12 April 2011

Caring for Older Australians
Productivity Commission
GPO Box 1428
Canberra City ACT 2601

To the Productivity Commission,

RE: CARING FOR OLDER AUSTRALIANS SUBMISSION

Thank you for the opportunity to contribute to the National Productivity Commission on Caring for Older Australians draft report.

Occupational Therapy Australia, the peak body representing Occupational Therapists believes that occupational therapists are uniquely positioned to offer professional insight into how the national aged care system can support the needs of Australia's ageing population.

Our members have identified the following points of feedback in relation to the Caring for Older Australians draft report:

Recommendations 10.2 and 10.2

Recommendations 10.1 and 10.2 are commendable and address some of the important issues in relation to Assistive Technology, including home modifications, that are important for supporting older Australians to continue living in their own homes. The discontinuity in the system for accessing assistive technology must be addressed as a matter of urgency. Accordingly, there are some notable omissions within these recommendations and the discussion within 10.1:

Long waiting periods for assessments

Occupational therapists who provide these assessments frequently work for health services, where lengthy waitlists exist in some states. A coordinated approach needs to remove this barrier as a matter of urgency.

Home Modifications

Where an older person resides in state run public housing, enormous difficulties can be experienced in accessing home modifications. These are due to local policies about the economic viability of providing home modifications in specific dwellings versus transferring the tenant to an alternative location.

Transfers are experienced as highly stressful by older people, and are declined with some regularity, leaving older people living in unsafe, inaccessible housing. Where a transfer is agreed to, it can take extensive periods (> 1-2 years) to locate an appropriate dwelling to transfer to.

Housing offices in some states do not always adhere to their own publicly available policy on home modifications, insisting on comprehensive occupational therapy assessments by state health service occupational therapists for minor modifications such as standard grab rails. This adds to waiting periods and leaves the older person at risk of falls, injury, disability and subsequent activity and participation restrictions.

Once modifications are eventually agreed to by Housing Departments, further extensive delays often occur in funding and providing these. The referring occupational therapist rarely receives appropriate communication about progress and spends much clinical time taking

enquiries and complaints from families frustrated with these delays, further compounding waiting periods.

Further complicating the process in public housing is the presence of asbestos in many dwellings in some areas. Where this is the case, a simple grab rail installation becomes a very expensive major modification, due to the safety requirements and policies in place to manage the associated risks. This often results in a decision to transfer rather than modify, adding to the extensive waiting periods for transfer to appropriate dwellings experienced by tenants of public housing.

Public housing must be considered as a special case and urgent attention must be paid to streamlining and resourcing home modifications processes for older public housing tenants.

Community Housing providers are a growing area of housing provision for older people on low incomes. Where dwellings are privately owned and leased to the tenants through this scheme, there is no obligation for the landlord to agree to any modifications. Community Housing operators in some areas appear uncertain of their ability to meet the needs of their tenants for accessible housing or home modifications. In areas such as the Blue Mountains in NSW, 100% of public housing has been transferred to Community Housing. This raises the question of how these tenants access required home modifications.

Clear policy and processes for managing this issue is urgently required as part of this recommendation.

This recommendation touches on, but needs to strengthen its focus on disability aids and equipment. Older persons in need of aids and equipment to support remaining in their own home experience lengthy waiting periods for assessments and difficulties accessing equipment funding, when they are unable to afford to purchase their own.

EACH and EACH-D packages include funding for equipment, but if the cost of provision of other elements of the care package consumes the allocated funds, the equipment is not purchased. Once assessed as eligible for EACH or EACH-D, state based equipment schemes can deem a person ineligible for their scheme, leaving the older person to wait an undetermined period before receiving their package, where that package may or may not provide for their equipment needs.

Outside of this issue is the often extensive waits for funding under state based schemes, once an occupational therapist assessment has been completed. Another problem is that low care residential facilities do not have funding to provide aids and equipment, and high care facilities struggle to stretch their budget to provide necessary aids and equipment. Both scenarios leave the older person at risk of falls and experiencing significant activity and participation restrictions.

It is imperative that there is a focus on streamlining access to aids and equipment, and to appropriately resourcing relevant programs to provide aids and equipment in a timely manner.

Home modifications and equipment should be assessed and prescribed together, as in everyday life they provide the package of adaptations that are required for safe performance of self care, safe mobility, access, and facilitate maintenance of activities and participation.

Chapter 11: Workforce Issues

Chapter 11, page 374 comments on the increased use of the allied health workforce through Medicare funding initiatives, however this assumes that there is a supply of multidisciplinary private allied health workforce in the region to provide this service. In the absence of private Allied Health services, the public sector (which may only employ a sole occupational therapist, physiotherapist or speech pathologist in regional areas who can also be the only health practitioner of that discipline in 400km) receive the referral and are expected to provide the service.

Also in chapter 11 and elsewhere in the report there is repeated mention of the various agencies/providers in aged care/community care/health/welfare/EACH/CACP/HMM etc. This reflects a metro centric view. In smaller or more remote communities there may be limited

provision of these services or there may be fully fledged programmes, however they may still be no allied health professionals employed within them and no private allied health workforce to draw upon.

Thus the allied health workforce is generally the only option to meet the service needs of the hospitals/community/clients in care programmes and/or residential aged care facilities. It seems that the report is presenting a summary of services available in a well resourced metropolitan area, without discussing the complexities in rural and remote locations beyond the allied health workforce shortage. These issues are amplified in regional areas. For example, the draft report seems implies the need to enhance multidisciplinary teams, however in regional areas, even securing a multidisciplinary team is difficult.

Home Maintenance & Modification Section

In this section it is mentioned that the Building Code of Australia / AS1428 is inadequate for home dwellings and aged care facilities. There is mention of being able to vary these requirements if the Council conducts an inspection but little mention of the fact that occupational therapists often vary from the standard based on clinical judgement due to restrictions of the environment and the person. Perhaps more emphasis is needed to be placed on the role of the occupational therapist who assesses and makes recommendations on these environments using their clinical reasoning, rather than on introducing more guidelines that builders can just "apply" without considering the person/environment match.

We hope that this feedback sheds light on how occupational therapy can support the lives of older Australians.

Yours sincerely,

Occupational Therapy Australia

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