

“The Future of Aged Care”

by

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(Adapted from an invited contribution by the Royal Australasian College of Physicians for the series “In the Public Eye” to be published in the Internal Medicine Journal)

The only thing certain about the future of Aged Care is that it will change. The best future scenario would comprehend change processes focussed on the aspirations of older people rather than reactive, cost-driven responses.

The current health system delivers excellent acute clinical services to deal with major disease entities in young and middle-aged people. There is however an escalating crisis in the acute and chronic care of the “older old”, representing persons over 75-80 years of age.

Acute illness is unambiguously the major driver of loss of self-care capacities and institutional placement in the elderly (McCallum et al 1995). These negative outcomes result in the victims of inadequate care systems being overtly “blamed” via the mindset that drives the use of terminology such as “bed blockers”. Hospital environments which are “friendly” to older people, sensitive to their needs, and competent in the delivery of the required acute care reflects an absolute infrastructure need to be created to deliver the ageing priority and inter-generational policies espoused by the Federal Government.

Residential care placement represents loss of autonomy and physical dependence – a breach of the cardinal values of older Australians (Davis et al 1999). The death rate in residential care is unacceptably high as documented by McCallum, Simons and others in the Dubbo Studies (McCallum et al 1995). These human issues compound the onerous economic costs associated with the capitalisation of the housing and delivery of services within the residential care system.

Fundamental system change is also mandated by simple linear extrapolation of the costs of acute and chronic care systems according to the rapid numeric escalation of the elderly population as part of the demographic change termed population ageing (Figure 1). Escalation of illness rates with age, and the acknowledged resource multipliers for therapy

with age compound this issue. A quantitative estimate of the resource multiplier with age comes from current Australian Health Care Agreements which specify a greater than 10 fold increase in hospital care requirements for an 85+ year old person versus a 30-39 years old adult. Federal funding formulae and allocation of resources to Health Departments by State and Territory administrations do not reflect these needs and priority.

Major increases in the efficiency and effectiveness of hospital based care of the elderly are possible, as documented in Australia and elsewhere (Flamer et al 1996, Davis et al 1999). The summary of the outcomes of re-engineering acute care of the elderly in Canberra at The Canberra Hospital is summarised in Figure 2. A 230% increase in completed episodes of care to individuals over 75 years of age was achieved (ie completed episodes meaning single events from admission to discharge as one entity with nil DRG fractionation or “gaming”, or use of subacute care facilities), with >20% reduction in bed-days used. Effectiveness of care was increased in parallel with these changes.

The management principles driving this improvement were as follows (Davis et al 1999): focus on patient values with principal attention to the problem precipitating admission; early and vigorous acute Geriatric medical care (with Geriatric care management initiated in Casualty); integrated multidisciplinary team care based on project management principles; co-ordinated physical, psychogeriatric and spiritual care; best-practice clinical care pathways; and optimal discharge planning involving close community relationships, and family physicians (“General Practitioners”) in particular.

Preventive care systems are also improving for major geriatric syndromes such as falls which are leading determinants of hospitalisation and adverse outcomes. Pharmaceutical preventive systems are proliferating for many disease-related ageing processes (“secondary ageing”), however these are often non-sustainable financially, and represent relatively poor cost-benefit propositions compared to life-style strategies targeting modification of primary ageing processes.

Basic biomedical, clinical and health services research is yielding useful gains in care processes and outcomes. Australian contributions are limited by a small and ageing research work force, funding levels which are relatively trivial, funding award systems which are disorganised and unfocussed compared to the integrated systems in place in the USA, Britain, Scandinavia and the European Union. The US system is pre-eminent in terms of size and organisation with the National Institute on Ageing, (National Institutes of Health), the

American Foundation for Ageing Research and the Geriatric Research Education and Clinical Centers (GRECC) of the Department of Veterans Affairs (NHMRC Scoping Study on Ageing Research).

Optimists look forward to the realisation of a long and healthy life-span for most Australians, with episodes of acute illness in older age treated efficiently and effectively, with the majority of nursing home beds consigned to the status of relics of past professional failure, and life ending with dignity after a satisfying “third age” of 30+ years.

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FIGURE 1

**POPULATION CHANGE (GROWTH RATE) BY AGE GROUP,
ACT AND AUSTRALIA 1998/99ⁱ**

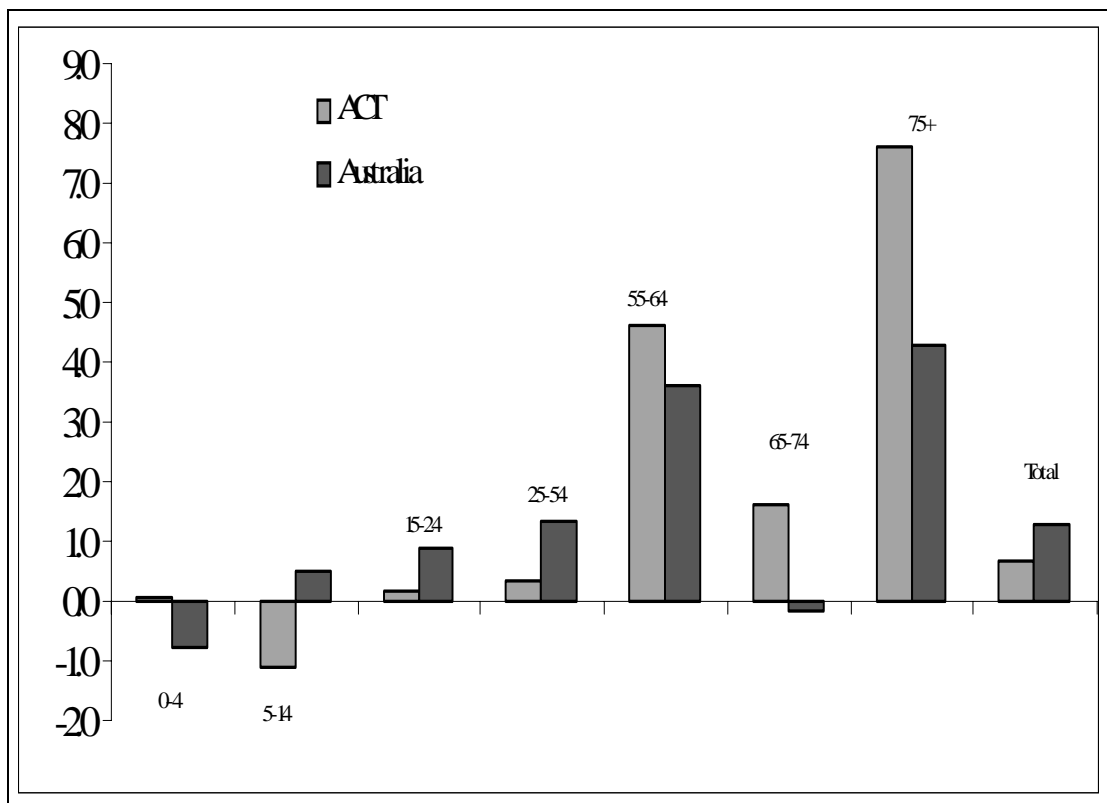


FIGURE 2

