CARING FOR OLDER AUSTRALIANS

A Submission from
Occupational Therapy Australia

The Peak Body Representing Occupational Therapists

Assistive Technology Committee
Occupational Therapy Australia

This submission was prepared for Occupational Therapy Australia by the Assistive Technology Committee.

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1   INTRODUCTION

This submission from Occupational Therapy Australia addresses 3 key areas identified by the Productivity Commission which are within the scope of expertise of Occupational Therapy Australia. It focuses on the Service Delivery Framework for Aged Care Services, and contains some comments regarding Government Roles and Responsibilities, and Workforce Requirements.

Occupational therapy is a profession concerned with promoting health and well being through occupation. The primary goal of occupational therapy is to enable people to participate in the activities of everyday life. Occupational therapists achieve this outcome by enabling people to do things that will enhance their ability to participate or by modifying the environment to better support participation.

Occupational therapists have a broad education that equips them with skills and knowledge to work collaboratively with individuals or groups of people who have an impairment of body structure or function due to a health condition, and who experience barriers to participation. Occupational therapists believe that participation can be supported or restricted by physical, social, attitudinal and legislative environments. Therefore, occupational therapy practice may be directed to changing aspects of the environment to enhance participation.

Occupational therapy is practised in a wide range of settings, including hospitals, health centres, homes, workplaces, schools, reform institutions and housing for seniors. Clients are actively involved in the therapeutic process, and outcomes of occupational therapy are diverse, client-driven and measured in terms of participation or satisfaction derived from participation.[1]

The Well Elderly

Demographic trends clearly demonstrate that Australia's population is living longer. As the Productivity Commission has noted, over the next 40 years, the number of Australians over 85 will quadruple. Public health and epidemiological researchers indicate that many of these will be 'well elderly', capable of maintaining a high quality of life and enjoying a high degree of productivity in their social, cultural and indeed economic lives. This changing face of ageing will require a rethinking of traditional attitudes to older people, and indeed the proliferation of services such as University of the Third Age and strength training for older people at Community Health Centres and private gyms, are positive signs that society is responding to this shift, and providing a diversity of occupational opportunities for maintaining social connectedness and engagement.

One essential element of Caring for Older Australians is therefore ensuring ongoing development of community based preventative programs and supports, as will be discussed in this submission.

The effects of impairment

Individuals may find themselves struggling with activities of daily life at any stage of the life span, and due to a myriad of impairments. In Australia currently, services are delivered according to criteria such as age, diagnostic group, compensable status, work status. Frequently individuals must engage with multiple service providers in obtaining the supports they require to continue to live at home and participate in their communities. This is particularly evident at transition points such as turning 65 (common entry age for Aged Care Services). Occupational therapists have an approach which is both holistic and functional: strategies to mediate impairments may be needed at any point within the course of an individual's life span; and during changes to life roles and life tasks. In our perspective therefore, services must be delivered on the basis of need. Moreover, the current focus

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[1] World Federation of Occupational Therapists (WFOT), 2004.

on harm reduction (prioritisation of those at risk from a safety perspective) within a limited funding environment has the consequence that obtaining the resources to work toward any 'strengths-based' outcomes has low priority. Early interventions, for example community mobility training, or supported re-engagement in the voluntary sector, have great potential to positively impact quality of life, slow functional decline and decrease downstream costs. However they remain a low priority area which is never reached within current funding scenarios.

Services must be delivered on the basis of need and capacity to benefit.

Mediating impairment effects

Ways to manage and minimise the impact of impairment and disability and enable participation fall into several broad categories[2]. These are:

- o Interventions to reduce or compensate for the impairment;
- o Provision of personal care or support work;
- o Redesign of activity;
- o Use of assistive technology devices (AT devices);
- o Redesign of environment.

Occupational therapists are well placed to deliver this suite of interventions. The first strategy is delivered primarily in health and rehabilitation settings, where occupational therapists have roles in emergency departments, in acute and rehabilitation units and community teams. Occupational therapists are the only health profession trained in assessment for AT devices and modifications or adaptations to the environment. Assessment for, and provision of, personal care hours is most effective when the mediating effect of AT devices or environmental change are considered: providing the appropriate combination of AT and environmental modification eg. a set of handrails and a stepless shower recess is a more cost effective and independent solution than introducing a shower stool and personal carer twice per week for showering support. These strategies or enablers are the primary means by which people with disabilities manage their situations and maximise their capacity to lead full lives. Most effective when delivered in conjunction with each other, they are termed an AT Solution.

Assistive Technology Solutions are effective interventions for ageing and disability

There is good evidence that delivery of AT solutions enables the achievement of life outcomes according to a number of indicators. The international literature provides firm evidence for outcomes of AT provision in the areas of:

1. Preserved independence, decreased functional decline and reduced hospital admission rates;
2. Prevention of secondary medical complications;
3. Prevention of falls; maintenance of occupational roles via enabling environments;
4. Alleviating carer burden;
5. Reduced residential care placement;
6. Enabled activity and participation in specific life domains;
7. Overall health and community life outcomes;
8. Quality of life.

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2 Smith, R. O. (2002). IMPACT 2 MODEL 2009, from http://www.r2d2.uwm.edu/archive/impact2model.html

The Potential of Assistive Technology and Environmental Adaptation

We note, however, a lack of specificity around assistive technologies and their potential. This is a rapidly developing field and several definitions are offered overleaf which, although not exhaustive may frame the discussion.

The Caring for Older Australians Issues Paper (May 2010) describes 'improvement in care technologies' as a contributing factor to the future demand for greater diversity in Aged Care Services. Certainly there is scope in Telehealth and Telecare (defined below) to mediate the impact of impairment due to age. We note however no reference to Assistive Technologies in the description of the current system, nor within most categories where comment is invited.

Substantial international evidence, research and development is responding to the trend of the elderly staying at home for longer via better integration of AT into service provision; and utilisation of new and emerging technologies (Telehealth, Telecare, Smart House initiatives and Universal Housing design)[3]. The recent report by the Australian Academy of Technological Sciences and Engineering noted, *'a national thrust on the development and application of smart technology for healthy longevity is vital to ensure a healthy, safe, secure and fulfilling future for the increasing aged population in Australia and the maintenance of a healthy, harmonious and prosperous society.'*

Another development of interest occurred in 2006 as the UK National Health Service undertook a major review of its community equipment scheme and embarked upon the Transforming Community Equipment Program. The program aimed at increasing availability of information, well designed and useful products and competent, knowledgeable individuals to provide assessment, product demonstration and advice, delivery, installation and fit of equipment that enables individuals to achieve choice and control over their lives. Their ambitious agenda to deliver a new service delivery model recognized three main categories of equipment: simple aids to daily living (low cost low technology); complex aids to daily living; and bespoke or special products. The new system has engineered a shift from a previous total loan equipment system to one of ownership by clients for low technology and low cost items which comprise a large percentage of the total products issued. The new system is prescription based: where there is an assessed need, government issues eligible users with a 'prescription' that can be exchanged for free equipment at an accredited retailer. Users are enabled to 'top-up' the prescription (building in both choice and empowerment) if they wish to have a similar item of different style or colour. This new system is creating an open retail market place intended to drive innovation and choice, and increase ease of access to equipment and services in more localities and during normal trading hours. The improved accessibility for all individuals including older people normalises the experience of accessing and using equipment and provides a previously non existent system for self funded retirees.

> **Assistive Technology and Environmental Adaptation must be integral parts of Government response to demographic changes**

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[3] Teggart,J. (May 2010). *SMART TECHNOLOGY FOR HEALTHY LONGEVITY: Report of a Study by the Australian Academy of Technological Sciences and Engineering (ATSE)*. Melbourne: Australian Academy of Technological Sciences and Engineering.

2. DEFINITIONS:

Aging in place (aka 'age in place') is the ability to **live** in one's own home - wherever that might be - for as long as confidently and comfortably possible. Liveability can be extended through the incorporation of universal design principles, Telecare and other assistive technologies

An Assistive Technology Solution: An individually tailored combination of hard (actual devices) and soft (assessment, trial and other human factors) assistive technologies, environmental interventions and paid and/or unpaid care'. [4]

Assistive Technology (AT): Any device, system or design, whether acquired commercially or off the shelf, modified or customised, that allows an individual to perform a task that they would otherwise be unable to do, or increase the ease and safety with which a task can be performed." [5]

Terms such as aids and equipment, invalid aids, gadgets or medical devices have been used interchangeably over the years to describe what is now internationally known as assistive technology devices.

AT Devices: Comprised of 'hard' technology, while related activities such as clinical advice, customising, and training represent 'soft' technology. Environmental controls and wheelchairs are examples of AT devices and systems that require a comprehensive understanding of the hard technology (device) itself, and systematic application of soft technology (needs assessment, set-up, trial, training and follow-up) for optimal outcomes.[6]

Environmental Control Unit (ECU) / Electronic aid to daily living (EADL)*:* Device that allows control of appliances (eg radio, television, CD player, telephone) through the use of one or more switches

The Technology Chain*:* Assistive technologies exist in relation to the environments in which they are used. Enabling environments (for example a level continuous path of travel in the home or community) directly impact the AT required (for a person with impaired balance, level pathways may remove the need for handrails; for the power wheelchair user, a stair climbing function will not be required) from:
AAATE. (2003). AAATE Position paper: http://www.aaate.net/aaateInformation.asp

Smart Homes*:* Denotes living environments in which automation is used to provide automatic functions including monitoring, communications, household functions (lights, air conditioning/heating, door locks) physiological measurements, medical alerts.

Telecare: The term given to offering remote care of elderly and vulnerable people, providing the care and reassurance needed to allow them to remain living in their own homes. Use of sensors allows the management of risk and is part of a package which can support people with dementia, people at risk of falling or at risk of violence and prevents hospital admission. Telecare refers to the idea of enabling people to remain independent in their own homes by providing person-centered reactive technologies to support the individual or their <u>carers</u>. In its simplest form, it can refer to a fixed or mobile telephone contact to monitor or to inform of any development. A technological more advanced solution is by using sensors, a range of potential risk situations including wandering (particularly useful for people with dementia), falls and intruders as well as environmental issues such as floods, fire and gas leaks. When a sensor is activated it sends a radio signal to a central home unit, which then automatically calls a 24-hour monitoring centre where operators can take the most appropriate action, whether it be contacting a local key holder, doctor or the emergency services. The system can equally link to members of a family support network.

Technology and Health: There is a growing body of terminology explaining systems and functions of technology and its relationship to supporting, maintaining, and improving health outcomes. Definition for the more common terms Telehealth/ Telemedicine / Telemonitoring / e health are given.

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[4] www.at.org.au
[5] Independent Living Centres Australia   http://www.ilcaustralia.org/home/assistive_technology.asp
[6] (Cook, A., & Hussey, S. (2002). Assistive Technologies: Principles and Practices (second ed) USA: Mosby)

Telehealth: The use of telecommunication technologies to provide health care services and access to medical and surgical information for training and educating health care professionals and consumers, to increase awareness and educate the public about health-related issues, and to facilitate medical research across distances.

Universal Design / Inclusive Design: Universal Design refers to a broad-spectrum solutions that produce buildings, products and environments that are usable and effective for everyone, not just people with disabilities. Inclusive Design is a general approach to designing in which designers ensure that their products and services address the needs of the widest possible audience, irrespective of age or ability.

3. THE SERVICE DELIVERY FRAMEWORK

Occupational Therapy Australia applauds the Productivity Commission for taking a system wide perspective to look at holistic needs of Older Australians and interfaces of related policy areas.

Ageing in Place is an essential principle to underpin the service framework. Older Australians should be enabled and supported to age in their own home and community, maintaining their participation in chosen activities, for as long as possible.

Australia has adopted the World Health Organisation International Classification of Functioning, Disability and Health (WHO ICF)[7], which offers a neutral language with which to describe 'disease', 'function' and 'participation'. Disease is understood as 'variation in body structure and functions. Function is understood as activities (execution of a task by an individual). Participation is conceptualised as involvement in a life situation. WHO ICF also recognises the environment as an important barrier or facilitator, which influences the impact of an impairment (for example wheelchair use is less problematic in an open plan office, than on a ski-field) and therefore on a person's ability to engage in activities and participations. Occupational therapists agree with the holistic view this proffers, where consumers' needs are based on function and participation in relation to occupations and environments.

The opportunity for strengths based assessment is also supported within this framework as it encompasses all people not just those with 'disability'. The Activities and Participations named in WHO ICF serve as a broad set of outcome domains which are strongly validated by UN Convention on the Rights of Persons with Disability[8]. These domains are:

- o Learning and Applying Knowledge
- o General tasks and demands
- o Communication
- o Mobility
- o Self-care
- o Domestic life
- o Interpersonal interactions & relationships
- o Major life areas
- o Community, social and civic life

Regardless of age of onset, consumers whose activities and participation in the domains listed above and who are restricted by body structure and function impairments that result from, or are associated with, age related processes or diseases, should be eligible for Aged Care Services,

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[7] WHO. (2001). *International Classification of Functioning, Disability and Health*. Geneva: World Health Organisation.

[8] United Nations Convention on the rights of persons with disabilities and optional protocol, (2008).

The existing Aged Care Service Sector

The current care system comprises community-based packages such as Transitional Aged Care Packages (TACP), Community Aged Care Packages (CACP), Extended Aged Care at Home Packages (EACH), Respite Care, and Low and High Level Care Residential Facilities. The intent is a continuum of care through which the ageing consumer moves, in line with assessed decreases in the ability to care for oneself. For this continuum to work effectively it requires further development and expansion, with increasing capacity for flexibility and innovation. The ACAT system of assessment and entry to the Aged Care System also presents a good model for entry to services and seamless transitions, but again it is not sufficient and needs to be expanded to include case management that facilitates care planning and smooth transition as needs change. The transition points at the conclusion of a package of care, or when the level of care being provided is no longer sufficient, can be extremely difficult, as there can be extensive waiting periods between services.

The "package" approach to provision of community care, where funding is allocated to discrete programs to provide discrete types of services has been seen to cause disjointedness of care. It also leads to health professionals working to available service types, rather than taking a consumer centred approach to assessment and care planning. This inhibits any innovation and stymies best practice.

There are insufficient places in residential facilities, insufficient community based packages of care, and insufficient funds for AT within all levels of the Aged Care System. There is limited capacity in the system to meet the growing demand, and this impacts on other systems of care, that play a caretaker role for those awaiting access to Aged Care Services well after the time when they first needed them. This again introduces long waiting periods for services, as there may be waiting periods to access community health and other primary care services, as well as ACAT assessments.

While the guidelines for Aged Care Facilities and community based "package" services incorporate provision of AT, there is often significant difficulty in enforcing this, with AT necessary for enabling activity and participation either not provided, or a diminished version of the guidelines implemented.

For example, it is expected that Aged Care Residential facilities provide "standard" items of AT. "custom" items are supposed to be provided by other programs. It is commonplace to hear of nursing home residents who cannot access an appropriate wheelchair to maintain their ability, especially when they require a lever drive wheelchair due to a past stroke, or a wheelchair suitable for an amputee. Nursing Homes can maintain that this is a "custom" item and that they therefore do not have to provide it. The relevant disability AT provider will maintain that it is not a custom item, and/or that a nursing home resident is a low priority. In the middle is the aged care resident who becomes isolated in their bedroom, dependent on a staff member to wheel them to the shower or dining room. The impact on activity, participation, quality of life and life expectancy is enormous.

Sector gaps and overlaps

A patchwork array of services is currently provided by health, ageing and disability sectors, with substantial gaps being managed by consumers themselves where possible, frequently with substantial strain, or unmet needs. The range of services provided is appropriate at a basic level, however, reducing service silos and increasing consumer knowledge and control could improve the range and flexibility of services, and collaboration between these services.

In the first instance, increased funding to the community sector would assist in reducing the number of people requiring low and high level residential care. More services that are more easily accessible, and are directed to maintaining older people in their own homes (ageing in place) are required. Greater flexibility in inclusions with these packages, promoting consumer choice within approved funding levels corresponding to assessed need, should be available.

Some carers are hesitant to attempt to keep their older family member at home, knowing the delays in finding an appropriate residential aged care placement they will experience, at a time when the burden of caring has become too great to bear. Aged care places need to be adequate and available when needed for permanent or respite care, to allow families to try to keep an older person in their own or in another family members home. This is consistent with the principle of Ageing in Place that should underpin all aged care service planning and delivery.

Early intervention in aged care

Most community care and residential services do not consider the need for, or benefits of, identifying AT that may assist in maintaining or increasing the consumer's independence. There is an urgent need to review access to AT for older Australians. Each State and Territory has different equipment funding schemes and eligibility criteria; procedural hurdles and extremely limited subsidy caps render these schemes less effective than intended[9].

Systems currently focus on people at risk of hospitalisation or admission to residential care. This results in reactive rather than proactive approaches to triage and management of wait lists. Interventions which enable consumers to remain active and independent generate downstream cost benefits and are a worthwhile investment. Occupational therapists strongly advise that responding to people's needs as they begin to develop activity restrictions and participation limitations is necessary, in addition to focussing on people with high support needs. This would enable older consumers to maintain their independence and activity, and entails entry into a staged service delivery system earlier. This requires a service sector with capacity. Cornerstones of an improved approach include skilled assessors working within a strengths-based framework, and broad outcome areas such as enshrined in WHO ICF to be within the policy scope.

Residential Care

Insufficient residential care places leave older people in hospital for long periods. This has a negative impact on health and function through deconditioning and loss of motivation, and places people at risk of hospital deconditioning, loss of function and independence, hospital acquired infections, malnutrition and falls. More flexibility in residential care places would allow people to function at an appropriate level and maintain their level of function on a temporary basis by moving through the level of care as it is required. People would be able to leave hospital at an appropriate time but could change their chosen option as required. For example, increased care in hostel may be required until greater level of recovery is achieved, and then they may be able to return to their own home.

Another impact of insufficient places, in combination with the current pressures on acute hospitals, is the pressure on older persons to accept the first available placement in a residential care facility. This can happen despite the older person not yet having achieved a full recovery. Once they have

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[9] Layton, N; Colgan,S; Wilson,E; Moodie, M & Carter,R (2010) The Equipping Inclusion Studies: Assistive Technology Costs and Outcomes in Victoria (www.aeaa.org.au)

fully recovered there may not be in need of a placement. More places and greater flexibility in the system are required to ensure that older persons have sufficient time to recover from illness or injury before needing to make a decision about their long-term future. It would also allow for temporary placement or provision of a higher level of care, with step down as recovery occurs.

Transition between services

A common fracture point is transition from hospital to community, and this can involve removal of supports (such as AT devices) and reassessment and wait times from community AT device provision. There are some examples within Australia where services span this gap (eg. Tasmania Community Equipment Scheme) however lack of funding still constrains their effectiveness. Substantial flexibility must be built into available options at the point of entry.

Consumers may complete one service/package and may then be waitlisted for any further service needs, leading to disjointed care and an intolerable burden on carers. More case coordination and planning would assist as well as more places/packages. Transitional Aged Care Packages (TACP) represent an attempt to introduce necessary therapy and support services at time of need, however at the end of the 12 week period, enablers such as AT devices are removed they belong to the TACP provider. This is despite the availability of access to another service, thus AT is not always present and need is unmet.

The health sector bears the cost of consumers waiting appropriate aged care services, with one example being long waiting periods for the limited number of Extended Aged Care at Home (EACH) packages.

Respite Care

Increased respite care is essential to caring sustainably. Additionally, AT devices and environmental alterations such as the introduction of mobile hoists can impact significantly on the ongoing health of the carer and to prevent breakdown of the caring dyad.[10]

Assistive technology, environmental intervention, universal design and future technologies

Most housing and communities in Australia have not been built with aged and disabled persons in mind. As the ageing process and age related disorders begin to impair body structures and functions, the home and community environments become increasing barriers to activities and participation. Hills and stairs become impediments to accessing the community; the existence of shower hobs and absence of grab rails make showering increasingly difficult; small buttons and handles become barriers to entering rooms and operating basic technology such as the TV. If an older person at home alone falls, it may be that no one will know for days, weeks or even months.

Assistive technology that addresses these issues is readily available. This includes basic items such as shower chairs, grab rails, hobless showers, as well as personal alarm systems connected to a monitoring service. It is imperative that there is ready access to these items, as well as to basic and complex home modifications. An occupational therapy assessment and prescription is essential for appropriate provision of assistive technology for the promotion of safe activity and participation.

Emerging "enabling" technologies, such as those incorporated in Smart Homes, have a significant contribution to make in our ability to support older persons to remain at home, engaging in their chosen activities and participating in their families and communities. There is an urgent need for a

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10 ILC WA. (2006). *Family Carers and the Physical Impact of Caring - injury and prevention: research report.* Perth: Independent Living Centre of WA. http://www.ilc.com.au/pages/research-and-projects

national research and development agenda to develop these technologies and make them widely available.

A lack of universal design principles at point of build cause major cost and disruption should mobility levels change. Calls for increased building regulation[11] are increasing to 'future proof' housing and enable ageing and disabled consumers to age in place, within their communities. Planning of communities, including housing developments, must promote accessible, safe environments that enable older persons to age in place, maintaining their participation in family and community life. Emerging technologies should be inherent in new housing developments and communities.

Accessing the community: transport and driving

Many aged persons cannot get where they need to go. They rely on family, friends, churches, community groups, charitable organisations, community transport services or taxis, including disabled taxis. All of these options are appropriate in some situations but some people cannot use, or do not have access to, these options. Frequent medical visits may be expensive for someone on a pension, even with the disabled taxi subsidy. Safe, affordable and readily accessible transport should be considered in any disability and aged care planning. Several current facilitators of travel deserve a mention and could be extended in scope, particularly half price taxi travel, public transport concession fares, and the Companion Card.

The absence of sufficient safe and affordable transport, and a desire to maintain their independence, leads some older drivers to continue driving well beyond the point when they should stop. This places themselves and all other road users at serious risk. While there are various state laws regarding testing of older drivers, there are people with age related disorders who continue to drive when they are no longer capable of doing so safely.

Some Occupational Therapists have undergone specialised training to be accredited driving assessors for persons with disorders and disabilities that impact on their ability to drive. Medical officers should take responsibility for either referral to an occupational therapy driving assessor, or for informing the relevant state authority that a person is no longer safe to drive, if this is consistent with their assessment and diagnosis. For a multitude of reasons, including an awareness of the difficulty in accessing necessary transport, as well as a limited supply of driver trained occupational therapists and the cost of an occupational therapist driving assessment, medical officers may fail to meet this responsibility. This places the older person, their passengers and other road users at grave risk. This can have serious consequences. There have been well known cases in recent years including the tragic case of Sophie Delizio in NSW.

> **Access to affordable and timely Occupational Therapy Driver Assessment and Training services is critical to maintaining safe drivers, to appropriate prescription of AT for driving, and to evaluate unsafe drivers via on-road and off-road assessments. Creating access to funding for vehicle modification (such as modified driving controls) in those States/Territories without current vehicle modification schemes is essential.**

A Continuum of Services Required Across Health, Ageing and Disability Sectors

From a consumer standpoint, the impact of impairment (whether generated by age related changes, by congenital or acquired pathology, or a combination of both) requires a seamless response regardless of the persons entry point into the system. Entry may be via the health sector or the disability sector (for those ageing with disability, or acquiring disability over the age of 65). For equitable and effective service delivery, a continuum of governance is essential to ensure a seamless transition between these three major sectors. Currently this does not occur, and substantial differences exist between these sectors as will be discussed within this submission.

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[11] http://www.vcoss.org.au/documents/VCOSS%20docs/Housing/platform-email.pdf

Particular groups of concern for the aged care system, who would particularly benefit from a continuum of services, are:

1. People under 70 where activity and/or participation are impaired due to a disease or disorder usually associated with ageing, for example, early onset dementia. The need for services and support (AT devices, personal care, environmental adaptation, health maintenance) in this group will substantially overlap with those required for over 70's with the same conditions;
2. Consumers with pre-existing disability present prior to entry into aged care system: many problems are currently noted with switching into aged sector and removal of current service delivery. These include, but are not limited to:
   - Degenerative /progressive diseases such as Multiple Sclerosis;
   - Spinal injury;
   - Brain injury – acquired and traumatic;
   - Loss of limb;
   - Intellectual disability;
   - Mental health disorder such as schizophrenia, bipolar disorder, depression.
3. Consumers in social housing should be identified as in need of additional support and help;
4. Consumers with multiple conditions/disabilities entering the aged care system;
5. Families providing care for their aged family member who are reliant on welfare payments;
6. Families where multiple family members have disability.
7. Young people in residential aged care facilities have been shown to have instances of mortality and increased morbidity due to lack of care appropriate to their needs (for example, if a nursing home does not provide a wheelchair with postural supports, increased instances of choking occur when a person is fed in a 'tub' chair).[12] Due to the existence of this group within the aged care system their needs also need to be addressed by this review.

Equity: Reducing unfairness, so that people with similar levels of need get similar support

Currently substantial inequity exists across funding streams for provision of enabling solutions such as AT devices, environmental adaptations, personal care, or occupational therapy and other allied health interventions. Different disability groups receive different supports, consumers with the same clinical need receive substantially different services and therefore substantially different outcomes due to their eligibility for different funding types or compensability status (eg. TAC funded spinal cord injuries). The Department of Veterans Affairs has tiered service provision based on eligibility rather than need. Rural, regional and State/ Territory differences also influence the playing field.

We have detailed below some examples of inequity noted by occupational therapists:

   o A palliative consumer assessed and provided with necessary AT device and care support, which was withdrawn when the consumer failed to die within three months;
   o Consumers on a community aged care package in most states do not have access to state funded equipment programs (with the exception of Victoria). Similar issues occur with EACH packages;
   o In some jurisdictions, clients lose all their equipment except their primary mobility aid when moved into aged care (often they are under 65);
   o There is insufficient funding within EACH packages and Aged Care Facilities for consistent provision of AT; despite this, state based disability aids and appliances programs may exclude these clients.

A real understanding of older people's needs is required so that funding and services can be developed appropriately. For example, assistive devices and environmental modifications have long

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[12] Winkler, D., Sloane, S., & Calloway, L. (2007). *My Future My Choice: Younger people in residential aged care: support needs, preferences and future directions*. Melbourne: Summer Foundation for Department of Human Services.

been established as being effective in reducing morbidity, mortality and functional decline but the need for these interventions has not yet been mandated in service delivery.

There are system wide impacts of inadequate funding across the aged care, disability and health systems. In other words, deficiencies in one system, lead to increased demand in another. In NSW, Health operated Equipment Loan Pools are propping up Disability and Aged Care Services eg PADP and EACH packages. This is because these Disability and Aged Care Services, both of which provide AT for older consumers, can have extensive waiting periods. NSW Health services frequently retain responsibility for care while older consumers await access to more appropriate services. This necessitates provision of AT from health services established to provide AT for their own consumers, with wide ranging impact on availability of AT essential for patients being discharged from hospital following surgery, illness or injury. The same applies for older persons who languish in hospital awaiting a place in an aged care facility. The impact of this is extensive stays in hospital, blocking access for those presenting to Emergency Departments, and leading to significant risks to health and well being including deconditioning and loss of function, falls and hospital acquired infections.

A continuum of care, providing enablers in a person's home, including AT, emerging technologies, personal support services, home based respite care giving carers a break, rehabilitation after illness or injury, easily accessed increased care and support after hospitalisation, and timely access to residential placement in a facility close to one's home or family must be available. The existing continuum of care, while continually expanding, is not sufficient to meet current demand, and needs considerable growth in funding and scope to meet future growth in demand.

4. THE KINDS OF SERVICES REQUIRED

Occupational therapists encourage the development of flexible care types, as these give the greatest opportunity to tailor packages of support to individual consumers. Examples of initiatives within current services along these lines are transitional care places, multi purpose services, and innovative care (a platform for testing new approaches to providing care in WA).

Assistive Technology

We note a general lack of attention to emerging AT devices or AT solutions at government level. For example, ILCWA put forward a submission to trial AT solutions that could replace respite to carer. The government response in WA at that time clearly indicated a failure to understand what AT was and how it could assist.

Funding and services for assistive devices and environmental modifications remains limited and extremely difficult to access. For example, Victoria only funds 25% or less of average home modification costs, and does this only once per lifetime. For those with AT funded by state schemes, they can be required to return the AT if moving interstate, even though it is essential for basic personal care and mobility; This can impact a consumers ability to move interstate and be near family support which may have reduced need to paid care supports to remain at home. Some other state schemes do not allow you to apply for funding before you move to that state, meaning a significant period of time without essential items for daily living and mobility. This can extend to years without AT, depending on funding availability. For an older person, death can come before the required AT solution, despite forward planning and timely submission of applications.

In the Western Sydney region of NSW, all funding for Level 2 Home Modifications for 2010 was allocated by mid 2009. Extensive waiting periods have resulted, leaving people isolated, at risk, and unable to complete daily activities or leave their house, in addition to those who have endured unnecessary periods of hospitalisation.

Coordination, cost effectiveness, timeliness and innovation should underpin the service delivery system

As foreshadowed in the introductory section, occupational therapists have identified the following features of good service delivery systems:

- o a consolidation of existing government funded departments to create an across the lifespan approach, with key principles of maximising independence and safety for the individual.
- o Single point of entry to services;
- o Smooth transition between service types when activity/participation needs change;
- o Strengths based assessment frameworks;
- o Based on principle of Ageing in Place;
- o Link to outcomes frameworks such as WHO ICF;
- o Benchmark to international standards such as UN Convention on the Rights of Persons with Disability;
- o Consumer and family to be given opportunities to take a more active role and participate in assessment and planning processes via information delivery about available funds and services.

A single process of entry with determination of level of funding/service at the entry point, and ongoing case coordination is required. This should entail triage, assessment and case planning and management by a qualified professional with specific skills and expertise in Aged Care. This person should continue to be involved with the consumer and their family, to monitor their well being, and provide guidance and support through transition points. This would involve referrals for assessments, additional services and access to respite or placement in an aged care facility if necessary. The aim is to promote ageing in place and smooth transitions, through planning and

timely provision of services in line with consumers' expressed preferences. As previously noted, interventions which enable consumers to remain active and independent generate downstream cost benefits and are a worthwhile investment.

A governance structure should be in place to monitor adherence to standards and performance against benchmarks. Key elements to be monitored would be:

- o Waiting times for assessments and entry to the system;
- o Expenditure of funds allocated to individual consumers;
- o Provision of prescribed assistive technology;
- o Flexible service delivery plans to meet individual needs.

The governance structure should also ensure that an appropriate balance is achieved between professional assessments and recommendations, and consumer choices, in order to ensure the most important needs for ageing in place are met.

Innovation would be supported through proactive planning and collaboration with ageing consumers and their families. Early intervention and case management underpin this approach. Flexibility in expenditure of funds and the ability tailor make packages of care to each individual's circumstances would further support health professionals and care providers in development of innovative approaches to services delivery.

5. RECOMMENDATIONS – SERVICE DELIVERY

1. Eligibility

Persons whose activities and participation in the WHO ICF outcome domains, are restricted by body structure and function impairments that result from, or are associated with, age related processes or diseases, should be eligible for Aged Care Services.

2. Entry to the system

A single process of entry with determination of level of funding/service required must be in place. This may be similar to current Aged Care Assessment Service functions now, however needs to be extended to provide case co-ordination over the longer term.

Experienced triage at point of entry is essential. Thorough knowledge of the Aged Care Sector and an ability to make referrals to appropriate health professionals and service providers in order to complete a comprehensive intake assessment is required.

3. Funding based on assessed individual need

A standardised tiered funding system, whereby an allocation of funding is made based on the outcome of a comprehensive intake assessment, undertaken by the Aged Care Assessor and the professionals and services to which referrals are made, must be implemented. Funding allocated to an individual must correspond to assessed needs in terms of the WHO ICF Outcome Domains, and the impact of age related impairments on activities and participation, taking into account each individual's personal and environmental factors, assessed in accordance with the WHO ICF. This would take into account factors in the home and community environments, as well as carer needs.

4. Flexibility and Consumer Choice

Consumers and their families should be empowered and assisted to make choices about how to spend these funds based on their own resource availability and preferences regarding activities and participation domains. This process must be embedded in the legislation that underpins the new Aged Care System.

5. Funding must support provision of Assistive Technology and environmental interventions as key enablers

Establish national standards for funding, to ensure sufficient funding in all sectors of the Aged Care System to provide AT and other solutions that enable ageing in place and maintenance of activities and participation in chosen domains.

Local service providers must be required to provide the full range of funded services including AT, based on assessed need, without lengthy waiting periods.

Sufficient funding for timely home modifications must be included within this requirement, along with a mandate to prioritise older persons who cannot return home without these being completed, as these people are at great risk of deconditioning, loss of function, falls and injuries while waiting.

1. Early intervention

Enhance the intake process to Aged Care Services to allow:

- o Earlier entry to the Aged Care System as activity and participation restrictions associated with ageing and age related disorders begin to emerge, enabling Ageing in Place through Early Intervention.
- o Case management over the long term, to facilitate planning and choice, as well as smooth transitions as activity and participation restrictions increase.

2. Case Management and Coordination over the long term

Aged care case managers should be funded and should work with older consumers and their families over the long term, enabling care planning, maintenance of activity and participation as well as a smooth transition between service types. Case managers should work with families to empower them to make choices, while also ensuring they receive appropriate professional assessment and advice.

A case manager can work with the older person and their family, taking into account their desires and personal circumstances, while also considering professional recommendations. The case manager's responsibility would be to ensure that appropriate AT, care and any necessary treatment is provided.

A process to manage for requests for change of case manager, and for dispute resolution must be established.

3. Sufficient community, respite and residential services must be available

Increase available community based services, respite and residential places to meet the need for these in a timely manner. Increase the flexibility and responsiveness within these to enable consumers to make choices appropriate to their individual circumstances, within their individually approved funding level.

4. National agenda for research and development of emerging technologies

A national agenda for research and development of emerging technologies, and for the inclusion of these in housing for older persons, must be developed and implemented. These include Smart Homes and Telehealth, and must be built into new housing and communities. Emerging technologies must be available to older persons in existing housing at low cost.

5. Transport and Driving

A range of supports for transport, that are accessible and affordable must be funded and implemented. This could include:

- Appropriate funding of vehicle modifications including wheelchair hoist installation and modified driving controls,
- more flexible and available community transport,
- improved standards for taxi operators providing services for older and disabled persons
- the development of a subset of taxi drivers trained to take frail and mentally impaired passengers
- taxi subsidy dependant on need, and
- the development of a range of other options.

The responsibility to ensure older drivers are able to drive safely must be promoted and enforced with the medical profession. Funding support for training of occupational therapy driving assessors must also be made available on an ongoing basis. This should include funding for driving assessments so that these are not beyond the reach of older persons with limited finances.

6. Benchmarking and Outcome Frameworks

Best practice in programme evaluation identifies the need to count actual 'outcomes' rather than programme 'outputs'. For example, the most meaningful outcomes to be captured from provision of AT funding such as a wheelchair would be an increase in mobility. Frequently however, funders count the 'output' as being subsidy provision ($1250 towards a $3,300 wheelchair). Obtaining top up funds can cause substantial delays in actual outcome (improved mobility) and indeed may not occur should funding not be found.

Service delivery performance should therefore be geared to person centred outcomes rather than programme outputs. It should also utilise accepted benchmarks such as the WHO International Classification of Functioning, Disability and Health (ICF) Classification System. Australia has adopted the WHO ICF, which, alongside the UN Convention on the Rights of Persons with Disability, enshrines the rights of Australians to participate in a wide variety of life areas, and to receive the necessary resources with which to do so.

6. GOVERNMENT ROLES AND RESPONSIBILITIES

Government policy and legislation

This section briefly touches on areas of government responsibility that need review and action to promote health ageing in Australia. Recommendations are embedded in the discussion and are not listed separately.

Policy across all sectors must ensure that opportunities to participate are available to older persons. Disability and Aged Pensions, Superannuation and Taxation, must ensure that older persons do not live in poverty and that they have sufficient financial resources to achieve appropriate nutrition and standard of living. This issue is well documented in other sources, however, little real improvement has been achieved at this stage.

Government has a role to enshrine in legislation the requirements for older citizens to age in place, with dignity, and with the capacity to make choices and achieve an acceptable quality of life. Consideration of issues such as transport and driving for older persons, accessible communities, and other policies that support continued participation in community life must be developed and implemented.

All government departments, federal, state and local, should be tasked with developing an Action Plan for Older Persons, to identify and remove barriers within their own operations, and to recommend changes to laws, or new legislation, to address issues that they identify.

Funding for all types of AT, including emerging technologies, must be provided. As has been previously discussed, AT is a key enabler of activity and participation for older persons, and allows ageing in place to be enacted in the everyday lives of older Australians and their families. Funding needs to grow with the ongoing development of technology, as the cost in this area is ever increasing. A national strategy to sustain this funding and the necessary ongoing growth is essential. This strategy must be implemented within relevant State and National services and programs.

Privacy and ethical issues that will arise from the introduction of Smart Houses, telehealth and other technologies need to be identified and appropriate protections established.

Particular consideration should be given to a review of Guardianship Legislation throughout Australia, together with the suitability of existing Mental Health Legislation for meeting the needs of Older Persons experiencing cognitive decline or mental illness.

Workplace flexibility for carers must be greatly improved, in order to make the caring role sustainable and to support Ageing in Place. Sufficient respite must be available to enable carers to continue to earn an income and sustain participation in rewarding vocational and leisure pursuits.

Specific policies to support the development of innovative and flexible approaches to delivery of Aged Care Services for special needs groups are urgently required. Older persons from Aboriginal or Culturally and Linguistically Diverse backgrounds; those who have multiple sets of needs; and older people living in rural and remote areas must have access to Aged Care Services that meet their unique needs. Local services must be empowered and enabled to develop innovative models to address these needs. A National Research and Development Agenda is required to develop and test out service models, and to support training and implementation initiatives. Included in these models could be incentive schemes and funding for existing services to travel and provide mentoring to local communities and service providers.

7. WORKFORCE

An expanded workforce and new areas of work underpin the success of aged care reform. New and expanded work roles need to be developed to implement the elements of an aged care service system that have been identified in this submission.

Overall aged care workforce issues:

- o Suitable workers to provide intake assessments, referrals and ongoing case management. A range of professionals would be suited to this area of practice, including occupational therapists, social workers, nurses and other health workers.

- o Sufficient workers to provide in home care and other services. This is a rapidly expanding area of service delivery, and it will continue to grow enormously if the principles of Ageing in Place and Enabling Participation are adopted to underpin the Aged Care System. Supply will be a significant issue, given the data on our ageing population reported at the beginning of this submission.

- o A new area of work in emerging technologies. A range of workers will be required to develop research, manufacture and supply these. A new knowledge and skill base will be developed. There will be education and training requirements in both the university and vocational education sectors.

- o Allied health workers will require training in relation to these emerging technologies, as they will be the main professional groups to work with these with older people.

- o Sufficient supply of health professionals to provide assessments and interventions for older persons, including in rural and remote areas. This is a well documented area of short supply in workforce.   Increasing intakes into university programs and incentive schemes for provision of services in rural and remote areas are required.

- o An emphasis on recruitment of workforce from Aboriginal and culturally and linguistically diverse backgrounds, to roles at all levels and within all service types throughout the Aged Care System is essential.   This workforce will not only provide culturally relevant and sensitive services, but can contribute to ongoing policy development and development of innovative service models to meet the special needs of these groups.

- o Ongoing education, mentoring and support systems for rural and remote practitioners and service providers must be built into the aged care system. This could involve the use of Tele Health, as well as funding for travel to access education and funding for mentors to travel to rural and remote locations. Relevant professional associations should be given financial support to develop and trial these initiatives.

- o Workers at all levels of the Aged Care Service workforce must receive specific training in collaborating with older consumers and their families, to empower them to make choices while ensuring they receive appropriate professional advice and are able to use this in their decision making processes.

Occupational Therapy workforce issues

Occupational therapists in aged care are professionals with perhaps the widest scope of practice to offer. Occupational therapists are trained in cognitive and physical assessment. Like our speech pathology and physiotherapy colleagues, we are able to maximise function through a variety of interventions in areas of rehabilitation and reconditioning, while our unique focus on the person, and their life occupations, tailors such interventions directly to the older person and their roles within in their environment.

Further, occupational therapists are the profession able to prescribe optimal sets of AT devices, environmental interventions and recommend tailored personal care, to maximise independent living and quality of life.

Demand for occupational therapy services are such that workforce shortages have long been an issue. Proactive workforce strategies are required by the government to address current and future need, including consideration of university places, and clinical placement capacity.

8. CONCLUSION

Occupational Therapy Australia applauds the Federal Government for tasking the Productivity Commission to review Australia's capacity to care for older people, through the Caring for Older Australians Inquiry.

This submission to the Inquiry from the Assistive Technology Committee of Occupational Therapy Australia presents an alternate view of human need, focussing on the effects of impairment regardless of diagnosis or age. The submission puts forward a view of the potential of enabling environments and strengths-based assessment to maintain a high level of independent living and good quality of life at any point in the spectrum of ageing or of disease progression.

To implement such nuanced and tailored service delivery, a number of key recommendations are made:

1. Broad Eligibility based on need
2. Streamlined entry to the system
3. Funding based on assessed individual need
4. Flexibility and consumer choice regarding service delivery and funding models (eg. direct funding)
5. Provision of assistive technology and environmental interventions as key enablers
6. Early intervention, understanding that preventative measures can slow functional decline
7. Availability of long term case management and coordination where needed
8. Sufficient community, respite and residential services
9. National agenda for research and development of emerging technologies
10. Transport and Driving
11. Benchmarking and Outcome Frameworks

Attending to the capacity for growth of the workforce is essential to implement a good service system into the future. This includes building on service models and roles that are currently working, and further developing roles of skilled assessors. And finally, aligned, accountable and connected governance across health, ageing and disability is required to genuinely build the whole service system around the consumer, as they move through their lifespan and as their capacities grow and change.