Office use only:

National Health and Hospitals Reform Commission

Submission Cover Sheet

Please complete and submit this cover sheet with your submission to:

By email: talkhealth@nhhrc.org.au
By mail to: PO Box 685 Woden ACT 2606

A. Details of the person or organization that prepared this submission

Date of submission: 13 June 2008

Who prepared this submission?
☐ Individual ☐ Organization

For individuals:

Name of individual: ?_____
Street address: _____
Mailing address (if different from above): _____
Phone (daytime): _____
Fax: _____
Email: _____

For organizations:

Type of organization. (Please tick all that apply)
☐ Consumer group
☐ Government agency
☐ Private company
☐ Professional body
☐ Other non government organization
x☐ Other (Please specify) _National Umbrella Stakeholder Organization_____

Geographic focus of organization. (Please tick all that apply)
☐x Nationwide
☐ Statewide (Please specify State/Territory) _____
☐ Metropolitan
☐ Rural / regional
☐ Remote

Office use only:

Please specify the particular sector focus of your organisation (if applicable).
Ageing and Aged Care

Purpose/s of organization. (Please tick all that apply)
☐ Research
☐ Education
☐ Service provision
☐x Advocacy
☐ Other (Please specify) _____

Name of representative: Rod Young
Position within organisation: Member
Name of organisation: National Aged Care Alliance
Street address: 3/28 Eyre St Kingston ACT 2604

Mailing address (if different from above): PO Box 4239, Kingston, ACT 2604
Phone (daytime): 02 6285 2615
Fax: 02 6281 5277
Email: office@agedcareassociation.com.au

Please note that in making a submission you agree that it may be made public.

B. Response to draft principles

☐ This submission specifically comments on the draft principles developed by the Commission to shape Australia's future health system. (Please tick if this applies)

C. Response to key themes x
This submission specifically responds to the following key themes taken from the Commission's Terms of Reference. (Please tick all that apply)

☐X A greater focus on prevention to the health system
☐ x Improving frontline care to promote healthy lifestyles and prevent and intervene early in chronic illness
☐x Improving Indigenous health outcomes
☐ x Integrating and coordinating care across all aspects of the health sector, particularly between primary care and hospital services around key measurable outputs for health
☐ x Improving the provision of health services in rural areas
☐X Integrating acute services and aged care services, and improve the transition between hospital and aged care

Office use only:

☐X Reducing inefficiencies generated by cost-shifting, blame-shifting and buck-passing
☐x Providing a well qualified and sustainable health workforce
☐x Maintaining the principles of universality of Medicare and the Pharmaceutical Benefits Scheme, and public hospital care
Maximising a productive relationship between public and private sectors
Providing a more seamless experience across public and private services
☐x Providing advice on the framework for the next Australian Health Care Agreements (AHCAs), including robust performance benchmarks
☐x Addressing the escalating costs of new health technologies
☐x Increasing access to services
☐x Addressing the growing burden of chronic disease
☐X Providing for an ageing population
☐x Managing the escalating costs of new health technologies
☐ xAddressing overlap and duplication including in regulation between the Commonwealth and states

☐ Other (Please specify) Assistive technologies, housing social fabric_____

NACA members

Aged Care Association Australia
Aged & Community Services Australia
Alzheimer's Australia
Anglicare Australia
Australian Association of Gerontology
Australian General Practice Network
Australian Healthcare Association
Australian Medical Association
Australian Nursing Federation
Australian Pensioners & Superannuants Federation
Australian Physiotherapy Association
Australian & New Zealand Society for Geriatric Medicine
Baptist Care Australia
Carers Australia
Catholic Health Australia
Continence Foundation of Australia
COTA Over 50s (Council's on the Ageing)
Diversional Therapy Association of Australia
Geriaction
Health Services Union
Legacy Co-ordinating Council Incorporated
Liquor, Hospitality & Miscellaneous Union

Office use only:

Lutheran Aged Care Australia
OT Australia
Palliative Care Australia
Pharmacy Guild of Australia
Royal Australian College of General Practitioners
Royal College of Nursing Australia
UnitingCare Australia

Office use only:

NATIONAL AGED CARE ALLIANCE

SUBMISSION TO THE NATIONAL HEALTH & HOSPITALS REFORM COMMISSION

INTRODUCTION

The National Aged Care Alliance is an umbrella representative body of thirty stakeholder organizations with constituents drawn from ageing, aged care, seniors housing, retirement living consumer groups, unions, providers and professional groups.

The Alliance have been meeting for six years and as a broad umbrella representative organization has proved highly successful in garnering the collective view of most stakeholder entities with an interest in ageing and aged care and being able to provide a consensus view across a substantial number of policy issues that impact upon this industry in the broad.

This submission endeavors to be a collective view of the Alliance representative organizations and has used for the format for this submission the twelve challenges set out in the Commission's April 2008 report 'Beyond the Blame Game: Accountability and Performance Benchmarks Australian Health Care Agreements'

The Alliance has endeavored in this submission to highlight issues that we feel are of particular importance to Australia's older residents with particular emphasis on the interface between primary, community, residential and acute sector services.

The Alliance recognizes the difficulties that the system faces with various levels of Government responsible for financing and policy setting frameworks. The Alliance believes therefore that the Review allows The Commission a unique opportunity to initiate reform of the Australian health and hospital systems.

NACA stakeholder organizations believe that the current system has some real weaknesses and that a rapidly ageing population placing greater demands on the overall system will create significant stressors which will further exacerbate workforce capacity at a time when peak optimum efficiency will be required system is going to meet both the service volume requirements and the community expectation of quality.

Finally, the Alliance would like to include an additional three challenges in its submission which we do not believe is adequately covered by the twelve challenges included in the initial report.

Office use only:

The first additional challenge relates to the deployment of assistive technologies particularly those with a capability to enhance staff and system performance and those capable of sustaining individual independence especially in a person's private residence.

The second additional challenge is housing and the link between housing affordability and health and well being.

The third additional challenge relates to the creation of community capital and the impact this has on the health and well being of the individual.

Office use only:

1. Closing the gap in Indigenous health status

Residential long term and community long term care services are often an integral part of the care regime available to indigenous communities. However, often the integration of these services with the other health and community care programs are disconnected and unable to maximize available public resources.

The Alliance is cognizant of the very significant difference between the average life expectancy in Aboriginal and Torres Strait Islander communities and that of mainstream Australia. NACA is also aware of the need to provide services and programs which are sensitive to local customs and needs and that best meet the requirements of a local community. These are often difficult to deliver within funding programs and government policy frameworks which are capital city centric and are often structured for mainstream service models that then require exceptions to be made for indigenous communities trying to provide local specific services to meet local specific need.

The Alliance believes that it should be much easier for the various funding silos to be captured into a universal budget for local community use and that centralized management and quality systems need to be changed from the outset to recognize the required flexibility to meet local service needs, in other words, rather than introducing centralized regulation and systems requirements, it would be more appropriate to start from a position of what does a local community require to meet its needs and structuring a service contract across the continuum of care with that community covering multiple programs rather than trying to squeeze local service delivery into an overall framework that then requires some specific exemption or exclusion to meet the original program design.

2. Investing in prevention

The Alliance is of the strong view that prevention goes across the age continuum. It is as important for a sixty five year old to recognize the benefits of preventive health measures as a ten or twenty year old.

In an ageing environment it is essential that prevention messages surrounding diet, exercise, regular health checks and reduction in negative activities such as alcohol and tobacco consumption are significant contributors to the medium to long term health status of the individual.

3. Ensuring a healthy start

Entering old age, the Alliance believes in a healthy and robust state is as important to the long term health of the Australian care system as a system that ensures the health status and longevity of a new born.

Indeed, the Alliance is of the view that the current Australian demographic in some respects should put even greater emphasis on the need to ensure older people are fit and active physically and socially engaged to ensure maximum health and vitality during their remaining years as it is to ensure access to substantial pre or postnatal care services.

4. Redesigning care for those with chronic and complex conditions

The Alliance believes that the current system of service delivery for persons with chronic and complex conditions is an extremely confusing mix of multiple silos and programs which often make it difficult for a long term or chronic disease sufferer to either know about or to access the services that are currently available.

A glance at the complex web of service arrangements for a chronic disease sufferer quickly emphasizes the need for simplification and aggregation of programs and funding sources to ensure that it is the needs of the individual that are being met not the needs of funding program accountabilities.

As a very large component of servicing long term and chronic conditions occurs in the community, there is, we believe, a significant deficiency in the Commission's Report in failing to recognize the importance and place of programs such as Commonwealth funded community aged care packages and state managed home and community care programs in servicing the needs of long term care.

Both these programs are of fundamental importance to the care and servicing of the elderly, particularly those in need of long term support to meet chronic or complex conditions, but are often not factored into considerations of the broader health and welfare of the individual with a continuing focus on mainstream primary health and acute health services.

The Alliance believes that there are some key characteristics of solutions that need to be considered by the Commission and has listed below a number of these under this heading, as we believe that future service delivery must have a greater focus on individual service requirements and silo removal whilst being integrated and able to provide continuity of care. These should be community focused, responsive, accessible and flexible whilst providing choice to the client, family and any voluntary carer involved with the objective of achieving efficient and effective service outcomes.

Solutions:

a. One stop shop community-based health and wellness centres with co-located ambulatory, primary and community health and support

services.

This type of model has been proposed in a number of reports: although there are variations in the models being proposed in terms of the breadth of the services that should be co-located, the common concept is bringing together GPs and other health professionals to work in community-based multidisciplinary teams. For example:

- "A new Approach to Primary Care for Australia" Doggett, J. 2007. Centre for Policy Development
  Recommends that Australia's health system reform should focus on the roll-out of integrated Primary Health Care Centres across Australia in which a broad range of health professionals are paid to manage the overall health of the local population including pre- and post hospital care, plus screening, education and other preventive health services.

- "New Directions for Australian Health – Delivering GP Super Clinics to Local Communities". Australian Labor Party, 2007.
  Outlines Labour's commitment to reinvigorate Australia's primary health care system by establishing these facilities where GPs and other health professionals come together and work in multi-disciplinary teams that can focus on both the prevention and management of chronic disease.

- "Directions for your health system – Metropolitan health strategy: Ambulatory care services" Department of Human Services, Victoria, 2003.
  Their strategic direction includes the development of community-based ambulatory services which are co-located and/or integrated with other services, such as community health centres, to improve continuity of care, maximise limited staffing resources, reduce professional isolation and enhance service organisation and coordination. The result will be health precincts where all relevant state government health and human services programs are brought together with local government, non-government agencies and private providers to meet the needs of the local providers.

- Curtin Health Innovation Research Institute - Concept Plan: Curtin University of Technology, 2008
  The proposed health and well being centre would co-locate primary and ambulatory care in a university based precinct providing the opportunity of research whilst at the same time providing health and well being services to the community and a centre of excellence for inter-disciplinary professional training. The foci of the centre would include: health promotion, primary prevention and early intervention; the management of chronic disease; community-based rehabilitation; and, interdisciplinary service models.

While supporting the concept of these centres, the Alliance would like to underscore that it is essential that:

- home care providers are also co-located at these centres and are included in the multidisciplinary teams responsible for providing services to older people

- there is a greater emphasis on inter-disciplinary working within the context of the multidisciplinary team both as a more efficient use of scarce resources but also as a way of ensuring greater continuity of care for the individual. A successful example of this way of working is provided by Silver Chain's Independence Teams. Such an approach needs to be supported by ongoing training and routine case discussions by the whole team, and eventually by the adoption of an inter-disciplinary model for professional tertiary training such as being developed at Curtin University of Technology as part of the Curtin Health Innovation Research Institute. The extension of this education/training model to all health care/support workers such that early course/modules are designed to provide the basic knowledge and skills required by all workers and professionals such that individuals completing different numbers of courses/modules are equipped to work at the different levels of responsibility and specialty within the health and aged care system.

- home care is recognised as providing an ideal opportunity for early identification and intervention as well as ongoing health promotion. Silver Chain research has found a high prevalence of depressive symptoms and loneliness among older home care clients, both are known to be associated with an increased likelihood of the development of further disability, residential care admission and poor health status. Routine screening together with early non- pharmacological interventions to assist individuals to improve the quality of their lives and reconnect with the community would be possible within the context of multidisciplinary teams, and coverage could be extended by the health professionals working in an interdisciplinary way and training non-professionals to deliver these types of interventions.

  Home care workers often visit people several times a week over an extended period and develop significant relationships with their clients. As a result they have the potential to assist individuals to adopt behaviours and lifestyles that can maximise the person's chances of staying well and healthy as they continue to age. The provision of more opportunities to home care workers to learn about healthy ageing and how they might help their clients help themselves may not only increase the likelihood that they will pass on health promoting messages to their clients but may also significantly effect their own behaviour which in turn will increase their effectiveness as health promoters through becoming role models.

- Hospital avoidance and Post hospital discharge programs should be delivered by community rather than hospital-based providers

b. Casemix funding for aged and community care across the spectrum of care needs

The current unit cost base funding model in community care promotes task centred care which has been demonstrated to promote dependency rather than independence. With the increased acceptance that we need to change the current service model within community care to one that more actively involves the client and promotes independence and well being, it becomes increasingly essential that the funding model be changed to one that is consistent with capacity building and independence promotion. Package funding allows for flexibility and matching the support to an individual's needs. Two package levels are however insufficient to cover the range of needs. A casemix funding model which has sufficient classes to describe the whole spectrum of needs across both community and residential care is required.

c. Integrated use of hospital beds and surgical facilities across public and private sectors

Public hospitals with waiting lists for elective surgery should be able to purchase the services and beds required from the private sector. In return private sector patients should have access to rehabilitation services in the public sector.

The majority of our ageing population which is rapidly expanding will continue to live in their own home until their death at home or acute hospital or spend only their last years in residential care. Flexible, coordinated, accessible, person-focused community care will thus be an imperative for quality of life, health maintenance and management of complex chronic medical conditions. This is a necessity if world class medical care across the continuum can continue to be delivered to our ageing population.

The Alliance believes provision of adequately funded community care should be an entitlement, not limited by availability. This allows the elderly to choose to remain at home, but have access to seamless health care provided by GP services, community nursing care and appropriate acute hospital care for serious episodes.

Timely return home after acute hospital stays must be supported by adequately resourced programs such as post-acute geriatric rehabilitation, transition care, home delivered personal and health care and access to in-home and residential respite, as well as access to permanent residential care.

This ensures appropriate use of high cost acute hospital care for what it is designed; especially in the ever increasing demand for world class high technology evidence based medical care. Community support must be an ever evolving program to ensure maintenance of autonomy, fostering independence and limiting dependency.

5. Recognise the health needs of the whole person

The Alliance considers that the needs of the whole person of whatever age should be the focus of any health or care program that aims to improve the health and well being of the individual.

Often a person's social or spiritual environment can be as important to that person as their medical status. Health professionals are sometimes challenged by an individual's priorities and stated needs when these may be at odds with someone else's norms.

In addition, normalization of life within a care setting can often be highly beneficial in the provision of the maximum benefit to the individual. Whether it is the perceived benefit of taking as much of the institution out of the institution or maximizing the care deliverable options in a person's home it is essential that health and care services wherever possible be delivered in the most humanely sensitive environment.

6. Ensuring timely hospital access

For the elderly, hospitals are particularly unhealthy places due to the high incidences of cognitive impairment and the systemic pressures within hospitals to comply diagnostic related group service timeframes which often are inadequate and unresponsive to the recovery needs of ageing care recipients. The Alliance would recommend that a significant program of education occur with the objective of retraining many hospital based health professionals about the needs of the elderly and provide some recognition regarding the capacity and disease management peculiarities of the older patient.

At the same time, the Alliance strongly supports the need for the older person to have access to acute services when the need arises.

However, this requirement needs to be closely managed with a strong emphasis being placed on the admission discharge planning of the individual with maximum emphasis being placed on the post recovery phase particularly post recovery outside of hospital and how this can best be managed.

System responsiveness (including flexibility)

The interface between the various service access points of hospitals, community services, aged care providers and social support systems is crucial to the

achievement of system responsiveness and continuity of care. We need to shift our focus from responding only to health breakdown and providing short and long-term expensive remedial care and treatment, to working with individuals and groups to preserve health and functionality. While ever the expectation is that people fend for themselves until they suffer illness and then bring their health problem to a hospital for treatment which may or may not be successful, the level of morbidity and disability within the community will continue to rise.

System flexibility needs to be re-introduced to hospital services so that the number of people, old and young, who have to travel to hospitals for treatment can receive high standard care and treatment closer to their homes or places of residence. Obviously these recommendations have resourcing implications and a shift in power structures within hospital services.

7. Caring for and respecting the needs of people at the end of life

The current experience of end of life care in Australia is disparate and inconsistent. People at the end of their lives cannot reliably access care that is both customised to their preferences and delivers good symptom control. While some patients experience quality needs-based care, the reality for others is one of fragmented care that fails to acknowledge their care preferences and, too often, delivers insufficient support to meet social, emotional and physical needs at the end of life. Our health care system can do better.

The Alliance agrees with the Palliative Care Australia (PCA) submission finding that good strategic planning around the management of the terminal phase of life promises better care for people at the end of life, and will also help alleviate the ongoing crisis around access and demand management in the health system, through a more effective and efficient use of services and the prevention of unwanted and unnecessary hospitalisations.

Linking existing resources and systems to provide mechanisms for coordinated care will achieve much better service integration and thus continuity of care.

Supporting the home as a meaningful choice for end of life care

Hospitalisation is often an inappropriate option for many people at the end of life. In many cases, adequate care can be more effectively and efficiently provided in the place of residence without the risks to patients implicit in hospitalisation.

Supporting dying-in place promises to better meet the care needs and preferences of people with terminal conditions, and to save unnecessary demand for, and expenditure on, hospitalisation and associated transitions.

Supporting the home – however described – as an appropriate place of choice for end of life care will require a re-prioritising in resource distribution to support enhanced access to coordinated community care services through a range of integrated services including: Medicare Benefits Schedule (MBS) items to help

ensure affordable in-home access to a multidisciplinary team of care providers including allied health professionals; enhanced access to pharmaceuticals by adjustments to Pharmaceutical Benefits Scheme (PBS) prescribing criteria to remove barriers to general practitioners and other primary care providers prescribing appropriate, affordable pain and symptom management drugs; increasing access to in-home support, including access to 24/7 on call support and support for carers; increasing access to respite care; and increasing recognition of and service development for post-death bereavement care for families and carers.

Supporting aged care homes as a meaningful choice for end of life care

The Alliance notes that supporting aged care facilities to work towards policies of adequately resourced dying in-place will require aged care facilities to be additionally resourced to provide appropriate palliation, pain and symptom relief.

This will include: appropriate access to general practitioners, nurses who can administer opioids, and to palliative care specialists; access to PBS-subsidised medicines for residents of aged care facilities; development of agreed and consistent referral and access criteria to specialist palliative care services; structuring and resourcing specialist palliative care services so that they are able to provide care and provide consistent support for primary health care providers in this setting; and options for coordinating management of pain and symptom relief pharmaceuticals through e-prescribing and tailored quality use of medicine software packages.

A valued workforce

To achieve quality care at the end of life, it is vital to address workforce education and shortages by increasing education and training opportunities in end of life care and palliative medicine for health and allied health care workers, and ensuring that workforce development plans for residential aged care facilities include end of life care needs.

Shortages of adequately skilled health workers across all care settings are central to current limitations to broad access to needs-based palliative care at the end of life. Inadequate links to, and resourcing of, specialist palliative care services compound the difficulties in ensuring that care needs are met.

The Alliance agrees that there is opportunity to begin addressing deficiencies by:

- promoting and valuing quality care at the end of life skills in health care staff working across all health care settings, including through the incorporation of end of life care into the core curricula of health and social workers, and as a fundamental component of continuing education for health and social service providers;
- increasing educational opportunities for clinical staff to develop or further skills

to support the provision of quality care at the end of life;

- developing and creating additional funded education and training opportunities in palliative care across Australia in nursing, medicine and allied health;
- working to ensure a sustainable workforce by attracting staff and health professionals to work in palliative care through competitive remuneration and conditions;
- facilitating health care services to support working practices that allow staff to most effectively use their skills to provide quality care at the end of life, including dedicating sufficient time to patients and their carers;
- ensuring workforce development plans for residential aged care facilities are established that are inclusive of end of life care needs, and recognising the necessity of ensuring access to health professionals who are qualified to prescribe and administer pain and symptom relief medications; and
- recognising the role of the volunteer workforce in community and service based end of life care.

Advance care planning

The Alliance supports end of life planning as a way to improve the circumstances of dying. Advance care planning provides the opportunity for people's care preferences to be clearly articulated and to enhance their choices and control over their care at the end of life. However, advance care plans are currently poorly understood by the general public, implementation can be ad hoc and piecemeal, and adherence is not guaranteed.

Unnecessary hospitalisation and failure to respect people's care preferences are potentially avoidable through planning for future care that is done in a considered way involving the person, their care team and, optimally, their family, carers and loved ones.

Broader application and implementation of advance care planning will require greater awareness and knowledge among treating practitioners to support the development of advance care plans, greater coordination across and among service providers to support the effective implementation of advance care plans, and enhanced community understanding of advance care plans.

Keys to achieving greater implementation of advance care planning include:

- a nationally coordinated communication plan to enhance community understanding and generate the community will to commit to integrating advance care plans into end of life care in a considered and sensitive way; and
- education for healthcare practitioners across settings to increase awareness of advance care plans and to aid their development, identification and

implementation.

8. Promoting improved safety and quality of health care

The Alliance would support the contention that the Australia health care system needs to have a strong focus on systemic quality improvement and maintenance to the full extent of the service delivery within the system.

In aged care settings there is a need for enhanced research to advise health professionals and aged care providers on the best practice service models based on solid evidentiary research.

9. Improving distribution and equitable access to services

In designing a system capable of recognising the needs of people across their lifespan, and in building the capacity of such a system to adequately meet this array of needs; several ideals need to be stated at the outset to establish a shared values basis upon which intersectoral collaboration becomes possible.

Therefore in envisioning the future for a system that will promote health and well-being, intervene in situations of health threat or breakdown, protect those unable to fend for themselves, and build capacity within the system to meet anticipated future needs, certain assumptions are made:

a. The context and focus of care is shaped by where a person lives rather than where a person has to travel to for services.

b. Individual choices about care and services must be realistic however demand management involving standardisation of options to a limited range of pre-determined options is the antithesis of choice.

c. A responsive system of services is needed to allow for real choice between services that can adequately meet the needs of people as they traverse their life stages.

d. To achieve efficiency and effectiveness, different parts of the health and hospital system need to work in tandem not competitively or in duplication of effort.

Integration not fragmentation or silos; better access and seamless access (continuum of care)

Given the assumption that health and hospital services are set up to respond effectively to the needs of people who make contact with these services; and that people will make multiple access points across a range of services depending on their needs; several issues concerning system efficiency and service credibility emerge. These are:

Efficient communication throughout the health and hospital system is now possible. From the person's viewpoint health and hospital services funded by government form an entity which is assumed to be internally connected and integrated. Information given and treatment received at one access point should

be able to be known and acted upon by all other system access points the person may decide to visit. Information technology has now achieved a level of sophistication that can support the integration of health and hospital information while at the same time preserving the privacy and confidentiality interests of the person accessing services. It is time to reintroduce the notion of a 'smart card' which the person holds and takes to each health or hospital access point, including pharmacies, which will link centrally to an information repository held for that person. In this way the control of the information is retained by each person and is activated by their choice of service which they may choose to vary from time to time. They would no longer be locked into a service that controls their health and hospital information.

A culture change is needed among hospital and health staff, especially clinicians and managers, to reduce the formation of organisational barriers which hamper effective communication and create pockets of resource scarcity or glut. If the current aged care industry is to be subsumed into the 'health' concept then changes to the illness-focused culture of hospitals will need to occur along with a dramatic re-think on resource allocation. The majority of older people are living in the community but as they age their need for various support services will increase and if not available, will result in illness leading to hospital treatment. As the Australian demographic profile moves further towards a more mature population the cost of social health care will increase. Inevitably more funding will have to be transferred from the remedial or hospital health system to the social care and support services as well as strategies to prevent health deterioration.

Government policy on resourcing health and hospital care will also have to undergo a substantial redesign. By breaking down established fortifications around hospital resourcing, opportunities for devolution of resources and services to community and primary care locations become possible. New funding models for hospital and non-hospital services to the general community as well as vulnerable groups will impact on the quality and sensitivity of services; who works in these services; and eligibility criteria for access to particular services. Some of the funding currently allocated for illness treatment will need to be redirected to social care and support services which reduce the need for illness treatment in hospitals. Across all of these service points there needs to be a focus on reducing waste and duplication as well as a redefinition of traditional professional roles and responsibilities to allow for skill-mix change and reductions in professional turfism.

10. Ensuring access on the basis of need, not ability to pay

The Alliance would certainly support the contention that health and care services across the Australian care continuum should be available to the Australian community based upon assessed need as opposed to ability to pay.

That said however, the Alliance would also contend that service capacity is often enhanced where the overall system expects some greater contribution from

those who have a capacity to pay, hence expanding the resource capacity of the system overall for the good of the broader community.

The Alliance would therefore be supportive of a system that though maintaining universal coverage does have the flexibility to have co-payments or some other contribution made by those who have a financial capacity to make some further contribution beyond the taxpayer funded regime.

Older people in particular, need specific arrangements to ensure that their access to services are guaranteed and that they are able to access the full range of services from often limited resources.

Ninety percent of residents entering long term residential care are either full or part pensioners which means the capacity of this group to expand their purchasing of anything beyond a publicly funded universal care program is extremely limited. Often the only resources available to this group is the family home and it is accepted public policy that that be protected to ensure appropriate housing for a spouse or partner before any call might be made upon that asset.

The Alliance believes that there is a need to maximise the choices available to the older person and in order to achieve that it may be necessary to look at additional funding sources to support the long term care needs of older Australians.

The Alliance is of the opinion that an examination needs to be made as to the place in the Australian long term care system for long term care insurance or specific preserved provisions within the superannuation guarantee fund which can only be accessed by individuals after the age of seventy or specific provision within Government programs for age related specific care services beyond an agreed age such as all persons over seventy years.

The Alliance believes that with the significantly ageing demographic profile of the Australian population over the next twenty five years, the enormous pressure that will be placed on the broader health and related service programs will unless specific provision is made for care services for the elderly, lead to the likely rationing of those services with the rationing having a particular impact upon the needs of the elderly.

11. Improving and connecting information to support high quality care

The pilot currently entering Phase 2 in the Northern Territory demonstrating the effectiveness of ePrescribing is an excellent example of the systemic improvement capable with the appropriate application of information technology. The ePrescribing pilot in the Northern Territory Phase 1 clearly demonstrated significant benefits to both the serving medical practitioner with a fifty percent decrease in time spent on prescription documentation management using the

electronic system and enhanced satisfaction and outcome results from both the community pharmacy participant and the aged care facility.

There is ample evidence within both the community setting servicing the elderly and long term care setting servicing the elderly of poor documentation and client transfer resulting in diminished care outcomes, increased staff anxiety and significant inefficiencies because information, diagnosis and particularly drug regimens are not available in a timely fashion.

In the residential care system alone, it is estimated that there are five hundred and forty million medication administration events per annum. Medication administration errors are one of the major issues of quality performance that creates adverse outcomes for long term care recipients and drives often extremely inefficient processes undertaken by staff in order to avoid drug administration errors.

There are now electronic administration systems which though not being one hundred percent foolproof are very close to one hundred percent foolproof by integrating the identification of the drug, the resident, the root of delivery and the timing starting with the initial GP generated prescription and automated delivery from the pharmacy dispensing operation to the long term care facility.

12. Ensuring enough well trained health professionals and promoting research

The Alliance is very conscious of the need for strategies to improve the workforce capability of health and care professionals to be able to deliver adequate service volumes and service quality into the future.

Community care providers are already striking considerable difficulty in recruiting sufficient staff but more particularly to be able to ensure staff operate in a safe and secure environment. Community care service provision is recognised as a workplace environment that cannot be controlled by the employer as it is a person’s individual home and the risks associated with a variety of components of home based care servicing are difficult and often impossible to manage.

In the context of providing services in such a setting, employers are struggling with both attracting and retaining sufficient staff but also providing an adequate and secure workplace environment for those staff to maintain appropriate safety.

In long term residential care, the difficulties are different and mostly relate to the workforce skills shortage that is currently impacting the whole health system.

The Alliance believes that there is a need for a substantial in-depth workforce strategy to be developed for the overall health and care systems for the next 30 years which will outline the current industry capacities and enable adequate

planning for training and recruitment of sufficient health and care professionals in the future. The Alliance is of the view that such a strategy should canvass all options that may meet the future workforce needs of the Australian health and care environments.

13. Additional components of a new Australian care system

13.1 Information and communication technologies (ICT) to enhance care delivery

The Alliance is of the view that the Commission's Report has a strong focus on electronic enablement of clinical health records and other clinician based information transfers.

The Alliance believes however this issue needs to be far broader and that we need to consider extending Medicare rebates or some other funding methodology to enhance the capacity of individuals to procure a range of assistive devices and information and communication technologies which will support those individuals in either managing their health services or managing their independence in their own home environment.

A significant range of devices are already available and the next two decades will see that capacity, sophistication and deployment capability of devices quadruple. These devices will allow individuals to substantially monitor their own health diagnostics with recourse had to health professionals only when a regular visit is required or the system alerts the health professional to a diagnostic indicator outside of pre-set parameters.

Assistive technologies such as height variable kitchen benches and sinks will enable many long term disabled and wheelchair bound persons to provide an enhanced domestic environment for themselves by being able to perform domestic tasks previously provided by voluntary or paid carers.

Centralized call monitoring services and video monitoring applications will enable a variety of devices to guide individuals in undertaking self diagnostics or reminders for medication administration or provide video contact with a health professional who can carry out a visual check and electronic verification of diagnostics and or interview the client face to face.

All of these systems are currently available, the difficulty for the Australian health and care environment is without Government grants access to them by the individual is often prohibitively expensive or system delivery capability from service providers is variable and intermittent and often based in a small number of metropolitan locations.

The Alliance believes that the Commission should take a bold step and look into the future and recommend to Government that either direct funding or a review of the Medicare rebate schedule be undertaken with a view to enhancing the capability of the system to provide these types of devices and services to persons suffering from long term chronic diseases, many of whom are in the older age group.

13.2 Housing

The Alliance believes that housing is an integral part of the health regime for any person. Without adequate and appropriate housing the health impacts for an individual are significantly diminished.

We recognise that the Commission's charter is primarily focused on improving the Australian health care system however, we would like to highlight that housing cannot be ignored in the consideration of improved health

13.3 Community Social Capital

The Alliance is also cognizant of the impact upon the wellbeing of the individual by virtue of their place and role in their local community. Though the Alliance recognises that the Commission's function is to focus substantially on potential improvements in the Australian health care system, we do not believe that any consideration of broader health outcomes can ignore the ramifications for the individuals' health and wellbeing if they are disconnected from their local community.

Community and social capital within the local community setting are essential ingredients to maintaining the health and wellbeing of the individual. Creating that environment and recognising its interconnection with the overall health status of the community is, we believe, essential to the long term positive health outcomes for any community.