

Feedback on the Draft Report – Caring for Older Australians

Presented to the Productivity Commission

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Australian Physiotherapy Association

The Australian Physiotherapy Association (APA) is the peak body representing the interests of Australian physiotherapists and their patients. The APA is a national organisation with state and territory branches and specialty subgroups. The APA corporate structure is one of a company limited by guarantee. The organisation has approximately 12,000 members, some 70 staff and over 300 members in volunteer positions on committees and working parties. The APA is governed by a Board of Directors elected by representatives of all stakeholder groups within the Association.

The APA vision is that all Australians will have access to quality physiotherapy, when and where required, to optimise health and wellbeing. The APA has a Platform and Vision for Physiotherapy 2020 and its current submissions are publicly available via the APA website www.physiotherapy.asn.au.

Background

The Caring for Older Australians Draft Report provides a comprehensive blueprint for the financing, governance and organisation of aged care into the future. The APA supports all the key recommendations made by the commission in particular those where older Australians would:

- contact a simplified 'gateway' for a range of services including: easily understood information, assessments of care needs, assessments of financial capacity to make co-contributions, entitlements to approved services, and care coordination — all at a regional level;
- receive a flexible range of care and support services that meet their individual needs and that emphasise, where possible, restorative care and rehabilitation; and
- choose, where feasible and appropriate, to receive care at home or in a residential facility and choose their approved provider

However, the APA is disappointed that while many of our concerns were identified as issues that impact on the wellbeing of older Australians few specific recommendations were made to address them. In addition, the different Allied Health Services have not been separated within the report; mostly this is appropriate but at times there is a need to identify more clearly how older Australians' care needs will be addressed by the individual professions: Physiotherapy, Podiatry, Occupational Therapy, Speech Therapy, Psychology and Dietetics.

Many of the APA's recommendations relate to client care, financing and provision of appropriate physiotherapy services for older people, and professional issues for aged care physiotherapists. It is hoped that the final report builds on the systems level picture presented in the Draft Report and addresses more practitioner level concerns related to client care.

The APA's Concerns

Funding barriers for physiotherapy for aged care recipients

The APA is pleased that the Productivity Commission recognised the significant funding barriers that limit access to physiotherapy for older Australians. However, few recommendations were made to address these issues. In our original submission, the APA outlined the following concerns regarding funding for physiotherapy in aged care:

- Inadequate funding for management of chronic health conditions through Medicare (Chronic Disease Management- CDM) items
- Use of a medical gatekeeper for Medicare CDM items and demanding administrative constraints for this program.
- The funding of RACFs through the Aged Care Funding Instrument (ACFI), that financially rewards RACFs when residents become less independent and therefore acts as a disincentive for RACFs to offer physiotherapy services.
- Emphasis in the ACFI funding model on passive physiotherapy treatments for pain relief.
- Lack of incentives for implementation of chronic disease management strategies (e.g. exercise groups in RACFs)
- Lack of a broad framework for physiotherapists to make their own decisions about the amount of care provided to residents of RACFs.

With regard to the Medicare Chronic Disease Management (CDM) Funding and Aged Care Access Initiatives for Allied Health Services, both these programs suffer by the model of service delivery employed. All RACF residents are assessed by ACAT for entry as having complex and chronic health needs but the Medicare CDM program is limited by having the GP as its' gate keeper. The GP's role seems redundant in this case. This system needs to be expanded so that there is the opportunity to provide meaningful services to this complicated group of clients. More intensive episodic therapy for community clients and RACF residents needs to be considered rather than the current five treatments per year under the CDM model.

The Aged Care Access Initiatives funding is directed through the Divisions of General Practice and despite providing services that might otherwise be lacking; the nature of the program hasn't allowed appropriate service provision of the required mix of allied health. For example, in one area in NSW the facilities particularly identified physiotherapy services as their preferred need but as funding was initially only granted for 6 months it was impossible to recruit a physiotherapist to this role. If the RACF had been allocated the funding they would have had a better chance of employing their own physiotherapist or increasing the hours of the one already employed. These types of arrangements don't address the needs for community clients.

Recommendations

The APA is keen for the Productivity Commission to provide recommendations to the Australian Government regarding these significant funding issues so that aged care recipients can receive appropriate levels of physiotherapy.

We recommend a funding model where:

1. Physiotherapists, collaboratively with their clients, are able to make decisions about their clients' therapy needs. These decisions should not be constrained by inflexible funding models and unnecessary administrative barriers - such as the requirement for a referral from medical professionals.

This could be encompassed within the "gateway" system recommended by the Commission.

2. Treatments carried out in RACFs are evidence based and not prescribed (either directly or by implication). Physiotherapists are independent and accountable primary contact practitioners who should be able to manage their patients according to their best clinical judgment.

This would be in keeping with the spirit of the reforms suggested by the Productivity Commission, where many regulatory restrictions (e.g. on bed licences and accommodation payments) have been removed. Unnecessary regulations regarding funding of client care should also be relaxed. If all care services provided by aged care providers are to have prices set, a fair price for early intervention, rehabilitation and physiotherapy services must be included.

3. RACFs are rewarded for funding innovative approaches to client management such as active treatments, rehabilitation and chronic disease management strategies that promote independence for residents where possible.
4. The model of service provision is reviewed so that affordable and accessible services are provided to older people where they reside. The funding should go either as directly as possible to the client to pay for the service; or to the provider to deliver the service. A similar model to the original Day Therapy Centre model would improve the access however services need to be time limited and intensive and based on assessed need. Due to workforce restrictions, GPs often find it difficult to service RACFs.

Allowing the physiotherapist working in the RACF to initiate the treatment, without the requirement of a medical referral, would ensure better access to care for the resident.

When physiotherapists are part of the RACF core team they are able to provide high quality multidisciplinary management.

5. The scope of practice of physiotherapists is expanded and advanced clinical roles are developed to provide primary health care in the most appropriate and timely way to older clients.

Rehabilitation and Early Intervention for Older People

The APA is pleased that many issues surrounding the need for older people to access rehabilitation and early intervention programs has been addressed but is disappointed that the Commission has failed to recommend mechanisms by which these problems can be solved. It is important to reiterate that a person's needs for rehabilitation and early intervention strategies do not necessarily stop when they enter a high care facility or become recipients of aged care in the community.

The APA notes that the Commission has recognised some of these concerns and placed restoration and rehabilitation under "specialised care" in its building blocks model. Not all aged care recipients require these services but they should be available when they are deemed appropriate. However, the APA would like to see these principles placed at the core of services provided to older people in the final report. Early intervention is vital for optimising health and function of older people, helping them to stay at home and reducing the need for other services.^{1 2}

The need for older people to be offered the opportunity to improve their function via restorative therapy, rehabilitation or re-ablement programs is a key finding in the report. These services enable people to remain in the community, have increased options and quality of life, and to utilise less services at all levels up to and including high residential care.

There needs to be a concrete plan to address this issue. At every point of entry to services the opportunity needs to be given for people to access affordable time limited (e.g. 6 to 12 weeks) rehabilitation to address their assessed needs. Conditions that have great potential for reversal such as incontinence, pain, muscle weakness, poor balance, and breathlessness, need to be treated to promote a better quality of life and ability to manage more independently.^{3 4 5 6 7 8} Too often decline in ability is put down to increasing age and so accepted where it often has a large component which can be reversed with a short intensive program of targeted rehabilitation.

This service would need to be domiciliary and centre based; as well as provided in residential facilities to maximise efficiency. In-reach services to residential aged care are an excellent means of providing specialised physiotherapy services such as continence physiotherapy and vestibular physiotherapy but RACF residents are best served by a well trained gerontological physiotherapist to be part of the core team of the RACF. RACF residents often miss out on rehabilitation in hospital because it is assumed that the RACF will provide this service. Sub acute services need to be funded and provided within aged care facilities; this is more economical than adding services in hospital but also it is more appropriate for rehabilitation to be provided in the resident's familiar environment. Intensive short term rehabilitation is at present expressly excluded from the Approved Care and Services that RACFs must provide for both high and low care residents. Community clients also require physiotherapy as a core service as it is critical for them to continue to manage more independently if they are to stay in the community.

Day Therapy Centres were originally designed to "prevent premature or inappropriate admission to residential aged care" and were able to provide a range of therapies including physiotherapy, to improve the ability to function, treat pain, and manage a range of conditions such as incontinence, Parkinson's disease, strokes and chronic respiratory conditions. This program was never a "respite service" as mentioned on page 351 of the Draft Report⁹ but was always about "Therapy". Successive governments have ignored this program and it has been a no growth program since 1987.

A program similar to Day Therapy but better targeted could be set up to provide both the domiciliary and centre based services for community dwelling people to have short episodic treatment focussed on functional outcomes and to review the level of support services required.

Recommendations

That the Commission make the specific recommendations that:

1. The provision of low intensity, longer term physiotherapy is made for frail older people.
2. Rehabilitation is available, when appropriate, for older people who live in residential care when they have been admitted to an acute hospital.
3. Recommendation 8.5 be expanded to provide higher level specialist services into RACF and community as well as providing intensive short term rehabilitation (6-12 weeks) against a background of maintenance therapy provided by physiotherapists who are part of the core team.
4. In-house services in RACF be expanded to provide sub-acute rehabilitation and Community Programs to also have in-house rehabilitation. Specialist physiotherapy services should be part of the regional or locally-based visiting multidisciplinary health care team to provide higher expertise and advice to these core physiotherapists. The sub-acute rehabilitation could be funded under a case mix model as suggested for Palliative care (page 261, PC Draft Report).
5. In residential care, therapy services ideally need to be provided by on site therapists who are part of the team and know the resident rather than visiting private contractors. Where private contractors are employed, they need to be given opportunities to engage with the aged care team as much as possible. RACFs should be rewarded (and funding provided) for quality practice that integrates visiting professionals (e.g. handovers for visiting staff). This is particularly important in residential aged care. This level of professional support will encourage more integrated care for aged care recipients and a better work experience for visiting physiotherapists
6. A program similar to Day Therapy but better targeted could be set up to provide both the domiciliary and centre based services for community dwelling people to have short episodic treatment focussed on functional outcomes and to review the level of support services required.

Professional Barriers for Physiotherapists in Aged Care

Draft recommendation 11.3 includes provision of advanced clinical courses for nurses to become nurse practitioners and management courses for other workers entering management roles. There is very little opportunity for career development in the aged care environment but it is vital that the sector attracts, retains and develops the skills of many different staff in order to meet the health needs of this complicated and vulnerable client group. Although it is recognised that nurses are not the only discipline required, there is little information available regarding the allied health workforce. The qualifications of the aged care allied health workforce vary. A recent study has shown that 17.95 have no post school qualifications, 36.9% had a Cert III in aged care, 17.55 had a Cert IV in aged care and 8.7% had nursing related qualifications.¹⁰ This demonstrates that the workforce being described as allied health encompasses many groups and probably contains physiotherapy aides, physiotherapy assistants, recreation officers, diversional therapists, physiotherapists, occupational therapists, speech pathologists and others. It is impossible to plan for the needs of a workforce whose make up you do not know. Older people need to have services provided by appropriately qualified allied health professionals. If treatments are to be delegated to other unqualified staff, they must be directly supervised and trained to safely and effectively carry out those tasks.

Gerontological physiotherapists are an important group of professionals who are much needed in the sector and have very poor career opportunities. The APA is disappointed that professional issues for physiotherapists were not addressed in the Draft Report. There are now APA Titled Gerontological Physiotherapists and a pathway exists to become Fellows of the College of Physiotherapists in Gerontology. These physiotherapists have considerable expertise in aged care.

Aged care physiotherapists (and physiotherapy assistants working in the sector) are often professionally isolated and have inadequate access to appropriate supervision and professional development. While important issues such as financing and governance of the aged care system have been addressed by the Productivity Commission, it is equally important that recommendations are made that will encourage health care professionals to want to work in aged care.

The APA is pleased that the Commission recognised the clinical needs of physiotherapy students and recommended the expansion of the “teaching aged care services” initiative to include allied health students. The APA encourages the Commission to include similar workforce recommendations in the final report to increase funding for physiotherapy professional development and supervision in aged care.

Recommendations

We recommend that:

1. Incentives are developed to encourage physiotherapists to seek work in aged care.
2. RACFs to be rewarded for quality practices that integrate visiting health professionals into the aged care team;
3. Funding for physiotherapy professional development and supervision in aged care;
4. Physiotherapists who become Fellows of the College of Physiotherapists should be recognised as specialist physiotherapists and have direct referral rights to Geriatricians, Orthopaedic Specialists and Neurologists;
5. All physiotherapists should be able to access the Medicare CDM scheme to treat without a GP referral;
6. Physiotherapists should be able to refer to other physiotherapists under the Medicare CDM scheme. These changes will encourage more community clients and RACF residents to receive the services that are needed and provide a more defined career progression to keep experienced therapists in the workforce;
7. The facilitation of skill development through expansion of funded courses to promote high quality therapy as traditionally physiotherapists have had to self fund all their professional development.
8. Physiotherapy Assistants Cert IV to be included in all programs to fund training for the industry to enable more safe and appropriate delegation of tasks.

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