23 December 2021

Committee Secretary
Health and Environment Committee
Parliament House
George Street
BRISBANE QLD 4000

By email: hec@parliament.qld.gov.au

Dear Committee

Inquiry into the provision of primary, allied and private health care, aged care and NDIS care services and its impact on the Queensland public health system

Thank you for the opportunity to contribute to the Health and Environment Committee's inquiry into the provision of primary, allied and private health care, aged care and NDIS care services, and the impact of these on the Queensland public health system (the **Inquiry**). Aged and Disability Advocacy Australia (**ADA**) appreciates being consulted on the potential introduction of this framework.

About ADA Australia

ADA is a not for profit, independent, community-based advocacy and education service with 30 years' experience in informing, supporting, representing and advocating in the interests of older people, and persons with disability in Queensland.

ADA also provides legal advocacy through ADA Law, a community legal centre and a division of ADA. ADA Law provides specialized legal advice to older people and people with disability, including those living with cognitive impairments or questioned capacity, on issues associated with human rights, elder abuse, and health and disability legal issues related to decision-making.

ADA has reviewed the terms of the Inquiry and provides the following comments for the Committee's consideration, with a focus on the impacts to people with disability and older persons.

Aged care

Limited choice and availability of care options

There are significant shortfalls in aged care provision, including a lack of appropriate choice and accessibility of health care services in the sector which have been well documented by previous inquiries – most recently, by the Royal Commission into Aged Care Quality and Safety (the **Royal Commission**).

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We also note the inquiry by the previous iteration of this Committee into aged care, end-of-life and palliative care, and the findings and recommendations of the same as detailed in report no. 33.[1]

These inquiries consistently demonstrate the gaps in comprehensive aged care and the over-reliance on the hospital system in lieu of high-quality and accessible general practice services and home care options.

Lack of available community and in-home services has a significant impact on older persons and persons with disability, who are commonly hospitalized in the first instance rather than being provided with in-home services and the facilitating of access (for example, transportation) to services that may be offered in the community.

This over-reliance on the hospital system is due in part to substantial underfunding of the aged care sector, which is yet to fully realise and implement the significant reforms recommended by the Royal Commission. This delay continues to negatively impact upon an affected individual's rights and personalized care options, and has a bearing on the accessibility of appropriate in-home services.

Following an acute episode and admission to hospital, it is often the case that an older person who is deemed unable to return to their home as a result of lack of appropriate support availability, will instead be transferred directly to a residential aged care facility (**RACF**) as it is the easiest option to free up beds.

ADA has supported people who after a period (3 - 6 months) recover from the acute episode and could return to the community living. However, doing so is antithetical to the usual trajectory experienced in our current aged care model and as such is systemically challenging, and would likely not occur without advocacy support. The process requires reassessment by an aged care assessment team (**ACAT**) to determine the level of support needed, and approval of a home care package in the community, appropriate supports to enable a safe return to their home or finding alternative accommodation if required – for example, when their house has since been sold.

Rather than be discharged from hospital and sent directly to a RACF, there should be an approval mechanism to direct the person to a transitional care arrangement in short-term restorative care or other residential respite accommodation. This would give persons who find themselves in these particularly vulnerable circumstances and experiencing sudden displacement, an opportunity to recover before a decision on permanent care is made.

Beyond healthcare specific services, there is a significant lack of Commonwealth Home Support Programme (**CHSP**) services across Queensland, particularly for home maintenance and domestic assistance. Whilst limited generally, lack of access and availability of services is particularly difficult in regional and remote areas. Should early access to packages and support be provided, more older persons could continue to live independent lives at home. Significant further investment is urgently required to address the gap in CHSPs and reduce the wait time for a home care package.

Management of dementia and mental illness

Significant behavioural issues associated with cognitive decline, such as those related to dementia, as well as social challenges associated with mental illness present complex challenges for accommodation services. In our experience, RACFs are often improperly equipped to appropriately manage older persons who exhibit behavioural problems associated with these conditions, and struggle to develop management practices that provide appropriate support and protection for an

[1] Health, Communities, Disability Services and Domestic and Family Violence Prevention Committee, *Aged care, end-of-life and palliative care*, Report No. 33, Paper No. 4, 56th Parliament, March 2020, <https://www.health.qld.gov.au/__data/assets/pdf_file/0027/952164/QldParl-Inquiry-Report-EoL.pdf>.

individual and those around them, as well as seeking to uphold the human rights of each individual and maintaining compliance with the Commonwealth Quality of Care Principles.

Where the RACF has not developed appropriate strategies and practices, the fallback position is to place a person exhibiting problematic behaviours into hospital, after which they are usually refused re-entry to the RACF on the basis that it cannot provide the care and support that the person requires.

There is a critical lack of qualified support services for persons in residential aged care who are experiencing mental health issues. In our view, social workers and mental health workers with appropriate experience with older persons would be valuable in this setting.

Lack of provider options for persons in aged care

The increasingly small number of general practitioners (**GPs**) who are able to support their long-term patients who have moved into an RACF is a critical issue that must be urgently addressed. Aside from reforms which may be necessary to the relevant Medicare rebate to ensure that aged care visitation is a financially viable care provision option for GPs, significant cultural reform is also required on the part of RACFs to support and facilitate residents to see a GP of their choice – whether that be in the aged care facility or elsewhere.

Where a medical appointment cannot take place in an RACF, or where it is the preference of the resident to attend the clinic, limited support is provided by the RACF to ensure that the person can attend their preferred appointment. Assistance is especially limited where the person requires someone to accompany them, and if the person is ineligible for ambulance transport.

Insufficient healthcare and support services for persons who reside at home, as well as a lack of accessibility, choice and control for persons in RACFs leads to adverse outcomes for older persons, and an increased likelihood of hospitalisation. Once this occurs, limited options are available to safely allow the person to return home, ending up in aged care and experiencing a further loss of independence and healthcare choice.

National Disability Insurance Scheme (NDIS)

The NDIS is a critical social program and a key tool in the funding and delivery of disability services. However, ADA has serious concerns, that we have raised with the Joint Standing Committee on the NDIS, in relation to its operation, procedural fairness, transparency and consistency in decision-making, and the impacts of these upon the scheme's ability to provide Queenslanders with disability with equal opportunity for community participation, choice and control in accordance with the requirements of the *National Disability Insurance Scheme Act 2013* (the **Act**).

Advocates report that clients with disability regularly encounter significant barriers when seeking access to the scheme and in dealing with the National Disability Insurance Agency (the **NDIA**), usually associated with undertaking a review of approved support services or negotiating a change in circumstances. The issues raised demonstrate a need for cultural reform, to ensure that the NDIA and delegated arms reflect the principles and objectives of the Act.

The impacts of restricted access to the scheme have clear flow on effects to the state public health system. For persons with psychosocial disability, some of whom may be experiencing intersecting challenges such as mental health conditions or risk of homelessness and who face a long and challenging application path to the NDIS (that is likely to include multiple rejection and review stages prior to access being granted), emergency departments and hospitalisation may be the only available option to obtain urgent treatment.

Recommendations relating to additional funding to support people with disability navigate the NDIS, as proposed by the 2019 review by Mr David Tune AO PSM[2] would be beneficial in assisting persons who may be eligible for the NDIS so that they might access allied health services through an NDIS package. Once access and required services have been established, it will relieve reliance on mainstream public healthcare services and will act as a measure to direct persons with disability away from risk of hospitalisation.

Significant improvement is required regarding the intersection of hospital services and the operation of the NDIS. ADA advocates continue to support clients who find themselves 'caught' between the parameters of the two systems. In one example, an ADA client with down syndrome who is an NDIS participant was admitted to hospital. The client is unable to independently feed himself and requires assistance with both eating and drinking. Hospital staff brought the man three meals a day but were unable to provide any staff to physically assist him with eating even though he was unable to do it himself. Upon advising the NDIA about the issue, the client was advised that no funding will be used to support a person in hospital. As a result, persons without family or friends who are able fill this gap are left in an impossible situation, and hospital staff or NDIA support coordinators are forced to 'break the rules' to ensure that basic needs are met.

Thank you again for the opportunity to comment. ADA would be pleased to further assist the Committee with its inquiry. Should you wish to discuss this submission, please do not hesitate to contact Vanessa Krulin, Solicitor and Senior Policy and Research Officer on 07 3637 6036 or via vanessa.krulin@adaaustralia.com.au.

Yours faithfully

Geoff Rowe

Chief Executive Officer

[2] Tune, David, *Review of the National Disability Insurance Scheme Act 2013: Removing red tape and implementing the NDIS Participant Service Guarantee,* December 2019 < https://www.dss.gov.au/sites/default/files/documents/01_2020/ndis-act-review-final-accessibility-and-prepared-publishing1.pdf>.