## Introduction

### About APS

The Australian Psychological Society (APS) is the peak national body for the profession of psychology, with over 19,000 members, representing over 60% of registered psychologists. As the representative body for psychologists, the APS has access to a vast pool of psychological expertise from both academic and professional service delivery perspectives. The APS has responsibility for setting professional practice standards, providing ongoing professional development and accrediting university psychology training programs across Australia. It is represented on a number of advisory groups involved in the planning, implementation and ongoing monitoring of Government policy initiatives.

Constant communication with its members, plus access to high level psychological expertise and detailed involvement in Government initiatives, enables the APS to significantly influence the psychology workforce to ensure best practice in health service delivery.

The APS has a proud history of working in collaboration with Australian Government departments and other organisations in the successful delivery of policies and programs aimed at improving the health outcomes of Australians.

### Services provided by psychologists to older Australians

Psychology is a diverse profession. The APS has nine specialist professional colleges for its members. They include

- Clinical neuropsychology
- Clinical psychology
- Community psychology
- Counselling psychology
- Educational and developmental psychology
- Forensic psychology
- Health psychology
- Organisational psychology
- Sports psychology

Psychologists provide a comprehensive range of services to older Australians in a number of roles and in a number of settings. They include:

- Diagnosis and treatment of psychological disorders such as depression and anxiety (clinical psychology);
- Improving management of chronic disease through treatment and behavioural change (health psychology);
- Formal assessment by a clinical neuropsychologist as part of a comprehensive aged care assessment, including diagnosis, evaluation of functional capacity and identification of potential for rehabilitation;
- Identification and management of disruptive behaviours;
- Bereavement counselling for clients whose partners have recently died or been admitted into aged care facilities (counselling psychology);

- Education of carers of the elderly on management of various issues such as difficult behaviours and memory loss (clinical neuropsychology, clinical psychology);
- Working with communities of elderly clients (e.g. Senior Citizens Clubs) on health promotional activities (health psychology); and
- Advocating for policy changes on behalf of elderly clients (community psychology).

Given the scope of this research study, it is not possible for the APS to provide detailed input into every aspect of the inquiry. The majority of this submission will focus on the health care needs and the associated demand on the workforce placed by an ageing population.

**Ageing as a normal biological process**

This submission views ageing as a normal biological process, and in keeping consistency with this view, this submission deliberately uses the term older adults in preference to "the elderly" or "the aged". It is well recognised that older adults contribute to the overall productivity of the community through paid employment and volunteer work from service organisations to informal carers of their immediate and extended family members. It is inevitable that a portion of the older adult population will eventually require medical care, but that does not detract from the fact that many older adults require minimal or no extensive medical interventions in the final stages of their lives. The impression that older adults are "problematic" for the economy is therefore questionable, if not discriminatory.

Medical interventions required for various diseases and conditions are therefore not unique for older adults. The range of support services is also not unique for this group; as other adults with complex and chronic conditions and disabilities have similar requirements. The need for intensive care and expensive medications are similarly required by those with critical injuries or terminal illness. What sets aged care apart is the combination of many of these issues and needs, often by the same person. Therefore "good" care for older adults is about seamless integration of these services so the needs of the individual are met in a timely, effective and efficient manner.

Of greater significance in aged care is the role of health providers other than medical and nursing professionals. Allied health professionals are playing increasingly recognised and pivotal roles in the assessment, treatment and ongoing management of health concerns, particularly for those with chronic diseases. In many instances, allied health professionals are often the primary care clinicians (e.g. dieticians for self management of diabetes, physiotherapists for management of arthritic exacerbations or "flare ups", and psychologists for depression or anxiety). The latter is particularly important because of the widely recognised effect of depression in magnifying disability.

Of equal importance is the need to recognise that "health" is not just an absence of illness or disease, but a state of bio-psycho-social wellbeing as espoused by the World Health Organisation. The "wellness" or quality of life of individuals should therefore be the focus of the health system, and not just episodic treatments. Therefore health care of older adults is not just about provision of medical, pharmaceutical and allied health services, but also encompasses support services, accessible environment (transport, housing etc) and other social policies in order for older adults to function at their optimal capacity.

While some of the above issues will be outside the scope of this inquiry, it is important to recognise that aged care does not occur in isolation from other systems, policies and programs and that any proposals or recommendations need to be examined against this background. The care of older adults – some of the most vulnerable of people in our society, often with complex health and social needs – can be viewed as a reflection of the overall "health" of a community or nation. Access to quality, safe and affordable aged care should be a right of every citizen in Australia, as enshrined in various legislative instruments.

**The need to focus on "ageing in place"**

The notion of "ageing in place" refers to the practice of supporting people to age in their chosen environment, usually their own home, instead of having to place them into a Residential Aged Care Facility (RACF). This is usually done through a range of services by an array of different providers, such as home visitation by health professionals (including home medicines), pre-prepared meals, home help services (including home modifications), transport and social options but to name a few.

The benefits of ageing in place are self evident: consumers usually prefer to stay in their own homes; the costs of services are usually considerable less than those provided from within RACFs; older adults are "seen" as part of the community rather than in a "home" and the demand for RACF places are lessened.

At present the support for ageing in place is fragmented and piecemeal at best. As outlined above, the range of services are funded at both the Commonwealth and State/Territory levels as well as at the local government levels. This situation presents fertile grounds for blame and cost shifting. As the Commission's Issues Paper outlined, existing community care packages can provide services equivalent to those in a low care RACF. However, demand for such services often exceeds supply, particularly outside of major population centres. As a result, consumers are unnecessarily placed into RACF. In addition, the provision of care packages is often in fixed combinations, resulting in inefficiencies and waste whenever a client does not need all elements of a package.

*Case study:* John is a widower living on his own. As a result of his stroke, he was provided with an electric wheelchair to maintain his mobility and independence in the community via State program funding. He also has meals on wheels 3 days a week and home help for cleaning 2 hours a fortnight provided by his local council. His daughter and son-in-law visit weekly and assist with home maintenance and gardening. In the past six months, he is finding it increasingly difficult to shower and dress himself due to his existing heart condition. He has also been neglecting his required foot care, due to his diabetes. He was referred by his GP for personal care and increased meals on wheels and home help. However, he is only able to obtain personal care for 3 mornings a week for 3 months and was put on a waiting list for increased council services due to high demand. As a result, John is assessed by ACAT and placed in a low care RACF, much to his distress and that of his family.

**Recommendation 1: That funding for community support services must increase beyond the rate of increase in the ageing of the population in order to support older adults to "age in place" and to minimise unnecessary RACF placements.**

**Problems with current system – or lack thereof**

The current aged care system in Australia is really a collection of programs, interacting with other similar collections of programs (health, community services, disability services etc). Each set of programs has its own guidelines and operational boundaries, which makes integration an impossible task and leaves consumers and their carers bewildered and confused. A typical example of this is the access to allied health services under Medicare by people living in the community and residents of RACFs. Under the current funding guidelines, RACFs are required to provide a range of services, including allied health services, to their residents. The reality is quite different. It is not unusual for some RACFs to purchase "group therapies" (e.g. music or other diversional therapies), in order to maximise their limited funding rather than to provide individualised assessment and intervention, which lead to better and sustained outcomes. Similarly, residents are often prescribed medications for behavioural management issues, which can be readily resolved through interventions by professionals such as psychologists, without medical complications such as poly-pharmacy.

*Case study continued:* John has been living in the low care RACF for 3 months now. He is finding the adjustment much more difficult than first imagined. He has only made two friends, as most of the residents there in his view "have lost their marbles". His only joy is his fortnightly outings organised by the RACF. He doesn't like the weekly music program even though he is asked to attend it every time. To make matters worse, he was asked to return his electric wheelchair as the guidelines under which he obtained the equipment stated that "all medical and rehabilitation equipments are responsibility of the RACF". His family noticed that John has become withdrawn and depressed and requested treatment. He was subsequently seen by a visiting doctor. As residents of RACF have limited access to allied health services, John was prescribed antidepressants, which required careful management, as it had some adverse reactions with his existing medications.

**Recommendation 2: Any artificial funding and policy barriers between "health" and "aged care" must be eliminated or at least minimised so that residents in RACF can access a full range of health services offered to all other members of the community.**

**Funding should be person centred, evidence based and outcome focused**

The provision of safe, affordable and accessible aged care requires delicate balance between Government regulation and industry competition. At the core of this balance is the funding for aged care services, particularly funding associated with RACF places. In an attempt to streamline funding, the Department of Health and Ageing introduced the Aged Care Funding Instrument (ACFI). The basis for the introduction of ACFI is that it assesses the function of the resident in various domains and therefore is a better tool to allocate funding. However, despite its good intentions, the administration of ACFI is often conducted in an over-medicalised context, thus rendering the functional focus of the ACFI minimal at best. For example, the administrator of the ACFI is asked to assess a range of resident's functional status from continence through to cognition. If these assessments are not done by appropriately trained and qualified health professionals or those with extensive experience, subtle signs can be easily overlooked, particularly in the mental health domain. This not only reduces the funding to the resident, it also has the potential to under-represent particular

conditions in RACF (e.g. depression) – further denying dedicated funding to the aged care sector.

*Using evidence to guide best practice: An Australian case study*
In a recent Australian study led by a clinical psychologist, the effectiveness of medication was compared with psychological interventions. Over the course of the trial, only one patient in the psychological intervention group (experimental) was hospitalised (for a total of two days) compared with more than 20% (total hospital days 93) of a medication group (control). Drug side effects were reported in 12 cases in the experimental group, and in 32 cases in the control group - a threefold reduction. Visits by general practitioners to deal with behavioural problems were reduced by half, an average of 4.5 visits in the experimental group, and 9.4 visits in the control group. Visits by consultant psycho-geriatricians were also less common, an average of 1.2 visits against 4.8 visits in the control group. There was an overall decrease in the use of anti-psychotics in the experimental group and an *increase* in the control group. This study has since been replicated internationally with similar results of increased overall cost- effectiveness of interventions through decreased reliance on medications.

The ACFI was the focus of a recent review by the Department, and the APS made the following recommendations:

1. Only appropriately qualified and experienced health professionals conduct or supervise assessments of need.
2. Only appropriately trained people administer and interpret tests of mood and cognition.
3. The Department of Health and Ageing develops a training package/program for people regarding the administration and interpretation of screening tools for cognitive function and mood disorders. Additionally, the APS urges that this training be a condition /requirement of accreditation for RACF operators.
4. Inclusion of neuropsychologists and clinical psychologists to the list of health professionals able to diagnose individuals with dementia, including a provisional diagnosis, as well as psychiatric and behavioural diagnosis.
5. Include psychologists as allied health professionals authorised to issue directives and provide services for purposes of Question 12 of the ACFI (complex pain management - complex health care).
6. Include allied health representatives on the ACFI reference groups. We can suggest the reference group should approach Allied Health Professions Australia for nomination and input.
7. Re-adjust behavioural supplement (BEH) subsidy to be equivalent to complex health care supplements (CHC).

A full copy of the APS submission to the ACFI review is attached to this submission.

**Recommendation 3: That any funding of aged care services must be aimed at maximising the health outcomes of consumers, based on best available evidence, including targeted or "quarantined" funding for specific therapies and services.**

**Recommendation 4: That any funding for aged care services should be linked to health outcomes, with active participation by consumers and/or their nominated representatives.**

**Getting the right care depends on the right clinicians making the right decisions**

The early detection and accurate diagnosis of degenerative neurological conditions such as dementia among older adults is crucial to ensure the right care can be tailored to order to maximise their functional independence. In contrast to many physical diseases and disabilities, which are visible, mental deterioration are often overlooked or even dismissed by health professionals and carers. Early and accurate diagnosis of degenerative neurological conditions has a number of benefits:

1. It gives older adults opportunities to seek help and interventions;
2. It gives older adults more time to plan their care, including their financial affairs;
3. It gives carers insights into sufferers' behaviours and opportunities to seek help to manage their conditions;
4. It gives the service and funding providers abilities to plan service type and mix in anticipation of the required needs.

Much of these benefits can only be realised if the right clinicians makes the right decisions at the right time. This in turn requires a workforce that has the requisite understanding of the ageing process, including relevant basic competencies in psychopathology and neuropathology. The success of these measures ultimately rests with increased funding and focus on age care in the current health workforce curriculum and training.

**Recommendation 5: That funding for health workforce development and training must incorporate relevant aged care components, including clinical placements at RACFs where appropriate.**

**Good aged care depends on a sustainable and flexible workforce**

Aged care is often viewed as "unglamorous" by those working in the health sector. It is certainly a fact that aged care workers are among the lowest paid in the health workforce. As with many other aspects of aged care, the issues surrounding the availability, sustainability and flexibility of the aged care workforce are multi-factorial and inter-related. While recent Government initiatives such as targeted scholarship programs provide a basis for workforce development in the aged care sector, other initiatives should also be considered. Examples include:

1. Adequate remuneration;
2. Access to professional/peer support and supervision;
3. Access to professional development opportunities and funding;
4. Access to career development opportunities; and
5. Increased job satisfaction.

No single agency or Government department will be able to solve all these issues. A collaborative approach is required with all stakeholders, including educational providers, industry associations and professional peak bodies to work out an agreed framework and timeline of action. This work must commence as a matter of urgency, as it takes a minimum of four years to train most health care workers.

**Recommendation 6: That funding for aged care services must have corresponding specific increases in workforce development in order to maximise the availability, sustainability and flexibility of the aged care workforce.**

**Recommendation 7: That a multi-agency taskforce consisting of relevant stakeholders, be established to address the long term workforce requirements of the aged care sector.**

## Further directions for reform

*Focus on health literacy to assist consumers to make informed choices*
It is increasingly evident that empowered consumers are seeking health related information from a range of sources and seeking health care from a range of providers and agencies. While Governments at both the State/Territory and Commonwealth levels have made considerable inroads in the dissemination of health information, there is still considerable scope for greater investment in public health initiatives to increase the health literacy of consumers, assisting them to make informed choices and decisions about services. In addition, increased health literacy among consumers will improve health outcomes through increased focus on quality of care, better communication with service providers and decreased associated costs.

*Increased focus on primary care while not losing sight of acute care*
It should also be noted that the current focus of health reform is focusing disproportionately on acute health, and, in particular, hospitals, at the expense of sub acute/rehabilitation and primary/community care. As noted previously in this submission, greater investments must be made in the latter two areas to deal with the challenges of an ageing population and the associated risks of chronic diseases. In this context, the alignment of aged care should be both within the “health” system, as well as in the “aged care” system, as consumers must experience seamless transition between the two, and not “fall through the gaps” as outlined in the case study involving John.

*Development of role of support workers for older adults*
The growth of the working “sandwich generation” – people who care for their offspring as well as for their parents, will increase in the coming years, and with it a corresponding decrease in the availability of informal care. This will require new additions to the workforce, “health visitors” or “support workers” for older adults. In practical terms, these support workers will provide services somewhere between a friend and that of a health care worker such as a district nurse. They will ensure that medications are taken, remind about appointments, assure their children of their general health status and even make inquiries or referrals to their GP if required. Greater investment is needed to train such support workers, including those existing volunteers in the community.

## Summary

The Australian Psychological Society is pleased to contribute to the initial Issues Paper of the Productivity Commission study “Caring for Older Australians”. We appreciate the enormity of the task before the Commission and therefore suggested 7 key recommendations to serve as guiding principles for any further discussions and/or publications the Commission may undertake.

**Recommendation 1: That funding for community support services must increase beyond the rate of increase in the ageing of the population in order to support older adults to "age in place" and to minimise unnecessary RACF placements.**

**Recommendation 2: Any artificial funding and policy barriers between "health" and "aged care" must be eliminated or at least minimised so that residents in RACF can access a full range of health services offered to all other members of the community.**

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The APS will be happy to contribute further to this inquiry or supply further information as the Commission sees fit.