VICTORIAN ASSOCIATION OF HEALTH AND EXTENDED CARE (VAHEC)

SUBMISSION TO THE SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE

INQUIRY INTO AGED CARE

JULY 2004

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VICTORIAN ASSOCIATION OF HEALTH & EXTENDED CARE

BACKGROUND

The Victorian Association of Health and Extended Care (VAHEC) is the largest peak body in Victoria representing the interests of aged and community care service providers.

Membership consists of over 300 organisations from the church and charitable sector, private sector and public sector. Members provide residential aged care to over 24,000 people across rural and metropolitan Victoria.

VAHEC members also provide over 5,000 community aged care packages, bush nursing centre and hospital services and a diverse range of community care programs to both older frail people and younger people with a disability.

Our submission to the Senate Inquiry addresses the 5 key themes outlined in the Terms of Reference.

VAHEC believes that this Inquiry offers an opportunity for providers of aged and community care services to put forward their views on how the current aged care system can be further improved to meet the growing needs of an ageing population.

VICTORIAN ASSOCIATION OF HEALTH & EXTENDED CARE

SENATE COMMUNITY AFFAIRS REFERENCES COMMITTEE INQUIRY INTO AGED CARE

(A) THE ADEQUACY OF CURRENT PROPOSALS INCLUDING THOSE IN THE 2004 BUDGET, IN OVERCOMING AGED CARE WORKFORCE SHORTAGES AND TRAINING.

In his report on the *Review of Pricing Arrangements in Residential Aged Care* Professor Hogan stated that:

- *The Australian Government should increase the number of registered nurse places at Australian universities by 2,700 over the next three years, with 1,000 first–year places commencing in the 2005 academic year. These additional places should only be available to universities that offer specialist training for aged care nurses, including preceptor programs for newly graduated nurses and aged care placements for students.*

- *The Australian Government should support aged care providers to assist at least:*
  - *12,000 enrolled nurses to complete medication management training,*
  - *6,000 aged care workers to complete a Certificate Level IV qualification,*
  - *24,000 aged care workers to complete a Certificate Level III qualification by 2007–08.*

  This training support should only be available to providers who are compliant with the education and staff development accreditation requirements, maintain their training expenditure at a minimum of their 2003–04 level and also provide in addition at least half of the cost of the additional training supported by this measure.

In its response to the Hogan Report the Australian Government has put in place a number of the above measures which are most welcome. However, they fall short of the numbers of places proposed by Professor Hogan.

REGISTERED NURSES

Instead of making 2,700 registered nurse places available over the next three years, the May 2004 budget measures provide 1,600 new RN places over a four year period. This will be inadequate to meet the growing demand for registered nurses in aged care settings.

People entering residential aged care today are older and frailer than they were 10 years ago. Over 60% of residents today have a high care classification. Registered nurses play a very important role in assessing the care needs of these residents, preparing care plans, overseeing the implementation of these care plans and carrying our reassessments as needs change.

With government plans to increase the total number of aged care places to 200,000 (currently at approximately 145,000) by 2006, providers will find it more and more difficult to employ registered nurses if there are not enough newly qualified nurses graduating from university.

A fact that must be taken into account in thinking about the future of the workforce is that 46% of registered nurses in the aged care workforce today are over 50 years of age (The Care of Older Australians, 2004). Unless more nursing places with built in incentives to entice new graduates to enter the aged care sector are made available in the short term, aged care providers will find it extremely difficult to employ adequate numbers of registered nurses; particularly when the current workforce starts to retire, which could impact on the quality of care provided.

DIVISION 2 NURSES – (STATE ENROLLED NURSES)

While Division 2 nurses (enrolled nurses) have played a very important role in the delivery of aged care services in Victoria, their inability to administer medication under their scope of practice for many years has made it extremely difficult for aged care providers to offer them employment. While the scope of practice of division 2 nurses was expanded early in 2004 to include administration of certain medications, only those who complete the relevant training and have their practicing certificate endorsed by the Nurses Board of Victoria will be able to administer medication.

The cost of the training is estimated at approximately $3,000 per person. For many nurses this cost will pose a barrier to undertaking this training. It will also pose a barrier for many aged care facilities who will find it extremely difficult to fund this level of training for their staff. With 17,553 division 2 nurses registered in Victoria at 30 June 2003 (NBV Annual Report, 2003), meeting the demand for medication administration training could be difficult for many.

Professor Hogan recommended that the Australian Government should support aged care providers to assist at least 12,000 enrolled nurses (nationally) to complete medication management training, by 2007–08

However, the government in its May 2004 budget allocated enough funding to assist 5,250 enrolled nurses over 4 years nationally. Division 2 nurse in Victoria alone could use that quota in a shorter time.

To ensure aged care providers have access to an appropriately skilled and educated workforce more must be done to assist existing Division 2 nurses (particularly those currently working in aged care) to complete training in medication administration over the next few years.
Division 2 nurses have skills and qualifications needed in the aged care sector; however, their inability to administer medication will continue to be a barrier to employment in the aged care sector.

NATIONAL APPROACH TO SCOPE OF PRACTICE FOR DIVISION 2 NURSES (ENROLLED NURSES)

Under current State legislation the educational requirements, role, and scope of practice for Division 2 nurses continues to vary widely from state to state. While division 2 nurse are able to administer medication in most States (including in Victoria since early 2004) the level and type of medication that can be administered varies, depending on the nurse's level of education and the particular state's legislation.

Moves by the Australian Government in 2003 to establish uniform national standards for enrolled nurses outlined in a report titled *Aged Care Enrolled Nurse Working Party (a Report to the Minister for Ageing)* in March 2003, is most welcome by the aged care sector. These recommendations should be implemented as a matter of urgency. Division 2 nurses trained and legally able to administer medication uniformly across the nation will provide a more robust and flexible nursing work force to meet the growing needs of an ageing population.

A consistent, national approach to the role, education needs and scope of practice of enrolled nurses, with national guidelines for supervision and delegation, will be essential if the aged care industry is to attract adequate numbers of nursing students. This will also make it easier for the aged care sector and the nurses themselves to continue employment when moving between states.

PAY AND CONDITIONS FOR NURSES IN THE AGED CARE SECTOR

The provision of more nursing degree places alone and/or funding for medication administration training will not ensure nurse graduates choose an aged care career over acute or other health areas.

The major sources of aggravation for nurses working in the aged care sector are their pay and an inability to spend sufficient time in providing quality care to individual residents (The Care of Older Australians, 2004, p.4). Nurses in aged care tend to earn at least 12% less than their counterparts in the acute care sector.

While the 2004 May Budget provided a welcome increase in the subsidies paid for residential aged care with a supplement of 1.75% being added to the care subsidies for the next four years, this will not be sufficient to enable aged care employers to pay wages that are competitive with the public hospital sector;
nor to alleviate the pressure of inordinate amounts of documentation required to meet the red tape imposed on nurses and other staff working in the aged care sector.

Until these barriers are addressed it will remain very difficult for the current workforce issues in residential aged care to be effectively dealt with.

Aged care providers must be funded to a level which enables them to pay wages that are competitive with the public hospital sector. This would best be achieved by linking aged care subsidies to an appropriate index of health sector wages. Alternatively a higher supplementary payment should be made.

The inordinate amount of documentation requirements must also be reduced.

PERSONAL CARE WORKERS

With the ageing of the population and the continued shortage of nurses, personal care workers continue to play a vital and growing role in both residential aged care and in community care settings. In 2003 57% of workers (67,000) in residential aged care were personal care workers (The Care of Older Australians, 2004, p.2).

To meet the increased demand for personal care workers Professor Hogan in his report recommended that the Australian Government should support (residential) aged care providers to assist at least:

- 6,000 aged care workers to complete a Certificate Level IV qualification,
- 24,000 aged care workers to complete a Certificate Level III qualification by 2007–08.

In the 2004 May Budget the Australian government proposed that 4,500 additional vocational training places will be created each year for aged care workers, to improve the quality of care and to provide better career pathways for aged care workers. These places will assist 15,750 aged care workers undertake vocational education and training over the next four years.
This falls well short of the 30,000 places recommended by Professor Hogan for residential aged care alone.

With the shortage of nurses predicted to continue over the next few years aged care providers may not have any choice but to employ more personal care workers to meet the needs of their residents.
With the number of residential aged care places and community aged care packages predicted to grow to 200,000 places by 2006, plus predicted growth in HACC funds the demand for personal care workers in both residential aged care and community care settings is set to escalate.

However, personal care workers in both residential aged care and community care settings, while achieving high levels of personal satisfaction from their work constantly feel underpaid and undervalued. There is high turnover of personal care workers in both sectors. The supply of workers in these jobs would be quire responsive to modest changes in the relative attractiveness of their pay and conditions (the Care of Older Australians, 2004; Who Will Care? Recruitment and Retention of community care workers, 2002).

MODELS OF CARE

There is a worldwide shortage of registered nurses which will have to be resolved before its impact on aged care can be negated. Given that the shortage is unlikely to be resolved in the near future, models of care which are not so strongly predicated on the availability of nurses must be considered.

The role of registered nurses in residential aged care needs to be reviewed so that nurses are utilising their “nursing skills” at all times. There are many tasks including administrative tasks currently carried out my registered nurses in residential aged care facilities that can be carried out by other staff.

Plans must be put in place to ensure that there is a flexible and growing workforce able to deliver residential and community care services. Co-ordination of efforts of State, Commonwealth and Industry – leading to the development of an industry wide (residential and community) workforce plan is urgently required.

COMMUNITY CARE WORKFORCE

While much of the research carried out by government to date on the aged care workforce revolves around residential aged care, there are equally as many issues and challenges for workers in the community care sector.

The workforce and training initiatives in the 2004 May Budget are mostly directly at residential aged care with very few initiatives for the community care sector. This is an issue that must be addressed in the broader view of workforce shortages and training for aged care in the future.

A report prepared by VAHEC and the Brotherhood of St Laurence in November 2002 titled *Who will care? The Recruitment and Retention of community care workers* outlines some of these challenges. A copy of this report is attached as part of this submission (Appendix 1).

NATIONAL AGED CARE WORKFORCE STRATEGY

The current National Aged Care Workforce Strategy effort needs to be continued and need to

- reflect the changing nature of the workforce with less availability of nurses requiring more strategic use of their time;
- deal with community care workforce demands and issues;
- expand the availability of traineeships for personal care workers entering either residential or community aged care and progressing to higher levels;
- pay special attention to developing innovative approaches to promoting aged care careers, particularly among young people; and
- address a number of, mainly state-based, regulatory barriers to the efficient and flexible deployment of existing staff which inhibit the provision of safe, economical and genuinely person-centred care.

(B) THE PERFORMANCE AND EFFECTIVENESS OF THE AGED CARE STANDARDS AND ACCREDITATION AGENCY IN:

IV. ASSESSING AND MONITORING CARE, HEALTH AND SAFETY

V. IDENTIFYING BEST PRACTICE AND PROVIDING INFORMATION, EDUCATION AND TRAINING TO AGED CARE FACILITIES AND

VI. IMPLEMENTING AND MONITORING ACCREDITATION IN A MANNER WHICH REDUCES THE ADMINISTRATIVE AND PAPERWORK DEMANDS ON STAFF.

The current structure of the aged care accreditation system - a single stand-alone process applying to only one of the many programs in the aged care field and on a single agency with a monopoly on accreditation service provision - is less than optimal and inhibits its overall effectiveness.

There are three main issues relating to the current provision of accreditation services:

- The lack of exposure of the Agency to price and quality pressures;
- The inability of the Agency to respond to the whole range of accreditation needs of aged care providers. Many of our members are involved in providing services to older people under a number of different government programs, or directly to older people themselves, and are therefore compelled to participate in multiple accreditation systems to cover the whole scope of their activities. This could be addressed if a market in the provision of accreditation services were to be allowed to develop and to respond to the industry's accreditation needs.
- The fact that a market exists for the provision of accreditation services to other industries, including other parts of the health and care system, and that this market is regulated under the Joint Accreditation System for Australia and New Zealand (JAS-ANZ).

The industry has also had long standing concerns with the internal quality control procedures in place in the Agency around such issues as consistency and objectivity. The existence of an overarching and active quality control framework in JAS-ANZ guards against this.

JAS-ANZ accredits accreditation bodies and subjects them to the same type of scrutiny that the accreditation processes apply to services. In so doing it provides for a regulated marketplace of accreditation providers who are able to tailor the range of areas in which they are certified to meet the needs of their customers.

If such a framework were to be adopted for the aged care sector in Australia VAHEC believes it would confer the following advantages:

1. It would enhance the credibility of the residential aged care accreditation process by providing for ongoing and regular scrutiny of the systems and processes employed by accrediting bodies. The Federal Government would retain responsibility for setting the standards against which services are assessed, though this should be done with input from stakeholders including providers, staff and consumers.
2. It would provide for greatly reduced duplication of effort in circumstances where an increasing proportion of our members provide a range of services, more than just residential aged care, to frail older people and currently are subject to a different accreditation process for each one.

   Providers of community care services suffer similarly - one ACSA member reported to a recent national Community Care Forum of having to comply with eight different accountability regimes for its total funding of $250,000!

   The open structure of the JAS-ANZ framework would facilitate a common approach to accreditation regardless of the funding source, though some additional work may also be required on the Standards themselves. This, in turn would promote the continuity and consistency of care for older people across their whole range of needs.
3. The JAS-ANZ framework is premised on the principle of continuous improvement both for the industry in question and its accreditation bodies.
4. The independence of the accreditation process would be assured, further enhancing its credibility.
5. Because accrediting bodies are able, under JAS-ANZ arrangements, to spread their fixed costs over a much broader range of clients and industry sectors they are in principle more economical.

6. One of the keys to the robustness of the JAS-ANZ arrangements is that they provide for contestable service provision. This is not about shopping around for a 'soft' auditor - the rigour of JAS-ANZ accreditation militates against this- but it is a powerful mechanism to ensure responsiveness to client needs, in terms for example of the range of services covered, and for continuous improvement.

The demonstrated effectiveness of the Agency in ensuring improved quality for residents was questioned in a report last year by the Australian National Audit Office, and the subsequent findings of the parliamentary Joint Committee of Public Accounts and Audit, on the management of the residential care accreditation process. Any accreditation system in a human services context should have the prime outcome of improving the quality of care for consumers.

While it is generally acknowledged in the aged care industry that the accreditation process has represented a step forward, it remains ACSA's view that better outcomes would be achieved if competitive service provision and quality control under the JAS-ANZ framework were to be introduced.

(C) THE APPROPRIATENESS OF YOUNG PEOPLE WITH DISABILITIES BEING ACCOMMODATION IN RESIDENTIAL AGED CARE FACILITIES AND THE EXTENT TO WHICH RESIDENTS WITH SPECIAL NEEDS SUCH AS DEMENTIA, MENTAL ILLNESS OR SPECIFIC CONDITIONS ARE MET UNDER CURRENT FUNDING ARRANGEMENTS;

C.1 Young People with disabilities in Residential Aged Care Facilities

There are approximately 1500 younger people with disabilities inappropriately placed in nursing homes in Victoria.

Nursing homes which are designed to cater for the needs of older frail people are clearly not appropriate for young people with disabilities. While all staff have the qualifications and training to deal with the day-to-day needs of the frail elderly, few would have the right skills to properly meet the needs of younger people with disabilities. This makes life difficult both for the staff and the resident.

An added dimension to this is that for every nursing home place occupied by a young person, an elderly person is being denied the care he or she requires. This in turn causes stress on both sets of families - the younger people's families, who see their loved ones inappropriately placed, as well as the families of the older people unable to find a nursing home bed.

Case Study

Over the past three years a member of VAHEC has cared for three younger residents with acquired brain injuries, in a thirty-bed aged care nursing home. Two were in their forties, and one in his twenties. Two were TAC clients and one an MS sufferer.

To meet the needs of these residents, staff at the facility endeavored to adjust their usual programs (designed to cater for the frail elderly) to be inclusive of their younger clients needs. This included where possible attracting volunteers to provide separate programs. However, these were felt by the staff to be stopgap measures, with the residents having very few alternatives for more appropriate accommodation. During this time the facility received very little complaint from these residents.

With this experience, staff at the facility have developed plans for a fifteen-bed ABI unit, to be attached to their existing thirty-bed nursing home.

They believe their model of care, which includes respite accommodation, can be financially viable in its own right; however they have encountered two issues in this process:

- *The first is obtaining Commonwealth approval for beds that will accommodate existing "aged care approved" clients.*
- *The second is capital.*

They have approached the state and commonwealth departments, and philanthropic groups. To date they have only raised $210,000 for a project that has been costed at $2.6 million to $3.0 million. However, in an effort to more fully meet the needs of these younger residents they have not given up on the project and are currently exploring options for financing the capital requirements and are reviewing and refining their operating model.

From their perspective and experience the staff believe there are three clear requirements to appropriately care for younger people with high care needs:

1. *They need their own facilities. This will enable their interaction with younger people with like interests. Care plans can be permanently established to adjust to their needs. The focus needs to be on long-term gains in physical and cognitive function (as distinct from palliative care for aged clients.)*
2. *Models should incorporate both compensable and non-compensable clients, to enable economies of scale. The price needs to increase for non-compensable clients to enable appropriate levels of care. Research by Joint Solutions Group and YPINH has clearly indicated the higher cost of care for younger people with ABI (as distinct from frail aged care). The price paid by TAC is also indicative of their recognition for the higher costs of care (for private providers TAC pays substantially higher than the current RCS price).*
3. *There is a lack of capital available to build appropriate establishments to accommodate younger residents. A pool is required, which will allow either up front payment, or financing options that may be repaid from the funding model. Within this, there need to be a clear delegation of responsibility to either the States or the Commonwealth. Client care should not remain in the trenches of the battle over state/federal responsibilities.*

As funding the needs of younger people with disabilities does not fit neatly within either the Commonwealth or State government funding structures,

VAHEC encourages both Commonwealth and State governments to work together to address this most unpalatable situation and to ensure the needs of younger people with disabilities are met in a more appropriate and humane way in a more suitable environment.

While improvements in technology can save the lives of many people with brain injury, as a community we must follow through and ensure we can also provide quality of life.

C.2 Special Needs such as dementia, mental illness or specific conditions.

DEMENTIA/MENTAL ILLNESS

IN 2002 there were over 162,000 people with dementia in Australia which is predicted to rise to 500,000 by 2040. Approximately 46% of these people or 74.520, live in residential aged care facilities - 33% in nursing homes and 13% in hostels (The Dementia Epidemic, 2003)

Today at least 60% of residents in high care facilities and 30% in low care have dementia. However more than 90% of those in high care and 54% in low care have an obvious cognitive impairment. (Rosewarne, 1997 in Dementia Epidemic, 2003). Despite the high numbers of people with dementia in residential aged care facilities only 5% of high care and 6% of low care beds are dementia specific – mainly separate wings and/or co-located units. This is due to the current funding system not recognizing the additional costs involved in caring appropriately for those with dementia.

Funding for residential aged care is determined through the resident classification scale. Each resident on entry to a residential aged care facility is assessed against the RCS which determines the resident's category and the level of funding applicable. There are 8 classifications in total – 4 high care and 4 low care.

However, the RCS does not adequately recognise the care needs of those with dementia and/or mental illness. Issues around behaviour are not captured in the RCS questions which results in residents being classified as having lower level care needs.

This in turn does not adequately support staff managing difficult and resource intensive anti – social behaviours, many of which are best managed through the provision of one-on-one care throughout the day.

People from Disadvantaged Backgrounds/Homeless People

The current aged care funding system favours elderly people who are more financially secure and/or own their own home and encourages low care facilities to admit residents who fit that criteria. While the Act does refer to financially disadvantaged people, the definition used does not sufficiently target the most disadvantaged people (e.g. homeless elderly) thereby failing to ensure they have access to services when required.

Homeless people who end up in residential aged care suffer from multiple cognitive problems (including psychiatric disability, intellectual disability, alcohol related brain impairment and associated permanent memory loss), poor health status, poor nutrition, premature ageing and social isolation.

The funding tool used by residential aged care facilities (RCS) even when maximised does not reflect the level of care and funding required by homeless people/residents assessed as having high and complex care needs. The intensive level of care and one-on-one support required by these people cannot be provided by organisations within the current funding structure.

As a result this marginalised group of people is often not admitted to residential aged care and/or in exceptional circumstances discharged from residential aged care facilities. Without the appropriate levels of staffing to care for these residents, the well being of other residents and the occupational health and safety of staff are at risk. As a result these people often end up in unsuitable boarding houses, supported residential services, moving in and out of the public hospital system or simply living on the streets where their needs are not being met.

In 2001 VAHEC prepared an issues paper on Homeless People in Residential Aged Care which makes a number of recommendations on how the needs of homeless people can be better met within the current residential aged care system. A copy of this paper is enclosed as part of this submission (Appendix 2).

HOGAN REPORT RECOMMENDATIONS

The Hogan Review recommended the extension of funding supplements to three special needs groups as follows:

- people with short-term medical needs;
- people with dementia or who have palliative care needs, and;
- people from diverse or disadvantaged backgrounds such as the homeless elderly and indigenous Australians.

GOVERNMENT RESPONSE – 2004 MAY BUDGET

The Government response in the 2004 – 2005 Budget however only picks up two of these special needs groups and does not address the needs of people from a disadvantaged background.

VAHEC believes a supplement should be made available for people from disadvantaged groups.

These new supplements appear to be funded from existing funds. This means that when implemented resources may be diverted from meeting other/existing needs. VAHEC does not support this. Like the existing enternal feeding supplement any new supplements should be in addition to existing RCS levels of funding.

In the longer term the use of supplements needs to be reconsidered in conjunction with the overall design of a more appropriate funding model.

DEMENTIA SPECIFIC SERVICES

As stated earlier only 5% of high care and 6% of low care beds are dementia specific. This means that the vast majority of people with dementia are placed in what are commonly referred to as “mainstream” residential aged care services. Whilst the majority of these services cater extremely well for residents with dementia, it is obvious they needs can be better responded to and met in dementia specific facilities.

However, the issue that is sometimes forgotten in this debate is the fact that older people who are mentally sound but physically frail are living side by side with people with differing levels of dementia – from mild to severe. This places considerable stress and anxiety on those residents and their families/friends that come to visit.
This can be a very threatening and at times frightening environment for those who do not understand the needs of people with dementia.

Those who do not have dementia can often find strangers wandering innocently into their rooms from time to time.

VAHEC supports the development of more dementia specific facilities that are appropriately financed to meet the particular needs of people with severe behavioural and psychological symptoms of dementia.

In addition all residential aged care services (dementia specific and mainstream services) should be funded to enable ongoing training of all workers (nursing and non nursing) to provide dementia care.

(D) THE ADEQUACY OF HOME AND COMMUNITY CARE PROGRAMS IN MEETING THE CURRENT AND PROJECTED NEEDS OF THE ELDERLY

Community care is the preferred choice for the vast majority of both older people and younger people with a disability who wish to remain in their own homes for as long as possible, rather than enter residential care.

For the last 20 years both Federal and State governments have supported this concept placing greater emphasis on home based care and shifting the balance of care from residential care to community care.

Increased government funding, particularly over the last 14 years, has resulted in many community care programs being set up to support this goal.

Community care programs today provide a range of services for older people and those with disabilities in their own homes:

- cleaning services
- delivered meals
- personal care
- nursing
- allied health
- property maintenance and;
- respite care.

HOWEVER, DESPITE THIS, THE CURRENT COMMUNITY CARE SYSTEM IS NOT MEETING ALL THE NEEDS OF THOSE WHO CURRENTLY REQUIRE IT.

- There are inadequate levels of service provision;
- Services are fragmented (Currently there are 42 different funded state and federal programs providing community care in Victoria alone)
- Services are often difficult to access and they are unevenly distributed across the state
- It's a nightmare for anyone who does not know the system attempting to find a way through.

The ageing of the population is now placing even more pressure on an already overstretched system. Demand for services is far outstripping supply with many providers feeling pressured to put people on waiting lists.

Over the next 20 years those aged 65years and over will increase from 2.4 million people today to 4.2 million or from 12% of the population to 18%.
It is estimated that by 2006, 1.3 million Australians will have a severe or profound disability.

In Victoria the 70-84 age group is estimated to increase by nearly 204,000 or 54.3%, and those aged over 85 are estimated to increase by 47,000 or 71% by 2021

This rapid growth in the numbers of people needing community care will place increased pressure, not just on the current formal service system already struggling to meet existing demand, but also on unpaid carers, without whom community care would not be an option for many people.

- There are currently 2.5 million Australians providing care for family members or friends with a disability, mental illness, chronic condition or who are frail aged. This represents one in every five households.
- Nearly 20% or 450,000 of all people providing assistance are primary carers, that is, they provide the main source of unpaid informal support.
- Most primary carers (54%) said that they provided care either because alternative care is unavailable or too costly, or because they consider they have no choice.
- A recent report by the National Centre for Economics and Social Modeling projects the number of principal carers for persons needing informal care will decrease by 40% over the next 30 years leaving 573,000 frail older Australians living in the community without a primary unpaid carer.
- The 1998 Survey of Disability, Ageing and Carers reported that 40% of people of all ages with a major disability who live independently and need assistance; felt their needs were only partly being met.

WHAT NEEDS TO BE DONE?

- What's needed is a bigger, better-funded system of community care that is far easier for consumers to access and navigate than at present.

- With the ageing of the population both State and federal governments need to acknowledge the extent of the impending problem and work towards finding solutions.

By 2021, there will be 4.2 million Australians over the age of 65. Many will require some form of care, and they will want it delivered in their own home.

Community Care as well as being preventative, is the most economically efficient and socially effective model of care. It improves people's lives and prevents premature admissions to residential care facilities. It literally is the way of the future.

Key Facts:

- Currently there are 17 separate Commonwealth funded programs providing community based care services.
- In addition each state funds many more separate programs all requiring separate reporting and administrative arrangements. For example in Victoria, there are another 22 separate programs operating covering specialist aged health care, disability services and community health services resulting in a total of 42 separate programs (three of these are jointly funded with the Commonwealth).
- In 2002-03, 26.3% of all HACC clients were self referred; family/friends referred a further 16.1%, Public hospitals 14.2%, and GPs 12.7 %.
- The lowest number of referrals (0.1%) came from Commonwealth Carelink Centres.

Case Study
(The following case study was provided by a member of VAHEC)

Mrs X is 72 years old. She was diagnosed in 2000 with Motor Neurone Disease. She lives alone in own home which has been fully wheelchair adapted, mostly at her own expense, but with some assistance from Victorian Aids and Equipment Program, She has PAC alarm. Current assistance is 7.5 hrs via a Community Aged Care Package and 10 – 12 hrs via Qualcare

Mrs X is very alert, takes a very keen interest in her condition and works extremely hard to minimise its impact. She has a broad range of interests and is very pro-active in her own care through use of her computer

***Self care**: although independent most of the time, unless feeling unwell,, it takes Mrs X much longer to perform simple functions due to MND e.g. 2 hours to shower; whereas if a Carer assisted it would take about 20 mins*

***Mobility**: Mrs X is dependent on an electric wheelchair for mobility is able to transfer slowly , and uses the wheely-walker late at night and first thing in the morning whilst her chair is re-charging unless unwell.*

***Allied health/therapy requirements**: Mrs X has the Primary Lateral Sclerosis form of MND, which means the muscles retain their strength; however exercise is **crucial** to achieve this; however she is not independent in exercising e.g. hydrotherapy- a carer is required at all times in the water, physiotherapy and the amount of exercise is limited by the availability of a carer*

***Continence:** Mrs X reports no bladder or bowel function problems; however she does experience difficulty if she can't get to the toilet in time due to mobility/dexterity problems*

***Sleep**: she has no problem sleeping, however does suffer from lack of sleep as she doesn't get to bed until 1-2am and due to the length of time it takes to accomplish day to day tasks. She also has to be up and out of bed for home care at 8am*

***Meals**: Current levels of care do not provide assistance with meals except breakfast; she misses meals or eats them cold. In maximising her general health Mrs X eats only non-processed foods which in turn increase preparation time. In addition MND makes swallowing difficult and she is on a soft-normal diet*

Mrs X needs are not fully met by the combination of CACPs and Qualcare, so she was assessed for EACH on 2/3/04 but ineligible as she was deemed functioning at LOW level of care according to ACAS assessment tool She was referred to Linkages in Sept 2002 but was not accepted as her current services with CACPs are higher than the Linkages program would provide.

In Sept 2003 she was referred to Home First and although classified as urgent, is also deemed as being above the age limit (i.e. over 65 years) Mrs X has recently requested a re-assessment for EACH

Mrs X has fallen into a large hole between service boundaries, and is kept there by costly red tape which prevents rather than assists access to services. Mrs X (Aged Care Pension) has already spent most of her disposable income in modifying her home to remain there as long as possible. Should she move into a residential facility the costs to maintain her there would be far greater than maintaining her at home

(E) THE EFFECTIVENESS OF CURRENT ARRANGEMENTS FOR THE TRANSITION OF THE ELDERLY FROM ACUTE HOSPITAL SETTINGS TO AGED CARE SETTINGS OR BACK TO THE COMMUNITY

Quality health and aged care need to be integrally linked. Governments need to act urgently to introduce policies to achieve a system of services where access is determined by the needs of people, rather than the particular point of contact or service setting.

Progress towards a continuum of care for older people requires policies and strategies for the integration of primary care; community care; health promotion and illness prevention; rehabilitation; acute care; sub-acute care; and residential care.

People in residential aged care need more appropriate health care, in the residential setting to avoid unnecessary hospitalisation. In the acute hospital setting, older people need access to specialist gerontic services. Currently their health care needs are not being adequately met in either setting. This unacceptable state of affairs is a result of the fragmentation of health and aged care service.

Older people are often forced to remain in hospital once well enough to leave because appropriate residential or community care is not available for them. Within the acute health system they are disparagingly called "bed blockers". In 2002/2003 people over 70 years of age accounted for 163,000 or 30% of all public hospital discharges in Victoria.

More residential homes and community services are required to enable older Australians to leave hospital safely and securely.

With the lack of resources in the acute sector older Australians are sometimes forced to leave hospital before they are fit enough and/or without appropriate discharge plans. There is substantial anecdotal evidence and many documented stories of inappropriate discharges.

These include people returning home with wounds, which still require medical care and no supports in place for meals, personal care and dressings. Patients are also sometimes sent back to their residential facility without any information about treatment and medication being provided. These types of situations place pressure and stress on the older person, their families and the service providers. It has been argued that poor discharge planning contributes to re-admission to hospital and premature admission to residential care. Residential homes and

community support services are not able to provide intensive medical treatment.

Acute hospitals need to modify their practices to provide appropriately for the care needs of frail older people. Governments need to agree on how to provide for the care needs of older people who require a level of care that lies between current hospital and residential aged care provision, egg sub-acute', 'transitional', or 'interim' care.

VICTORIAN ASSOCIATION OF HEALTH & EXTENDED CARE

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