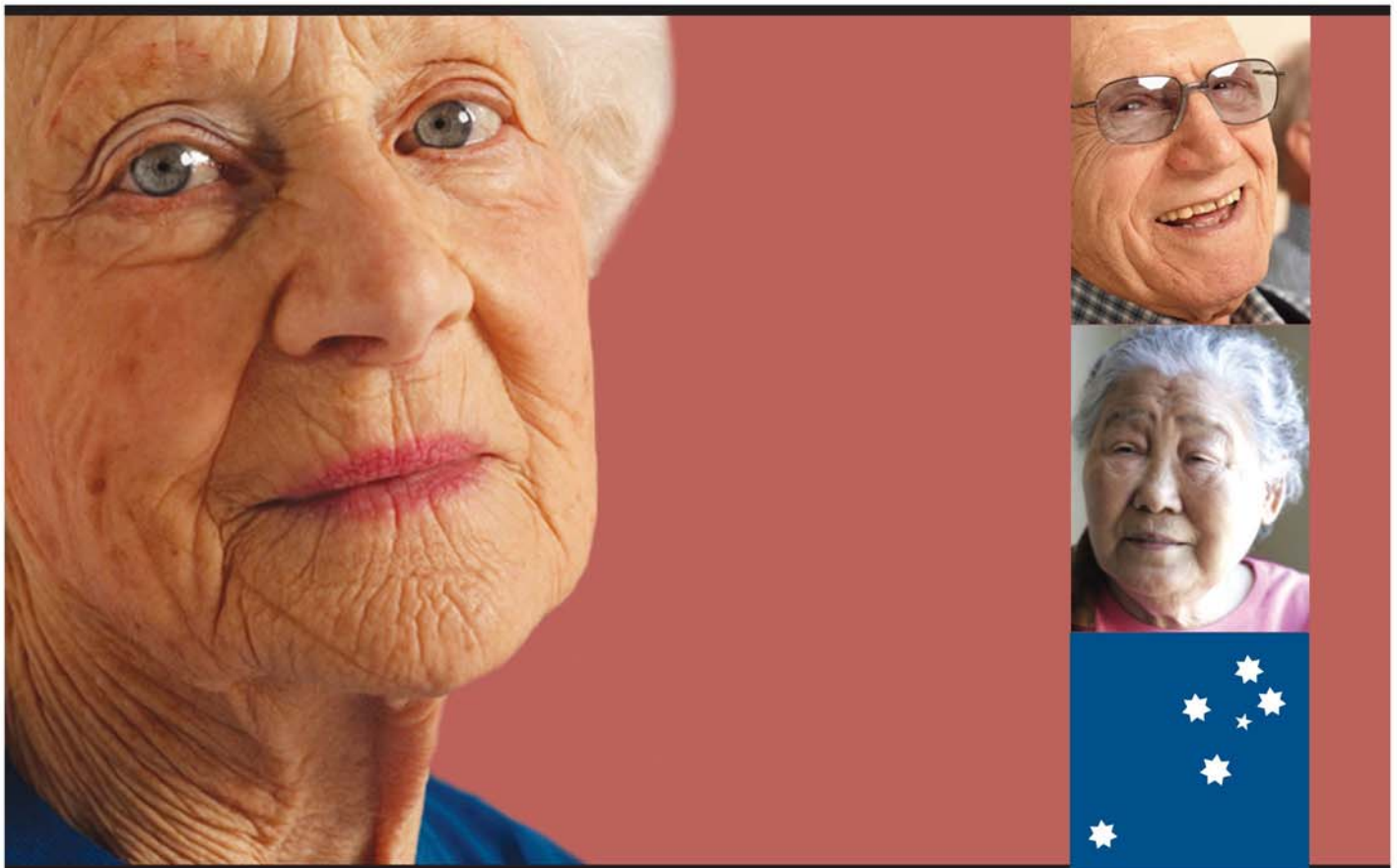


New Directions for older Australians

Improving the transition
between hospital and
aged care



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Introduction

The health and wellbeing of older Australians is of paramount concern to us all.

While older Australians today generally enjoy greater independence and better health than their parents and grandparents, they are more likely to require acute hospital care and in some cases, residential aged care at some stage of their lives.

But too often problems arise at the interface between hospital and residential aged care – resulting in older Australians spending more time in hospital than they need to.

For older Australians and their families the decision to enter residential care is a difficult life transition, and waiting weeks or even months for a bed makes this all the more distressing. It also means that much needed hospital beds are not available to Australians of all ages waiting for surgery or medical treatment.

As the proportion of our population aged over 65 increases into the future, this issue will touch the lives of an increasing number of Australian families.

In the current breakdown of responsibilities between the different levels of government in Australia, the States and Territories manage the acute hospital system while residential aged care is funded solely by the Commonwealth.

These divisions and the narrow scope of the current Australian Health Care Agreements between the Federal and State and Territory Governments, do not aid the transition of older Australians from acute settings to residential aged care. In addition they fail to prevent aged care residents ending up in hospital Emergency Departments for treatments which could be better delivered in the residential aged care setting.

The failure to bridge the divide between the two forms of care for older Australians is a classic example of the blame game between the levels of government.

There are adverse consequences for everyone: for the frail, elderly person, for public hospital patients whose access to needed services is restricted by the lack of available beds, and for overall costs and efficiencies in the health and aged care sectors.

A Rudd Labor Government will tackle these issues through decisive action where responsibility lies with the Commonwealth and fostering better cooperation where responsibility is shared, resulting in a better system of care for older Australians.

Federal Labor has already announced two New Directions health papers:

- ***New Directions for Children's' Health and Development*** details Labor's plans for a *Healthy Kids Check* when children are starting school, the development of a *Healthy Habits for Life Guide* for parents, and the national roll-out of the Australian Early Development Index
- ***New Directions: An Equal Start in Life*** is a \$261 million down-payment on Federal Labor's commitment to closing the gap in Indigenous and non-Indigenous life expectancy at birth.

Labor has now announced ***Fresh Ideas, Future Economy: Preventative Health Care for families and the Economy*** which sets out the economic case for greater investment and reform of primary health care and the prevention of chronic disease.

This New Directions paper, in seeking to improve the interface between hospitals and aged care, builds on Labor's commitment to improve health services for all Australians.

The current problem

The current delays in helping older Australians move from acute hospital settings to aged care stem from our failure to use the Australian Health Care Agreements – the major health agreement between our levels of government - to provide some continuity of care and dignity for frail older Australians.

It is also the product of unaddressed problems within the residential aged care planning system.

The Australian Health Care Agreements

The Australian Health Care Agreements have now been in place for more than 20 years. During this time significant changes have occurred in clinical practice, the organisation and delivery of health services and in the type of health care that is required by Australians of all ages.

Despite this period of considerable change, Federal and State and Territory funding arrangements have remained largely unchanged. Today these agreements which determine the type and level of health care people receive reflect historical practice rather than contemporary models of care and clinical practice.

The rules governing payment for health services at the interface between hospitals and other locations of care are rigid, often failing to provide patient centred systems and solutions. The existing agreements have only one performance indicator on which funding is contingent - a commitment by State and Territory Governments to provide free public hospital inpatient services at an agreed level.

In April 2002, a Joint Statement by the Federal and State and Territory Health Ministers acknowledged that previous negotiations had focused more on health funding than on health outcomes.

The Statement recognised the long history of 'buck-passing' between States and Territories and the Commonwealth. It provided some hope that the long blame game between levels of government in many areas of health care, particularly in the delivery of quality services for older Australians, might finally be at an end.

The Ministers developed a framework for a cooperative approach to the 2003–2008 health care agreements, with a focus on the provision of best care and health outcomes and with jurisdictions working cooperatively to advance community health and well-being.

To this end, they decided the agreements should, for the first time, contain a statement of principles, objectives and proposed outcomes. They also decided that work should be organised around a health continuum across preventive, primary, chronic and acute care.

There was to be a particular focus on improvement of the interface between aged and acute care. Unfortunately none of the proposed reforms found their way into the 2003-08 Australian Health Care Agreements.

Ultimately, the regular politics of Commonwealth-State policymaking intervened to thwart a more reformist agreement covering areas of care where Australians feel they are most caught between service systems.

In addition to the constraints of a narrow hospital-focused set of health agreements, the Federal Government imposed financial constraints.

Between 2000 and 2005 the Federal Government reduced its share of the cost of running and maintaining public hospitals from 50% to 45%.¹ State and Territory Governments have picked up the shortfall, which now totals \$1.1 billion per annum.

The Federal Government has delayed initiating negotiations for the 2008-13 AHCA's. This means the opportunity to use the agreements as cooperative tools for improving the efficiency of the healthcare system and health outcomes for the Australians who use that system may again be lost.

Frail aged Australians and their families have the most to lose from narrowly focused health care agreement making. They are far more likely to need an acute hospital bed and would benefit greatly from the ability to move between hospital and home or aged care with few disruptions or delays.

However, because these movements occur across traditional funding boundaries, the various levels of government have an interest in seeing them spend more time in someone else's services.

Worse, neither bureaucracy seems to display any interest in ensuring older Australians return home or to an appropriate aged care facility in a timely way.

Better defining the health and aged care boundaries may assist, but ultimately only national leadership and a determination to prioritise people's health and quality of life will produce results.

This is a goal Federal Labor has set itself.

Residential aged care bed shortages

The most glaring issue which prevents older Australians from making a timely move from hospital to residential aged care is the shortage of available aged care beds.

As a proportion of the population aged over 70 years, the ratio of aged care beds has declined since 1996.

In 1995, there were 92 operational aged care beds for every 1000 people aged 70 years and over.

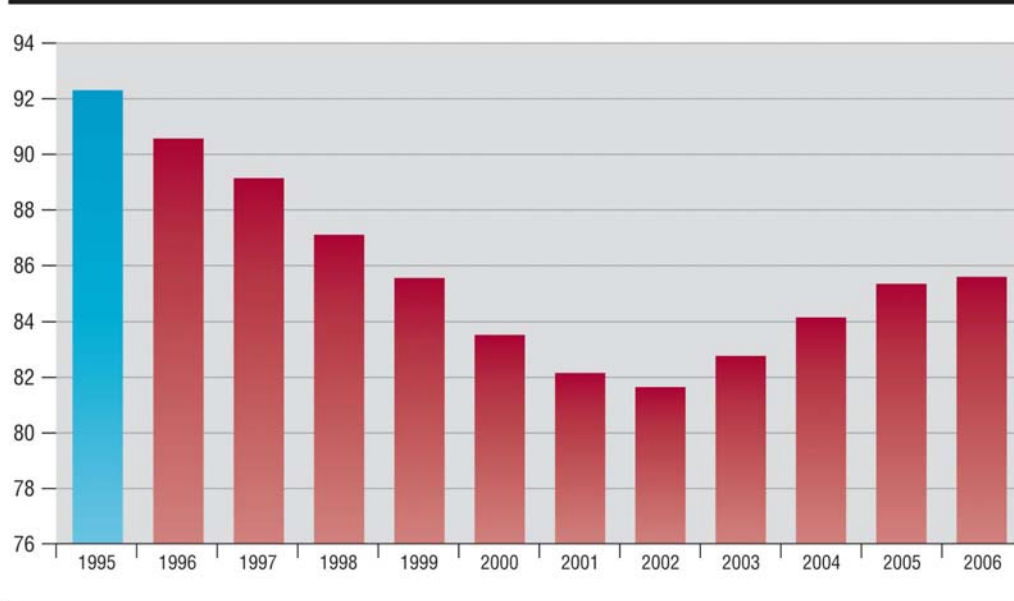
¹ *Caring for our health?* A report by State and Territory Health Ministers, June 2007.

The current target is 88 operational beds for every 1000 people aged 70 and over, but in June 2006 there were only 85.6 operational beds for every 1000 people aged 70 years and over (Figure 1).²

In 11 years, the current Federal Government has turned a net surplus of 3,217 aged care beds into a national shortfall of 2,735 at December 2006.³

Often the figures presented distort this reality. The Government's definition of 'aged care places' includes both residential aged care beds and Community Aged Care Packages.⁴ This disguises the fall in residential aged care beds since 1995.

Figure 1: Aged Care Beds per 1,000 people aged over 70 years



From: AIHW, *Residential Aged Care in Australia 2005-06: A statistical overview*, June 2007. These figures are the most recent released after Labor's media statement of 8 June 2007.

Federal Labor understands and supports the fact that older Australians prefer to receive care in their own homes with the help of community support. However, sponsoring community aged care support does not reduce the obligation to provide sufficient aged care beds to meet demand.

The current annual competitive allocation of residential aged care bed licences and Community Aged Care Packages requires that aged care beds become operational within two years. However, many are not and this has produced charge that these are 'phantom beds'.

The most recent data from the Department of Health and Ageing indicates that at the end of June 2005, 3,400 aged care bed licences allocated prior to June 2003 were yet to be made operational at that time.⁵

These delays in bringing allocated beds on-line are a major factor in the current shortage of aged care beds. The result of this shortage is low overall vacancy

² AIHW *Residential Aged Care in Australia 2005-06: A statistical overview*, June 2007, p.4.

³ Department of Health and Ageing, Stocktake figures, December 2006.

⁴ Community Aged Care Packages also includes Extended Aged Care at Home and Extended Aged Care at Home – Dementia Packages.

⁵ Senate Community Affairs Legislation Committee, Answer to Question on Notice, E05-076.

rates in the aged care sector and diminished choice for consumers who often must place relatives in care which is unsuitable or distant from family and friends.

The Productivity Commission's *Report on Government Services* indicates that waiting times for entry into residential aged care have increased over the period 2000 to 2006.

Today, more than 28% of people who have been assessed as requiring a bed wait three months or more to move into residential care, compared with 15% in 2000.⁶

One innovation which has provided a step-down option for older Australians leaving acute hospital facilities and aiming to return home or to aged care is transitional care.

Transition care provides personal care and medical, nursing and allied health services such as physiotherapy and occupational therapy helping to maintain physical and mental health and improving capacity to undertake daily living activities.

Case management services can include establishing community support and services and if required, identification of residential care options. The services provided as part of transition care are individually tailored and can be delivered in a residential or community setting.

Transition care is provided for a defined period of time and the average period is eight weeks.⁷

In 2005, following recommendation from all Health Ministers and the Hogan Review of Pricing Arrangements in Residential Aged Care,⁸ the Federal Government committed to establish 2,000 transition care places by June 2007.

These places are funded jointly by the Commonwealth and the States and Territories.

The Hogan Review recommended the creation of a strategic pool of up to 3,000 places each year for four years to be used to support innovative care models such as transition care.⁹

This promising model of care is limited only by the fact that insufficient places are available to meet demand.

Ineffective planning and approval processes for residential care

The annual Aged Care Approvals Round is inefficient and ineffective.

The number of allocations fluctuates widely from year to year whereas the steady growth of the aged population requires similarly steady increases in allocations.

⁶ Productivity Commission, *Report on Government Services 2000*, p.941 and *2007*, p.12.35.

⁷ (see Appendix 1 for further information)

⁸ Hogan, W.P., *Review of Pricing Arrangements in Residential Aged Care*, February 2004.

⁹ Recommendation 2 in Hogan, W., *Review of Pricing Arrangements in Residential Aged Care*, February 2004.

In most regions around Australia the number of residential aged care beds does not match need.

In February 2007, the ratio of aged care places was changed to 44 high-care residential beds: 44 low-care residential beds: 25 Community Aged Care Packages (CACP) for every 1000 people aged 70 and over.

The previous ratio was 40 high-care beds; 48 low-care beds and 20 CACPs per 1000 people aged 70 and over.

This change was intended to reflect the fact that there are increasing numbers of people entering aged care facilities as high-care residents. A very small number of regions meet the new ratio but the majority are well behind.

The AIHW Residential Aged Care in Australia 2005-06 report, released in June, shows that 69% of permanent residents required high-care in June 2006 demonstrating a mis-match on the allocation of beds licences and the requirements of the people who need an aged care bed. The under-supply of places is aggravated when there is a delay in allocated beds becoming operational.

In considering the allocation of new beds it is necessary to consider regional needs on the basis of both demographics and the prevalence and severity of disability in older age groups. The level of dependency of people admitted to residential care is increasing and an increasing proportion of residents have dementia¹⁰

The consequences

Too many older Australians waiting in hospital care for residential aged care

One of the consequences of the above-mentioned mismatch between supply and demand of appropriate aged care places is that many older Australians requiring a bed are left to wait in an acute hospital setting.

As the *State of our Public Hospitals* report released this week blithely acknowledges, public hospitals provide 'longer-term maintenance care for patients who are unable to return to their home or may not be able to access a suitable placement in an aged care facility'.¹¹

In August 2006 there were about 2,300 older Australians in public hospitals who should have been in residential aged care, as recommended by an Aged Care Assessment Team.¹²

The situation has deteriorated since 2004 when it was estimated that on any one night in Australia there were 1,684 people in public hospital beds waiting for aged care.¹³

¹⁰ Ibid

¹¹ Department of Health and Ageing, *The State of our Public Hospitals*, June 2007.

¹² *Caring for our health? A Report by State and Territory Health Ministers*, June 2007.

¹³ *From hospital to home: Improving care outcomes for older people*. AHMAC Care of Older Australians Working Group, July 2004.

The current shortfall of aged care beds is 2,735. If this shortfall was addressed there would be beds for all those older Australians left inappropriately in a hospital bed.

While older Australians are well cared for in hospital, acute care facilities are not equipped to provide the social interactions and personal environment that contributes to their quality of life.

Acute hospital beds are also a very expensive and therefore an inefficient place for people to wait for an aged care place.

The average cost per day of an acute public hospital bed is about \$967, whereas the average cost for a residential aged care bed is just over \$100 a day.¹⁴

Put simply we are paying eight times more to have frail elderly Australians remain in an environment that is not best suited to their needs.

The total cost of having 2,300 people waiting in acute hospital beds for an aged care place is in excess of \$700 million each year.¹⁵

This is before the costs and inefficiencies caused by hospitals' inability to place other patients into the acute beds are taken into account.

The current division of responsibilities between Federal and State and Territory Governments creates an incentive to perpetuate this false economy even though the costs could be invested elsewhere to improve health care for the benefit of all Australians.

¹⁴ Productivity Commission. *Report on Government Services 2007*. The pensioner supplement and other supplements will add another \$8 per bed per day.

¹⁵ This is based on the data provided in reference 12, released after Labor's media statement of 8 June which used 2000 as the figure for the number of older Australians in hospital beds on any given night.

New directions for frail older Australians

Federal Labor has already made clear that ending the blame game will be a key priority of a Rudd Labor Government.

Nowhere is this more important than in the interface between hospital and residential aged care for frail older Australians.

There are a range of stakeholders - older Australians and their families, aged care providers, aged care workers and State and Territory Governments - who have a critical interest in seeing the relationship between residential and community aged care and hospitals improved.

A Rudd Labor Government will work co-operatively with all stakeholders to address these issues.

Low interest loans for the provision of new residential aged care beds in areas of need

A Rudd Labor Government will provide up to \$300 million in loans to build or expand residential and respite facilities in areas of need. These loans will attract a zero real interest rate.

These loans will be available to aged care providers to build or expand facilities in areas where there is a shortage of beds for permanent and respite care as assessed by the provision ratio of beds against the benchmark.

Federal Labor will fast track these loans to those providers who can begin building or redeveloping facilities immediately to bring new places online as swiftly as possible.

This initiative will provide up to an additional 2,500 aged care beds.

More step-down places and funding for innovative models of transition care

A Rudd Labor Government will invest \$158 million over the next five years to provide 2,000 additional transition care places for older Australians.

This will bring the capacity of the transition care system to 4,000 places which will assist up to 26,000 older Australians each year.

Labor's commitment to provide 2,000 new Commonwealth-funded transition care places will not only help up to 13,000 older patients move from hospital more appropriate care and recovery each year, but will benefit an equal number of public hospital patients who are waiting for a bed. There is also a major financial benefit to the States and Territories.

A Rudd Labor Government will also work cooperatively with the States and Territories through the AHCA's to:

- Establish a planning mechanism that will regularly assess the need for transition care places, develop benchmarks for the level of provision of

these places, and ensure that transition care places are distributed nationally on the basis of need;

- Establish an integrated system of related programs including transition care, rehabilitation, and the current COAG Pathways Home and Improving Care for Older Patients in Public Hospitals programs to provide a flexible range of services without unnecessary duplication; and
- Continue the national pool of flexible care places available for allocation to innovative services outside of the Aged Care Allocation Round.

Making the transition from hospital to aged care a priority area for agreement in the Australian Health Care Agreements

A Rudd Labor Government will extend the scope of the upcoming negotiations on new Australian Health Care Agreements between the Commonwealth and the States and Territories to include:

- Funding reforms to improve the transition between aged care and hospitals; and
- Agreed health outcomes to drive reforms for the benefit of patients and frail, older Australians.

Labor has previously announced that a Rudd Labor Government will work collaboratively with the States and Territories to broaden the Australian Health Care Agreements to include preventative health care.¹⁶

This new *Preventative Health Care Partnership* aims to reduce the burden of chronic illness borne by older Australians, enabling them to enjoy a more active retirement.

More operational residential aged care beds in areas where they are needed

A Rudd Labor Government will reform the residential aged care planning and allocation arrangements.

Making the bed allocation process more efficient

Federal Labor will ensure that the time between the allocation of residential aged care beds and these beds becoming operational is reduced to a minimum by streamlining the Aged Care Approval Round (ACAR) process.

This will be done by:

- Identifying regions where need is high and prioritising the allocation of new beds to these areas through the ACAR process;
- Tighter monitoring of the milestones between allocation of beds and the beds becoming operational;
- Allocating beds in line with the receipt of census data to ensure a steady flow of bed allocations and development;
- Developing a system of 'reserve' applications in the ACAR process so that unsuccessful applications remain valid within a cycle of allocation; and

¹⁶ *Fresh Ideas, Future Economy: Preventative health care for our families and our future economy*,. Kevin Rudd, MP, and Nicola Roxon, MP, June 2007.

- Tighter matching of the number of operational places with the planning ratio.

The advantages of a reserve approach are savings to providers (it can cost up to \$40,000 to develop applications), a reduced number of excess applications making more time available for fuller assessment of suitable applications, and timely announcements of new bed approvals when allocations need to be redistributed.

Reviewing the planning ratios

A Rudd Labor Government will review the current aged care planning ratios which were originally introduced in the mid 1980s. This will be done on a regular basis to take better account of demographic changes and changing patterns of use of aged care services.

There are strong grounds for adjusting the population-based planning ratios to take account of changes that have occurred and likely future trends, including:

- Increases in life expectancy and improved health of older people since age 70 was introduced as the basis for planning in the mid 1980s;
- Trends in the prevalence and severity of disability in older age groups, including specifically the prevalence of dementia;
- Availability of the results of the 2006 Census and new population projections;
- The changing balance between high and low care, including recognition of the expansion of community care;
- Changing patterns of use with ageing-in-place; and
- The impact of the availability of respite and transitional care on overall levels of demand for residential aged care.

The review of the planning ratios will consider the need for culturally appropriate care for older Australians of Indigenous and culturally and linguistically diverse (CALD) backgrounds.

It will also consider the need to adjust the low asset/income concessional ratio in line with up-to-date Census and ABS data, and the ability to develop and implement a range of concessional ratios that reflect more accurately the local demographics.

Further steps

Federal Labor is committed to improving the quality of support for frail older Australians who need residential aged care. Improving the transition from hospital, home and from hospital to aged care is an important first step in meeting this aim.

Federal Labor expects that the savings and efficiencies that will flow to State and Territory Governments from these measures to lift the burden off our hospitals will be reinvested by them in significantly improved hospital services.

Labor will make further announcements on availability and quality of aged care - both residential and community-based – in the lead-up to the election.

APPENDIX 1- Transition Care¹⁷

Transition Care provides short-term support and active management for older Australians who have been hospitalised and who require more time and support in a non-hospital environment to complete their recovery. Transition care can minimise inappropriate extended hospital lengths of stay and premature admission to residential aged care.

Depending on their assessed level of need, transition care offers eligible older people several or all of the following:

- nursing support;
- low intensity therapy or rehabilitation (such as physiotherapy, occupational therapy and social work) to maintain physical and cognitive functioning and to facilitate improved capacity in activities of daily living;
- personal care;
- medical support such as GP oversight; and
- case management including establishing community supports and services and where required, identification of residential care options.

Transition care can be delivered in either a residential or community setting. A patient must be approved for transition care by an Aged Care Assessment Team (ACAT). An individual is eligible to receive transition care only if:

- the person has completed his/her acute and sub-acute episodes of care, is medically stable and ready for discharge at assessment, and discharged from hospital upon entry to transition care;
- The person would be ACAT assessed if he/she applied for residential aged care as eligible to receive permanent residential aged care at least at the low level of care;
- The person has been assessed by the ACAT as being able to benefit from a period of care in a non-hospital environment; and
- The person wishes to access transition care.

The average duration of transition care is expected to be 8 weeks. Aged care subsidy will be paid for all transition care clients up to a maximum of 12 weeks.

The Federal and State and Territory Governments jointly fund the Transition Care Program. Funding from the Federal Government for the program is provided through the Flexible Care Subsidy. In addition to the Federal subsidy payments and the funding contributions from the State/Territory government, transition care service providers can also request fees from care recipients who are able to contribute to the cost of their care.

ACAT approval for residential aged care and/or community care, an EACH package or respite care remain in effect for up to 12 months even if the client is subsequently approved for transition care.

A recent report from the AIHW¹⁸ shows that at all of the 2000 approved transition care places have been rolled out. However it is not known how many of these are operational.

¹⁷ Information taken from the Department of Health and Ageing website

¹⁸ AIHW, *The state of our public hospitals*, June 2007.