The Australian Psychological Society Ltd

Submission to the Productivity Commission Draft Report on Caring for Older Australians

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Executive summary

The Australian Psychological Society (APS) welcomes the Draft Report on Caring for Older Australians by the Productivity Commission. The Draft Report canvassed a range of issues including the funding and viability of, and access to, quality aged care services in the context of Australia's ageing population. While the APS agrees with Key Points and the majority of recommendations outlined in the Draft Report, there is a missing stress on the human dimension in the caring for older Australians. There is an overemphasis on the economic imperatives of reform in the aged care sector in order to streamline access to services and produce efficiencies. Less obvious emphasis is placed on factors such as the quality of life of aged care recipients.

The APS contends that reforming health and care for the general community will benefit the quality of life of older Australians.

To achieve better care for older Australians, the APS believes that there needs to be better recognition of, and adequate funding for, evidence-based behavioural interventions; a focus on healthy ageing rather than the view that ageing is a medical phenomenon; and an active partnership between older Australians and policy makers through the development of an overall engagement framework with regards to the reform options in aged care policies and services.

Recommendations

The recommendations proposed by the APS are of two types: those that reflect the psycho-social perspective and those that refer to improvements in the current system that may also be cost effective or, at least, less wasteful.

The APS recommends:

1. That the Productivity Commission outlines a set of guiding principles on caring for older Australians to set its final report in context. This will assist readers to gain a greater appreciation of the views of the Commission and act as a foundation for future evaluation of the success of reform initiatives.
2. That the Productivity Commission's final report be constructed to specifically focus on psychological and human factors, such as quality of life, that are known to interplay with procedural, structural and economic dimensions of caring for older Australians.
3. That any funding for aged care services be linked to health outcomes, with active participation in decision-making by consumers and/or their nominated representatives.
4. That the proposed Australian Aged Care Regulation Commission be tasked with an additional key function of developing a comprehensive engagement framework to enable consultation with consumers, stakeholders and Government agencies so that any subsequent consultations involve consumers from the outset.
5. That the Productivity Commission redefines the concept of ageing in place as a broader concept of supporting older Australians to remain in their place of residence of choice with available health, psychological, social and environmental support.
6. That funding for support services (health, psychological, social and environmental) 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 placements into aged care facilities.
7. That the proposed Australian Aged Care Regulation Commission be tasked with an additional key function of liaising and coordinating workforce initiatives specific to the aged care sector with relevant stakeholders.
8. That the Productivity Commission examines ways to increase efficiencies within the current aged care system, particularly in relation to evidence-based non-pharmaceutical (psychological and behavioural) interventions.
9. That the Aged Care Funding Instrument (ACFI) be re-adjusted so that the behavioural supplement (BEH) subsidy will attract equivalent funding to complex health care supplements (CHC).
10. That any funding of aged care services must be aimed at maximising the health outcomes of consumers, based on the best available evidence, including targeted or "quarantined" funding for specific therapies and services.

Introduction

The APS thanks the Productivity Commission (the Commission) for the Draft Report and the opportunity to comment. While respecting the depth and quality of the data, analysis and recommendations in the Draft Report, the APS has some reservations about whether the Commission has achieved a balance between economic/structural drivers and the human factors such as the psychosocial needs of older Australians, the consequential benefits to the individual of the recommended reforms and quality of life outcomes. The Draft Report acknowledges in places specific aspects of social and psychological needs but does not seem to grapple with the complex interplay of human and systems issues in a way that would more clearly guide decisions and evaluate outcomes beyond pure economics. For example, one needs to feel in control in order to be an active participant in one's own care. But if infrastructure and services fail to acknowledge and accommodate this, it will negatively impact on the individual's motivation for compliance with care, and treatment outcomes which can be compromised. Worse still, failures to encourage a level of personal control can bring about negative psychological responses such as mood disorders and disruptive behaviours. This will be elaborated in later sections of this submission.

It is understood by the APS that infrastructure, procedures and financial aspects are not only easier to conceptualise and discuss, but are also easier to measure, specify and describe. However, both experience and theory have shown that psychological features of the individual – consumer, carer or provider – such as self esteem, active participation in decision-making, individual perception, need for achievement and need for stimulation, and the negative outcomes associated with poor motivation, dissatisfaction and lowered mood can determine the success or failure of what appears to be a perfectly sound cost-efficient process. It is with this in mind that the APS offers some commentary on, and examples of, how the Commission might address human factors in its final report.

As a starting point, the APS would like to outline its principles on the care for older Australians as a guide to its responses to the Draft Report.

1. *The need for principles to guide reform*

The Commission produced a very useful framework to assess aged care (Draft Recommendation 4.1). However, this framework should be underpinned by a set of principles, reflective of the values of the society in caring for older Australians. These principles will allow for objective assessment and prioritisation of reform options and can form the basis for their evaluation in the future.

2. *The need to focus on individual quality of life*

While the Draft Report is comprehensive in its coverage of issues, there was variation in the depth of discussion for each. There is a greater emphasis on the economic imperatives and insufficient attention given to the human factors aspects of ageing. The APS believes that there needs to be greater recognition of the latter, as this should be the primary aim of an aged care system. It is not until issues such as quality of life, healthy ageing, and psychological wellbeing are fully attended to, that economic measurement of the system's efficiencies can be evaluated and improved in a meaningful way.

3. Health care as a right and an entitlement

Draft Recommendation 6.2's suggestion that health service components of aged care attracting universal "subsidies" implies charity and seems to ignore the fact that health care is a right and an entitlement for all Australians. Recommendations suggesting means-testing of recipients of aged care service funding are inconsistent when compared to health care – one is not means tested when undergoing emergency surgery or treatments for cancer. The distinction between personal care and health care as defined in the Draft Report is artificial and does not address the holistic needs of individuals requiring care. For example, assistance with feeding may be personal care, but lack of food intake can lead to health problems. Similarly, lack of assistance in personal hygiene can lead to skin infections and preventable hospital/GP presentations so then becomes a health care issue. Therefore, personal and health care not only overlap, but in many cases they may be fulfilling the same purpose.

4. *Any reform of the aged care system must have a "no disadvantage" clause for the spouse/partner*

The APS urges caution over "user pay" systems when applied to aged care services. If they are not carefully monitored and well regulated, user pay systems can place not only those admitted into care facilities at risk, but also their partners or spouses who may be financially disadvantaged and therefore require additional care themselves, even if they continue to live in the community. Therefore, a "no disadvantage" test needs to be applied so that those not going into care are not faced with unnecessary hardship. Similarly, attention also needs to be given where both partners are high-care recipients. To ensure reforms are inclusive of care recipients and their carers, a framework to engage with older Australians regarding their care is required to ensure consultations are planned and thorough and policies are developed with support of all consumer groups.

5. Ageing in place as a broader concept

It is unfortunate that the Draft Report defined ageing in place only in the context of residential aged care facilities. The APS sees ageing in place as a much broader concept that includes aspects of positive ageing as a normal biological process, assistance to help older Australians stay in their own homes (via community, social and environmental services such as home modifications), being an active members of society and receiving care in a consumer-centred fashion (similar to the way the Commission initially defined). In this context, the perception that older Australians are somehow a burden, that growing older is associated with increased dependence, loss of self-control and lack of capacity for informed decision-making needs to be challenged. Most older Australians remain healthy, independent and active right up until the end of their lives. "Ageing in place" is not just an economic benefit when applied to the broader community; it is most importantly a preservation of self-respect, identity, independence and control.

6. Workforce training and education underpinning reforms

The Commission is to be congratulated for the comprehensiveness of its Draft Recommendations in relation to workforce training and education. In addition to making the aged care sector a rewarding work environment by paying competitive wages and focusing on multidisciplinary care, there needs to be a shift in the education and training of the health workforce in general to focus on healthy

ageing, diversity and building positive partnerships with older adults. Given the current health reform initiatives at both Commonwealth and State/Territory levels, close liaison and coordination with stakeholders are critical to avoid duplication of effort and resources. The proposed Australian Aged Care Regulation Commission can play a vital role in such efforts.

7. The need to focus on allocative efficiencies as well as structural efficiencies in aged care

The APS agrees that the funding structure of aged care is complex and requires simplification and streamlining. However, there are also gains to be made through improving efficiencies within the aged care system. An example of system efficiency is the better utilisation of behavioural management as well as, or instead of, medication to moderate mood or minimise disruptive behaviours for those requiring care. Polypharmacy is a real and complex issue for older Australians. The Draft Report made almost no mention of the issue of increased costs associated with medications in terms of their costs to clients and to the community via the PBS, and the issue of contraindications between various medications. The only reference to the issue of medication management was in the context of efficiencies to be gained with electronic prescribing and increased safety for clients.

8. Current funding does not allow adequate behavioural interventions

Dealing with disruptive behaviours is a labour-intensive process, both in facilities and community-based settings, and it is one that is not adequately recognised (and therefore inadequately funded). This is captured succinctly in the criticism by the various providers of the behavioural component of the Aged Care Funding Instrument (ACFI). The issue of disruptive behaviours requires significant investment in workforce training and development not only for aged care staff, but also health care staff in general (GP practices, staff in accident and emergency departments, hospital registrars etc). Consistent with this, a greater recognition of behavioural issues needs to be made in the Aged Care Funding Instrument (ACFI), so that behavioural issues attract the same funding as other areas of dysfunction. In addition, targeted use of behavioural interventions by health care professionals and carers can often result in reduced frequency and severity of disruptive behaviours. This not only benefits the recipient of aged care services through reduced reliance on medications, it can also reduce feelings of anxiety among other residents and carers and significantly reduce labour costs.

The following section provides details on the APS's proposed principles and recommendations.

Principles guiding reform

The reform of any complex system requires a clearly articulated set of principles, not only to guide the reform process, but also to assist the public to evaluate the proposals or suggestions outlined. The Draft Report outlined a useful framework for assessing aged care (Draft Recommendation 4.1), but did not articulate the principles that underpin the suggested framework. Moreover, the focus of the framework was in the context of a single policy objective, namely a consumer-centred aged care system, rather than a broader vision for a new reformed health and community system incorporating aged care.

Where principles were stated in the Draft Report, they were in the context of funding only (Draft Recommendation 1.2). As a starting point, a broader set of principles underpinning a vision for a reformed aged care system is required. This will assist both the public and the policy makers to determine the priority and merits of various recommendations. Conversely, a plan or vision without a set of principles can be easily hijacked by vested interests. This will not only signal a failure of policy setting, but also disadvantage the very population such policies are designed to protect and benefit.

The principles should comprehensively cover a range of issues such as:

- aged care as a right for all older Australians, irrespective of their race, gender, socioeconomic status, place of residence, religion etc;
- a broader definition of aged care in health, social and environmental contexts and ageing in place (see later section);
- acknowledgement that the aged care "system" is really a collection of programs and initiatives at Commonwealth, State/Territory and even local levels;
- funding of care for older Australians and its elements (as per Draft Recommendation 1.2);
- access to services by older Australians;
- delivery of services to older Australians, particularly to those with specific needs; and
- a focus on healthy ageing and wellbeing, as opposed to the current medical or illness model. This is covered well under Draft Recommendation 4.1, but can be more accurately captured under its core elements:
    - a service-orientated system that enhances the quality of life and wellbeing of older Australians;
    - promoting independence by supporting and encouraging older Australians to make their own life choices; and
    - acknowledging the importance of connectedness with others and participation in local communities.

Recommendation 1: That the Productivity Commission outlines a set of guiding principles on caring for older Australians to set its final report in context. This will assist readers to gain a greater appreciation of the views of the Commission and act as a foundation for future evaluation of the success of reform initiatives.

Addressing quality of life

The aim of the health care system, of which the aged care system is a part, should be to improve the quality of life of those people the system is designed to care for. In this context, the traditional market-based approaches such as competition and regulation must be reshaped with human factors in mind. When people are sick or are in need of services, they do not have the luxury of choice regarding the medication they are prescribed (other than generic versus brand name in some circumstances), the type of health professional they will see or even the type of care they will receive. They are often passive recipients with care directed to them in a system that is designed around the workflows of the providers – they are not "consumers" in the classic economic definition. These issues are compounded in the aged care setting where there are supply shortages of aged care beds, service providers and clinicians, despite the growing demands. In addition, people accessing aged care services, particularly those entering aged care facilities, often do so after some form of traumatic event (e.g. a stroke), which can further contribute to the "medicalisation" of older individuals. To make matters worse, the strict criteria for assessment of health services and the rigid routine of service delivery further entrenches "learnt helplessness" among care recipients. This is reflected in the fact that the prevalence of depression and other psychological disorders are significantly higher among older adults in aged care when compared with the general population (Hyer et al., 2005) and incur significantly greater health care costs (Katon et al., 2003; Welch et al., 2009).

This is not to suggest quality of life as a panacea to reform challenges in the aged care system. Rather, the quality of life of aged care service recipients needs to be used as a view point to assess the merits of reform proposals and to evaluate their successes, rather than using purely economic efficiency measures. The APS acknowledges that quality of life measures can be seen as subjective and can be influenced by a number of factors such as the settings in which they are used, respondents' interactions with other health and related services and even demographics of the respondents. Therefore, it would be irresponsible for a single quality of life measure to be used as a benchmark, as no single measure can provide a comprehensive and valid way to quantify quality of life. There are a number of principles that the APS would present to the Commission in guiding the issue of quality of life measures:

- No single measure will reliably measure the various dimensions of well-being, satisfaction or even quality of life;
- The best measures will have been extensively validated and researched, often in specific settings;
- Measures targeting specific population groups or settings are much more accurate than "happiness measures" for the general population.

While neither an exhaustive list, nor specially recommended, the APS is aware of the following measures of quality of life for older adults:

1. World Health Organisation Quality of Life - Older person's version (WHOQOL-OLD; Power et al., 2005) – The WHOQOL-OLD was developed from the WHOQOL-100. The WHO quality of life measures are carefully developed, tested and validated across cultures, making them suitable for the general older population, including people from culturally and linguistically diverse communities. The WHOQOL-OLD is tailored for people aged over 65 years and is

comprised of seven sub-scales (sensory abilities; autonomy; past present and future activities; social participation; death and dying; and intimacy) and has a total of 24 items. Higher scores on the WHOQOL-OLD indicate higher levels of functioning and quality of life.

2. Older People's Quality of Life (OPQOL; Bowling & Stenner, 2011) – a new 32-item measure developed specifically for people aged at least 65 years. The questionnaire asks people to respond, on a five point Likert-type scale, to questions about life overall, health, social relationships and participation, independence, control over life, freedom, home and neighbourhood, psychological and emotional well-being, financial circumstances and religion/culture. Higher scores on the QPQOL indicate better quality of life. Bowling and Stenner demonstrated that this measure has good validity and reliability. They did however illustrate that test re-test reliability can be difficult to assess as "small" events related to respondents' health and/or functioning can have a disproportionately large impact on quality of life.

3. Short Form Health Survey-36 (SF-36; Ware & Sherbourne, 1992) – a widely used measure of patient health measuring eight domains (vitality, physical functioning, bodily pain, general health perceptions, physical role functioning, emotional role functioning, social role functioning and mental health). There are two versions of the measure available – one free, from the RAND corporation (http://www.rand.org/health/surveys_tools/mos/mos_core_36item.html), and a revised and improved version available from the original researchers (http://www.sf-36.org/). The SF-36 has demonstrated reliability, validity and internal consistency. It has however been recommended that when using the SF-36 with older people, that the questionnaire be administered with an interviewer rather than in the context of a mail out.

It is also important to note that there is no overall agreement in the research literature as to what "quality of life" is or should constitute (Bowling et al., 2002). Given this, if different measures have been used, direct comparisons of quality of life will not be valid.

Recommendation 2: That the Productivity Commission's final report be constructed to specifically focus on psychological and human factors, such as quality of life, that are known to interplay with procedural, structural and economic dimensions of caring for older Australians.

Health care as a right and an entitlement

The Draft Report contained some conflicting recommendations. For example, Draft Recommendation 6.2 made a distinction between health services and personal care services, with the former attracting universal subsidies and the latter reliant on personal contributions. This distinction is very difficult to make in real life. For example, a person's ability to wash and groom (personal care) contributes to their overall functioning and health status. Similarly, a person's ability to self-feed can directly impact on their food intake, nutrition and ultimately their health status. Just as one cannot examine the aged care system in isolation from the health system, the separation between personal care and health care is artificial and does not address the holistic needs of

individuals requiring care. Therefore, the APS sees costs associated with aged care as falling into two major categories only: accommodation/living expenses and care costs.

The APS is also seeking further clarification regarding the issue of subsidies and means testing. The notion of subsidies implies that those seeking care need to contribute toward the cost of care, usually via some form of means testing. Consistent with the view that care costs include both personal and health care costs, the APS questions the need for means testing of older Australians accessing care, particularly at the "health" end of the care spectrum. The universal entitlement to health care is a right of all Australians (even though universal *access* to such care can be problematic, particularly among disadvantaged groups). The same right and entitlement should therefore apply to aged *care* costs, while acknowledging the same difficulties in translating entitlement to aged care services to their actual access.

As indicated above, caring for older Australians should not be seem as an adjunct to, or separate from, caring for the rest of the community. On the contrary, policies directing aged care need to be more cognisant of the link between care, health and wellbeing, due to the very nature of the aged care community. This can be achieved through explicit acknowledgement of the health outcome benefits (rather than *outputs*) of aged care policies. Once again, this requires an explicit acknowledgement that human factors such as quality of life should be given equal recognition to economic imperatives during policy formulation and evaluation processes. To apply this in practice, there needs to be active participation by the older Australian community. This is explained in the section to follow.

Recommendation 3: That any funding for aged care services be linked to health outcomes, with active participation in decision-making by consumers and/or their nominated representatives.

Any reform of the aged care system must have a "no disadvantage" clause for the spouse/partner

The APS is broadly supportive of the building block approach toward aged care and support (p. 28-29 of the Overview). However, it does not agree with the Commission's view of Carer Support as a single isolated building block. Instead, the APS is of the opinion that Carer Support should be an integrated activity inherent in all other building blocks – Basic Support, Personal Care (Community and Residential) and Specialised Care. Therefore Figure 3 (p.29 of Overview) and Figure 8.2 (p.256) should be reconfigured so that Carer Support is removed as a horizontal building block and repositioned as a vertical column covering Basic Support, Personal Care and Specialised Care (similar to the way in which the "Culturally and linguistically diverse, Indigenous, rural and remote, special needs" column is positioned). This more accurately reflects the fact that carer support must be evident in all aspects of aged care and support and not an "add-on".

While the APS does not object to the Draft Report's proposal that some form of "user pay" system be applied in aged care residential facilities, there needs to be significant regulatory oversight to ensure there are "no disadvantage" clauses. This is particularly important in situations where both partners require high levels of care or where one partner is admitted into a care facility and one stays in the community. The pre-requisite asset assessment and subsequent payment for aged care services by the admitted partner can leave the remaining partner more dependent on social support

services because the latter is now financially worse off. This leaves both partners more dependent, adding further psychological distress that, may in turn, lead to the need for more care for the remaining partner.

The proposed functions of the Australian Aged Care Regulation Commission should therefore be expanded to protect not only the interests of those being admitted into care facilities, but also to those left behind. This will facilitate the healthy ageing of those remaining in the community, as they no longer have to make dramatic changes to their lifestyles due to their partners being admitted into care facilities and still know that those entering care facilities are receiving care appropriate to their needs.

In addition, older people are now more informed than generations before and therefore have greater expectations of their care (both regarding access to care and its quality). They want to be actively involved in decisions that affect their lives and to participate more broadly in the community. While it is commendable that the Commission acknowledges the link between consumer choice and positive wellbeing, and that a highly regulated system is unlikely to produce such outcomes, further emphasis is needed on the centrality of older people participating in all types of decisions across the aged care system. This involvement ranges from choices about which services they access at which time in their lives to how organisational decisions are made, how aged care services are provided and how the needs of older Australians may be met more broadly in the community in which they reside. Enhancing connection to others and the community, including by encouraging volunteering and integrating aged care services within the broader community are central to realising the right to choice, to achieving quality care and to reducing social isolation.

One mechanism for informed and active decision-making by older Australians is via a clearly articulated engagement framework with consumers and representatives regarding caring for older Australians. This means that an active partnership is formed between the policy makers and the consumers at the beginning of the policy formulation process, rather than policies being presented to consumers for comments and input after they have been drafted. This is also where the "top down" economic imperatives of aged care policies (and those of health, social and environmental support services) can be balanced with "bottom up" human dimensions and needs of consumers. A planned consumer engagement framework ensures consultations are well planned and extensive rather than ad hoc. It can ensure "buy-in" from consumer groups the beginning, leading to more robust policies than compromises made from differing viewpoints between policy makers and consumers resulting from top down policy making.

Recommendation 4: That the proposed Australian Aged Care Regulation Commission be tasked with an additional key function of developing a comprehensive engagement framework to enable consultation with consumers, stakeholders and Government agencies so that any subsequent consultations involve consumers from the outset.

Ageing in place as a broader concept

The APS does not agree with the Draft Report's definition of ageing in place as "the provision of care which allows a person to remain in the same residential care facility even if their care needs change". This is a very narrow view and ignores the fact that a significant portion of the older

Australian population remains active and healthy in the community (often in their own homes) with varying levels of health, psychological, social and environmental assistance.

One cannot examine the aged care system in isolation from other systems that influence and affect its operations. Three such systems are health (including mental/psychological health), social and infrastructure/environmental systems. The Draft Report acknowledges the interplay between aged care and these three systems in chapter 4, contradicting the narrow definition of ageing in place above.

Another way of defining ageing in place is the ability of health, psychological, social and infrastructure or environmental services to meet the needs of older Australians. In this context, ageing in place is promoted through service planning and provision at a local level, which would enable older adults to remain healthy and active in their communities, rather than having to rely on specific "aged care services". There is also added benefit for the wider community. For example, the introduction of accessible public transport would be of benefit not only to older adults, but also to those with mobility issues (temporary and permanent) and parents with prams.

The APS contends that ageing in place can be more readily achieved through increased investments in the infrastructural support mechanisms that support people remaining healthy, active and engaged in their local communities, than through focusing on the demand placed on those support mechanism for an ageing population. Therefore, from both a quality of life perspective and from an economic perspective, Government policies need to give greater recognition and funding to increase health, social and environmental support services – more than simply indexing their increase in line with ageing of the general population.

Recommendation 5: That the Productivity Commission redefine the concept of ageing in place as a broader concept of supporting older Australians to remain in their place of residence of choice with available health, psychological, social and environmental support.

Recommendation 6: That funding for support services (health, psychological, social and environmental) 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 placements into aged care facilities.

Workforce training and education underpinning reforms

Workforce issues are well canvassed in the Draft Report, particularly in relation to workforce training and education (Draft Recommendations 11.3 and 11.4). The aged care sector is not a workplace of choice for health professionals for all the reasons outlined in the Draft Report: poor remuneration, lack of access to professional development and poor career paths.

In addition to the existing workforce-related recommendations in the Draft Report, there needs to be a focus on healthy ageing embedded in the education and training of the health workforce, from entry level through to postgraduate levels and professional development in the workforce. Ageing needs to be viewed as a normal biological and psychosocial process, rather than the current view of ageing as a medical phenomenon where illness dominates. In focusing on healthy ageing, the APS would like to highlight two key issues: diversity and individuality. The APS supports the Draft

Report's findings of the increasing diversity of older Australians in their preferences and expectations including a greater desire for culturally relevant care, particularly relevant for many culturally and linguistically diverse and Indigenous communities. In particular, the APS supports improved funding, better skills training of staff, flexible service delivery models, culturally appropriate assessment tools and enhanced recognition of special needs in standards and practices as outlined by the Commission. It is also important to understand that older people from minority groups often experience obstacles constructed earlier in life that can become barriers to wellbeing later in life. In addition, it is important to understand how marginalisation functions *among* older minority groups such as Gay Lesbian Bisexual Transgender Intersex (GLBTI) people as well as considering the issue of marginalisation generally for disadvantaged groups. That is, one should not assume any disadvantaged groups are homogeneous. Individuality exists within these groups as it does in the wider community.

A coordinated approach to healthy ageing would address the issue of ageism inherent in the general community, including the health practitioner community. Ageism results in the tendency to see older people as all alike and to overlook differences between individuals (e.g. older people are a burden, growing older is associated with increased dependence and loss of self-control). Ageism impacts on health and community services and the aged care sector in a range of ways including the perceived attractiveness and status of aged care as an employment or career opportunity, the value placed on older clients, and decision-making about treatments and services. For example, research by Gatz and Pearson (1988) has shown that misconceptions about older people and ageing have been reported to affect professional decision-making, leading to a failure to attend to treatable symptoms. More recently, Helmes and Gee (2003), though they reported that psychologists and counsellors in Australia were able to correctly identify whether a person was depressed or not, also found that they displayed attitudes that were less favourable to the older person than the younger one (e.g. the older client was rated as being significantly less able to form a good therapeutic relationship, had a poorer prognosis and was less appropriate for therapy). These examples highlight the need for practices and policies that limit the adverse effects of ageist beliefs held by healthcare professionals – the same beliefs that need to be changed.

The APS supports the proposed establishment of the Australian Aged Care Regulation Commission (Draft Recommendation 12.1), as streamlining of regulations will ultimately benefit the community through improved service delivery and increased efficiency in operations. However, the APS believes that the proposed AACRC needs to have a liaison and coordinating role in relation to the aged care workforce, particularly given the range of stakeholders involved (e.g. Health Workforce Australia, Australian Health Practitioner Regulation Agency, universities, professional associations etc). This will minimise "silo building" between health workforce initiatives and those relating to the aged care workforce.

Recommendation 7: That the proposed Australian Aged Care Regulation Commission be tasked with an additional key function of liaising and coordinating workforce initiatives specific to the aged care sector with relevant stakeholders.

Allocative and structural efficiencies in aged care

The current aged care system is complex in both design and funding. These complexities result in inefficiencies in both the process and structural mechanisms of aged care services and their delivery. The Draft Report highlights many such inefficiencies, but most focus on the structural or funding element – indeed chapters 6 and 7 were devoted to this issue.

The APS agrees with the Commission's view that existing regulations in the aged care system need to be streamlined and harmonised, and that the proposed Australian Seniors Gateway Agency (Agency) can play a significant role in this process (chapter 12). Less obvious in the Draft Report is any focus on improving allocative efficiencies within the existing aged care sector. This was referred to, but not tackled explicitly, in chapter 10 (aged-friendly housing and retirement villages).

The APS contends that one area that can result in significant cost-efficiencies in the aged care system is the application of evidenced-based behavioural interventions for older Australians instead of, and/or in addition to, standard medical interventions and medications. In an Australian study led by a clinical psychologist (Bird et al., 2002), the effectiveness of medication (considered the "control" or "treatment-as-usual condition") was compared with psychological interventions (experimental group) for treating challenging behaviours commonly associated with dementia patients. Over the course of the trial, only one patient in the psychological intervention group was hospitalised (for a total of two days) compared with more than 20 per cent (total 93 hospital days) of a medication group (control). Drug side-effects were reported in 32 cases in the control group and 12 cases in the experimental group – a threefold reduction. Visits by general practitioners to deal with behavioural problems were reduced by half in the experimental group to an average of 4.5 visits compared with 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-psychotic medications in the experimental group and an *increase* in the control group. This study has since been replicated with similar results of increased overall cost-effectiveness of behavioural interventions through decreased reliance on medications (see Bird et al, 2007; and Bird, Llewellyn-Jones & Korten, 2009). Not only have psychological interventions demonstrated greater efficacy than medications in reducing challenging behaviours in these instances, they have also demonstrated effectiveness in situations where some challenging behaviours have been deemed "treatment resistant" to medications (Davison et al., 2007). There are numerous other examples demonstrating reductions in medical and overall costs associated with psychological interventions among older adults (Creed et al., 2002; de Jonge, Latour & Huyse, 2003; Fahrion et al., 1987; Gater et al., 1998; Gonick et al., 1981; and Schlesinger et al., 1983).

The issue of polypharmacy among older adults is significant, both in terms of financial costs and safety concerns due to side effects (including the added financial cost of managing side effect) (Mittal, 2011; and Sink, 2005). Decreased reliance on medications has the potential to increase efficiencies in the aged care system through decreased medication intake, reduced likelihood of medication errors and increased patient safety.

Other studies focussing on non-pharmacological interventions for people in aged care facilities and/or with dementia have reported efficacious psychological interventions that address some memory and learning problems (Camp et al., 2002) and neuropsychiatric symptoms of dementia such as disturbed perception, thoughts and mood (Livingstone et al., 2005).

These studies form part of an extensive review of the research literature regarding the effectiveness of psychological interventions for older adults. Please refer to Attachment 1 for a full copy of the literature review.

Recommendation 8: That the Productivity Commission examines ways to increase efficiencies within the current aged care system, particularly in relation to evidence-based non-pharmaceutical (psychological and behavioural) interventions.

Increase funding to deal with emotional and behavioural issues

The APS supports the removal of the current distinction between residential high care and low care places (Draft Recommendation 6.3). However, this removal must not be associated with any decrease in funding levels to residents in high or low care places. To the contrary, funding for residents of low care places should be *increased* in order to assist with the "ageing in place" of these residents.

Associated with the distinction between high and low care is the way in which care is assessed, classified and funded. The Draft Report recognises the frustration some providers experience when trying to use the Aged Care Funding Instrument (ACFI) for residents with behavioural and emotional support needs (p. 111 and pp.116-117). This mirrors the concerns raised by the APS in our initial submission to the Commission – "*if these (ACFI) 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*".

Emotional and behavioural issues, particularly those associated with psychosocial disturbances, are not well recognised and their treatment is inadequately funded within aged care facilities. In some circumstances, even experienced medical practitioners have difficulty assessing levels of pain and psychological symptoms of people with dementia (Cohen-Mansfield & Lipson, 2002). Getting it right first time will save time and money and will improve outcomes for everyone involved. Two reports by Access Economics (2009a, 2009b) suggest that the rates of dementia and demand for services within aged care facilities will increase significantly over the next 40 years. This will drive the demand for timely and accurate cognitive and psychological assessment, which will increase the overall efficiency of the aged care system. It has long been recognised that the incidence of psychological disorders is much higher among residents of aged care facilities than in the general community (Rovner et al., 1990). In addition, the presence of co-morbidities – the existence of two or more diagnostic disorders – is often the rule rather than the exception in long term care (Lichtenberg & Duffy, 2000). These factors underscore the critical interdependence between physical and psychosocial aspects of health and wellbeing among older Australians.

There have been several studies into the mental health status and wellbeing of older adults who are residing in long term care facilities. In one study, prevalence of any psychiatric illness was 76.3 per cent at admission to a facility (Wancata et al., 1998). Dementing conditions, depression and anxiety are probably the most common psychiatric conditions in nursing home residents (e.g. Smalbrugge et al., 2005a). Estimates of major depressive disorders range from 6 to 24 per cent of all residents, and for minor depression and dysthymia the estimates rise substantially to between 30 and 50 per cent (Hyer et al., 2005). Furthermore, co-morbidity with dementia is common (Hyer et al., 2005). Anxiety

symptoms have been estimated as occurring in approximately 30 per cent of nursing home residents (Smalbrugge et al., 2005b). One study in Australian aged care facilities has found the prevalence of depression was 32 per cent (Anstey et al., 2007). All of these prevalence rates are significantly above those found in older people living in the community. Researchers have suggested that risk assessment and targeting of intervention strategies to prevent and treat depression and anxiety in later-life and in residents of aged care facilities, in particular, should be a priority and should target improving functional capacity and wellbeing.

In order for the non-pharmaceutical interventions for older adults with behavioural and emotional disturbances outlined above to be effective, there must be adequate funding to identify such disturbances in a timely and accurate manner in the first instance. In the medium to long term, specific or targeted funding needs to be allocated so that older adults can have access to appropriate behavioural therapies in addition to services for their medical and physical needs.

Recommendation 9: That the Aged Care Funding Instrument (ACFI) be re-adjusted so that the behavioural supplement (BEH) subsidy will attract equivalent funding to complex health care supplements (CHC).

Recommendation 10: That any funding of aged care services must be aimed at maximising the health outcomes of consumers, based on the best available evidence, including targeted or "quarantined" funding for specific therapies and services.

Conclusion

Caring for older Australians has both economic and human factor dimensions. The APS is of the view that aged care policies and reforms incorporating the human factor dimension will have positive benefits for older Australians, both psychologically and economically and will also benefit the community. Consistent with this view, the APS demonstrated how human factors, such as the quality of life of older Australians, should be used both as a benchmark for assessing priorities of reform options and as an indicator for evaluating their successes. The human elements of aged care services require an emphasis on healthy ageing, ensuring no disadvantage and an active partnership between older Australians and policy makers. Finally, there is a need to recognise and support reform with adequate funding for evidence-based psychological interventions for older Australians.

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