Submission

Australian Physiotherapy Association

Submission on Terms of Reference for the Inquiry into Residential and Community Aged Care in Australia

Presented to the Senate Finance and Public Administration Committee

November 2008

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APA
AUSTRALIAN PHYSIOTHERAPY ASSOCIATION

Inquiry into Residential and Community Aged Care in Australia

Australian Physiotherapy Association

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups. The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 12,000 members, some 70 staff and over 300 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and current submissions are publicly available via the APA website www.physiotherapy.asn.au.

Introduction

As the proportion of older Australians increases, the need for aged care services and for staff to deliver those services also increases. The APA recognises the importance of reviewing current funding practices to ensure that future delivery of aged care services will meet the needs of older Australians.

Physiotherapy can help older people to maintain optimal health and thus maintain independence. Specific programs designed by physiotherapists have been shown to improve strength, balance and functional ability in older people dwelling in the community[1, 2].

Many of the chronic diseases that contribute to poor health later in life, such as type 2 diabetes, cardiovascular diseases, osteoporosis, and arthritis can be prevented, treated and/or managed by physiotherapists in conjunction with other health professionals. Older people dwelling in the community or in residential aged care facilities (RACF) have the right to access physiotherapy to help prevent and manage chronic illness and to maintain their maximum physical capacity. Some specific areas where physiotherapists have particular expertise are falls prevention[3, 4, 5], incontinence[6, 7], exercise[1] and rehabilitation[2, 8].

The issues surrounding appropriate and effective use of funding within residential and community aged care are complex. This submission responds to areas a), b) and e) of the Senate Inquiry's terms of reference, and focuses on issues related to maximising physical function and independence in older Australians; an area of speciality for physiotherapists. If done effectively, maintaining and increasing physical capacity in older people would reduce the burden of care within the aged care sector.

a) Are current funding levels sufficient to meet the expected quality service provision outcomes?

Aged Care Funding Instrument (ACFI)

The new ACFI funds levels of dependency, after problems have occurred, rather than focusing on the prevention of physical decline and the maintenance of optimal function. The ACFI gives RACFs little incentive to promote optimal physical functioning in residents, and many concerns have been raised by physiotherapists working in residential aged care settings that the new ACFI has led to a reduction in older people's access to physiotherapy services.

The present levels of funding are not sufficient to allow adequate access to physiotherapy for people residing in aged care facilities.

The APA recommends that the ACFI be revised to include funding that is specifically allocated to preventative models of care for the elderly and that promotes optimal physical function.

Enhanced Primary Care (EPC)
In residential care, access to allied health services for those with complex care needs is limited. The Medicare EPC program provides only five visits annually for an individual's total allied health requirements. Residents must be referred by a GP who has completed a care plan under Medicare item 731. This occurs *after* they have been assessed by an ACAT team as being unable to live independently in the community due to their complex and chronic health conditions. The GP's reassessment under item 731 is an unnecessary burden on already overworked doctors, and the five allied health sessions are often taken up by necessary routine care in other allied health areas. Consequently people with high physical rehabilitation needs often fail to gain access to vital physiotherapy services which would maximise physical function.

For elderly people dwelling in the community, access to allied health services through the EPC program requires the GP to prepare a GP Management Plan (item 721) and Coordination of Team Care Arrangements (item 723) prior to referral. In large practices that utilise computer based patient records and have a practice nurse who primarily manages this system, the patient is readily referred for services that they need. However for GPs who operate a sole practice (especially those who offer a mobile service) there is great reluctance to refer using the EPC program. The administrative burden for these sole GPs is a significant barrier to their patients accessing services needed to maintain their function or continue physical independence.

The APA recommends that if EPC is to remain the primary mechanism by which access to physiotherapy services occurs, then access to EPC funding must be simplified, and the maximum number of sessions be extended to provide treatment options for physical rehabilitation needs.

b) How appropriate is the current indexation formula in recognising the actual cost of pricing aged care services to meet the expected level and quality of such services?

Indexation in the aged care sector has not maintained parity with salary increases in the health sector. Competitive salaries are needed to ensure that sufficient numbers of appropriately trained and qualified staff can be employed within aged care to maintain quality of service.

The APA recommends that indexation be consistent with salary increases in the aged care and health sectors, in order to attract and retain suitably qualified and experienced staff.

e) Is the current planning ratio between community, high- and low-care places appropriate?

Current funding mechanisms for high and low-care residents in RACFs fail to result in positive outcomes for elderly residents. The ACFI funds residents' *dependency* instead of their requirement for support, thus failing to provide for the maintenance or improvement of physical functional. By funding dependency, there is an active disincentive for facilities to provide services that will improve their residents' level of function.

Much of the disability and frailty we see in older people in Australia, whether they reside in an RACF or in the community, is due to functional decline as a result of a sedentary lifestyle and the expectation that decline is part of the normal ageing process and inevitable. This leads the person and their carer to accept the condition and not actively seek assistance to reverse the decline. For

example, incontinence is a very common problem for both elderly women and men and is usually managed by wearing incontinence pads and using a toileting schedule. The problem is rarely referred to a physiotherapist specialising in continence care, despite there being high level evidence to support the efficacy of physiotherapy intervention[6, 7, 9]. Another common misconception is that the gradual muscle deterioration which results in difficulty getting out of a chair is a symptom of normal ageing (as opposed to sudden deterioration after illness or hospitalisation). It is therefore rarely referred to a physiotherapist for a simple program of quadriceps strengthening that can reverse the problem[10].

In both of these examples the ACFI funds the need for assistance to get out of a chair, and manage incontinence by a regular toileting schedule and changing pads but does not specifically support a physiotherapy intervention – particularly for low care residents. These low-care residents will often benefit most from intervention as they have greater cognitive and physical ability to more actively work with a physiotherapist.

If a resident enters a facility and is rated high on the ACFI for mobility, there is potential for the facility physiotherapist to work with the resident to improve their function to bring their rating down. However the ACFI provides no incentive for a resident who is admitted at a low-care level to improve or even maintain their physical functioning.

There is a large unmet need for slow stream rehabilitation for elderly people both in the community and RACF. The EPC program cannot supply the service level required with only a five visit limit. Specified Care and Services required to be provided for high care residents specifically excludes "intensive long-term rehabilitation service required following for example serious illness or injury, surgery or trauma"[11]. Physiotherapy is not provided to low care residents by an RACF, even though slow stream rehabilitation is often required on entry to a facility in order to optimise function.

The application of episodic intensive physiotherapy has been shown to improve the ability of elderly people with complex and chronic health problems to function at a higher level and thus improve their independence and quality of life. It has also be shown that intervention is likely to be more clinically effective and cost effective when applied in the early stages of disease[12].

The APA recommends that the committee examine amendments to the ACFI aimed at allocating more resources to maintaining and improving physical function for low-care residents. The committee should also examine the potential to implement incentives for this purpose.

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