



**AUSTRALIAN AND NEW ZEALAND SOCIETY
FOR GERIATRIC MEDICINE**

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

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Dear Sir,

Re: Caring for Older Australians: Productivity Commission Draft Report, January 2011

The Australian and New Zealand Society for Geriatric Medicine commends the Productivity Commission on this comprehensive document and as a significant stakeholder in Aged Care, we welcome the opportunity to respond to it. We believe the many recommendations are generally in the right direction. They offer older Australians significant reform to the aged care sector which ideally will provide seamless, integrated, accessible, affordable, appropriately assessed, individualised, high quality, equitable, and adequately funded care for our citizens, supported by sufficiently remunerated, appropriately educated and adequately numbered staffing as we face the challenge of an ageing Australia towards 2050.

In general, the link between health care and aged care is pivotal to the provision of appropriate, affordable and high quality aged care across the continuum. Integrated geriatric services must be part of this service to ensure care is only instituted when all diagnostic efforts have been undertaken to assess symptoms and functional decline and restorative and rehabilitative efforts have been undertaken. Only then can sustainable care be accurately prescribed.

With regard to specific numbered sections and recommendations we make the following comments.

1.

8.Care and Support

Recommendation 8.1-8.2.

The proposals listed have the potential to liberalise the market in aged care, deregulate to stimulate competition and drive increased choice for consumers.

- As in much of the report, vulnerable aged persons with dementia are given limited consideration, especially given the predicted major increase in sufferers by the year 2050. More specialist geriatric and psycho-geriatric services need development to cater for these people's complex needs both at home and in RACF's.
- Those with dementia have limited capacity for choice and need appropriate surrogate decision makers. It is not clear how these aged persons with impaired capacity and no designated power of attorney will access the system proposed which depends on intact personal autonomy or a designated power of attorney. Existing state based "guardianship boards" will need increased staffing especially with specialised staff, such as geriatricians, psycho-geriatricians and neuro-psychologists to provide the complex assessments required.
- The mechanics of assessment at entry ie the Gateway, to the new system are not clearly enunciated and need development if fair and equitable access is to be achieved.
- Management of demand is not clearly set out to deal with waiting for suitable accommodation in acute and sub-acute hospitals, especially if places are uncapped and it depends on a package of money. Affordability in this situation has not been addressed.
- Aged persons must have access to a rehabilitative restorative approach based on accurate diagnosis rather than the potentially erroneous choice made by the aged person, family or carer, of high levels of assistance or residential level of service, without adequate assessment and management. Unless recovery where possible is an imperative, overuse of services in a resource constrained environment will lead to queuing for the service and or blow-out of expense.
- The integration between the aged care and health, as well as mental health and disability services must be strengthened. The assessment process needs linking with specialised geriatric services with links to rehabilitation beds to ensure this approach is carried out before entry to long term care. The relationship between state and federal assessment services should ensure no duplication of assessment to avoid wasting money, staffing and resources.
- Aged care services need to be funded in such a way that they are not penalised, when they take a restorative approach. Innovative funding models such as aged care services taking a restorative approach receive a financial incentive, when a person no longer needs a service because they have received training to care for themselves. Moderation of demand at low levels of disability will result. Severe disability and advanced dementia will obviously not benefit by this approach.
- Transition care is not explicitly discussed and needs to be aligned with and complement the state run rehabilitation and geriatric, evaluation and management (GEM) services. Integration of services must be the goal to avoid duplication, competing for clients and wasting of resources.
- Respite services both in the community and RACF's need more resources both staffing and monetary to ensure individualised, realistic, flexible and timely delivery of care, especially for dementia sufferers who wish or their families wish to remain in their own homes.

- The proposed decrease in regulatory demands on providers will need monitoring so that quality of care is not undermined and statutory oversight then fails to protect vulnerable older especially demented people from neglect and exploitation.

2.

8. Care and Support Recommendation 8.3

The relationship of quality end of life care to aged care needs careful consideration. Linkages to specialist state funded aged care and palliative care services must be forged, strengthened and appropriately funded. Payment arrangements for this service need further discussion. For example, a fee for this service must encompass the whole support system including phone support services, multidisciplinary care and on-site nursing advice and counselling. Enabling an elderly person to die in their home or RACF, after all their home, should be the right of all aged persons, supported by their relatives and friends, but implies the ability to deliver the most appropriate, adequately resourced, educated and skilled nursing care to the dying person, supported by palliative care specialists or geriatricians. Over-use of acute care services can then be avoided, if the care has been appropriately anticipated and delivered in the home or facility.

3.

8. Care and Support Recommendation 8.5

Similarly, in-reach services delivered to aged persons in their home or RACF has the potential for preventing inappropriate admissions to acute care institutions, improving quality of life and improving economic considerations. Delivery of this type of care must be supported by adequate assessment, which may include that provided by skilled geriatric nursing and specialist geriatrician involvement as well as general practitioner, pharmacist and paramedical support. Importantly it should not replace appropriate, properly assessed need for acute care in hospitals, just to "keep aged people out of acute care" or risk ageist delivery of care with the potential for poor quality care with less than ideal outcomes.

4.

11. Delivery of Care to the Aged- Workforce Issues Recommendations 11.1-11.4

The society applauds the premise of more training of all associated with aged care including managers, general practitioners, medical under and post-graduate students, paramedical personnel and nursing in both community and residential aged care facilities at all levels and ideally should be extended to support services of ambulance, police and volunteer staff. Geriatric medicine and aged care must be seen as core training for all under-graduate medical students. This will promote aged care as a worthwhile specialty and will improve quality care. Promotion of the specialty, geriatric medicine will increase the number of trainees who will then be able to provide specialty services increasingly to general practitioners and in RACF's, community centres, ACAT's or at the Gateway proposed, to ensure accurately assessed need for services. The establishment of academic and training aged care facilities will be a wonderful

innovative step to ensure delivery of well researched, evidence based quality care.

5.

12. Regulation -the future direction

Recommendation 12.9

As already mentioned the importance of Advance Care Planning , Enduring Powers of Attorney and Guardianship matters is paramount to delivery of appropriate care across the board to aged persons especially those with dementia. It needs separate consideration away from infectious disease outbreaks, occupational Health and Safety, food safety and nursing scope of practice. There is an urgent need for Commonwealth legislation to ensure consistency across states and removal of "erroneous and inconsistent regulations". Specialist geriatricians are uniquely placed to act in an advisory role as well as offering expertise in capacity assessment, where needed for example in the construction of Enduring Powers of Attorney and wills.

We hope these comments will be found useful to the Commission in constructing the report to be released in June, which holds such promise in delivering better quality care services to our ever increasing aged population. We have found being involved in the process invaluable in developing improvements in the way specialist geriatricians deliver their services across the aged care continuum, emphasising the integral relationship with delivery of world class health care to this population. We look forward to being involved in subsequent deliberations to address the multifaceted complexity of service delivery to older people.

Yours sincerely,

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Chair Clinical Issues Sub-Committee
ANZSGM

Dr Craig Whitehead
Chair Finance and Administration Sub-Committee
ANZSGM

Dr Jeff Rowland
President ANZSGM.