ADDENDUM

The Dubbo Study of the Health of the Elderly 1988-2002

A Commentary by W.P. Hogan

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1. Introduction

The pursuit of this long-term study of the health of the elderly in one small region of rural New South Wales is to be commended. There is scant information available on this topic and most of all on residential care. Hence the support for this study over the fourteen years since it was inaugurated is to be applauded while hope for its continuation must be fervently expressed. No less important are the issues requiring further research, such as the interface between acute and residential care.

A major reservation about the general applicability of the study lies in the weight of Australian-born participants, amounting 90 per cent of the Dubbo aged group. Given that the Dubbo group comprised 2,805 people born before 1 January, 1930, this percentage is not surprising. When the study was initiated, the percentage of locally-born in the Australian population was about 73 per cent. Given the major structural changes in the Australian population during recent decades, the past cannot always illuminate the present, let alone provide insights to future possibilities. Hence the claims for generality advanced in various parts of the study, such as on page 12 of the report, may be challenged.

This commentary is directed mainly to the issues bearing upon residential aged care, and reflects current interests of the author.[1] The general description of the Australian aged care system offered in Section 2.2 is comprehensive; it only lacks some mention of domiciliary situations.

2. General Themes

The setting for the study is the region based upon Dubbo Base Hospital. Recognition is given to the activities associated with other facilities in and around Dubbo, though less specifically than would seem desirable for a clear understanding of the capacities of the various providers of services. For example, references are made to other hospitals in the region around Dubbo, but no quantitative statement of bed capacity is advanced. Only Lourdes Hospital rates a mention, and this facility is one combining sub-acute hospital care with respite, transition and rehabilitation capacities as well as a specific residential high-care capacity soon to be expanded.

It would be helpful to have some indication of the distribution of the residential aged care services around as well as within Dubbo. The specification of high-care and low-care places must be qualified by the impact of ageing in-place which transcends the initial allocation of places to one or other category. Ageing in-place does make a difference to the ways in which residential care is offered as well as identifying the extent to which flexibility has been brought to residential aged care arrangements.

When so much attention is directed to residential aged care, the study reveals how small a proportion of elderly use these facilities at any one time. More attention to what happens in the domiciliary situations is called for in the study. This means much more than referring to Community Aged Care Packages (CACPs). What offerings of Home and Community Care (HACC) are there in and around Dubbo? Some information on these items is required for a more comprehensive grip on the broad range of facilities.

Reference is made to Multipurpose Services (MPSs). This brief mention is not developed. One would like to know what MPSs, if any, operate in the Dubbo spheres of interest. For example, do they work as transition places accepting patients in sub-acute conditions prior to entry in residential aged care in the MPS itself or in some other residential aged service? The particular role of the MPS needs clarification because it lies outside the requirements to which residential aged care facilities must adhere. Moreover, does an MPS amount to competition with existing residential aged care facilities in the locality?

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[1] The writer was appointed late last year by the Commonwealth Government to conduct the *Review of Pricing Arrangements in Residential Aged Care.* This review belies its name as it is directed mainly to structural and efficiency issues. Price is not mentioned in the terms of reference and only in the title.

More information about Dubbo Base Hospital might have been offered. We read about the reduction in beds over an unspecified period   This is stated to be between 30 to 40 in total. Of interest is what was the scale of the reduction; was it 10 per cent or 20 per cent or more? Then again one would wish to know more about the average length of stay. Did this include day surgery activities or not? These questions are relevant to assessing the position of the very elderly in the hospital system because their recovery periods are longer than those recorded by the more sprightly.

On reflection, this absence of important data leaves an unfortunate impression of this study being on hospitals rather than the elderly in general.

3. Experiences

The study gives impressive results on the use of Dubbo hospital by the elderly in the region and the very elderly most of all. (This study defines the very elderly as 80+ whereas the contemporary specification is based upon 85+.) Almost all the very elderly have some stay in Dubbo Hospital. In many ways this reflects the experience with residential aged care where the same age group predominates. What one might wish for is something more about the lesser hospitals around Dubbo to test whether they reflect the same patterns of patient stays.

The different functions performed by Dubbo Hospital and the residential aged care services are revealed by the deaths related to length of stay. Tables 4 and 5 are indicative of deaths taking place within a short time from entering hospital on the last occasion of entry. This specification reflects the frequency with which the patients may have been in hospital in the closing months of their lives. Deaths within residential aged places, as shown in Table 5, point to the tasks associated with palliative care. While many deaths take place within three months of admission to residential care, the proportion is not anywhere as concentrated as for the hospital system.[2]

Another aspect relates to admissions to high care. The diagnostic groupings record the dominance of dementia, stroke and heart disease. There is no mention of co-morbidity conditions which is in much contrast with the propositions advanced in explanation of the care requirements in high care facilities before the Review. Thus the table on diagnostic groupings shown Subsection 3.4 requires much more explanation.

No less of a problem in understanding is Table 4.3 treating the conditions experienced by survivors in the study. They amount to 1767 people. Yet the survey on their condition lists just 989 full interviews and 314 short ones. This total of 1303 is nearly 74 per cent of the total survivor group. The rest could not be interviewed owing to their condition. As their condition would be known this should have been recorded with most experiencing dementia in all likelihood. All this is a necessary clarification if judgements are to be made about quality of life for the elderly.

Perhaps it is not necessary to list the reason for more women being in high-care placements; presumably it is their greater longevity.

4. Big Policy Issues

The executive summary and conclusions raise general policy themes which extend well beyond coverage from the results of this study. The researchers offer insights into these policy issues. The most obvious is the very great reliance of the elderly - especially the very elderly - on hospitals for support in the closing years of their lives.

In these circumstances it cannot be any surprise that the interface between hospitals and residential aged care facilities is a major issue. Attention to the need for sub-acute hospital facilities looms large in any consideration of this matter. Rehabilitation should be to the fore.

No less important is the question of avoidance of acute hospital care. The study does bring a focus to this theme especially when the function of hospitals in relation to dementia and Alzheimer's disease sufferers is advanced. The question calling for much further exploration is the connections between providers of primary care and residential facilities. Getting a grip on issues and needs before the reliance on acute facilities to deal with problems seems the most fruitful avenue for exploration.

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[2] This comparison is an interpretation of Table 4 made difficult by the numbers recorded in that table being far in excess of the number of deaths in hospitals recorded in the text as 683. In contrast the data for residential places shown in Table 5 adds up to the number of deaths stated in the text.