Dr Peter J Rudolph
Glen Forrest WA 6071

8/09/2010

Caring for older Australians
Productivity Commission
PO Box 1428
Canberra City ACT 2601

Re: Submission to productivity commission

Dear Sir

Kindly accept my submission concerning 'caring for older Australians' which is based on my personal experience of over 20 years working in aged care as a doctor both in hospitals and in the community as well as serving on boards of management for aged care providers. It is set out under a number of headings as follows:

Dementia care

As has been well recognised, the number of people suffering dementia is increasing dramatically. The major significance of this particular illness is that it disables people, not because of its physical effects, but because of its effects on cognition. There are not only the negative effects of being unable to perform tasks but, because of lack of insight, such patients engage in unsafe and sometimes reckless activities, and they may display overt behavioural and psychiatric symptoms. As a consequence, there is an indirect impact on everybody associated with the dementia sufferer. These effects are very much under recognised and, as a consequence, training in these areas for doctors, nursing staff and carers has been quite unsatisfactory. In addition, government funding for these patients has been woefully inadequate.

The following need to be addressed:

1. Training professionals
    a. Doctors - training in dementia care for geriatricians, general practitioners and general physicians, in particular, needs to be dramatically improved
    b. nurses
    c. Allied health
    d. professional carers.
2. Community programs - readily accessible, high-quality programs to assist nonprofessional carers and relatives of dementia sufferers need to be available.
3. Funding - improvements in funding for all elements of dementia care are required. This includes training, as mentioned above, residential care, subacute care and community care.

Residential care

Funding:
It is becoming quite evident that the funding going to residential care is not adequate to meet the needs of those residents. I have mentioned funding the dementia care, above, but I must emphasise that government subsidies for the care of dementia sufferers with behavioural problems are unsatisfactory. Often patients with dementia respond best to a prolonged period of one-on-one attention but this is not possible with current subsidies - as a result, nurses and carers far too readily use drugs to sedate residents unnecessarily.
I think that where possible individual residents should support their own accommodation costs. Therefore, if a person, who moves into a residential facility, has resources that they have accumulated over the years, then these should be used to supplement the cost of their care. This certainly happens in the case of low care residential facilities with the paying of bonds etc but essentially does not happen in high-level residential care. I think these regulations need to change immediately so that, if a resident of a high level facility has resources, these should be used to assist with the provision of care.
Notwithstanding my comments in the previous three sentences, there is an urgent need for the government to increase its nursing home subsidies particularly for residents with dementia.

Medical care:
There has been considerable discussion regarding the adequacy of medical care of nursing home residents. There is a lack of willingness for doctors to attend nursing homes and those that do tend to be nearing the end of their working career. The main reason for this is that there is essentially no training of doctors in the care of residential care patients. When I was a junior doctor in Victoria, there were a number of state funded nursing home facilities; there were also a smaller number in the other states. These gave the opportunity for budding geriatricians and general practitioners to gain experience in this area of care under the supervision of experienced doctors. However, the state governments have essentially abandoned the concept of state funded nursing homes to "save money" and, as such, this has removed a valuable training opportunity. Nowadays, trainee general practitioners get a little opportunity to learn about this type of care and trainee geriatricians get no opportunity despite the fact that they are meant to provide expert advice in this area (How can anybody provide expert advice when they have never actually had any experience in it?). The concept of 'training' nursing homes needs to be introduced to aid in the training of doctors, nurses and students as well as facilitate research.

Subacute care

20 years ago, I was involved in what we now term "subacute care". At the time, we introduced a form of slow stream rehabilitation in what were effectively nursing home beds as a result of not having adequate numbers of rehabilitation beds. These days the idea has gained some resurgence as a result of acute hospitals wanting to save money by discharging patients earlier than they would have done otherwise. By discharging patients out of acute hospital beds into what are essentially nursing home beds with various forms of supplementation, state health departments can save a lot of money. This type of subacute care is "interim" or "transitional" care. The other form of subacute care that needs to be considered relates to permanent nursing home residents who develop an acute illness.

Interim/transitional care:
As indicated above, the theory behind this type of care is to discharge patients from acute hospital beds to a less intense and less expensive form of care. The patients in this category tend to be those who are either awaiting permanent nursing home care or need some form of slow stream

rehabilitation. The type of accommodation provided is nursing home type accommodation and the nursing/care staff complement is not dissimilar to that seen in nursing homes. This is supplemented, as a general rule, by additional Allied Health staff with pharmaceuticals being supplied by local pharmacies and paid via the pharmaceutical benefits system and medical staff are essentially interested general practitioners paid through the medical benefit schedule visiting possibly once weekly. There is sometimes involvement of Geriatricians providing some limited supervision. Theoretically, patients are referred to this form of care are "medically stable".
I think that this form of interim/transitional care can be an effective way of providing low-cost slow stream rehabilitation however the current model is flawed. Firstly, the patients are rarely "medically stable" - in fact, one of the main reasons that they require additional care is because they have not recovered medically from the acute illness. For this type of care to work effectively for the patient, there needs to be a greater emphasis on the quality of medical care provided to the patient - on a basis of possibly three times a week by doctors experienced in the care of the elderly. It is important that the funding model takes this into account.

Subacute care of permanent nursing home residents who become acutely unwell:
I feel that this is a type of care could be provided quite readily in the nursing home, saving multiple admissions to acute hospital beds. This would be beneficial to the patient as well as saving substantial money for the community. I believe that a small amount of funding supplementation is required predominantly for education of nursing staff and doctors as well as providing money for a small amount of additional resources. Education of the public, in particular relatives of nursing home residents, will also need to occur so that they can be aware that additional care can be provided in nursing homes when their relatives become unwell. Education of hospital emergency department staff also needs to occur. I would certainly encourage the development of this type of service.

Community services/care

Home and community care services such as meals on wheels, home help as well as district nursing have been provided many years and have assisted people living in the own homes. Community aged care packages (CACPs) were instituted by the government as an alternative to low-level residential care - the idea was to stop people having to go into low-level residential care, both to facilitate individual preference and to save money. My own personal view is that they did little more than existing home and community care services to keep people out of residential care - I think that there has been a certain degree of waste of money with this form of community care support. The advent of higher-level community care packages, e.g. EACH or EACH-D, have been able to provide additional level of care which really has had the effect of maintaining people at home who would otherwise require residential care. My own conclusion is that home and community care services are helpful for people who need a bit of extra help and higher-level community care packages (e.g. EACH) can be effective at keeping people out of residential care. Overall, I think low-level packages are a waste of time and money.

Retirement villages

There is certainly a significant proportion of older people who like the concept of living in a retirement village. Consequently, I think that the development of retirement villages should be encouraged for that group of older people. However, I also think that the villages should be developed in such a way that they are capable of supporting old people if and when they become more disabled. In other words, the structural design should allow for this situation and they should have ready access to care packages and services to support people who develop disabilities in this type of accommodation.

Aboriginal people

Unquestionably, people of aboriginal background have a shorter life expectancy and greater morbidity from a younger age. As a result, they need better access to appropriate medical care and support services from a younger age. However, I think it is wrong that unwell or disabled aboriginal people in their 40s and 50s, for example, are included with the elderly. Even though they need extra care, they are still relatively young - I think that there needs to be specific support services set up for this purpose and not have relatively young disabled aboriginal people lumped in with care of the aged (which has a different focus).

Aged care assessment

The aged care assessment programme flourished in response to the "nursing home and hostels review" in 1985. It was set up as a combined federal and state government program - Federal government provided funding to salaries and running costs and the State government provided the infrastructure. The aged care assessment teams have tended to be linked to hospitals with the advantage that patients assessed by the aged care assessment team might have better access to geriatric assessment or rehabilitation beds, if required. Staff working for aged care assessment teams have tended to be employed under the state health department structure.
One of the main reasons for introducing aged care assessment teams was to distinguish between patients who genuinely required residential care and those who just needed extra support at home or those who required a period of geriatric medical treatment or rehabilitation. As a result, there would be a reduction in the number of people unnecessarily referred to nursing home care. Unfortunately, as a result of state government hospitals wanting to "get patients out more quickly", geriatricians and members of the aged care assessment team (who are employed by the state hospital system) are effectively being forced to assess patients as requiring nursing home care, prematurely. I am uncertain as the best way to resolve this situation although removing the aged care assessment staff from the direct employee of the state hospitals is one option worth considering (however, this would be unpopular from a number of quarters). The system certainly needs an overhaul.

Yours faithfully

Dr Peter Rudolph
MBBS DipGerMed