Submission to the Productivity Commission on the Health Workforce

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The Brotherhood of St Laurence (BSL) is pleased to provide a response to the Productivity Commission's Issues paper on The Health Workforce (May 2005). Our response focuses on four areas:

1. General practitioners and residential aged care;
2. Issues specific to older people in insecure housing and their access to health services;
3. The direct impact on the residential aged care sector of an insufficient supply of nurses in the acute health sector; and
4. The importance of suitable staff to allow the successful transition of older people from the acute health setting to the home.

1. GPs and Residential Aged Care

The Brotherhood of St Laurence has had mixed experiences with provision of GP services in our residential aged care facilities (ACF). Factors that have influenced and continue to influence the availability of GPs include:

> Location (of the facility to available GPs and of the facility and the resident's GP), relationship already established between the GP and the resident prior to being admitted to the facility, the strategies the staff have been able to successfully implement in regard to the establishment of a successful relationship with various local GPs, and the range of support services that are available to GPs e.g. allied health and psycho-geriatric practitioners.

GPs and GP organisations report that current levels of MBS rebates discourage them from providing services to residents of aged care facilities (ACF). They also report that some practitioners see the work in ACFs as hard, unglamorous and lacking in variety. Visits to ACFs reduce the time GPs spend working from their own surgeries (e.g. in doing drug chart rewrites), have been mentioned as contributing to this problem. Finally, the complexity of medical care required by aged care residents often requires a GP to spend considerable periods of time with the patient.[1]

The GP shortage problem (in both aged care and the community) has been documented in the recent Commonwealth Government Inquiry into long term strategies for ageing over the next 40 years (March 2005) (pp166-174).

GP Skills and Knowledge

Our experience at the Brotherhood of St Laurence is that even if you are lucky enough to receive adequate GP support, they may not have suitable experience and knowledge suited to diagnosing and treating disorders common among older people, such as dementia.

It is widely acknowledged that the care needs of residents have increased and become more complex in the wake of increasing life expectancy and following recent reforms in the aged care sector. The result of this is that people enter ACFs with generally higher care needs. A large number of residents suffer from complex medical conditions, often associated with dementia, depression and behavioural disorders. Not all GPs who provide services to residents are highly skilled in managing such conditions; a problem that could become more prominent with the increased demand for GP services that can be expected to accompany the ageing of the population.

Access to After Hours Medical Care

While it is not a major issue at present for Brotherhood of St Laurence services, we are aware that some other residential aged care facilities are experiencing particular problems in accessing after-hours GP services. Some of the issues we are aware of include:

- The majority of after hours primary medical care is provided by either locums or ambulance;
- Decisions about after hours care are heavily influenced by staff skills and confidence, residence workload and equipment, information or protocols being available, and systems;
- Often the lack of prevention and preparation for chronic health conditions results in acute episodes.

2. Issues Specific to Older People in Insecure Housing and their Access to Health Services

The BSL has extensive experience in working with older people who have found themselves in an insecure housing situation.

Relationships

- The homeless elderly often have a history of poor treatment by institutions, the health system and/or the legal system and are reluctant to accept any form of assistance or services. As a result, personal care staff have to spend a lot of time working on an individual basis with clients to build up trust before they will agree to accept services. The amount of time spent on this important activity is not recognised within the funding received.

- To assist with social isolation and development of relationships, homeless people need opportunities, through meaningful social interaction, to relearn to interact with and meet others.

Personal Hygiene

Many homeless people require assistance with personal hygiene. Lack of personal hygiene skills can be caused by cognitive problems and/or poor experience in institutional care. Poor hygiene practices can result in eviction from rented accommodation.

Interaction with other Community/Social Systems

Some clients need constant assistance in dealing with police, the court system and the health system. Carers can spend many hours attending court, local police stations, medical appointments and hospitals. Due to funding restrictions, time allocated by the carer to these issues means clients may miss out on other personal services required.

Health Needs of Older Homeless People

Homeless people tend not to have the same access to the medical/health system as other people. As a result, carers spend inordinate amounts of time trying to arrange and attend medical visits with their homeless client, assisting with recuperation from surgery and ensure their clients return for follow-up visits with various health practitioners.

Homeless People Presenting to Hospital Emergency Departments

Many homeless people are taken by ambulance or other means to hospital emergency departments. Those who arrive intoxicated and/or with mental illness requiring social support as well as medical treatment are usually discharged after medical treatment has been administered. They end up within a few hours back on the street with no accommodation or support services in place. Emergency department hospital staff are generally not provided with appropriate training to cater for the needs of these people and are therefore unaware of their social needs.

The VHSWR[2] (p10) states that "people without direct access to support and accommodation who also have complex needs such as mental illness are frequently discharged from hospitals and treatment services into homeless".

However, some hospitals, notably St Vincent's, Royal Melbourne and the Alfred have care coordinators who deal with homeless people arriving for emergency treatment.

Post Acute Care

For homeless people who undergo surgery and recovery services, post acute care proves extremely difficult to maintain. Those living in boarding or rooming houses find it extremely difficult to return to their accommodation, due to a lack of support services or the inability of the proprietor to organise needed services. They are also at risk of abuse and/or theft of pension money.

Carers may be unaware that their client has been admitted to hospital and may not be contacted once the person has been discharged. Locating the client following surgery can also be an extremely difficult task.

With the current trend for more and more health and welfare services including medical procedures to be delivered in the home under programs such as *hospital in the home*, people who are homeless will suffer even greater exclusion and difficulty in obtaining appropriate medical care and treatment (VHSAP[3], p5).

Current Programs to Assist Homeless People Recover From Surgery

The following programs currently provide post acute care and an opportunity for recovery to a small number of homeless people:

- Brotherhood of St Laurence use two unfunded rooms in a Commonwealth-funded hostel for this purpose;
- A community health centre in Yarra provides assistance in the form of physiotherapy and other allied health services to assist with recovery;
- RDNS Homeless Persons Programs;
- The "Cottage" is a facility and program operated by St Vincent's Admissions Program.
- State Government Hospital Admission Risk Program (HARP); and
- Treatment Response and Assessment for Aged Care Program (TRAAC).

Rehabilitation Services

Some homeless people may not require hospital treatment but would benefit greatly from rehabilitation services. This is a service type that should be further investigated and pursued.

Medical Appointments

It can be extremely difficult to make appointments for homeless people with health practitioners such as a GP, optometrist, hearing specialist, podiatrist, etc. Structural issues such as Medicare cards and referrals from one professional to another can be difficult to obtain. Homeless people do not tend to want to sit in waiting rooms and their behaviour and lack of personal hygiene practices can be offensive to others. Carers are therefore required to set up all health practitioner appointments, attend each appointment with their client to ensure information is passed on, treatment is received, prescriptions are filled and follow-up visits are scheduled. The carer must also ensure their clients attend follow-up visits.

3. The Impact of Lack of Nurses in the Acute Health Sector on the Residential Care Sector

Currently aged and community care is attempting to deal with a national shortage of registered nurses, an ageing workforce and wage rates set in the public sector. This issue has been extensively documented[4].

Australia as a whole has an ageing workforce. This is impacting in a number of employment areas and is having a marked effect in aged and community care. Some 57% of all aged care workers are older than 45 years of age and this is higher than the Australian average for all workers.

Nurses

The ageing of the aged care workforce is most acute for registered nurses. When this is combined with the existing shortage of nurses, it places the system under considerable pressure. The model of care provided in high level residential care, in particular is predicted on the availability of registered nurses.

The difference in salary levels experienced by aged care nurses compared with the acute health sector is a significant barrier to attracting and retaining a suitably qualified workforce. Other barriers that would detract recruitment of nurses to work in the aged care sector include poor image of older people and the age care sector and the excessive paperwork which takes nurses away from utilising their specialist skills.

The shortage of nurses in the acute health sector therefore has a direct impact on the availability of nurses for the aged care. It is acknowledged that the National Aged Care Workforce Strategy has been developed to deal with many of these issues.

4. From Hospital to Home

There is a strong relationship between the provision of timely medical, nursing and allied health assistance, and reducing the admission or the risk of re-admission of older people to the acute health sector.

Both levels of governments have as a policy priority the preparation of admission of anyone into the acute health system. Once in the acute health system, the objective is to reduce the length of stay and to prevent re-admissions.

To achieve any of these objectives an available, flexible, experienced and committed health workforce is crucial. At the BSL our experience is that due to an inadequate level of support for older people or people with disabilities living in the community, some individuals are experiencing worsening health problems, isolation and poor quality of life. Governments are incurring increased costs as people are inappropriately forced into the acute care system and residential care as a result

of their care needs not being addressed early enough. Some carers are suffering from stress and poor quality of life.

The BSL congratulates the Australian Health Minister's Advisory Council (AHMAC) and the AHMAC Care of Older Australians Working Group on the development of a National Action Plan for the Care of Older People[5] [6]. The National Action Plan focuses on those elements of the acute aged care continuum that can improve the health and well-being of older people including services at the surface. It covers the areas of:

- acute care services (inpatient and ambulatory);
- sub-acute care (inpatient and ambulatory)
- aged care (community and residential)
- transition care services.

Principle 6 of the Action Plan focuses on the provision of a skilled, responsive and sufficient workforce to meet the needs of older people across the broad range of health and aged care services. This strategic direction for the health workforce has been endorsed by health ministers.

The BSL fully supports identified goals for achieving the strategy.

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[1] Author unknown – *General Practice In Aged Care Homes (Draft) Background Paper for the Aged Care Advisory Committee,* May 2003.

[2] VHSWR – *Victorian Homelessness Strategy Working Report*. Homelessness Department of Human Services, Melbourne, 2001.

[3] VSAP – *Victorian Homelessness Strategy Action Plan and Strategic Framework*, Homelessness Department of Human Services, Melbourne, 2002.

[4] House of Representatives Standing Committee on Health and Ageing *Future Ageing report of the 4th Parliament Inquiry into Long-term Strategies to Address the Ageing of the Australian Population Over the Next 40 Years*, Commonwealth of Australia, Canberra, March 2005.

[5] Senate Community Affairs Reference Committee *Inquiry into Aged Care*, Commonwealth of Australia, , Canberra, June 2005.

[6] COAWG: *The National Action Plan for Improving the Care of Older People Across the Acute Aged Continuum*, Department of Human Services, Melbourne, 2004.

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