



Australian Association of Gerontology

Submission to

House of Representatives
Standing Committee on Health and Ageing

Inquiry into Health Funding

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1 INTRODUCTION AND BACKGROUND

The Australian Association of Gerontology (AAG) has a broad multidisciplinary membership of academics, researchers, government administrators, service providers, consumers and others interested in the issues of ageing.

As people age they are more likely to require health care, not only acute care for sudden illnesses but ongoing care and monitoring of chronic conditions. The ageing of the baby boomers will increase the number of people who are 65 yrs and over during the next two decades. Improved life expectancy will also see the numbers of people aged 80 yrs and over doubling during the following two decades. The majority of those over 65 years are well and independent, often providing services to families and communities. The majority of those over 80 have complex health concerns and rapidly increasing levels of disability. Towards the end of life, for many older people health care and aged care needs become integrally linked.

2 DEFINING THE HEALTH SERVICES NEEDED FOR AN AGEING POPULATION

The provision of quality health services is a fundamental right of older people. As a general principle, all older people in Australia should have access to planned and properly resourced integrated quality health care that is flexible, equitable, accessible and affordable, that recognizes diversity and promotes choice and respect for users.

The challenge of a truly effective health care system for older people is firstly, to promote a longer period of healthy active life, with extension of our (non-disabled) life span; and secondly to provide world class healthcare for the frail aged, disabled and those with chronic and complex conditions. The aim is to develop a model system of health care for the increasing numbers of older people in Australia, which gives the best care for the older person, in the best setting, using best practice to achieve maximum physical and mental capacity and minimum disability.

The AAG believes that consideration of mechanisms for funding and delivering health services cannot be considered in isolation from broader considerations as to just what quality and type of service is to be delivered. Decisions about the type of services which are to be delivered and the quality and quantity of each such service must underpin subsequent determinations about how they are delivered or who pays.

The AAG strongly supports the AHMAC goal that “there is an adequate supply of basic services to ensure a timely response to older people’s needs when their health deteriorates and social support networks weaken”. AHMAC lists basic services as including:

- Rehabilitation and geriatric management services, both inpatient, outpatient and community
- Specialized health programs that help older people stay independent in the community longer

- Home support services, particularly Community Aged Care Packages, Extended Aged Care at Home and the Home and Community Care Program
- Residential aged care services
- Respite services
- Palliative care services
- Psycho-geriatric services.

This list while comprehensive is not complete, since a full framework for health care for older Australians should also consider access to primary health care, including nursing, allied health care and GPs and should also acknowledge that there must be adequate access to acute hospital care when needed.

The essential elements of the model are:

1. An affordable and accessible primary health care service which ensures that all older people have access to GPs or other service providers as needed, and does not rely on acute hospitals to fill gaps in service availability. This will require ensuring there are sufficient primary health care providers to meet growing needs, plus a system for ensuring that primary health care services can reach those with limited mobility. This service must be well integrated with acute, residential care and community services.
2. Community and care centred services, which provide to older people the nursing, allied health and personal services needed to allow them to stay at home as long as possible. Adjuncts to this service are carer support services, respite care, day care/therapy facilities. Fundamental to the success of these services is an elder friendly built environment, which would require an integrated and interdisciplinary approach from acute hospitals, RAC, government and independent providers.
3. Hospital community interface programs including as far as possible post acute care services and “hospital in the home or nursing home” type services that may avoid unnecessary hospital admissions or reduce length of stay. It should include also a specialist support network, which is integrated with all care settings and is able to provide support for GPs and patient review and assessment.
4. An efficient quality residential aged care health system (RAC) for frail older people no longer able to reside in the community. This must be integrated with hospital outreach services to prevent avoidable admissions. Residents must have access to primary care, rehabilitation, or palliative care as required.
5. An acute hospital system, which has the capacity and skills to manage complex older patients. Adjuncts to the hospital service must include adequate subacute/ rehabilitation places. The acute system must adapt to the growing older population by integrating specialist gerontic care into hospital activity, initially at the point of entry (usually through ED), but also by providing trained gerontic staff and/or specialist advisory services in other areas of the hospital.
6. A sustainable and responsive workforce that reflects the changing health care needs and required interdisciplinary approaches to care.

3 REHABILITATION AND SUBACUTE CARE

Subacute and rehabilitation beds need to be increased to meet expected demand. To the extent that these beds promote discharge back home rather than to residential care, they will prove successful. While typically provided in hospitals there are many complementary models of service delivery for rehabilitation. However, where patients are cognitively impaired, changes of residential environment or surroundings should be minimised.

Often highlighted as a prime area of concern for cost shifting, most “Nursing Home Type Patients” (NHTP) in hospital beds are in smaller rural hospitals rather than major metropolitan hospitals. While there will be an on-going need for transitional beds, especially as the effectiveness of rehabilitation programs improves, the demand for Transitional Care beds and units should not distract the government from the primary role of providing sufficient Acute Care and sub-acute rehabilitation for complex older people.

4 TERMS OF REFERENCE

(a) Examining the roles and responsibilities of the different levels of government (including local government) for health and related services;

The Australian Association of Gerontology notes the difficulties that are sometimes encountered in patient care because the division of responsibilities between service providers is not always clear. This may sometime lead to gaps in available services, to patients being shifted between services or to duplication of services.

Perhaps the biggest problem for the patients is the confusion that can occur when there are several service providers. For older patients, particularly if frail and unwell or if dementia has begun, the objective should be to minimise disruption and to reduce the need for moving between care settings.

The Australian Association of Gerontology is strongly supportive of an increased role for local government in service delivery, since this level of government is better able to interact at the community level and can be both responsive to local needs and directly accountable to the consumer. However, the Australian Association of Gerontology stresses that all services provided must be well integrated. This may require some creativity, in terms of community services, where local government areas are small geographically, or do not have the population base, to provide adequate aged care services

(b) Simplifying funding arrangements, and better defining roles and responsibilities, between the different levels of government, with a particular emphasis on hospitals;

The way the health system is funded cannot be divorced from the overall health framework and the range, quality and accessibility of the services provided. The Australian Association of Gerontology is concerned about current service delivery arrangements where there is opportunity and incentive for providers to shift care costs as people move between care settings. The current Commonwealth/state divide discourages good use of services, since funding source depends upon condition classification rather than patient need. State funded hospitals have incentive to discharge patients to commonwealth funded residential care facilities, while residential care facilities have an incentive to place ill residents in acute hospital care if additional staffing or care is needed.

This is particularly evident where people move between residential care, usually Commonwealth funded and acute hospital care, which is state funded. As problematic as this is already, the lines are becoming even more blurred and funding interfaces more complex as the Commonwealth increases its role in providing community support for older people through CACP and EACH packages, while at the same time there is an extension of (state funded) hospital type services provided in the home and in nursing homes. Scope for cost shifting, or in many cases, duplication of services can be expected to increase when there are multiple agencies delivering services to the same person or same location.

There will be an increased need for multidisciplinary geriatric services, which will include specialist geriatricians, psychogeriatricians, gerontic nurses and a range of specialist allied health professions to support general practitioners in their delivery of primary health care in the community. Whatever funding or administrative models for service delivery is selected, it will be essential that the full range of multidisciplinary services is delivered to the patient/consumer, preferably while still residing in their own homes. Essential ingredients will be:

- a system for co-ordination of services
- a system of tracking service delivery and
- a system of patient monitoring and follow up.
- A funding system that supports the continuum of care
- A system for review of quality and efficiency of service provision

The AAG believes that whatever funding model is adopted for management of health care, especially the care of older patients, it must recognise the vital role played by the acute sector. Although the AAG accepts the principle of avoiding hospital admissions wherever possible, through provision of quality and timely primary care or home delivery of services, it must still be accepted that older people will always form a large portion of the hospital population. Currently people over 65 represent 35% of admissions and 49% of total acute hospital bed days. These proportions are set to increase as the share of the population over 65 increases and will become even more apparent as the share of the population aged more than 85 increases. A well-staffed acute hospital sector where most staff has training in management of older patients must remain the core of the health service. There are many possible models for determining just how the acute hospital sector interfaces with other health care settings, especially in the delivery of health services to older people. However, the AAG stresses that the acute hospital is likely to be the most appropriate location for a number of essential services, which also extend into the community, including specialist geriatricians and gerontic nurses. Community hospital extension programs operate in many places and have typically proved successful where the acute sector provides a central hub of expertise. In the future residential care could also be expected/ supported to diversify services and may provide more sub-acute services and even triage to reduce the extent to which older people are left on trolleys in ER.

(c) Considering how and whether accountability to the Australian community for the quality and delivery of public hospitals and medical services can be improved;

The AAG notes that accountability in health care is usually best achieved when the service provider has a direct relationship with the consumer. In general community, based services prove more accountable than large centralised institutions, especially for on-going care needs. However there will also be a place for centralised services providing specialist expertise.

As already stated it is first necessary to determine what is to be delivered and develop benchmarks for service quality and delivery. This is an essential element of ensuring accountability especially to ensure that services meet rigorous professional standards.

It is however, also recognised that accountability against inflexible benchmarks may result in reduced diversity of service providers and in some cases increased cost. There is no simple solution but the use of outcome determinants to measure the overall health and well-being of consumers may provide accountability while still maintaining scope for innovation and diversity in practices.

(d) How best to ensure that a strong private health sector can be sustained into the future, based on positive relationships between private health funds, private and public hospitals, medical practitioners, other health professionals and agencies in various levels of government;

The AAG recognises that effective service delivery requires co-operation between both public and private service providers. In particular, it stresses the important role for primary care providers and the need to integrate these (generally privately provided) services with the acute health sector.

(e) While accepting the continuation of the Commonwealth commitment to the 30 per cent and Senior's Private Health Insurance Rebates, and Lifetime Health Cover, identify innovative ways to make private health insurance a still more attractive option to Australians who can afford to take some responsibility for their own health cover.

The AAG has no specific comment on the role of health insurance in payment for medical services.

Investigation of options such as long-term care insurance as is available in countries such as Japan or the Netherlands is encouraged and could well be an option in the future, allowing most older people to fund or partly fund their long-term care needs.

AAG notes however that the greatest need for health care will come for most towards the last years of life. It is probable that for many, even those who have made provision for retirement income, these health costs will come at the same time as income levels drop, either because scope for working or supplementing income has reduced or because annuity levels have dwindled with the passing years. Expected increases in longevity are likely to decrease the scope for self-funding of health care.

It is probable therefore, that scope for self-funding of health care, especially for those at the end of their lives will be limited. A core public health service in hospitals and community, for the cognitively frail and mobility impaired oldest-old (typically those over 85), will be required to complement private health care provision.

5 CONCLUSION

The AAG recognises that the question of long term funding for health care is of very great importance to the wellbeing of older Australians. As the share of the population who are over 85 increases, there will be rapid growth in the need for health services. This will include personal and health services to support the chronically ill, frail or

cognitively impaired aged. It must also include access too acute hospital care when needed.

The current funding system is far from ideal with discontinuity between state and Commonwealth services. Reform of funding is needed. However AAG stresses that funding decisions must be made in the light of first understanding the quality of services needed for a dignified old age.