

## GUEST EDITORIAL - Professor Jennifer Abbey, Professor of Aged Care Nursing Queensland University of Technology and the Prince Charles Hospital Health Service District, Queensland, Australia.

### HEALTH CHOICES FOR AN AGEING POPULATION

The ageing of the Australian population is well publicised with the 85-years-and-above cohort, the 'old old', being the fastest growing. This profile is not unique. Far from a looming burden or impending catastrophe, it represents a triumph of public health and the health sciences generally. That said, once the crowds of longer-living baby boomers start turning, more often, to the health services for relief from the ailments of age, we will face an unprecedented strain on services.

The fast-rising cost of developing and delivering existing and new services, together with other converging factors, will force on us the kinds of choices we haven't faced previously. The politics of making such choices are further complicated by the sense of urgency that accompanies the need for re-development in the first place. Some fundamental rethinking of existing institutions, beliefs and practices in the healthcare sector is inevitable; and we are likely to have to confront major changes at the individual and public policy levels. In many cases, probably most, older Australians will be in the front line when the hard choices are made.

Let us recall some of the likely hot-spots – residential care, community services, workforce issues and cost cutting measures – before commenting on the nature of healthcare choices in a liberal and increasingly privatised, mass democracy.

Currently Australia has approximately 3000 accredited residential aged care facilities (RACFs). In 2002-03, 184,095 people were in permanent residential care, and 731,186 people received some form of community package (Hogan 2004). The level of provision, combining RACF beds and community care packages, has risen from 100 places per 1000 persons over 70 years of age to 108. Hogan sees this as sufficient to meet overall needs.

However, there is a significant and worsening imbalance between the supply of high care and low care beds. The main single obstacle is the anomalous funding system that makes raising capital to build low care beds easy but makes the same thing almost impossibly difficult for high care beds – the most needed type of bed now and for the foreseeable future. This obstacle must be addressed, and soon, in a way that neither allows profiteering nor puts decent accommodation out of reach of the less well-off. We missed an opportunity in 1997 when the issue was on the table and probably missed another chance a year ago when the government failed to act on many aspects of the Hogan report (Hogan 2004). There is no room now for another failure of political nerve.

The residential sector is under funded overall and, as usual, penny pinching defers, or even creates, costs rather than avoiding them. Are there plans afoot to push more of the costs of accommodation (at least) onto the elderly resident? Impending changes to the draw-down rates of the most popular types of retirement income streams suggest to me the Australian Government will expect self-funded retirees to divert more of their future retirement income into paying for their own residential care. If this is so, charging regimes will require careful monitoring and the public needs to know what is in store. Transparency, not furtive planning, allows individuals time to re-jig their plans and adjust their hopes and dreams.

Much of the recent provision in RACF beds is in the 'extra service' segment of the market. Those who can pay more get more. There should be no intrinsic objection to this. Such choices have a legitimate role so long as broad considerations of social equity are upheld. Catering to the well-to-do must not distract us from the legitimate needs for quality care and accommodation of those who cannot afford to take the 'extra service' path to extra comfort. An effective regulatory body with the necessary teeth will help ensure that increased 'choice' doesn't become a problem in itself.

The transformation of Australia's community-delivered services over the past two decades has shown how expanding choice can benefit clients, service providers and health and welfare budgets. The gain in improved coordination of health and social services has been enormous in its implications, although there is still much further to go. But just how far can we go with home delivery? The dementia epidemic in the coming forty years – we anticipate more than 500,000 cases by 2040 (Access Economics 2003) – will challenge us in this sphere. We urgently need to learn how to offer choice in community-based services for this new army of elderly Australians if we are not to replicate our scandalous failures in the mental health area in the wake of de-institutionalisation. Research into the closer and better-informed coordination of existing services is proceeding, but this is a race we could win or lose.

If the word crisis is to be used it must be in relation to workforce issues. We have failed dismally in workforce planning and many Australians have already paid the price. Queensland's doctor supply crisis is an extreme but not an isolated example. An ageing Australian nursing workforce is already hard-pressed and globally shortages are the norm. Our reliance on 'borrowing' – or should that be 'stealing' – doctors and nurses from poorer countries, with already insufficient human resources or health

professionals, is not only unethical from a global perspective but short-sighted. That other appalling 'make-do' measure – the hospitals' undue reliance on agency staff – is bad for continuity of care and disastrous for budgets. 'Nurses working in aged care earn nationally about \$200 per week less than their colleagues in the public sector but are still expected to have the same level of qualifications and experience to undertake their work.' (ANF 2005) This wage discrepancy is a cause of shame. Pressure must be brought to bear immediately if we are to match supply and demand while raising standards of care.

Cost reduction measures are creeping in, largely unnoticed, in the form of raised benefit thresholds, larger co-payment requirements, longer waiting lists, reduced servicing, temporary bed closures and the like. Will it come to the explicit adoption of rationing? There is growing interest in the subject in the professional literature. If it comes, will it be by price, by the estimated impact on the quality of active years left to the patient, or perhaps as a reward for good self-care choices? For example, we already see some areas in the UK putting smokers down the waiting list for certain kinds of treatments. Who decides whether we need such choices? Who would make them?

Choice doesn't come cheap. It can be costly to create and maintain. Can we afford to sustain the astonishing choice of health insurers we now have – about 40 funds – when 10% or more of client contributions go to meet management overheads and contributions are rising at near double digit rates each year? Is that a cost effective

way of supporting the health system? And is saving 'choice' so important we should allow the flood of fast food advertising in children's TV programs? Anyone remember the cost of the choices we *didn't* make in the tobacco debates of the 1960s?

We must ask: is it choice for its own sake that we want; or would we happily settle for less choice and more of other desirable qualities in many areas? We need to distinguish choosing among the options others decide to offer us and making choices about what options should be available. We need to know how to become better at making health choices, about our own affairs and about public policy. Health expertise is not available to everybody and most of us have trouble in understanding all the choices the experts, who are usually the 'sellers', can offer. In an area where the dollar stakes are so high and the lobby groups so powerful, these are not minor concerns.

In financial matters the coming craze is courses in 'financial literacy' for the public. Can we invent ways to make us better, more influential and ultimately more satisfied shoppers in an expanding health marketplace?

## REFERENCES

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