MERCY AGED CARE SERVICES BRISBANE

Submission to the Productivity Commission Inquiry: Caring for Older Australians.

July 2010

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About Mercy Aged Care Services. Brisbane.

Mercy Aged Care Services is a ministry of the Sisters of Mercy, Brisbane Congregation. The service has a focus on dementia care based on an integrated model, care for people with intellectual disability who are ageing, palliative care and care for people with complex clinical needs.

Mercy Aged Care Services is a member of Catholic Health Australia (CHA) and supports the initial and supplementary submissions of that organisation.

This submission provides additional information relating to the strategic focus areas of Mercy Aged Care Services.

1. Palliative Care

In 2004 the Department of health and Ageing developed the publication ‘Guidelines for a Palliative Approach in Aged Care’ recognising that palliative care had a distinct place in residential aged care. Palliative Care requires specialist clinical skills, collaboration with primary health care support services and the provision of emotional support.

Many aged care services have developed the clinical capacity, the networks with specialised services and medical practitioners, and the pastoral and emotional support services to deliver excellent palliative care outcomes.

Palliative care within residential aged care is not only addressing the needs of the aged but is increasingly responding to needs of people who do not have access to alternative palliative care options or who choose a residential care setting for end of life care.

Good palliative care involves addressing the emotional and spiritual needs of the resident and providing care and support for families. The costs of pastoral support and specialised clinical services should be recognised as legitimate additional care costs where a palliative care program is in place.

Palliative care within residential aged care is funded on less than $200 per resident per day. Equivalent care in a hospice or specialised palliative care services would cost about $600 per day and in excess of $1,000 per day in an acute care setting.

The National Health and Hospitals Reform Commission recognised the need to expand of the capacity of primary care services to deliver palliative care in residential aged care. While there are clear economic efficiencies in supporting palliative care in residential care any expansion must be based on recognition of the role of the provider and be based on realistic and equitable funding arrangements that cover the costs of providing care.

Recommendation

> **That an additional palliative care supplement be included in the aged care funding instrument (ACFI). The supplement would apply for the duration of a medical practitioner approved palliative care program in residential aged care.**

2. Pastoral Care

Pastoral care aims to respond to the emotional and spiritual needs of residents and their families. Pastoral care happens on a number of levels including through the work of pastoral care staff, through the facilitation of relative support groups, through volunteer programs and through access to external counselling support services.

A critical time for effective emotional and pastoral support is during the transition to residential care. Transition to care programs involve personal contact with a resident prior to admission, early assessment of support needs during transition and in the longer term, discussing expectations and establishing relationships and points of contact with families. The benefits are enhanced resident well being, an understanding of resident care needs from the outset and improved communication and relationships between the provider and families.

Funding for transition to care programs has the potential to reduce the cost to government of complaints investigation.

Recommendation.

> **That pastoral care be recognised as a legitimate cost of providing comprehensive aged care.**
>
> **That a 'one off' payment ($200 - $300) be made on resident entry to residential care where a transition to care program is in place.**

3. Care for People with a Disability who are Ageing

People in this population are disadvantaged by the division of program responsibility and associated program boundaries between the States and the Commonwealth. The recent COAG agreement, where the Commonwealth has assumed responsibility for funding care for people over 65 and the States and Territories responsibility for care services for younger people, has the potential to further limit access to appropriate services for people with a lifelong disability who are ageing.

Many people with an intellectual disability 'age' at a younger age. Like all other citizens these individuals need access to a continuum of services and supports. This access should be timely, appropriate and responsive to the presenting need.

Functional abilities, not age, should be the factor in determining the suitability of services and supports for adults who are ageing with a lifelong disability.

People in this population should have the range of choices available to the wider community. Service options should include community care, assisted living, respite care, residential aged care and access specialised aged care services.

While individuals should be supported to live independently for as long as possible the development of a parallel 'aged care' system in the disability support sector would be inefficient.

Service provision should be based on collaborative cross sectoral planning involving aged care, disability support and health care. It should be person centred with whole of life planning and transition preparation rather than having to manipulate a 'fit' with existing supported accommodation (State) or aged care (Commonwealth) program guidelines.

This is reflected in the Australian Government's paper on *Working Together: Policy on Ageing and Disability*, July 2005, which stated that 'people with a disability who are ageing will be adequately supported by both disability and aged care services working within a seamless interface'.

"There is a strong focus on developing an integrated service planning approach focussing on the needs of this population rather than developing a specific service model or responding to the requirements of the existing funding programs"

Funding

The special needs of this population should be considered in structuring both recurrent and capital funding arrangements.

Funding under the aged care funding instrument (ACFI) does not recognise the complex clinical, behavioural and support needs of this population. This support often involves long periods of one on one staff time. The current (maximum) behaviour supplement of $30 per resident per day provides less than one hour of direct care staff time per resident per day associated with the management of behaviour and emotional support. Most residents in this group have significantly higher support needs.

The cost of equivalent levels of care provided outside the aged care system can exceed funding under the aged care system by 100%.

The annual recurrent cost of providing care for people aging with intellectual disabilities within the aged care system is approximately $65,000 per resident. This compares very favourably with the cost of alternative accommodation and care options, especially in the acute care sector. Our research shows the (cash) cost of alternative accommodation in the acute care sector can be well in excess of $110,000 per resident per year.

However, the real economic cost to the acute care sector is higher. By occupying beds, pressures on the acute care system are increased. The State Government largely carries the financial burden, the community suffers the systemic inefficiencies and patient care is not optimal as acute care facilities are stretched and unable to provide the specialist care needed for these vulnerable patients. This economic cost applies to not only people with a disability who are ageing but to the ageing population generally.

A significant deficit exists in the provision of capital funding. The majority of people with an intellectual disability who are ageing do not have the financial capacity to pay an accommodation bond (the principal source of capital development funding in aged care). Capital subsidies paid by the Commonwealth on behalf of these residents only cover part of the new capital development costs. Services that provide access for this population should have better access to Commonwealth and State capital funding.

There is an opportunity for efficient aged care service providers to ease the daily strains placed on the acute care sector by expanding capacity and accommodating for people aging with intellectual disability presently occupying acute care and other beds. The need for specialist care and accommodation services for this group is clear and compelling.

Recommendation

Implement collaborative cross sectoral planning for people with a disability who are ageing involving aged care and disability services. This could be initiated through a national pilot program involving the Commonwealth and States.

Include cross sectoral based transition planning in quality service standards.

Provide an additional supplement in the Aged Care Funding Instrument (ACFI) to recognise the complex clinical, emotional and behavioural support needs of people with and intellectual disability and the additional costs of providing care.

Improve access to Commonwealth and State capital funding grant programs for this group.

4. Access to Primary Health Care

The Commonwealth has recognised the need to provide incentive payments to encourage General Practitioners(GP) to attend residents aged care facilities.

While this initiative is welcome and supported it does not recognise the costs to aged care providers of supporting and facilitating GP and other primary health provider access. These costs can include;

The provision of dedicated consulting rooms and associated facilities.

Registered Nurse support during consultations and associated administration of prescriptions, medications and pathology.

Access to general practice clinical management computer systems including licensing costs, technical support and support for remote network access and access to medical and pathology reporting systems.

The provision of a payment to providers, linked to GP access, would recognise the real cost of support for GP access and would be an incentive for providers to support and facilitate increased GP access.

Recommendation

The Commonwealth provide a payment to providers, linked to GP access in residential aged care, in recognition of the cost to providers of supporting GP access and as an incentive for providers to facilitate and support GP access.