health.gov.au/nhmrc/research/train/ postdoc.htm>, <http://www.nhmrc.gov.au/research/train/palcare.htm>.

108 Department of Health and Ageing, Budget Measures 2004-05, Budget Paper No. 2, 2004, p 190; Department of Health and Ageing, *Investing in Australia's Aged Care*, viewed 29/07/2004, <http://www.health.gov.au/investinginagedcare/q_a>.

109 Australian Palliative Residential Aged Care Project, viewed 30/07/2004, <http://www.apacproject.org/showpage.asp?ButtonID=1>.

- 37% of all male residents were over the age of 85;
- 90% received a full or part pension – 74% received a Centrelink pension and 16% a DVA pension; and
- 6215 residents (4%) were under the age of 65.[110]

8.121 Evidence to the Committee suggested that older people are entering care at a later, frailer stage, increasing the demand for high care.[111] This is borne out by Table 8.2 which shows the proportion of residents in each RCS category between 1999 and 2002.

8.122 The Committee heard wide-ranging evidence about the care currently provided in aged care homes, and about the adequacy of the system to meet future demands for care as the number of older Australians increases. The main concerns identified were as follows:

- access: appropriateness of the planning ratio and allocation processes;
- assessment and the role of Aged Care Assessment Teams;
- quality of care;
- adequacy of care for individuals with special needs;
- the interface with acute care; and
- funding and the viability of aged care facilities.

Table 8.2: Proportion of residents in each RCS category, 1999 to 2002

| RCS Category | Unit | June 1999 | June 2000 | June 2001 | June 2002 | Change 1999 to 2002 |
|---|---|---|---|---|---|---|
| RCS 1 | % | 14.2 | 17.2 | 18.8 | 19.3 | 35.9 |
| RCS 2 | % | 25.7 | 25.4 | 25.1 | 24.9 | -3.1 |
| RCS 3 | % | 16.5 | 15.4 | 14.7 | 14.5 | -12.1 |
| RCS 4 | % | 4.6 | 4.6 | 4.6 | 4.6 | 0.0 |
| **High Care** | **%** | **61.0** | **62.6** | **63.2** | **63.3** | **3.8** |
| RCS 5 | % | 8.8 | 9.8 | 10.5 | 10.5 | 19.3 |
| RCS 6 | % | 10.2 | 10.5 | 10.8 | 10.8 | 5.9 |
| RCS 7 | % | 16.9 | 14.9 | 13.9 | 13.8 | -18.3 |
| RCS 8 | % | 3.1 | 2.2 | 1.6 | 1.5 | -51.6 |
| **Low care** | **%** | **39.0** | **37.4** | **36.8** | **36.7** | **-5.9** |

*Source: WP Hogan, Review of Pricing Arrangements in Residential Aged Care, The Context of the Review, p 7.*

110 Hogan WP, *Review of Pricing Arrangements in Residential Aged Care, Final Report*, p 167.

111 Australian Nurses Federation (SA Branch), sub 97, p 5; Young R, transcript 7/03/2003.

8.123 It should be noted that the Committee heard evidence relating to residential care before the Hogan Review report was released. Many of the issues raised with the Committee and discussed here are consistent with those presented to the Hogan Review.

## The availability of residential care

8.124 Issues of major concern regarding the availability of residential care included the adequacy of the planning ratio, the bed allocation (licensing) process, and the need for allocated places to become operational much more quickly. Together, these factors were seen as limiting access to care, causing long waiting lists in many areas, and (for one reason or another) jeopardising the viability of aged care homes.

8.125 The planning ratio of 50 low care, 40 high care and 10 CACPs for every 1000 people aged 70 years and over was widely regarded as inadequate. The Committee heard that this ratio failed to keep pace with growth in the older population or the demand for high care and no longer reflected preferences for continuing to live in the community. Further, tying the ratio the over 70 years age group was considered to not acknowledge that users of residential aged care are mostly over 80 years of age.[112]

8.126 A major criticism of the allocation process was its short-term focus, with places being announced and allocated on an annual basis making it difficult for providers to plan ahead, including marshalling finance. Dr Howe summed up the effect as follows:

8.127 [It requires] the sector to gear up and wind down in short cycles rather than continue at a steady rate of development, with effects felt at all stages throughout the development process from land acquisition to engaging architects and builders and finally commissioning and staffing facilities.[113]

8.128 In addition, local governments with rapid increases in their older populations due to retirement migration were concerned that allocations were based on outdated census data.[114]

8.129 Concerns about the lag between allocation of places and the time older people can access the services is consistent with figures in the

112 Anglican Aged Care Services Group, sub 99, pp 1-2; Moreland City Council, sub 37, p 3; Gray R, transcript 17/08/2003, p 699; Lgov NSW, sub 89, pp 15-16; ANHECA, sub 111, p 11; COTA, sub 157, p 2.

113 Howe A, sub 128, p 5.

114 Blackwell J, transcript, 24/02/2003, p 96; Anglican Aged Care Services Group, sub 99, p 4; Lgov NSW, sub 89, p 16; Lipscombe J, transcript 7/03/2003, p 241.

most recent *Report on the Operation of the Aged Care Act 1997.*[115] Suggestions to reduce or offset the lag time included releasing sufficient places to catch up with the planning benchmarks, developing better designed allocation processes including addressing the short term focus of annual releases which makes it difficult to plan ahead.[116] The Committee also heard about the efforts some local governments are making to reduce the lag time by identifying and making available suitable land so that approval processes can be simplified and expedited.[117]

8.130 The Hogan Review also identified these issues as major concerns and made recommendations regarding the planning ratio, introducing more flexibility to the allocations process, and providing incentives for new places to become operational more quickly.[118] In the 2004-05 Budget context the Australian Government announced that:

- The provision ratio will be increased to 108 operational places for every 1000 people aged 70 or over comprising: 20 CACPs, 40 high care places, and 48 low care places.
- An estimated 27,900 new places will be allocated over the next three years, including 13,030 in 2004.
  - ⇒ Up to 2000 transitional care places will be provided over the next three years on a cost-shared basis with the states and territories.
- Indicative numbers of new places will be announced three years in advance so providers have more time to plan ahead and enable beds to in use more quickly.
- A flexible pool of places will be created within each allocation round to address structural and regional requirements.
- The effectiveness of the new planning arrangements will be reviewed in 2007-08.[119]

8.131 The Committee notes that these commitments have the potential to address the concerns presented to it. The Minister for Ageing has

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115 *Report on the Operation of the Aged Care Act 1997*, 1 July 2002 to 30 June 2003, p 5;

116 NSW Health, sub 160, p 6; Anglican Aged Cares Services Group, sub 99, p 2; National Aged Care Alliance, sub 88, p 2; Moreland City Council, sub 37, p 3

117 Moreland City Council, sub 37, p 3; Brady P, transcript 25/06/2003, pp 553-554, Blackwell J, transcript 24/02/2003, p 96.

118 *Review of Pricing Arrangements in Residential Aged Care,* Final Report, pp 276-78.

119 The Hon Julie Bishop, Minister for Ageing, Budget 2004-2005, Fact sheet 1, Summary of Aged Care Measures, p 2, viewed 1/06/2004, <http://www.health.gov.au/budget2004/abudget/afact1.htm>.

already announced indicative places for the coming years. However, the number of places overall falls short of the recommendation made by the Hogan Review. The Committee endorses the need for a thorough and fundamental review of planning arrangements in 2007-08.

8.132 While by far the majority of those who expressed concerns about the process for allocating (licensing) places wanted the process to be fixed, Mrs Cusworth, of the Chamber of Commerce and Industry WA, suggested that licensing should be abandoned in the longer term: 'The idea that you have a bed licence for which there is an informal competitive market in a government funded system is just nonsense'.[120] The Hogan Review considered the implications of the secondary market for bed licences and the value providers accrue from the intangible asset allocated 'free' by the Government. The Hogan Review suggested that the Government should consider progressively replacing the 'free' allocation process with an auction system – however few details of how this might operate were provided. In response, the Australian Government announced that it will consult the community and aged care providers on the appropriateness of this option.[121]

8.133 The Committee considers that such a move is likely to discriminate against small not-for-profit providers, including homes managed by community organisations in rural areas. Any future consideration of an auction system must include safeguards for the provision of aged care in rural and remote areas, and the potential for the auction system to contribute to financing care in those areas.

## Assessment for residential aged care

8.134 Although the work of individual Aged Care Assessment Teams (ACATs) was praised, overall a high level of frustration with assessment arrangements was described, including the need for better coordination to streamline assessment and access to services (see above, 'Community care services').

8.135 More specifically in relation to residential care, the Committee heard suggestions that ACATs should play a stronger role in waiting list management and in helping people to make informed choices. The

120 Cusworth N, transcript 29/04/2003, p 433.

121 Cusworth N, transcript 29/04/2003, p 433; *Review of Pricing Arrangements in Residential Aged Care,* Final Report, pp 300-01; Australian Government's Response to the Review of Pricing Arrangements in Residential Aged Care, p 1, viewed 1/06/2004, <http://www.health.gov.au/investinginagedcare/response/response.pdf>.

Aged Services Learning and Research Collaboration also proposed that where ACATs are attached to hospitals, they should control discharge planning and home care services as well as being gatekeepers for residential care.[122]

8.136 Concerns were expressed that pressures on current assessment arrangements mean that people from culturally and linguistically diverse backgrounds do not always receive targeted information to assist them in making informed decisions about their care. Nor may assessment teams have access to the range of skills and cultural knowledge to ensure that people from culturally diverse backgrounds are not disadvantaged by the assessment process.[123]

8.137 ACATs and aged care homes both raised the inconsistency between the assessment of needs under ACAT guidelines and under the RCS categories. While these assessments have different purposes, the inconsistency can impact on the level of funding received. The requirement for ACAT approval to upgrade care from low to high as a resident's care needs increase was also raised as a source of frustration, both in terms of working against the concept of ageing in place and the administrative burden for both the home and ACAT staff. ACATs prioritising heavy workloads and relative urgency at times give lower priority to upgrades than to assessing a person in the community in danger of fractures from falls. In rural areas especially, delays in upgrade assessments can mean that homes may be paid at a lower RCS rate than that for the actual care received.[124]

8.138 While the Committee heard that improving coordination and streamlining requirements are essential, Ms Alanson stressed that change without adequate funding will achieve little:

> My concern is that we keep arguing about and being critical of the aged care assessment teams but they can only be as good as they are funded. … There are some wonderful people in ACAT. As I said, if they are underfunded, they cannot meet the objective of the Aged Care Act.[125]

8.139 Even increased funding may not solve the recruitment problems experienced by some assessment teams, especially the general

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122 Aged Care Assessment Services, Victoria, sub 61, p 2; Aged Services Learning and Research Health Collaboration, sub 151, p 15.

123 Council for Multicultural Australia, sub 74, p 2.

124 Harvey D, transcript, 31/03/2003, p 290; Byron D, transcript 25/02/2003, pp 175, 177; Mahajani S, transcript 3/02/2004, p 794; Fullerton and Allanson V, transcript 25/02/2003, pp 177-78; Phillips C and Jeffrey R, transcript 3/02/2004, pp 782-83

125 Allanson V, transcript 25/02/2003, p 178; Harvey D, transcript 31/03/2003, pp 290-91.

shortage of geriatricians and allied health professionals and the more acute shortages in rural areas.[126]

8.140 In some remote areas, staff shortages have led to pragmatic approaches which incidentally lead to better integration across programs. Ms Gwynne, whose team of four services the entire East Arnhem region, stated that:

> The team leader there also wears the hat of the local area coordinator and the hat of the ACAT assessor. … it is nonsense to separate out those particular functions … when we are going out to remote communities; it is meaningless to them for a white person to say, 'I can only talk to you about disability issues today.'[127]

8.141 Australian Government funding for the Aged Care Assessment Program in 2003-04 was $47.2 million which was distributed according to a new needs-adjusted, population based funding model. Funding included a one-off amount of $2.5 million provided in the 2003-04 Budget which was targeted to under-funded ACATs. The states and territories supplement this with additional funding or access to other resources such as specialist staff to support assessments and access to hospitals and rehabilitation services.

8.142 The Committee notes some changes to funding for the Aged Care Assessment Program and ACAT responsibilities are being implemented following decisions in the 2004-05 Budget context. Funding of $47.9 million over four years (including extension of $2.5 million one-off funding from the 2003-04 Budget) will be provided to increase the capability of ACATs and allow better case management, more timely assessments, and better links between community and residential care. The funding will also enable the development and implementation of common assessment processes, eligibility requirements and standards of provision. In addition, an ACAT assessment is no longer required to upgrade a resident from low to high care within the same aged care home.[128]

## Quality and accreditation

8.143 Evidence to the Committee reflected a strong commitment to quality care for people in residential aged care and concerns about factors considered to limit residents receiving such care. It also reflected the

126 O'Donnell G, transcript 31/03/2003, p 292;

127 Gwynne K, transcript 3/02/2004; p 752.

128 *Budget Paper No. 2, 2004-05,* p 188.

fact that gaining a shared understanding of what constitutes quality and how best it may be assessed and rewarded is an ongoing challenge.

8.144 Ms Iliffe identified a set of inter-related factors that can contribute to, or diminish, the quality of care: quality buildings, quality staff, quality funding, quality accreditation and a quality complaints system. As other evidence indicated, quality management should be added to these. [129]

8.145 Concerns were raised about staff competence and shortages, the quality of management, requirements and administrative arrangements that generate paperwork burdens, and the role of the Aged Care Standards and Accreditation Agency.

8.146 The Committee heard that quality care is directly related to the availability and competence of staff. As Ms Iliffe stated: 'To be able to provide quality aged care, providers must be able to attract and retain quality staff'. Others stressed the importance of continuing education for care staff (see further, 'Workforce shortages', below).[130]

8.147 The competence of all staff was seen as critical to quality care, including that of facility managers and boards of management. Mr Kennedy, of Catholic Health Care Services, advised the Committee that his organisation is frequently called on to assist homes establish better management and management systems:

> We … come in and assist them with their RCS classification, with their workers compensation premium and risk management strategies. We often have to assist them with their basic financial management systems and their clinical care systems, to help them with the accreditation process.[131]

8.148 Over reliance on agency nursing staff can diminish the quality of care residents receive. The Committee heard that for many shifts some homes 'are totally dependent on agency staff to provide registered nurse cover'.[132]

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129 Iliffe J, transcript 7/03/2003, p 231; Lewit J, sub 96, for the importance of facility design to support overall service provision, dementia care, carers and other staff, and relatives and other visitors.

130 Iliffe J, transcript 7/03/2003, p 225; Russell C, transcript 4/07/2003, p 671; [others]

131 Kennedy M, transcript 23/02/ 2004, p 825. See also, Lipscombe J, transcript, 7/07/2003, p 243.

132 Holmes B, transcript 4/07/2003, p 650. Se also, Baptist Community Services, sub 172, p 5.

8.149 Ms Warn, for example, warned that by using agency nurses and casual nurses, aged care facilities may not be best serving its residents needs:

> You could not possibly see how somebody's condition had changed from one day to the next. You could read it in the nursing notes if you had time, but you could not actually see it, because you do not know the people. There is little sense of responsibility for someone if you are moving in and out willy-nilly. It makes it very difficult.[133]

8.150 Under the *Aged Care Act* 1997 (Section 96-3(5)), the Aged Care Standards and Accreditation Agency has been delegated responsibility for managing the accreditation process using the Accreditation Standards, and for promoting high quality care.

8.151 At the time submissions to the Inquiry were received, aged care homes had experienced the first round of the accreditation process – a new experience for the Agency and for all the homes. The rough edges of a 'settling in' stage were reflected in evidence to the Committee. As Ms Houghton explained to the Committee:

> I think that was around the time of the first accreditation process for facilities. It was an enormous exercise for those facilities to get all their paperwork up to scratch. That is a good thing because that is a process of being accountable, but it really was at the cost of direct care time of the residents.[134]

8.152 Other evidence also expressed concern that focus on the fundamental issue of quality was in danger of being displaced by a focus on documentation, and the right choice of words.[135] Ms Warn was among those who stressed that documentation tells only part of the quality story:

> …in terms of accreditation, there is not sufficient effort made to talk to carers, to talk to relatives and to interact in any way with residents.[136]

8.153 The importance of involving consumers and their families was seen as particularly important to improving the Agency's capacity to accurately assess evidence of culturally appropriate outcomes.[137]

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133 Warn P, transcript, 3/07/2003, p 611. See also, North R, transcript 23/02/2004, p 814.

134 Houghton P, transcript 31/03/2003, p 301.

135 Millar J and Miller G, transcript 23/02/2004, pp 808-09;

136 Warn P, transcript 3/07/2003, p 604-06; Older Women's Network, sub 58, p 3;

137 NSW Aged Care Alliance, sub 11, p 18.

8.154 Suggestions were put to the Committee that quality (and funding arrangements) could be improved by the introduction of a benchmark of care (see further below, 'Funding and the viability of aged care homes'.

8.155 In the 2004-05 Budget the Australian Government provided the Aged Care Standards and Accreditation Agency with additional funding of $36.3 million over four years. The funding will place the Agency on a more secure financial footing and allow it to maintain its current level of monitoring and accreditation activities, including spot checks. In addition, in response to a Hogan Review recommendation, $3 million is being provided to develop an internet information system and a 'star rating' system. Families and people in the community will be able to more easily access information on the quality of care in aged care homes (including accreditation assessments), together with information on fees and services.[138]

## The interface between residential care and acute care

8.156 The transfer of residents between aged care facilities and hospital is common however the circumstances of transfer and the impacts on residents were questioned in evidence to the Committee.

8.157 The Committee heard that aged care providers sometimes shift residents to acute care as a way of removing them from the facility permanently. Mrs Harvey of the Aged Care Assessment Service in Victoria told the Committee that:

> There are also some issues around security of tenure that emerge when someone who is ageing in place in a facility goes into acute care because of an episode of ill health and the facility uses that time to make the decision that they do not want to have them back, that it is time for them to move on. That seems to be fairly commonplace. We see that when we are doing the assessments at the hospital end…it is an issue that acute care often precipitates the transition to a nursing home.[139]

8.158 Residents' security of tenure is protected by the User Rights Principles 1997(s23.4 – s23.6) under the *Aged Care Act 1997* which ensure that residents can not be removed from an aged care facility without sufficient cause. Reasons why a resident may be asked to leave include the facility no longer being able to provide the

138 *Budget Paper No. 2*, pp 189-90.

139 Harvey D, transcript 31/03/2003, p 300.

'accommodation and care suitable for the care of the recipient'. As Mrs Harvey noted, transfer to acute care is a 'fairly common' way of precipitating the issue, and not always in the best interests of the resident. As part of the Australian Government's changes to the aged care assessment scheme there is no longer any requirement for an ACAT assessment to upgrade a resident from low care to high care within the same aged care facility.[140] However, cases such as that raised by Mrs Harvey which would involve a transfer between facilities, should be protected by the user rights principles provided these are adhered to.

8.159 If a resident is being transferred to acute care for the benefit of the aged care facility rather than their own health, it is likely that the move will be detrimental to their wellbeing.

8.160 Transferring a resident into hospital is sometimes motivated by legal reasoning. Aged care staff may wish to avoid any possibility of legal action from family or relatives of the person should the aged care staff or visiting GP not be seen to take action to 'prolong life'.[141]

8.161 Professor Picone, of the New South Wales Department of Health, considered some transfers unnecessary, adding to the pressure on hospitals:

> …what we then do is take an old person out of their home, disrupt them, stick them in the back of an ambulance, send them up to emergency department – which are absolutely flat out at the best of times – and then put them in a queue of other people for services that could be provided in their homes, like a blocked catheter or listening to their chests if they need to start some antibiotics.[142]

Professor Picone attributed unnecessary transfers to poor GP remuneration for visits to aged care homes and/or to inadequate nursing skills. At the same time, such attitudes are consistent with a general perception that older people have 'less right' to hospital care than other people.

8.162 The Committee also heard of strategies being trialled to avoid the stress to residents of unnecessary transfers. Some public hospitals are now sending nurses to aged care facilities to train nurses in administering treatment that residents would normally only receive in hospital. While this may minimise the need for any transfers to

140 Treasury, Budget Paper Number 2, 2004-2005, p .

141 Glover A, sub 5, p 2.

142 Picone D, transcript 3/07/2003, p 569.

hospitals and smooth transfer back to residential care, concerns were put to the Committee that hospitals may be off loading responsibilities onto aged care home – and onto aged care nurses who receive lower pay than acute care nurses. [143]

8.163 The problems of older people being discharged before they are sufficiently recovered was raised by the Coffs Harbour Health Campus, [144] and the by Local Government Association of New South Wales which was:

> …concerned about the repeated incidents of inadequate coordination between hospital discharge planning and residential and support services. Discharge planning is essential to ensure adequate continuity of care for older people, to ensure that they and their carers are prepared for a return to the home or to minimise the wait for residential based care.[145]

8.164 The need for proper discharge planning has already been raised above in relation to transitional care and is also pertinent to the need for more age friendly hospitals (see below).

## Ageing with disability

8.165 A further issue brought to the attention of the Committee is that of people with disabilities who are ageing. Around 4% (13,000) of those aged 65 or over with severe or profound core activity restrictions have lived with disability since before the age of 18.[146] However, access to disability funding and associated services ceases at age 65, just when their needs may be increasing because of age. Indeed, the Aged-care Rights Service stated that:

> …people with longstanding disability who are ageing experience an earlier decline in function than others of a similar age … they can also experience 'secondary disability' or health complications which can arise as a result of the long-term effect of the disability itself.[147]

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143 Holmes B, transcript 4/07/2003, p 648.

144 Bartlett K, transcript 19/05/2004, p 473.

145 LGov New South Wales, sub 89, p 22.

146 The Aged-care Rights Service, sub 87, p 37 based on the ABS 1998 Survey of Disability, Ageing and Carers. Preliminary analysis of the ABS 2003 Survey of Disability, Ageing and Carers (Cat. 4446.0) shows very little difference between the 1998 and 2003 rates. See also, Australian Society for Geriatric Medicine, sub 64, p 2; Stockton Hospital Welfare Association Inc., sub 29, pp 1-2.

147 The Aged-care Rights Service, sub 87, p 37.

8.166 The Latrobe Community Health Service Inc. suggested to the Committee that changing eligibility for services at age 65 could constitute a form of age discrimination.[148]

8.167 The Aged-care Rights Services proposed, *inter alia*:

- Challenging perceptions within the disability and aged care sectors to ensure flexible, appropriate and timely services for people with longstanding disability who are ageing.
- Developing responsive, integrated models of service provision that support collaboration and address the transition issues for people who are ageing.

8.168 The Committee notes that the Bilateral Agreements under the third Commonwealth State Disability Agreement 2003-2007, express commitment to collaborative work on improving issues at the interface between disability support and aged care programs. Commitment across states and territories varies from general agreements to begin discussions, to progressing specific policy and service delivery tasks, and recognition that there will be resource implications for both parties.

8.169 The Committee considers that this component of the new agreements is a positive step however all parties must ensure there is real action within the period of the agreement.

## Funding and the viability of aged care homes

8.170 Baptist Community Care summarised their concerns about funding and viability as follows:

- Ageing building stock yet inadequate capital funding available to rebuild it, particularly high care.
- Recurrent funding declining significantly in real terms as particularly wage inflation, driven by State awards, acute sector pay differentials and growing nursing shortages, continues to exceed price increases paid by the Federal government to providers. … The focus therefore needs to be on new sources of recurrent funding.
- Consumer resistance to the payment of bonds has been much documented. The increasing trend to high care in residential settings will only exacerbate this concern as stays become increasingly short. In any event, neither accommodation bonds nor charges will satisfy capital needs. Indeed, the latter generate 3.5 times less income

148 Latrobe Community Health Service Inc., sub 39, p 2.

than bonds. Additionally bonds are not uniformly available across city and country.

- A proliferation of aged care providers in both residential and community. This not only spreads competent senior staff very thinly but acts against the creation of regionally based service continuums which consumers can easily navigate.[149]

8.171 Similar concerns were raised in other evidence.

8.172 Difficulties in raising bonds in locations with low property values were seen as a problem for UnitingCare but, as a large operator, less of a problem than for small homes. Further, in light of the trend to later entry into care, some homes feel that high care is no longer viable. Older aged care homes, even those that have passed the new certification requirements, require ongoing capital works which, Mr Millar explained, was difficult with a maximum daily accommodation payment in high care of $13.84.[150]

8.173 The adequacy of the indexation formula (COPO) was questioned, and seen as a contributor to wages gap for nurses (see further, Workforce, below).[151]

8.174 Mrs Jeffery of Uniting Church Frontier Services, informed the Committee that Frontier Services has to top up the funding of their remote homes because of extra costs caused by distance:

> We pay extra freight, we pay extra for everything … We spend a lot of money on recruitment and getting staff into Alice Springs. We have to pay airfares, accommodation, meals and all sorts of things to deliver the same care, the same amount of work…[152]

8.175 The Committee notes, that these concerns are broadly consistent with the issues in evidence to the Hogan Review.

8.176 To better assess the impact of these factors on the viability of residential care providers, the Hogan Review undertook extensive analysis of financial information for the year 2001-02 covering 912 aged care facilities or around 31% of the total number of facilities. Of

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149 Baptist Community Care, sub 56, p 1.

150 Herbert H, transcript 3/07/2003, p 579; Millar J, transcript 23/02/2004, p 807; Baptist Community Care, sub 56, p 2, 18-19; Lgov NSW, sub 89, pp 15-16; COTA, sub 157, p 2.

151 Iliffe J, transcript 7/03/2003, p 248; Miller G, transcript 22/02/2004, p 805, Miller J, transcript 23/02/2004, p 808-9; ANHECA, sub 109, p 4; Baptist Community Services, sub 171, pp 1-2.

152 Jeffrey R, transcript 3/02/2004, p 776; Miller G, transcript 23/02/2004, p 805

these, 224 were for information covering a single facility, and some 83 providers submitted information covering two or three facilities.[153]

8.177 Analysis of earnings before interest, taxes, depreciation and amortisation (EBITDA) was used as this allows analysis and comparison across the for-profit and not-for-profit sectors. Analyses were undertaken by state and locality, sector, and size of facility; and by the top 10% and quartile groups according to EBITDA for each provider.[154]

8.178 Table 8.3 shows that there are high performers and poor performers in all the categories of analysis. There is no pattern of provider characteristics (locality, sector/ownership, size, resident mix) that determines high or poor performance, although services were more likely to fall into the bottom quartile if they were provided by the state government sector, had mainly high care residents, and/or were small facilities with less that 30 residents. The Hogan Review noted that the relatively strong performance of rural providers 'belies much of the folklore about residential aged care'. It also concluded that the quality of facility management probably explains poor performance.[155]

8.179 Comparisons of average EBITDA per bed year for aged care sectors are shown in Table 8.4 for the top 10% of services and for each quartile. These demonstrate that while services in the fourth quartile are struggling, those in the top two quartiles (and especially the top 10%) are well placed for viability.

8.180 The Hogan Review highlighted that within the first quartile services, can be considerably better placed than the average. Services performing well in the top ten percent group include community based services. Victorian community services reported the highest average of $18,790. The religious sector, represented over a third of the top quartile of services, reported an average of $9,149 per bed year. Within those religious services placed in the top ten percent grouping, more than half are located in capital cities and had an average EBITDA of $14 674 while more than 75% of community based services are based in rural areas and had an EBITDA of $16,977 per bed.

153 *Pricing Review of Residential Aged Care,* p 27.

154 *Pricing Review of Residential Aged Care,* pp 34-35.

155 *Pricing Review of Residential Aged Care,* pp 38, 55-56.

8.181 In total rural services made up 39% of the first quartile, with an average of $10 236 per bed year. Rural providers made up 46% of the top ten percent group. Of these Rural services, Victoria and NSW reported EBITDA figures of $18 461 and $12 133 per bed year respectively. These results illustrate that rural services can perform just as well or better than metropolitan and capital city services.[156]

Table 8.3: Numbers of State, Sector, Locality, Size and Resident Mix for Top 10 percent and Quartile Groups according to EBITDA for each provider

| **State** | **Top 10%** | **1st Quartile** | **2nd Quartile** | **3rd Quartile** | **4th Quartile** | **Total** |
|---|---|---|---|---|---|---|
| NSW (ACT) | 35 | 93 | 63 | 64 | 40 | 260 |
| QLD | 6 | 19 | 14 | 9 | 11 | 53 |
| SA (NT) | 11 | 27 | 28 | 24 | 11 | 90 |
| TAS | 2 | 3 | 5 | 2 | 3 | 13 |
| VIC | 22 | 44 | 63 | 64 | 104 | 275 |
| WA | 2 | 9 | 22 | 32 | 27 | 90 |
| **Total** | **78** | **195** | **195** | **195** | **196** | **781** |
| **Sector** | **Top 10%** | **1st Quartile** | **2nd Quartile** | **3rd Quartile** | **4th Quartile** | **Total** |
| Charitable | 6 | 18 | 26 | 22 | 14 | 80 |
| Community | 21 | 58 | 40 | 45 | 24 | 167 |
| Local Govt | 5 | 7 | 6 | 6 | 3 | 22 |
| Private | 11 | 26 | 33 | 30 | 23 | 112 |
| Religious | 29 | 74 | 76 | 78 | 79 | 307 |
| State Govt | 6 | 12 | 14 | 14 | 53 | 93 |
| **Total** | **78** | **195** | **195** | **195** | **196** | **781** |
| **Locality** | **Top 10%** | **1st Quartile** | **2nd Quartile** | **3rd Quartile** | **4th Quartile** | **Total** |
| Capital | 35 | 95 | 120 | 126 | 111 | 452 |
| Other metro | 6 | 22 | 16 | 11 | 6 | 55 |
| Remote | 1 | 1 | | 3 | 7 | 11 |
| Rural | 36 | 77 | 59 | 55 | 72 | 263 |
| **Total** | **78** | **195** | **195** | **195** | **196** | **781** |
| **Size** | **Top 10%** | **1st Quartile** | **2nd Quartile** | **3rd Quartile** | **4th Quartile** | **Total** |
| 0-30 | 21 | 44 | 41 | 35 | 79 | 199 |
| 31-60 | 42 | 105 | 101 | 113 | 78 | 397 |
| 61-90 | 13 | 32 | 37 | 29 | 23 | 121 |
| 90+ | 2 | 14 | 16 | 18 | 16 | 64 |

156 *Review of Pricing Arrangements in Residential Aged Care*, p 40, 41, 42.

| **Total** | **78** | **195** | **195** | **195** | **196** | **781** |
|---|---|---|---|---|---|---|
| **Resident Mix** | **Top 10%** | **1st Quartile** | **2nd Quartile** | **3rd Quartile** | **4th Quartile** | **Total** |
| High Care | 33 | 83 | 78 | 81 | 118 | 360 |
| Low Care | 30 | 77 | 73 | 83 | 60 | 293 |
| Mixed Care | 15 | 35 | 44 | 31 | 18 | 128 |
| **Total** | **78** | **195** | **195** | **195** | **196** | **781** |

*Source: Hogan W, Pricing Review of Residential Aged Care, p 38.*

Table 8.4: Average EBITDA per bed year ($) in each Sector

| **Sector** | **Top 10%** | **First Quartile** | **Second Quartile** | **Third Quartile** | **Fourth Quartile** |
|---|---|---|---|---|---|
| Charitable | 10 292 | 7 521 | 3 757 | 1 040 | - 4 204 |
| Community | 15 146 | 9 477 | 3 443 | 1 163 | -2 941 |
| Local Govt | 12 043 | 10 300 | 4 438 | 303 | -5 010 |
| Private | 10 003 | 7 992 | 3 584 | 928 | -2 569 |
| Religious | 13 537 | 9 149 | 3 640 | 1 216 | -6 186 |
| State Govt | 16 444* | 11 305 | 3 983 | 273 | -8 281 |
| **Average** | **13 350** | **9 116** | **3 655** | **1 044** | **-5 771** |

*Notes: Tasmania reported an EBITDA of $4362 per bed year. This was higher than other states and affects the State Government top 10% average.

*Source: Hogan W, Pricing Review of Residential Aged Care, pp 40-47.*

8.182 The Hogan Review also commissioned the Centre for Efficiency and Productivity Analysis (CEPA) at Queensland University to analyse the efficiency of the residential aged care sector. CEPA indicated that, 'The average level of technical inefficiency is around 17 per cent (on a conservative estimate)'. That is, there is scope for inefficient providers to do more with the resources they receive.[157]

8.183 The issue of COPO indexation was also considered by the Hogan Review which reached the conclusion that other means are available to employers to improve wages than through increasing COPO or changing the basis of indexation.[158]

8.184 The Committee notes that to assist industry efficiency and viability the Hogan Review recommended: streamlining administrative arrangements causing a high paperwork burden; new funding supplements for particular care needs; a new conditional incentive

157 *Review of Pricing Arrangements in Residential Aged Care*, Recommendations

158 Review of Pricing Arrangements in Residential Aged Care, pp 146-480

supplement; increasing the viability supplement for rural and remote services; changes to concessional transitional and assisted resident supplements; abolishing the adjusted subsidy reduction; and changes to accommodation payments.[159]

8.185 The Australian Government's response addressed most of the recommendations although not all precisely as the Review proposed. In addition, to help ensure that all providers meet improved safety and building standards required for 2008 certification, the Government is providing a one-off payment of $3,500 per resident (total funding $513.3 million).[160]

8.186 The Committee notes that responses to the administrative streamlining and increased funding in the Budget have been mixed. The National Aged Care Alliance lobby group considers the measures provide a short-term patch up, leaving the long term underlying problems to still to be addressed. The Alliance continues to push for 'a benchmark of quality care' as a funding mechanism (including a capital component), with changed indexation, and wage parity for nurses.[161]

8.187 A more optimistic outlook was taken by Mark Moran, of Moran Health Care Group, who hopes 'to open at least another 100 beds in NSW alone as a result' of the $13million funding boost received from the $3500 per –resident bonus. The Committee also notes that Ramsay Health continues to look for opportunities to purchase aged care beds, indicating that the industry continues to be regarded as an attractive investment opportunity.[162]

> …a new funding system for aged care based on a defined and properly costed benchmark of care. This benchmark of care must reflect the real costs of providing a quality aged care service in different regions around Australia, and allow for the flexible delivery of aged care services responsive to the needs of the individual.[163]

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159 *Review of Pricing Arrangements in Residential Aged Care* , pp xvii – xxv;

160 The Government's response to the *Review of Pricing Arrangements in Residential Aged Care*, <http://www.health.gov.au/investinginagedcare/response/index.htm>, viewed 20/05/2004.

161 National Aged Care Alliance, *Get Aged Care Right*, <http://www.naca.asn.au/election_2004.pdf>, viewed 2/07/2004.

162 'Cashed-up nursing homes still want bonds', Sydney Morning Herald, 13 May 2004; 'Ramsay tipped to impress', Financial Review, 4 August 2004, p 17.

163 National Aged Care Alliance, sub 88, p 2; McGuiness M, sub 60, p 4.

> The AMA referred to the Productivity Commission's 1999 recommendation for a benchmark – a benchmark that the Commission envisaged could be based on outcomes against the four accreditation standards.[164]

8.188 Evidence also pointed to the challenge involved in designing a benchmark (or benchmarks) combining quality of care and a basis for funding. Mr Gray sketched some of the complexity:

8.189 As noted above, the National Aged Care Alliance called for the introduction of a benchmark of care as a funding tool with emphasis on the real costs of care:

> … Clearly, it is not just one level of a mix of things; it is more complex than that, because you have numbers of residents with individual needs. If we are talking about person centred care as the basis of how the system should be funded, we have to look at what the needs of that individual are in terms of quality care and adequately skilled staff to provide that care, and that becomes the benchmark.[165]

Similarly, Ms Allanson highlighted the challenge in setting prices for benchmarks: '… in principle we would like to see a benchmark of care that is funded. But the scary point there is: who is going to say how much would be funded?'[166]

8.190 A benchmark of care for funding purposes raises the question of the relationships between:

- such a benchmark and the Accreditation Standards – which were designed for the purpose of accreditation;
- such a benchmark and the Quality of Care Principles – which provide a basis for quality care, together with the flexibility to provide the person centred care stressed by Mr Gray and the National Aged Care Alliance.

8.191 A major criticism put to the Committee concerned confusing the purpose of the RCS by using it as a funding tool and care planning tool, resulting in a plethora of documentation more concerned with defending funding than care planning. There is a danger that a benchmark of care which attempts to combine the purposes of quality standards and a funding mechanism may run into similar difficulties.

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164 AMA, sub 86, p 17; see also, sub 104, Uniting Care, pp 3-4. Productivity Commission, *Nursing Home Subsidies* (Report No. 4), 1999, pp 85-86.

165 Gray R, transcript 7/03/2003, p 230.

166 Allanson V, transcript 25/02/2003, p 180.

8.192 The notion of a benchmark of care was also proposed to the Hogan Review. However, the Hogan Review considered that a 'benchmark of care' in regard to quality is already provided by the Quality of Care Principles (s18.9 (2)), and concluded that this should continue to provide the benchmark.[167]

## The need for age-friendly hospitals

> But there is always the stigma of old people being bed blockers. No-one wants to admit them…[168]

8.193 Evidence was put to the Committee that the health of older people, particularly those with dementia, can decline during a stay in hospital so that they may end up more dependent than when they entered.[169] Professor Picone explained to the Committee that:

> It increases the person's dependency as well. … we are not experts in long-term residential aged care. It obviously increases their chance of contracting a hospital acquired infection. The longer you are in, the more that can happen. It also results in a deterioration of their functioning and cognitive ability, because they are not in an environment where a model of care has been set up to care for them …[170]

8.194 Early or poorly planned discharge too often results in distress for patients and/or un-planned readmissions:

> We had a lady who was discharged home following massive surgery and was left to go to her own home, which is a two-storey building. The only other person living there is her husband, who is in his late 70s and very frail. That really is a recipe for disaster. …This sort of discharge is unreasonable.[171]

8.195 For older patients, especially those with cognitive difficulties, issuing only verbal instructions for post-discharge care can be confusing and jeopardise recovery.[172] Aged care residents at times return from

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167 *Review of Pricing Arrangements in Residential Aged Care*, Summary of the report, p28

168 Mahajani S, transcript 3/02/2004, p 789.

169 Aged-care Rights Service, sub 87, pp 29-30; Mahajani S, sub 181, p 2; Harvey D, transcript 31/03/2003, p 305.

170 Picone, D, transcript 3/07/2003, p 576

171 Barrand P, transcript 3/02/2004, p 759.

172 The; MacGuiness M, sub 60, pp 2-3; ANHECA, sub 111, p 4; Pollard D, sub 153, p 9.

hospital with problems arising from neglect or oversight of their specialised aged care needs.

8.196 The Committee is concerned that in evidence put to them, the issue of the quality of hospital care for older people often became submerged in arguments about responsibility for shortages of acute and/or residential aged care beds, and the potential of transitional care to 'fix' the bed shortage.

8.197 The Committee appreciates the pressures these issues place on hospitals and agress there is an urgent need for the development and implementation of transitional care (as discussed above). However, this does not remove hospitals' responsibility for improving care for older people and minimising negative impacts such as those identified above.

8.198 Other evidence demonstrated that in some locations action is already being taken to minimise practices that affect the health of older patients. Central Coast Health (NSW) are:

> … trying to have the health services have more age-friendly hospitals for patients and their carers. … if you go to almost any hospital you will find that about 70 or 80 per cent of patients are over 70. … So actually making sure that we run health facilities which are age friendly … understanding the needs of older people on the wards … is extremely important.[173]

8.199 A clinical nurse consultant in gerontology has been appointed, and admission and discharge protocols have been rewritten through a process involving all the agencies affected by the protocols. Extra nurses have been engaged to liaise between the hospitals and community and residential providers – an initiative that is actually smoothing the path between services.

8.200 Professor Nair suggested that there is a need to employ people with broader skills – such as geriatricians – to look after older people in hospital, and to adopt a case management approach to help ensure continuity of care from admission to discharge. [174] A similar approach was put forward by the Australian Medical Association (AMA) which also suggested that general hospitals should improve their services to older people by ensuring they have medical practitioners with expertise in aged care and by providing a designated geriatric

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173 Blackwell J, transcript 24/02/2003, p 90. See also, L Worrall, transcript, 20/05/2003, p [504].

174 Nair K, transcript 3/07/2004, pp 560, 561.

medical service with beds for acute care, assessment and rehabilitation. The AMA also proposed that hospitals should provide multi-disciplinary out-patient services for older people with complex syndromes such as falls, dementia and incontinence.[175]

## GPs and the care of older people

> There needs to be much more attention paid to the potential and realising the GP role in encouraging self-management and working with their patients in an earlier, preventative kind of mode…but they are too bogged down in the day-to-day medicine of the traditional kind…[176]

8.201 This evidence from Professor Boldy to the Committee suggests there is a need for change in the role of doctors and the ways they interact with other service providers. Similar evidence was received from physiotherapists, nurses, aged care providers, academics and other health care workers as well as doctors themselves.

8.202 Issues around GP involvement in care of people as they grow older were identified as the shortage of GPs,[177] limited knowledge of the ageing process and care of the aged, especially diagnosing and caring for people with dementia,[178] the reluctance of GPs to visit older people outside their practice (home visits),[179] or to visit aged care homes,[180] and the need for better collaboration between GPs and other health professionals.[181]

175 AMA, sub 86, p 2.

176 Boldy D, transcript 29/04/2003, p 404.

177 Department of Health and Ageing, sub 119, p 39; Australian Medical Association, sub 86, p 23.

178 Nair K, transcript 3/07/2003, p 560; Le Couteur D, transcript 3/07/2003, p 45; Russel C, sub 133, p 1; Ward J, transcript 25/02/2003, pp 141-142; National Rural Health Alliance, sub 131, pp 34-35; Federation of Ethnic Communities Councils of Australia, sub 140, p 2; Council of the Ageing Australia (New South Wales), sub 157, p 7; New South Wales Department of Health, sub 160, p 9; Centre for Ageing and Pastoral Studies Charles Sturt University, sub 167, p 5; National Aged Care Alliance, sub 88, p 3.

179 Waverley Council, sub 73, p 1; Aged Services Learning and Research Collaboration, sub 151, p 10.

180 Ward J, transcript 25/02/2003, p 140; Phillips C, transcript 3/02/2004, p 783.

181 Mersiades N, transcript 7/02/2003, p 2; Pharmacy Guild of Australia, sub 75, p 6.

## GP shortages

8.203 A fundamental limiting factor is the overall shortage of doctors and the even greater shortage in rural and remote areas. In recent years substantial efforts have been made to address shortages in the longer term. Making a difference in the short term is still proving a challenge.

8.204 Table 8.5 tracks GP supply over the period 1995-96 to 2002-03, by headcount, full-time equivalents (FTE), and by full-time workload equivalent (FWE). In rural areas the headcount increased by 25% and the full-time workload equivalent also increased appreciably by 15.5%. Urban areas experienced a drop in headcount and a slight increase in FWE. These figures, however, provide no indication of the extent to which supply meets demand.

Table 8.5: GP headcount, FTE and FWE by broad RRMA, 1995-96 to 2002-03

| | Urban | | | Rural and Remote | | |
|---|---|---|---|---|---|---|
| Year | Headcount | FTE | FWE | Headcount | FTE | FWE |
| **Number** | | | | | | |
| 1995-96 | 18,959 | 10,416 | 12,501 | 5,417 | 3,120 | 3,551 |
| 1996-97 | 18,937 | 10,599 | 12,719 | 5,589 | 3,164 | 3,596 |
| 1997-98 | 18,524 | 10,659 | 12,791 | 5,706 | 3,216 | 3,641 |
| 1998-99 | 18,208 | 10,613 | 12,754 | 5,968 | 3,232 | 3,635 |
| 1999-00 | 18,024 | 10,587 | 12,761 | 6,210 | 3,287 | 3,672 |
| 2000-01 | 17,905 | 10,555 | 12,668 | 6,363 | 3,417 | 3,825 |
| 2001-02 | 17,719 | 10,564 | 12,731 | 6,588 | 3,555 | 4,005 |
| 2002-03 | 17,521 | 10,485 | 12,608 | 6,739 | 3,650 | 4,101 |
| **% change on previous year** | | | | | | |
| 1996-97 | -0.1% | 1.8% | 1.7% | 3.2% | 1.4% | 1.3% |
| 1997-98 | -2.2% | 0.6% | 0.6% | 2.1% | 1.6% | 1.2% |
| 1998-99 | -1.7% | -0.4% | -0.3% | 4.6% | 0.5% | -0.2% |
| 1999-00 | -1.0% | -0.2% | 0.1% | 4.1% | 1.7% | 1.0% |
| 2000-01 | -0.7% | -0.3% | -0.7% | 2.5% | 4.0% | 4.2% |
| 2001-02 | -1.0% | 0.1% | 0.5% | 3.5% | 4.0% | 4.7% |
| 2002-03 | -1.1% | -0.7% | -1.0% | 2.3% | 2.7% | 2.4% |
| **% change on 1995-96** | | | | | | |
| 2002-03 | -7.6% | 0.7% | 0.9% | 24.4% | 17.0% | 15.5% |

| | |
|---|---|
| GP headcount | A count of all GPs who have provided at least one Medicare Service during the reference period. |
| FTE | Full-Time Equivalent: measures the number of doctors working full-time and the partial contribution of part time doctors. |
| FWE | Full-Time Workload Equivalent: a measure of service provision because it takes into account doctors' varying workloads. It is generally considered a good overall indicator of workforce supply. |

Rural, Remote and Metropolitan Areas Classification (RRMA) categorises geographic areas into an index of remoteness according to population size based on the 1991 Census. Urban Areas: RRMA1 and RRMA 3. Rural Areas: RRMA3 to RRMA 7.

*Source: Department of Health and Ageing.*

8.205 Dr North mentioned the importance of the new Rural Clinical Schools including the one in Dubbo in encouraging medical students to practise in rural areas. Ten Rural Clinical Schools have been established since 1999 under the Australian Government's policy to encourage at least 25% of medical students to receive a significant part of their clinical training in rural and remote areas.[182] The rural clinical school in Dubbo, for example, provides medical students with half a year of training in the region, including geriatric medicine. This policy is intended to help address the problem of GP shortages in rural and remote locations however the full effects will not be felt for some years.

8.206 The Committee is aware that the shortage of GPs in some regions is placing an even greater demand on doctors. Older people generally have more complex and time consuming care needs, which is extremely demanding for GPs, as indicated by the Central Coast Division of General Practice:

> Our GPs are telling me that they are busier…their workload has increased exponentially…because of the complexity of care that is required with ageing people…so the demand means that our GPs are busier and dealing with more complex cases. Obviously, with new medications and treatments, they are saying that their day is busier and more mentally exhausting. Our GPs are saying by seven o'clock at night they are mentally exhausted. The issues of after hours care and nursing home care are obviously complicated because of that.[183]

## GP skills and knowledge

8.207 Concerns were raised about whether GPs' experience and knowledge best suit them to diagnosing and treating disorders common among older people.[184] Dr Menzies summed up the issues as follows:

182 North R, transcript 23/02/2004, p 817; Department of Health and Ageing, Rural Clinical Schools, viewed 19/08/2004, <www.health.gov.au/workforce/new/rurclinical.htm>.

183 Hanrahan M, transcript 24/02/2003, p 118.

184 Catholic Women's League Australia Inc, sub 65, p3; New South Wales Department of Health, sub 160, p 9; Catholic Health Care Services Ltd, sub 174, p 8.

> Health care of the elderly is a specialty in itself. There are differences when looking after the health of an elderly person, for instance in the use of medications, the care of patients with dementia and the care of patients with very limited mobility.[185]

## GPs and care of older people in the community

8.208 The Committee received evidence recommending GPs need to become more flexible in their practice to ensure that the aged receive appropriate care. Of particular concern was about the need for GPs to recognise the value of including carers as part of the care team:

> …about [carers] being included in the medical model somehow. That is about finding a way for GPs to acknowledge that the carers actually are a key component in that and looking at it more holistically so there is more care inclusion there.[186]

8.209 Preventative approaches were identified as one of the keys to ensuring that the diseases associated with ageing are minimised.[187]

8.210 In recent years a range of new MBS items and other initiatives have been introduced to encourage doctors to engage more fully in the care of people as they age, especially in encouraging preventive behaviours (see Box 8.1). Building on the Enhanced Primary Care (EPC) initiative introduced in 1999, they also aim to encourage greater collaboration between GPs and other health care providers.

8.211 Evidence to the Committee indicated that while there is support for the underlying objectives of these initiatives, not surprisingly there is also some resistance to changing ways of working and some concerns about the structure of the items and administrative arrangements. The Committee also heard of practices 'looking at ways of working smarter' and of maximising the opportunities provided by working as a team.[188]

8.212 Department of Health and Ageing statistics for the March quarter 2004 indicate that less than half of all GPs use the EPC items provided through the Medicare Benefits Scheme. Media reports suggest the

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185 Menzies R, transcript 24/02/2004, p 841.

186 McKell J, transcript 3/02/2004, p 774.

187 McCallum J, sub 132, p 20; O'Donoughue R, transcript 7/02/2003, p 4; Complementary Health Care Council of Australia, sub 147, p 2; Boldy D, transcript 29/04/2003, p 404.

188 Haikerwal, transcript 7/03/2003, p 216; NSW Aged Care Alliance, sub 11, p 6; Australian Medical Association, sub 86, p 15; Hanrahan M, transcript 24/02/2003.

national average for the use of EPC items by GPs could be as low as 17% nationally.[189] At the same time it should be noted that use of EPC items generally (and specific EPC items) will in part depend in the patient profile of each GP.

Box 8.1: Measures to increase GPs involvement in the care of older people in the community

- 2004-05 Two new MBS items for certain allied health services for people with chronic conditions and complex care needs who are being managed under an EPC multi-disciplinary care plan. $162.6m over 4 years. Limit of 5 allied health and 3 dental consultations per year.
- 2004-05 Incentives for GPs to bulk-bill concession card holders include a $7.50 payment per consultation, at a cost of $1.131 billion over four years.
- 2003-04 Continued funding ($108.1m over 4 years) for voluntary health assessments for people 75 years and over (55 and over for Indigenous Australians). Introduced under EPC in 1999, assessments may be conducted at GP surgery or at home.
- 2003-04 Continued funding ($5.4m over 4 years) for multi-disciplinary case-conferencing to determine the best treatments for people with chronic or terminal conditions and complex care needs. Introduced under EPC in 1999.
- 2003-04 Continued funding ($69.2m over 4 years) for co-ordinated, multi-disciplinary care planning for patients with chronic conditions and complex health needs. Introduced under EPC in 1999.
- 2003-04 Focus on Prevention $16.4 million over four years to help primary care providers, including pioneer practices and Divisions of General Practice developing evidence based approaches to prevention and early intervention of chronic disease.
- 2001-02 Ongoing funding for Extended Aged Care at Home (EACH) giving older people with high and complex care needs the option of care at home.
- 2001-02 New MBS item to enable doctors and pharmacists and other members of the health care team to make home visits to conduct Domiciliary Medication Reviews. Funding $18.1 m over 4 years.
- 1999-00 Enhanced Primary Care (EPC) items created under MBS to provide health assessments for people aged 70+ (55+ for Indigenous people) multi-disciplinary case planning; multi-disciplinary case conferencing and multi-disciplinary discharge.

*Source: Department of Health and Ageing, Budget Fact Sheets*

8.213 The Department of Health and Ageing commissioned a review of EPC item use for the years 2001 and 2002, which showed that the free health assessments were used more than any other item, while case

189 http://www.health.gov.au/pcd/programs/epc/epcstats/index.htm, viewed 9/08/2004; The Age, *Red tape hurting Medicare plan*, 2/04/2004.

conferencing is the least used. Of the small number of GPs who claimed for case conferencing, most consider that it is effective. It is notable that most of those who have used case conferencing are younger, more recently qualified doctors. Doctors who do not utilise case conferencing claim it is too complex and remuneration is not sufficient. The evaluation also identified 'a number of positive impacts on practice and systems both within practices and between general practices and allied health service providers' although more needed to be done to enable better management.[190]

8.214 Although little direct evidence on the issue was received, the Committee is aware of concerns expressed about the administrative costs associated with EPC. The EPC program evaluation commissioned by the Department of Health and Ageing identified some complexities, the Productivity Commission estimated that EPC contributed 14.9% of total GP administrative costs in 2001-02, and a recent Senate Select Committee sought evidence on the impact of the burden. It should be noted, however, that questions have been raised about the some aspects of the assumptions and methodology used by the Productivity Commission. For example, estimates of administrative time include time spent providing EPC care planning and health assessment services (ie the clinical services) as well as the time spent on any associated administrative tasks.

8.215 At the same time, the matter was being considered by a Red Tape Taskforce established by the Prime Minister and the then Minister for Health and Ageing.[191]

8.216 Following consultations with doctors, the Minister for Health and Ageing has announced measures to reduce red tape for general practitioners including:

- simplifying administrative requirements and conducting a second stage review of PIP and EPC that may lead to more substantial changes in the future;
- developing a GP communications entry point;
- developing a template for electronic forms; and

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190 Wilkinson D, et al, *Evaluation of the Enhanced Primary Care (EPC), Medicare Benefits Schedule (MBS)items, and the General Practice Education, Support and Community Linkages Program (GPESCL)*, Final report July 2003, pp 18, 20, 24, 26, 39.

191 Wilkinson D, et al, *Evaluation of the Enhanced Primary Care (EPC), Medicare Benefits Schedule (MBS)items, and the General Practice Education, Support and Community Linkages Program (GPESCL)*, Final report July 2003; Productivity Commission, *General practice administrative and compliance costs,* Research Report, 2003, Canberra, p xxi; Senate Select Committee on Medicare, *Medicare – health or welfare?* October 2003, Canberra, pp 24-26;

- improving communications between the Department and GPs.[192]

## GPs and residential aged care

8.217 Aged care providers reported to the Committee that it is difficult to obtain regular, reliable GP services in residential care homes. Juninga Aged Care in Darwin, for example, stated that doctors are reluctant to visit as it is not financially viable for them.[193]

8.218 The number of GPs making visits to aged care homes is of concern to the Committee. The Australian Medical Association stated that only 16% of GPs are visiting aged care facilities:

> Even though the number of beds rises each year, we see the number of GP visits each year going down…it is something that GPs are not keen to do.[194]

8.219 Reluctance to visit aged care homes was attributed to remuneration arrangements, time lost travelling, and the disruption to GPs schedules which also diminishes remuneration. GPs often give visits to aged care facilities low priority. Overall, only GPs with a strong interest in the elderly make regular visits to aged care facilities.[195]

8.220 Dr Ward of Hunter Health informed the Committee that GPs consider aged care facilities difficult environments to work in:

> …The patient is not necessarily where you want them at the time you arrive…you have to find a nurse who knows what is going on. … For GPs, usually when the patient comes in, all their equipment is there. That is the environment they like to work in. So aged care facilities are not what you would call GP friendly.[196]

8.221 The Australian Medical Association suggested that aged care homes need appropriate facilities for medical consultations, including computer access.[197] Ensuring that aged care facilities are equipped with computer facilities to enable GPs to access patient records and prescribe electronically would assist GPs and improve patient safety and care.

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192 The Hon Tony Abbott MHR, Minister for Health and Ageing, Media releases: 'Government's response to red tape', 11 May 2004; Government acts to reduce red tape for GPs', 12 July 2004;

193 Phillips C, transcript 3/02/2004, p 783.

194 Rivett D, transcript 7/03/2003, p 217.

195 North R, transcript 23/02/2004, p 814. Aged Services Learning and Research Collaboration, sub 151, p 10; Poole J, transcript 3/02/2004, p 800; AMA, sub 86, p 14.

196 Ward J, transcript 25/02/2003, p 140.

197 Haikerwal M, transcript 7/03/2003, p 219; National Aged Care Alliance, sub 88. p 8.

8.222 The Committee notes that such evidence may also indicate there is a need for GPs to develop more flexible ways of working when making visits to aged care facilities. Mr Hanrahan told the Committee about pilot projects on the Central Coast of New South Wales, to identify better ways of working with aged care homes. He stressed the importance of communication with staff and working as a team to coordinate 'whether the GP goes in, the nursing staff, the pharmacist or the carer', depending on the immediate need. Similarly, the AMA stressed that to ensure older people receive age-friendly care, team work and good communication are essential: 'GPs can not work in isolation: the team must be encouraged to participate'.[198]

8.223 In a Hunter Health initiative the employment of a full time primary care nurse enables smooth team work and maximises care for residents:

> She arrives at work at about 7.30 in the morning. She goes around all the 12 or 15 lodges. She knows exactly what is going on … who needs to be seen urgently, what the issues are for the day. She has practice worked out by the time [the GP] arrives at 9 o'clock. In four hours they can get through 20 or 30 people with no trouble at all. She organises the enhanced primary care items, the case conferences, the care plan reviews. She is working in proactive sense.
>
> We have done primary care plans on everybody, so we are not just reacting to the situation. We are planning their care in the way that they would in a general practice. I believe that is the ideal way to provide good primary care in aged care facilities.[199]

8.224 The Australian Government has recently introduced measures to address the level of remuneration attached to working with residential facilities and to encourage GPs to be more actively involved in the care of the aged residents. A new MBS item will provide a rebate of $150.05 for doctors to undertake comprehensive medical assessments and enable doctors and other health staff to better manage residents' health care. Divisions of General Practice will also receive funding to set up panels of GPs to act as visiting doctors at aged care homes in their area. These GPs will also provide

198 Hanrahan M, transcript 24/02/2004, p 123; Australian Medical Association, sub 86, p 15.

199 Ward J, transcript 25/02/2003, p 140. See also Australian Medical Association, sub 86, p 14., and attachment p100.

advice on strategies to improve the quality of health services for all residents.[200]

8.225 The Committee concludes that there is increasing consideration being given to the implications the ageing of the population has for general practice and general practitioners. The ongoing workforce shortage limits the effectiveness of GP involvement in the care of people as they age and continuing efforts are needed to maximise all avenues for attracting, and keeping GPs in the workforce.

8.226 The Committee concludes that many GPs are accepting the challenges involved in adapting practices to provide age-friendly and age-appropriate care of older people, including adapting to working with allied health providers. At the same time, there are GPs who continue to resist change to the detriment of care for people as they age and for older people in residential care.

## Workforce shortages

8.227 Workforce issues were among those most frequently raised with the Committee. Solving the critical shortage of nurses (especially in aged care) and other health professionals topped the list, together with the factors that are seen as contributing to the shortages.

8.228 The critical shortage of nurses is now widely acknowledged and well documented.[201] The impacts of this shortage were reflected in evidence to the Committee.

8.229 Evidence to the Committee also shows that consideration is being given to the wider workforce involved in aged care and health services for older people, whether supply is adequate now and to meet future demand, and the changes in roles and work practices that will be necessary. In part, concerns point to shortages of other health professionals who will become increasingly important in services to assist people maintain health functioning as they grow older.

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200 The Hon Tony Abbott MHR, Minister for Health and Ageing, and The Hon Julie Bishop MP, Minister for Ageing, joint media release, 'Better medical services for residential aged care', 30 June 2004.

201 See, for example, AIHW, *Nursing Labour Force* 2001, AIHW Cat. No HWL 26, 2003; National Review of Nurse Education, *Our Duty of Care, …..*; La Trobe University, *Recruitment and Retention of Nurses in Residential Aged Care – Final Report,* Canberra, 2002; Senate Community Affairs References Committee, Inquiry into Nursing, *The Patient Profession: Time for Action,* AGPS, Canberra, 2003

8.230 The Committee found that the extent of the shortages is difficult to quantify numerically. However, the National Skills Shortage List maintained by DEWR indicates the extent of shortages across the general and specialist areas in which nurses are employed. The majority of these areas are relevant to aged care and health services for older people (Table 8.6, National Skills Shortage List, Nurses and Health Specialists, March 2004).[202]

8.231 Table 8.6 also shows the shortages across eleven health specialist areas. Of the eleven health specialists, seven areas were mentioned in evidence to the Committee as being critical to services for older people, and/or were identified as suffering from workforce shortages: dentists, pharmacists, occupational therapists, physiotherapists, speech pathologists, podiatrists and audiologists.[203]

Table 8.6: National Skills Shortage List, Nurses and Health Specialists, March 2004

| Occupation | AUST | NSW | VIC | QLD | SA | WA | TAS | NT |
|---|---|---|---|---|---|---|---|---|
| **Registered Nurses** | | | | | | | | |
| Registered Nurse (general) | N | S | S | S | S | S | S* | S |
| Accident/Emergency | N | S | S | S | S | S | S | S |
| Aged Care | N | S | S | S | S | S | S* | S |
| Cardiothoracic | N | S | S | S | S | S | S | S |
| Community | N | S | | S | S | S | S* | S |
| Critical/Intensive Care | N | S | S | S | S | S | S | S |
| Indigenous Health | N | * | | S | S | S | | S |
| Neonatal Intensive Care | N | S | S | S | S | S | S | S |
| Neurological | N | S | S | S | S | S | S | S |
| Oncology | N | S | S | S | S | S | S | |
| Operating Theatre | N | S | S | S | S | S | S* | S |
| Paediatric | N | S | S | S | S | S | S | S |
| Palliative Care | N | S | S | S | S | S | S | |
| Perioperative | N | * | S | S | S | S | S | S |
| Rehabilitation | N | S | S | S | S | S | S* | S |
| Renal | N | S | S | S | S | S | S | S |

202 DEWR bases the National Skill Shortage Lists primarily on surveys of employers who have recently advertised vacancies for selected occupations. Industry and employer intelligence is considered together with statistical information on demand and supply trends for selected occupations.

203 Australian Physiotherapy Association, sub 118, p 14; The Aged Care Rights Service, sub 87, p 35; National Rural Health Alliance, sub 131, p 34; Speech Pathology Australia, sub 52, pp 3-4; The Deafness Forum of Australia, sub 66, p 11.

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| **Registered Midwife** | **N** | **S** | **S** | **S** | **S** | **S** | **S** | **S** |
| **Mental Health Nurse** | **N** | **S** | **S** | **S** | **S** | **S** | **S** | |
| **Enrolled Nurse** | **N** | **S*** | **S** | **S** | **S** | **S** | **S** | **S** |
| **Health Specialists** | | | | | | | | |
| Dentist | N | S* | R* | S | | S* | | S* |
| Pharmacist (Hospital/Retail) | N | S | S* | S | S | R | | D |
| Occupational Therapist | N | S* | S* | S | D | D* | S | R |
| Physiotherapist | N | S* | S* | S | S | S* | S | S |
| Speech Pathologist | N | M | S* | S | R | | S | D |
| Podiatrist | N* | * | * | * | * | * | * | * |
| Diagnostic Radiographer | N | S* | | S | | | S | S |
| Radiation Therapist | N | S | S | S | S | S | S | |
| Nuclear Medicine Technologist | N | D | | S | | S | S | |
| Sonographer | N | S | | S | S | S | S | S |
| Audiologist | | | S | S | | | | S |

Notes: * Shortages may be restricted to specialist skills

N=National Shortage R=Shortage in regional areas D=Recruitment difficulties

S=State-wide shortage M=Shortage in metropolitan areas

*Source: National Skills Shortage List, Nurses and Health Specialists, March 2004, p 3-4.*

## Nurses

8.232 The Committee heard that difficulties in recruiting and retaining nurses jeopardises the continuity and quality of care in aged care homes. Shortages also affect older people's wishes to continue to live at home, and access to timely assessment by Aged Care Assessment Teams.

8.233 Several factors contributing to the shortage of nurses and other care staff have been consistently identified in evidence to the committee and in recent research:

- ageing of the nursing workforce;
- lack of wage parity;
- working conditions experienced by care staff in aged care homes;
- lack of education and training opportunities; and
- poor public image of caring for the aged.

### Ageing of the nursing workforce

8.234 The average age of registered nurses in the public sector is 44 years. In the aged care sector the average age of registered nurses is 54 years with some nurses working over the age of 75 years. As Mr Holmes of the New South Wales Nurses Association stated:

> There are many very dedicated aged care nurses who carry on past 60—some even work to 75, we have found. It is truly amazing that they can carry that workload.[204]

8.235 Table 8.7 shows the proportion of nurses aged over 45 years of age between 1987 and 2001. The proportion of registered nurses aged 45 years or older nearly doubled between 1987 and 2001. The proportion of aged or disability person carers aged 45 years or older increased from 19 per cent in 1987 to 45 per cent in 2001.[205]

Table 8.7: Summary statistics of employment in nursing and carer occupations by age and hours worked per week, Australia, 1987 and 2001.

| | Percent 45 years of age and over | |
|---|---|---|
| | 1987 | 2001 |
| Directors of nursing | 71 | 71 |
| Nurse managers | 22 | 45 |
| Nurse educators & researchers | 26 | 34 |
| Registered nurses | 20 | 38 |
| Registered midwives | 20 | 25 |
| Enrolled nurses | 15 | 35 |
| Personal care and nursing assistants | 26 | 37 |
| Aged and disability person carers | 19 | 45 |

Source: *Shah & Burke 2001 as cited in National Review of Nursing 2002*

8.236 As these nurses age and retire, a greater demand will be placed on the health and aged care workforce, impacting upon the quality and quantity of care available.

8.237 Mr Holmes stressed to the Committee:

> …That means that we have less than five years to turn that around to ensure that we actually reduce that average age to ensure there will be a work force.[206]

### Lack of wage parity for nurses caring for the aged

> …many employers refuse to negotiate fairly over wages and conditions. This results in a significant wages gap between

204 Holmes B, transcript 4/07/2003, p 650; Australian Nursing Federation, Sub 97, p14; National Review of Nursing Education 2002, *Our duty of* care, viewed 30/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/duty_of_care/doc5.html#8>; New South Wales Nurses' Association, sub 120, p 6-7

205 National Review of Nursing Education 2002, *Our duty of* care, section 2.6 Changing nursing worker profile, viewed 30/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/duty_of_care/doc5.html#8

206 Holmes B, transcript 4/07/2003, p 650.

> the public and private acute sectors and the aged care sector, and less favourable working conditions, making it difficult for aged care providers to recruit and retain nurses in a very competitive employment market.[207]

8.238 The Australian Nurses Federation (ANF) informed the Committee that the wage differential nationally between the acute care sector (private and public) and the aged care sector increased from $92.72 in 2001 to $123.06 in September 2001. By the beginning of July 2004, ANF data showed a gap of $170.50 per week national average. Gaps vary from state to state reflecting differences in State Awards/Enterprise Bargaining Agreements (EBA) for the sectors (see Table 8.8). [208]

Table 8.8: Disparity in pay rates RN (Year 8 or equivalent) across states and territories at June 2004

| State/Territory | Public Sector EBA Rate Weekly Earnings $ | Aged Care Award Rates Weekly Earnings $ | % Difference |
|---|---|---|---|
| Victoria | 930.10 | 784.20 | 18.6 |
| NSW | 1074.20 | 922.70 | 16.4 |
| Queensland | 950.25 | 793.90 | 19.7 |
| WA | 942.60 | 754.60 | 24.9 |
| SA | 929.60 | 742.60 | 25.2 |
| Tasmania | 896.90 | 773.70 | 15.9 |
| NT | 970.49 | 802.00 | 21.0 |
| ACT | 960.94 | 757.57 | 26.8 |

*Source: Australian Nursing Federation, Nurses Paycheck, Volume 3 Number 3 June – August 2004.*

8.239 According to the ANF the wage disparity between nurses employed in homes where EBAs are in place and those in the public sector is reduced (see Table 8.9).

Table 8.9: Disparity in pay rates RN (Year 8 or equivalent) between Public Sector and Aged care EBAs in selected states and territories as at June 2004

| State/Territory | Public Sector EBA Rate Weekly Earnings $ | Aged Care Award Rates Weekly Earnings $ | % Difference |
|---|---|---|---|
| **Victoria** - Anglican | 930.10 | 857.17 | 8.51 |

207 Australian Nursing Federation (ANF), sub 97, p 11; see also, eg, Anglican Aged Care Services Group, sub 99, p 3; Chamber of Commerce and Industry WA, sub 70, p 7.

208 ANF, sub 97, p 11; ANF, 'The National Aged Care Phone-in', p 1, viewed 20/04/2004, <http://www.anf.org.au/>.

| | | | |
|---|---|---|---|
| Aged Care Services Group and ANF Certified Agreement | | | |
| **SA -** Nurses – ANF – Flora McDonald Lodge Enterprise Agreement 2001 | 929.60 | 874.06 | 6.35 |
| **Tasmania** – Tasmanian Aged Care Nursing Enterprise Agreement 2001 | 896.90 | 829.35 | 8.14 |
| **ACT** – Anglican Retirement Services – Brindabella Gardens, ANF Enterprise Agreement 2002-2004 | 960.94 | 793.00 | 21.18 |

*Source: Australian Nursing Federation, Nurses Paycheck, Volume 3 Number 3 June – August 2004.*

8.240 The Hogan Review also expressed concern that the disparity in wages decreases the capacity of the sector to attract and retain nurses. The Review noted that the ANF data indicates the potential of EBAs to improve salary outcomes for employees. However, the aged care sector has been slow to negotiate EBAs at individual workplaces.[209] Analysis by the Review also demonstrated that there are significant differences in pay rates within the residential aged care. These variations depend on whether homes are state government or non-government owned, and whether non-government homes have access to Fringe Benefits Tax (FBT) advantages to offer salary packaging to their staff.[210]

8.241 Proposals were put to the Committee suggesting that the Australian Government should increase funding to address wage parity, either directly or by developing and funding a 'benchmark of care' covering the real costs of providing staff.[211]

8.242 The Committee notes that in the 2004-05 Budget the Australian Government announced funding of $877.8 million over four years for a new conditional adjustment payment, in addition to the usual indexation increases. This payment is designed to enable aged care homes to offer more competitive wages and increased training opportunities to nurses and other staff. The payment will be 1.75% of the basic subsidy amount payable in respect of each eligible resident

209 *Review of Pricing Arrangements in Residential Aged Care, Final Report,* p 224

210 *Review of Pricing Arrangements in Residential Aged Care,* p 223.

211 Australian Nursing Federation, sub 97, pp 11-12; Aged Care Alliance, sub 88, p 6. See also, Sullivan F, transcript 17/08/2003, p 695.

in 2004-05, rising to 7 per cent of the basic subsidy amount by 2007-08. The first payments are being made in July and August 2004.[212]

8.243 The new payment is conditional upon homes meeting certain requirements including encouraging workforce training, making audited accounts publicly available annually, and participating in a periodic workforce census. Details of the conditions are being developed by the Department of Health and Ageing in consultation with the industry. [213]

8.244 The Committee considers that while the intent of the new payment is to improve wages and conditions for nurses and other staff in residential aged care, success in achieving such improvements will depend on the commitment of providers to their staff.

8.245 As indicated above, the ANF has found that many aged care employers are still not willing to negotiate improved conditions to secure and keep good staff. Equally, organisations such as the Kingston City Council are putting significant investment into making working in aged care more attractive. In their HACC services, the Council has recruited a higher number of carers (where possible) to reduce work loads, increased skills training, and at times reduced the number of hours worked to help limit the risk of injury. The comprehensive and innovative approaches the Council is taking to ensure their low care facilities are less likely to face shortages of skilled staff are summarised in Box 8.2, together with the benefits for both staff and the homes.

8.246 The Committee concludes that details of the conditions attached to the new payment will be critical and must provide a strong incentive for aged care employers to ensure that nurses and other care staff do reap the intended benefits of the payment. Residential care employers must also demonstrate commitment to investing in their staff to improve quality of care for residents.

212 *Budget Measures 2004-05*, Budget Paper No. 2, p 185.

213 Department of Health and Ageing, Conditional Adjustment Payment, viewed 28/07/2004, <http://www.ageing.health.gov.au/finance/cap.htm>.

Box 8.2: Kingston City Council: Strategies to invest in staff

Council has made significant investment in the upskilling and career development of the hostel staff to develop and sustain high levels of quality care to the residents.

In 1999, Council made a conscious decision to embark on a range of strategies to improve career development within its hostel staffing structure. Workforce issues of untrained staff were addressed through provision of traineeships that gave staff skills, knowledge, experience, and a qualification. These traineeships covered the full range of occupations in an aged care facility, with nursing traineeships being introduced for the first time. Council also developed an in house training program that focused on the provision of care and introduced a performance management system that was linked to the hostel's quality system. Benefits, apart from increased retention levels, job satisfaction, and the attainment of formal qualifications was the empowerment of staff and an enormous increase in self esteem resulting in a hunger to continue personal development.

There were financial benefits to the organisation of approximately $100,000 in training subsidies and this income was used to create opportunities for this further development to take place. Additional financial benefits were gained through staff knowledge that enabled them to maximise care relating funding. Workcover claims went from extremely high to nil; premiums reduced significantly. This team was recognised by Workcover Victoria, winning the risk minimisation award in 2002.

To consolidate staff satisfaction and retention, and to ensure the future viability of Kingston's staffing structure and delivery of quality care, succession planning and career pathways were developed. Key staff were identified and a tailored internal education program developed and implemented. Staff have progressed from no qualification to Certificate III, Certificate IV Nursing, Diplomas and Advanced Diplomas in Business.

Three managers have been recognised at national level, winning awards for leadership excellence.[214]

*Source: Kingston City Council sub 144, p 1*

## Working conditions

8.247 Evidence indicated that the level of the paper work burden in aged care (compared to that in acute care and other areas of employment) is a major disincentive for nurses to work in aged care. In particular, the work involved in the resident classification scale (RCS) assessments and validations was frequently mentioned together with the stress the 'inspectorial' validation process generates.[215] Claims were made that registered nurses spend an hour a day writing up paperwork just to support the RCS, and that the nature of the documentation required places stress on assistants in nursing and

214 Kingston City Council, sub 144, Case Study 2 Attachment, p 1.

215 ASLARC, sub p 32

other care workers who do not always have high level literacy skills.[216]

8.248 Family friendly conditions were also a matter of concern. The ANF drew the Committee's attention to the fact that aged care is a female dominated profession. Yet too few aged care homes consider introducing flexibilities to attract and retain staff, especially young, newly qualified staff.[217]

8.249 As Mr Otomancek explained to the Committee, the working conditions are leading to many nurses leaving permanent employment to become Agency nurses:

> I queried one Agency RN why she was working for an Agency, the reply was simple but true; 'Great hourly rate. Minimal responsibility. No crap from management or Government Agency for documentation!'[218]

8.250 Occupational health and safety issues, in particular those associated with managing challenging behaviours, the amount of lifting associated with frailty, and longer working hours to cover absences all contribute to shortages. The ANF stated that nursing homes experience higher claims rates made under Commonwealth, state and territory workers' compensation acts than hospitals, including psychiatric hospitals. Other evidence indicated that in part the high injury rate may be due to inadequate skills and training. Kingston City Council, for example, dramatically reduced their Workcover claims as a result of concentrating on skills and career development for their staff.[219]

8.251 Distance and isolation make working in rural and remote areas unattractive, despite the investment aged care homes make to attract staff. As Ms Gwynne reminded the Committee, places like Nhulunbuy and Tennant Creek are:

> … a long way from family and home and you need a very experienced person to work there … So finding the right incentives to encourage people to work here is an enduring challenge.[220]

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216 Bryon D, transcript 25/02/2003, p 169; West K, transcript 24/02/2003, p 130; *[others??]*

217 Australian Nursing Federation, sub 97, p 12;

218 Mr Goran Otomancel, sub 169, p 6

219 Australian Nursing Federation, 97, p 116-17; Nall C, transcript 31/03/2003, p 332; Kingston City Council, sub 144, Case Study 2 Attachment, p 1.

220 Gwynne K, transcript 3/02/2004, p 753. See also, Miles M, transcript 2/02/2004, pp 713-14; Jeffery R, transcript 3/02/2004, p 776.

8.252 The Committee notes that in the context of the 2004-05 Budget, the Australian Government committed to reducing the paperwork burden associated with the RCS and with other time consuming administrative procedures. It plans to streamline the RCS from eight categories to three. An ACAT assessment to upgrade residents from low to high care within the same aged care home will no longer be required. Together these changes should free nurses from a significant paperwork burden and enable them to focus of the care of residents. In addition, homes will no longer be required to assess the assets of new residents, sensibly separating decisions on assessment of needs and future care from a task better performed by Centrelink.[221]

### Lack of education and training opportunities

8.253 The Committee heard that while some employers encourage and support nurses involvement in further education and professional activities, a survey in NSW showed that close to 50% of employers fail to do so.[222] Where training and continuing education opportunities are available, they are not necessarily relevant to the needs of age care staff (see further, 'Education and training', below).

8.254 Evidence also highlighted both a lack of access to continuing education opportunities and an urgent need for recognition that aged care has its own care practices and body of knowledge which should underpin education and training. The ongoing care of very frail people with complex co-morbidities (including dementia) combined with periodic acute episodes is different from care in other contexts. Not all nurses have the skills and knowledge to provide such high acuity care or to develop person-centred team work and systems to support it. [223]

### Poor public image of caring for the aged

> … young people not wanting to go into nursing, full stop, because it is seen as lackey work…[224]

8.255 It is a well known problem that a major impediment in recruiting people to work in the aged care sector is its poor public image. A key finding in the Department of Education, Science and Training report into Australian Aged Care Nursing was that while:

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221 *Budget Measures 2004-05,* Budget Paper No. 2, p 188.

222 Australian Nursing Federation, sub 97, p 11

223 Australian Nursing Federation, sub 97, p 10; Royal College of Nursing Australia, sub 28, p 3-4; National Aged Care Alliance, submission 88, p 3; Nair B, sub 154, p 1.

224 Emerson F, transcript 7/03/2003, p 209.

> …both aged care and acute care sectors have significant difficulties in recruiting nurses, aged care experiences greater staffing difficulties, as it is often perceived to be the poor cousin of acute care nursing. Aged care is typically viewed as a field that lacks glamour and excitement, and often receives very poor media presentation. [225]

8.256 Evidence to the Committee explained that there are perceptions that aged care is more menial, less skilled, and rewarding than other types of work. Mrs Gregg explained to the Committee that potential aged care workers need to see aged care as a challenging and rewarding career option, '...not an off-the-street job that anyone can do.'[226]

8.257 The Anglican Diocese in evidence to the Committee, stressed that the image of the aged care sector needs to be improved so that potential workers realise that 'what goes on in those places is very socially uplifting'[227]

8.258 The government is addressing the negative perception of aged care through a number of strategies. The Department of Health and Ageing is working in collaboration with the aged care sector and the media to improve the image of aged care in Australia.[228]

### Beginning to turn the shortage around

8.259 A range of initiatives is being put in place to address the shortage of nurses but, given the underlying causes, turning the shortages around will take some years. In the 2002-03 Budget, the Australian Government provided $47.5 million over four years to boost aged care nurse numbers. In the first two years:

- Over 400 aged care homes nationally have provided training and education opportunities for more than 4,400 care staff through 38 training and education programs;

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225 Department of Education, Science and Training, *Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, Chapter 1, viewed 17/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/aust_aged_care/3.htm>.

226 Gregg S, sub 48, p 3. See also Otomancek G, sub 169, p 9; Anglican Diocese of Sydney, sub 67, p 2; Russell C, transcript 4/7/2004, p 467; Hogan W, *Review of Pricing Arrangements in Residential Aged Care*, 2004, p 225-26.

227 Anglican Diocese of Sydney, sub 67, p 2

228 Department of Education, Science and Training, *Australian Aged Care Nursing: A Critical Review of Education, Training, Recruitment and Retention in Residential and Community Settings*, Chapter 4, viewed 17/8/2004, <http://www.dest.gov.au/archive/highered/nursing/pubs/aust_aged_care/2.htm>.

- Over 990 aged care nursing scholarships have been awarded to encourage more people from riral and regional area to enter or re-enter aged care nursing; and
- Recipients of aged care nursing scholarships have received additional support to maintain their connection with the aged care specific networks, members and quality clinical placements.[229]

8.260 A further package in the 2004-05 Budget provides $101.4 million to assist providers to attract and retain qualified staff and will help the development of a more skilled aged care workforce.

8.261 These funds will underpin a major expansion in training places for aged care workers and nurses. This will allow up to 21,000 aged care workers over four years to obtain and upgrade their qualifications up to Enrolled Nurse, including training in medication management. In addition, up to 8,000 additional aged care workers will be assisted through the Workforce English Language and Literacy (WELL) program to improve their literacy and language skills. The funding will also allow 1,600 more students to commence nursing studies over the next four years.

## Other health professionals

8.262 The recruitment of sufficient appropriately qualified staff is becoming an increasing challenge for the care of people as they grow older. As mentioned previously in this chapter, there is a serious shortfall across a range health services and health specialist areas to meet the needs of an ageing population.

8.263 Evidence to the Committee identified workforce shortages in the areas of: geriatrics; orthopaedics; pathology; podiatry; psychiatry; radiology; oncology; mental health; dermatology; ear nose and throat surgery; nutritionist and dieticians; and anaesthetists. This is consistent with analysis undertaken from the Australian Medical Workforce Advisory Committee.[230]

8.264 The Committee also heard about some of the impacts these shortages have on older people: 'Waiting times and waiting lists are ballooning.

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229 Investing in Australia's aged care: More places, better care, p50.

230 The Aged-care Rights Service, sub 87, p 35-36; Department of Health and Ageing, sub 119, p 39-40; Aged Services Learning and Research Collaboration, sub 151, p 32; National Rural Health Alliance Inc, sub 131, p 34-37; Australian Medical Workforce Advisory Committee, *Australian Health Workforce Shortages – January 2004*, p 1, viewed 10/08/2004, <http://amwac.health.nsw.gov.au/amwac/pdf/Austhealth_shortages.pdf.

A large number of residents travel elsewhere for specialist care. This is a significant burden on the aged'.[231]

8.265 While shortages are being experienced across Australia, they are increasingly affecting rural and regional areas. The National Rural Health Alliance Inc explained that health professionals who cater specifically to the needs of elderly people are already in short supply and:

> As the population ages in rural and remote areas more quickly than in urban areas the relative needs in rural and remote areas for the services of all types of health professionals will increase.[232]

8.266 The shortage in rural and remote areas places additional pressure on those who do work there leading to:

> … excessive overtime, inability to get back-up for continuing professional development or leave, increasing demand without additional providers and having to provide services which would in better supplied areas be provided by other types of health professionals. Adverse consequences from this are burnout, leading to rapid turnover and extra stress for those working in circumstances where their skills may be out of date.[233]

8.267 Future supply problems will be exacerbated by the number of older professionals, who will have retired by 2021. The percentages of professionals aged 45 and over in 2001 were 61.8% (general practitioners), 54.5% (pharmacists), 42.2% (registered nurses), 54.9% (psychologists) and 49.0% (dentists).[234]

8.268 The national implications of these shortages have been recognised by the Australian Government and State and Territory Governments. The *National Health Workforce Action Plan* was endorsed by the Australian Health Ministers in July 2004. It is to be supplemented by a range of Australian Government and State and Territory Action plans and health workforce initiatives. The action plan provides a set of

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231 Aged Services Learning and Research Health Collaboration, sub 151, p 10

232 National Rural Health Alliance Inc, sub 131, p 34-37; Department of Health and Ageing, sub 119, p 39-40; Australian Medical Workforce Advisory Committee, *Australian Health Workforce Shortages – January 2004*, p 1, viewed 10/08/2004, <http://amwac.health.nsw.gov.au/amwac/pdf/Austhealth_shortages.pdf>..

233 National Rural Health Alliance Inc, sub 131, p 35.

234 NSW Department of Health, sub 160, p 12; Department of Health and Ageing, sub 119, p 40; National Rural Health Alliance Inc, sub 131, p 34-37; NSW Department of Health, sub 160, p 12.

guiding principles for government and workforce stakeholders to address health workforce issues (See Box 8.3).

Box 8.3: The National Health Workforce Action Plan Principles

**Principle 1:**
Australia should focus on achieving, at a minimum, national self-sufficiency in health workforce supply, whilst acknowledging it is part of a global market.

**Principle 2:**
Distribution of the health workforce should optimise equitable access to health care for all Australians, and recognise the specific requirements of people and communities with greatest need.

**Principle 3:**
All health care environments regardless of role, function, size or location should be places in which people want to work and develop; where the workforce is valued and supported and operates in an environment of mutual collaboration.

**Principle 4:**
Cohesive action is required among the health, education, vocational training and regulatory sectors to bring about an Australian health workforce that is knowledgeable, skilled, competent, engaged in life long learning and distributed to optimise equitable health outcomes.

**Principle 5:**
To make optimal use of workforce skills and ensure best health outcomes, it is recognised that a complementary realignment of existing workforce roles or the creation of new roles may be necessary. Any workplace redesign will address health needs, the provision of sustainable quality care and the required competencies to meet service needs.

**Principle 6:**
Health workforce policy and planning should be population and consumer focused, linked to broader health care and health systems planning and informed by the best available evidence.

**Principle 7:**
Australian health workforce policy development and planning will be made most effective when undertaken collaboratively involving all stakeholders. It is recognised that this will require: cohesion among stakeholders including governments, consumers, carers, public and private service providers, professionals, and the education, training, regulatory, industrial and research sectors; stakeholder commitment to the vision, principles and strategies outlined in this framework; a nationally consistent approach; best use of resources to respond to the strategies proposed in this framework; and a monitoring, evaluation and reporting process.

*Source: Australian Medical Workforce Advisory Committee, National Health Workforce Action Plan, pp 5 – 13.*

8.269 The Committee endorses the principles in the National Health Workforce Action Plan and considers that several have particular relevance to increasing the workforce to care for older people:

- all care environments should be places people want to work, where the workforce and their work are valued and they operate in an environment of mutual collaboration;
- cohesive action among broader education, training and regulatory sectors to ensure the workforce is knowledgeable and skilled;
- realigning existing workforce roles or the creation of new roles may be necessary; and

- collaboration involving all stakeholders is essential to developing and planning workforce policy.

8.270 The Australian Health Ministers' Advisory Council (AHMAC) is overseeing further research to examine health workforce shortages in the medium and long term and to provide a sufficient health workforce by 2020, and is investigating recruitment and retention strategies to ensure workforce supply and distribution best meets the needs of all Australians. Both projects are expected to be completed by May 2005.[235]

8.271 The Committee understands that there is no quick fix for solving workforce shortages in the health care sector. It will take considerable time for policies and practices to fully take effect, to ease the strain on the workforce caring for people as they age, and enable holistic approaches to care.

## Summing up

8.272 Several broad themes emerged, demonstrating that there are areas of common concern in aged care and health services:

- inadequate focus on services aimed at maintaining healthy functioning: physiotherapy; podiatry; nutrition advice; speech pathology; oral health services; and podiatry.
- *diverse settings* the availability and quality of care for people with dementia or mental health problems, and for those needing respite or palliative care – care which may be provided at home, in the community or in an institutional setting;
- working on it
- confusion caused by multiple community care services, and issues around the quality of community care services;
- the availability, quality and viability of residential care;
- hospitals that are seen as becoming increasingly unfriendly to older people and poorly integrated with other care services for older people;
- the need for changes in general practice and the ways GPs work with other health professionals to provide better care for people as they grow older; and

235 Health Workforce Australia, *2004-05 Health Workforce Program*, viewed 10/08/2004, <http://amwac.health.nsw.gov.au/amwac/projects.html>.

- workforce shortages, especially nurses and other residential care staff.

## Conclusion 12

8.273 **The Committee concludes that the Department of Health and Ageing liaise with the state and territory agencies so that:**

- **the new dementia care supplement should be set at two levels, consistent with the rates for the new medium care and high care RCS categories; and**
- **the medium care level supplement should also be made available for the care of people with challenging behaviours who are still living in the community.**

## Conclusion 13

8.274 **The Committee concludes that, to provide a better incentive for aged care providers to provide respite care, including for people with complex high care needs, the subsidy for respite care in residential aged care facilities should be set at two levels, consistent with the rates for the new medium care and high care RCS categories.**

8.275 While the care needs of the elderly while in hospital are beginning to receive attention, the Committee concludes that this requires urgent action. The types of initiatives being successfully developed by some hospitals indicate that wider adoption of a safety and quality approach should be pursued. The Committee considers that it would be appropriate for the Australian Council for Safety and Quality in Health Care to promote examine the occurrence of adverse events relating to older people in hospital and recommend ways of improving their clinical governance.

### Conclusion 14

8.276 **The Committee concludes that Australian Health Ministers, through the Australian Council for Safety and Quality in Health Care, should identify the care of older people while in hospital as a safety and quality priority and recommend specific actions to improve the standard of their care.**