Aged care services in Australia and commentary on lessons learnt

Daniel K. Y. Chan¹ | Luke K. M. Chan²

¹Faculty of Medicine, Director of Aged Care and Rehabilitation, Bankstown Hospital, University of New South Wales, Sydney, NSW, Australia
²Griffith University, Brisbane, Qld, Australia

Abstract
The Australian aged care service is a mature and evolving service. It is comprehensive with good continuity of care between hospital and community. Innovative models of care that are built on the principles of improved efficiency, better quality, and safety are constantly being introduced as our population is aging, resulting in higher demand in our healthcare services and increasing healthcare cost. Collaborative effort of a multidisciplinary team underpins our successful aged care model as most of our older patients have multiple comorbidities with various functional and psychosocial needs. General practitioners play an important role in the care of older patients in the community.

KEYWORDS
aged care services, Australia, commentary, geriatrics

1 | INTRODUCTION
The population in many parts of the world is aging rapidly. For example, in 2015, 15% of the Australian population was aged over 65, and this will rise to 19% by 2030.¹ Similarly in the United Kingdom, 17.8% of the population was aged over 65 in 2015, and this is predicted to rise to 24.6% by 2045.² A comparable increase in the proportion of the population over 65 is also expected in Hong Kong from 13% in 2011 to 30% by 2041.³ China had 9.1% of her population aged 65 and over in 2011, with an annual increase rate of 0.25% for those who are aged over 65.⁴

Many Asian countries are becoming wealthier and more westernized. Families are smaller with children and parents no longer living together. As a result, older people are increasingly less likely to receive support from their children.

Aged care services vary from country to country. In Australia, the services can be artificially divided into acute inpatient services, rehabilitation, and community services.⁵ In practice, there is considerable overlap between these services. To provide optimal care, there should be close linkages between services and continuity of care. A brief overview of the Australian aged care services will be provided, followed by a commentary on the lessons learnt.

2 | ACUTE INPATIENT SERVICES
Acute inpatient services for the elderly are available in most countries.⁵ Depending on the availability, such aged care services are provided by geriatricians, general physicians, or general practitioners (GPs). An ideal model would entail a multidisciplinary team of medical, nursing, and allied health personnel. The focus of the multidisciplinary team is not solely on medical illnesses, but also on functional and psychosocial domains.

A well-resourced inpatient geriatric team (acute and rehabilitation) ideally consists of the following:

- Geriatricians and/or rehabilitation specialists
- Resident medical doctors
- Nurses
- Physiotherapists
- Occupational therapists
• Social workers
• Speech pathologists
• Dieticians
• Pharmacists
• Podiatrists.

However, the team composition is dependent on available resources, especially in rural areas of Australia. For example, where a geriatrician is not available, a general physician or general practitioner may take over the role.

The multidisciplinary team is essential for managing the broad range of the older patient’s needs. Mobility impairment, difficulty with activities of daily living, and social issues require the expertise of physiotherapists, occupational therapists, and social workers. In addition, difficulty with swallowing or speech and poor nutrition require coordinated care from speech pathologists and dieticians.

Most acute services concentrate on the care of the acutely ill older patients presenting with geriatric syndromes such as falls, delirium, or functional decline. However, acute care services may also manage general acute medical illnesses (may include conditions such as stroke) sometimes with psychiatric manifestations (such as depression).

3 | REHABILITATION

Rehabilitation is an important aspect of aged care. The key principles of aged care rehabilitation include the restoration and preservation of functional status. The elderly often become physically deconditioned following an acute illness, resulting in increased disability. Inpatient rehabilitation may be required for the more severely disabled patients. While some rehabilitation may be carried out in an acute care setting, many facilities have separate rehabilitation wards located either at the same hospital or at another subacute hospital. Sometimes rehabilitation is also carried out in a day hospital or outpatient setting. Important aspects of rehabilitation include mobility training, self-care training, and arranging appropriate services to support elderly patients at home. In this process, realistic functional goal-setting is essential. Placement in residential care facilities such as hostel or nursing home may be required if patients are unable to return home.

4 | ORTHOGERIATRIC SERVICE AND OTHER PERIOPERATIVE SERVICES

The purpose of this type of acute service is to provide a safe and effective model of care perioptatively to older patients undergoing orthopedic or other surgical operations. For instance in orthogeriatric service, orthopedic surgeons and geriatricians would work together perioptatively to provide a comprehensive coverage for both medical and orthopedic issues instead of the traditional model of consultation only after a medical problem has occurred. Patients who require further rehabilitation after surgery will also be assessed in due course and are referred at the end of this acute service.

Likewise, other types of perioperative services for older surgical patients have begun in Australia. Such cooperation complements the surgical care provided to older patients and further provides an earlier discharge care plan for patients (eg, able to be discharged after surgery or needs further rehabilitation).

5 | COMMUNITY SERVICES

Aged care community services vary widely. However, the principles are similar. Such services aim to cost-effectively support the elderly at home. Most elderly are reasonably independent in self-care, but some need help with activities such as household duties, meal delivery, shopping, or gardening. Others are more dependent and need help with basic personal care activities. These services may be provided at a subsidized cost by the government or charitable organizations in situations where family members or carers are unable to provide adequate care. Sometimes, day care or respite care (in institutions) is available. Aged care assessment teams, where available, can provide assessment and advice to the elderly or their relatives. This will help decide whether the patient can remain at home with support services where appropriate or requires institutional care.

General practitioners provide essential care for the elderly in the community in Australia. They manage common chronic medical problems and minor acute illnesses. They have an important role in primary disease prevention programs such as administering influenza vaccinations. For more complex problems, patients are often referred to geriatricians or other medical specialists. If the problems are acute and serious, patients are usually referred to acute hospitals. Many GPs in Australia perform home visits for disabled elderly who cannot come to the doctors’ clinics.

In contrast to Australia, in some Asian countries (such as Singapore), GPs with special interests in geriatric medicine are employed by government-funded polyclinics. In China, many GPs are now practicing in clinics operated by local authorities to provide primary care to the elderly. However, in many Asian countries, including Hong Kong, Singapore, and Malaysia, GPs face financial disincentives in providing care to the elderly, mainly because consultations are usually lengthy. In such situations, hospital or government clinics are the main healthcare providers.

6 | TRANSITIONAL CARE

Transitional aged care program (TACP) aims to provide short-term support consisting of multidisciplinary services to help patients transit back to home environment after acute hospital stay. In essence, short-term goal-oriented rehabilitation is provided by a
multidisciplinary team either at home or in a residential care setting temporarily before the patient returns home. In Australia, this program is government-funded. Accessibility is via approval from aged care assessment teams.

There is some evidence that providing TACP services helps suitable patients reduce their length of stay in hospitals and also reduces the burden of inpatient rehabilitation.

7 | NURSING HOMES, HOSTELS, AND RETIREMENT VILLAGES

Many of these institutions were established by nongovernment and not-for-profit organizations. In Australia, these institutions are long established and many are subsidized by the Commonwealth government. In many Asian countries, the number of aged care residential facilities is increasing in response to social changes and a majority are run privately while some are subsidized by the government.

8 | AMBULATORY CARE

Ambulatory care units have been developed over recent years to treat less severe medical conditions on an outpatient basis. Suitable conditions include cellulitis and deep vein thrombosis. Success of such ambulatory care treatment programs depends on careful selection of patients. Generally, patients with more severe illness or significant functional impairment require inpatient care.

9 | PALLIATIVE CARE

Traditionally, palliative care has been provided in hospices. However, in recent years in Australia, palliative care services are provided at patients’ homes. Palliative care doctors and nurses visit patients at home and provide appropriate treatments in conjunction with the GPs.

10 | EMERGENCY DEPARTMENT GERIATRIC SERVICE

In emergency departments (ED) in Australia, there is a concerted effort to reduce patients’ stay in ED, freeing up bed availability, as there is a backlog occasionally caused by older patients who are complex in their medical assessment and have a relatively longer waiting time before being admitted to the wards. Many use 4 hours of wait in ED before transferral to the ward as a benchmark. An arbitrary percentage of patients who are required to wait no longer than 4 hours before transferral to the ward is being used as a satisfactory benchmark. In New South Wales, this benchmark is 80%.

11 | OUTREACH SERVICE TO NURSING HOMES

Outreach service is relatively new in New South Wales. For appropriate patients (usually acutely ill but not extremely sick) who may require geriatric assessment of their condition within 24 hours, a team consisting of a geriatrician and a nurse is sent to the patient in the nursing home. The service can include intravenous antibodies or subcutaneous fluid replacement. This service may avoid the need of frail elderly patient presenting to EDs for assessments and/or admissions.

12 | MEDICAL ASSESSMENT UNIT

As another means of reducing ED backlog and fast transit to the ward, many elderly patients are being admitted to a ward called medical assessment unit. The aim of this service is to provide suitable patients who have a shorter expected length of stay in the hospital (usually 5 days, implying less ill) with rapid assessment by a multidisciplinary team. If patients have a longer stay, they are usually transferred to proper wards as the unit has less nursing staff. The unit also caters for patients requiring further investigation or evaluation to differentiate diagnoses.

13 | LESSONS LEARNT

No system is perfect, and despite efforts to improve the Australian aged care services, many challenges remain. As the services evolve in Australia, many lessons are also learnt which are worth sharing.

13.1 | The Good

The Australian aged care service is a mature and evolving service. It is comprehensive with good continuity of care between hospital and community. Many older patients with geriatric syndromes and other illnesses or disabilities are managed satisfactorily in most institutions or at their homes, although there is always room for improvement. The services provided are comprehensive, and in many cases, continuity of care is good.

The multidisciplinary team is well trained ensuring a high-quality comprehensive geriatric assessment.

The funding of such a service is well supported by our universal healthcare system, supplemented with private funding. Many innovative care models are developed and complemented by research evidence. For instance, transitional aged care service and outreach service to nursing home are recent editions which help to fast-track some rehabilitation patients out of the hospital or avoiding hospital admission, respectively. Many quality assurance activities are set up to reduce medical incidents and errors. Furthermore, steps are taken to reduce early readmission to hospital (usually within 28 days) after discharge from...
the hospital ward. Regular accreditation from independent organizations such as Australian Council on Healthcare Standards (ACHS) or professional bodies ensures a good standard of care.

13.2 | The Bad

As services evolved and further subdivided, it can bring fragmentation of services and the frequent change of teams and wards can be detrimental to the care of elderly in the hospital. New teams and new wards can cause confusion in older patients, setting them back from their medical progress.

As our health funding is derived from various sources, there is a cost-shifting phenomenon, in which state government and Commonwealth government try to shift the cost responsibility to the other side. This can create unnecessary services. For example, if patients are followed up in hospital clinic, the hospital which is funded by the state government can bill the Commonwealth government through the Medicare program. This financial reimbursement may induce incentive to request patient to come to hospital outpatient service. However, such service may not be necessary as patients can be followed up by GPs instead.

The multidisciplinary team can sometimes be difficult to manage as different professions have different training and different perspectives in the care of patients. Despite nominally being the team leader, a doctor can find it hard to lead a team made up of different professionals whose line of responsibility is not directly under the doctor, rather to their professional bosses. Conflicts especially about discharge plan can occur as a result.

Challenges also arise in competition for funding between hospital and community services. As resources are limited, competition is probably difficult to avoid. Nevertheless, the outcome is usually one that may favor the stronger and the more vocal group, and not necessarily the needier group. In many cases, community—being the weaker sector—suffers as a consequence.

14 | CONCLUSION

The Australian aged care service is multidisciplinary and comprehensive, covering both hospital and community, with good continuity of care. Our goals of care are in general trying to help older patients to have good quality of life, to support them to live in their own
environment (sometimes through rehabilitation or with the aid of services), and when living at home becomes difficult or impossible, to assess them whether they need nursing home or hostel level of care. Where appropriate, end-of-life care is also part of the services provided to older people.

The commentaries of lessons learnt above are by no means universal or comprehensive. To provide the best care possible to patients, continuous learning and improvement from lessons is crucial, in addition to innovation. Adequate resourcing is also a very important factor in addition to a safe and efficient service.

ACKNOWLEDGMENT

Some content of this article was adopted with permission from “Chan’s Practical Geriatrics.”

CONFLICT OF INTEREST

The authors confirm that they have no conflict of interest.

REFERENCES

1. Australian Bureau of Statistics 2015. 3101.0 - Australian Demographic Statistics, Jun 2015: Population by Age and Sex, Australia, States and Territories (Feature Article).
2. Overview of the UK population: March 2017. Office for National statistics. https://www.ons.gov.uk/peoplepopulationandcommunity/populationandmigration/populationestimates/articles/overviewoftheukpopulation/mar2017. Accessed February 20, 2018.
3. Hong Kong Population Projections 2012-2041. https://www.statistics.gov.hk/pub/B71208FB2012XXXXB0100.pdf. Accessed February 20, 2018.
4. National Bureau of Statistics of China: China’s Total Population and Structural Changes in 2011. http://www.stats.gov.cn/english/pressrelease/201201/t20120120_72112.html. Accessed February 20, 2018.
5. Kam Yin Chan D. Chan’s Practical Geriatrics, 3rd edn. Chapter 1. Brookvale, NSW: BA Printing and Publishing Services;2015:9-11.
6. NSW Agency of Clinical Innovation. The orthogeriatric model of care: clinical practice guide. https://www.aci.health.nsw.gov.au. Accessed February 20, 2018.
7. How assessment works | My Aged Care. https://www.myagedcare.gov.au/eligibility-and-assessment/acat-assessments. Accessed February 20, 2018.
8. Department of Health and Ageing. “National evaluation of the Innovative Care Rehabilitation Services (ICRS) pilot program.” Canberra, ACT: Department of Health and Ageing;2005.
9. Ngian V, Ong B, O’Rourke F, Van Nguyen H, Kam Yin Chan D. Review of aged care service assessment team in emergency department. Age Ageing. 2008;37:696-699.
10. Lung Ling S, Cheng C-T, Liu F, et al. Impact of acute geriatric service to nursing home on local emergency department and subsequent hospitalisation rates. Asian J Gerontol Geriatric. (in press).

How to cite this article: Chan DKY, Chan LKM. Aged care services in Australia and commentary on lessons learnt. Aging Med. 2018;1:50-54. https://doi.org/10.1002/agm2.12012