23rd July 2010

Caring for Older Australians
Productivity Commission
PO Box 1428
Canberra City ACT 2601
agedcare@pc.gov.au

Dear Sir

Re: Caring for Older Australians: Productivity Commission Issues Paper

The Australian and New Zealand Society for Geriatric Medicine welcomes the opportunity to respond to the comprehensive Productivity Commission Issues Paper: Caring for Older Australians.

The report requests input on a range of topics in provision of aged care for older Australians. It must be clear that aged care is across all settings coordinated and linked and does not just refer to individual areas such as the residential aged care sector. The future development of aged care services must address the increase in absolute number of aged persons, the increase in longevity, the rise in prevalence of chronic often multiple co-morbid diseases, especially neuro-degenerative diseases and in particular dementia, the diversity of the population and increasing consumer affluence and awareness. These anticipated challenges to the aged care system will require a substantial increase in funding across all levels of care provision, significant expansion of the workforce with in-built flexibility and innovative strategies to improve the present system. Access, quality and efficiency for rural, indigenous, non-English speaking communities and other minority groups must be equal in ideal health delivery. Attitudes and tolerance to ageing and aged people in general will need to improve by the population at large, all levels of government and in particular all health disciplines to ensure the most appropriate, comprehensive, exemplary and accessible care for older Australians.

We thus provide comments posed by documented questions on the current system, objectives of the aged care system, fiscal arrangements, the role of regulation, the role of different levels of government, workforce implications and transition issues as configured in the document, as they apply to the different levels of service delivery.

1. Community Care

There are still gaps in funding, access, provision, streamlining and coordination. HACC based services would benefit by improved linking with ACAT's and provision of CACP, EACH and EACH-D along a continuum of assessment with funding to optimise the chance of the aged person being realistically able to stay in private housing, which is so often desired. The hours provided are often insufficient and inflexible to cater for the very frail and those with dementia either living alone or with a carer.

Local planning and management of services to support community care and general practitioners could be improved by more coordinated specialist geriatrician, nursing and allied health availability, in a structure possibly similar to GP networks. GP access to specialist geriatricians in many areas is not available or is limited by long waiting lists and domiciliary visiting by geriatricians is still unusual.

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Transition Care Packages are still limited, to allow more timely transition to home care from acute and sub-acute care and the 12 week time limit is insufficient to allow seamless transition to HACC services, which are often inadequate especially where cognitive issues are impacting on the success of community care. There are insufficient geriatricians to offer ongoing surveillance.
Transport issues will need to be addressed to guard against social isolation, to facilitate access to leisure activities and health provision and address the need for rural communities to access quality health care equal to urban communities.

This formal area of service delivery will require considerable increase in funding, provision of education and encouragement for the community aged workforce to support the anticipated demand for community based services to accommodate the increasing desirability for the aged person to remain in their own home. Decline in informal family support and stretching of volunteer supply will need innovative programs of formal support.

2. Residential Aged Care Facilities (RACF's)

The present system for planning for RACF numbers and resources is not comprehensive enough to accommodate the increasing prevalence of dementia at all levels, the complexity of medical care required, increasing frailty and changing demographics of the aged population. The proportioning between residential and community care may need to be revised and based on an older population than the present 70. There are significant gaps in the provision of care for clients who have limited care needs but would benefit by a functional safe supportive environment with low level nursing input and “hotel services” provided, which cannot be provided in the private sector, especially for those who cannot afford serviced apartment accommodation or for whom the hours of surveillance offered by CAPS and EACH and EACH-D are not enough to address safety, nutritional and family support issues.
Geriatrician and psycho-geriatric involvement in RACF’s is still limited and thus needs development.
Dementia specific places across all levels need to increase with appropriate support and education of nursing staff.
Adequate remuneration of nursing staff must be addressed to boost morale, staff retention and support the increasing complexity of care eg PEG feeding, dialysis and catering for those colonised by MRSA and VRE.
Many aged persons cannot afford the bond for low care and if there is introduction of bonds for high care an extra burden will be created.
There is limited support for families when organising admission to RACF’s to address financial management, legal issues and handle stress and guilt.
Funding support for ageing in place should be increased so that preventive and rehabilitative strategies to minimise disability and maximise independence, which will in turn be cost saving should be instituted, whilst addressing high care needs, when residents do deteriorate.
The potential advantages of deregulation of the system will be mitigated against, if quality and continuous development are sacrificed for monetary benefit and efficiency.

3. Acute Care

In some areas particularly in private hospitals, rural communities and provincial centres, there is limited access to a specialist geriatrician or allied health personnel for preventive rehabilitation strategies for the acutely ill aged person to address the high incidence of delirium, prevent acute functional decline and optimise medical management. If these personnel were available, they would have the potential to decrease the reliance on the stretched resources of sub-acute care in rehabilitation and geriatric units. These units are often not available in a particular locale close to family support.

The availability of telemedicine via such innovative technologies as interRAI could address the lack of geriatrician and allied health input and should receive adequate funding, technological and educational support.

There is limited access to psycho-geriatric services especially to admit dementia sufferers with challenging behaviours either from the community or RACF’s.

4. Sub-acute Care.(Rehabilitation and geriatric assessment and rehabilitation)

There are still insufficient resources in this area which are often unavailable, especially in rural areas for recuperation of aged persons after acute illnesses, which leads to premature and inappropriate transfer to RACF's. Waiting for transfer in acute wards still occurs carrying the risk of further deterioration. Some elderly require slow stream rehabilitation to avert the inevitability of residential care when resources are scarce and time-limited.

The New System.

Pivotal to designing a new aged care system will be the provision of adequate, effective and appropriate multidisciplinary assessment and management of complex medical conditions which have such significant psychological, psychiatric, physical and cognitive impact on social engagement, function and quality of life.

The new system must be seamless across all settings, facilitated by technologies to improve sharing of information and communication to prevent duplication whilst maintaining confidentiality.
The concept of consumer directed care and choice needs support but is challenged when the aged person has diminished capacity and proper, timely and efficient mechanisms need to be in place to ensure appropriate assessment of capacity and appointing of surrogate decision makers.

New funding models are likely to be required to address the necessary improvements in service delivery which may not necessarily involve more expensive care if funds are more equitably, timely and appropriately distributed.

In closing we would like to comment on specialist geriatrician manpower challenges implicated in the above points. Specialist geriatrician services ideally have a role across all levels of care to guarantee quality outcomes. The rise in number of advanced trainees in geriatric medicine recently may address some of the above areas of need, but clearly all professionals dealing with aged persons will need education and support to develop and maintain aged care expertise across all settings, from inception of training and in continuing education programs. Thus geriatric medicine and ageing must be part of core training for all health disciplines apart from paediatrics and obstetrics as their practice will be spent increasingly providing care for our older Australians.

We hope these comments will be found useful to the Commission in constructing the first draft report. We look forward to being involved in subsequent deliberations to address adequately the multifaceted complexity of service delivery to older people.

Yours sincerely

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ANZSGM.

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