The interface between hospital and residential aged care

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Abstract

The last 15 years have seen substantial changes in both the aged care and the acute hospital sectors. This article focuses on the impact of those changes on the interface between hospital and residential care. It examines trends in expenditure, supply and patterns of service use in the two sectors. Despite good national databases on hospitals and aged care services, there is little national information on the interface of the two sectors. The material presented here is based on work being undertaken at the Australian Institute of Health and Welfare, as part of a project aimed at developing a national database linking residential aged care and hospital morbidity data.

Introduction

In the health care sector, co-ordination was one of the major buzz words of the 1970s, and remains a catchcry of health care reform thirty years later. In 1975, co-ordination was one of the five major goals set for the Community Health Program; the pre-occupation at that time was with the development of a non-institutional-based health care sector and one which recognised prevention, maintenance and rehabilitation services as well as those aimed at acute care. In the period since that time, the shape of the health care sector has certainly changed, with a burgeoning of community care and community health services. In the fields of aged care, disability services, mental health and indeed acute care hospitals we have seen a movement away from services provided in institutions and toward those which are community based. The size of that shift, particularly when all of these sectors are taken together, has been truly formidable (AIHW 2001:Chapter 4). With regard to services for older people, the transition started somewhat later than in other fields, around the mid 1980s (McLeay 1985), but has been particularly rapid in the period since (AIHW 1993: Chapter 5, 2001, Chapter 6). If the patterns of care provided in 1986 had remained in place in 1996, there would have been an additional 53,000 older people in institutional care than there actually were; a policy favouring the 'de-institutionalisation of care' led to a 25% reduction in the number of older people who would have been in institutional care in a mere 10 year period (calculated from AIHW 2001: Chapter 5).

Despite the emphasis on co-ordination of health care in the 1970s, it has not proved to be an easily attainable goal. Co-ordination remains an icon of good health care—the co-ordinated care trials were, after all, one of the major health care innovations of the late 1990s. Through all this, however, there has been a duality associated with the term, a deliberate vagueness which allows co-ordination to refer both to the co-ordination of care to individuals, and to the co-ordination of systems. While some attention continues to be paid to both elements, it is fair to say that the co-ordination of care systems rather than the co-ordination of care to individuals is the major concern in the tough minded early 21st century, particularly when compared to the relative emphasis during the peak of the Whitlam government reforms in the early 1970s. And this shift is not a surprising one given the extent of change that has been wreaked on the system of care in the last fifteen years, especially as it relates to older people.

This article focuses on the impact of those changes on the interface between hospital and residential care. To do so, it examines the patterns of expenditure and service use in the two sectors, with a particular emphasis on movements at the boundary of the two sectors. The material presented here is based on work undertaken in the Ageing and Aged Care Unit of the Australian Institute of Health and Welfare over the past 18 months, as part of a project aimed at developing a national database linking residential aged care and hospital morbidity data.

While policy interest has been firmly focussed on the boundary between hospitals and residential aged care for some time, research activity has lagged behind, tending to view the two sectors in isolation. Researchers interested in the health care sector write, for the most part, on hospitals. Those interested in aged care write about residential aged care and community care services. The formation of the AHMAC Working Group on the Care of Older Australians in 2001 signalled the political will to engage with the issue of care across sectors of the health/aged care system, and across jurisdictional (Commonwealth/State/Territory) boundaries of responsibility. It is timely for researchers and data analysts to follow that lead.

Expenditure trends

Over the past 25 years, expenditure on older people in hospitals has grown from $1.9 billion to $5.2 billion; expenditure on older people in residential care has grown from $0.9 billion to $3.6 billion, and expenditure on community-based care has grown from $22 million to $800 million. While the hospital sector remains the 'big ticket' item, the proportion of expenditure on older people which is occurring in the hospital sector has shifted substantially, down from 68% to 54%. By way of contrast, the proportion of expenditure going to residential care has increased from 31% to 38%, as has that to community care (from 1% to 8%).

Of more immediate policy interest, however, are trends in the last 10 or even five years. While expenditure in all sectors continues to grow in real terms, the growth is most rapid in the community care sector, and least rapid in the hospital sector. The last 10 years has seen a 136% increase in expenditure on community care for older Australians, a 72% increase in expenditure on residential care for older Australians, and a 61% increase in expenditure on hospital care for older Australians. The proportion of expenditure occurring in acute care hospitals has declined over the last decade, while that in residential and community care has increased.

Service trends

Supply

Since the mid 1980s, the total number of hospital beds has been falling, while the number of residential aged care beds has been increasing. Between 1985-86 and 2000-01, the total number of hospital beds fell by 11,000, from 86,000 to 75,000. Over the period, the number of residential aged care beds increased by 31,000, from 112,000 to 144,000. In the mid 1980s there were around 1.3 aged care places for every hospital bed; today there are around 2 aged care places for every hospital bed.

If both expenditure and bed numbers in the residential care sector have been going up in relation to that in the hospital sector, it seems at first glance difficult to understand why arguments are occurring about the boundary between the two sectors. In particular, one might be led to question the salience of concerns about older people 'blocking' beds in hospitals due to an inadequate supply of aged care beds.

The explanation lies partly in the now commonly recognised ageing of Australia's population (ie the increase in the both the number and proportion of the population aged 65 and over), and partly in the less commonly recognised ageing of the aged population. In 2001, 12.2% of the population aged over 65 were in the 85 and over age category. In 1986, that proportion was 8.3%.

As the absolute number of hospital beds decreased over recent years, so too did the supply of beds in relation to the growing numbers of older people. Of course, hospital beds are not the exclusive province of older people, so these numbers are generally quoted in relation to the population as a whole – in this case supply declined from 5.4 to 3.9 beds per 1000 people.

While the number of residential aged care places has increased substantially over this period, this increase has not kept place with the growth in the aged population. Supply in relation to the size of the aged population declined—from 66 places per 1000 people aged 65 and over in 1986 to 60 places per 1000 people aged 65 and over in 2001. This trend is arguably more dramatic than it appears, given that use of residential care places is heavily concentrated in the 85 and over population, and that this group now constitute a much larger proportion of the aged population than it did previously. These are the numbers which are often cited as crucial to the 'bedblocker debate'—the reduced supply of residential care in relation to the size of the older population means that older people are remaining in a hospital context longer than is either necessary or desirable.

Patterns of use

If both hospital beds and residential aged care places have declined in relation to the size of the aged population, then one might reasonably predict increased problems at the interface. As supply in relation to the population 'at risk' is reduced, then increased pressure at the edges of systems could be expected. Supply, however, is not the whole story. The pattern of use of these two institutional types has also changed substantially over the period under review. Hospital beds may have gone down, but hospital separations in relation to people aged 65 and over have gone up, from 3,338,000 in 1985-86 to 6,138,000 in 2000-01. This is a consequence of changes in the way hospital resources are used, most commonly characterised by reductions in length of stay and increased numbers of same day admissions and separations. Meanwhile, in the aged care sector, there has been no corresponding reduction in length of stay; in fact the reverse pattern has occurred with length of stay increasing, leading to reduced turnover in residential aged care.

This changing pattern of use is an important element in understanding the boundary problems which are occurring between the two sectors. But it is not simply a matter of numbers of days and rates of separations or admissions. The nature of the services provided is also at issue. There has been a growing construction of hospitals as acute care hospitals; indeed this very label—acute care hospitals—is favoured by state and territory officials to describe the hospital sector, while the more traditional 'hospitals' is favoured by the Commonwealth. Regardless of the label, there has been an increasing emphasis on acute care in the hospital system. Palliative care, convalescent care and rehabilitation have far less currency in modern hospitals than they did twenty years ago, and many of the patients in need of such services are aged over 65. It is not immediately clear that these clients belong in the residential aged care sector, but the shortage of alternative services for these 'chronic care' clients is another factor building the pressure on the hospital/residential care interface.

The community care context

This account of the hospital/residential care interface should not be considered in the absence of the dramatic expansion of community care over this period, but data on the change in actual service quantities delivered are not available over this time period. It is worth at least noting, however, that the community aged care package program which came into existence in 1993 now offers 24,000 places (this program is intended to provide a home based alternative to 'low care' residential places), and that the dollars associated with the HACC program have ballooned since the mid 1980s.

The data shortfall

These trends suggest that the interface between residential care and hospital care is an important area for study, but there is little by way of national data available on the topic. It is likely that around 3% of hospital discharges for people aged 70 and over are to residential aged care, but there are data quality problems with this particular item in the national hospital morbidity collection. It is estimated that around 45–50% of residential aged care admissions come from hospitals, but no national data are collected on this variable.

The Australian Institute of Health and Welfare has undertaken a feasibility study to link national hospital morbidity data and residential aged care data, matching records on several shared variables in the two collections. The results of that linkage work are preliminary, and not yet available for general release. The preliminary analyses do suggest some interesting trends, however. It appears likely, for example, that people entering residential aged care from hospitals have very similar age and sex profiles to those entering from the community. On the other hand, those leaving hospital and returning to the community are likely to be younger, and more likely to be male,

than those entering residential care. With regard to length of stay, the preliminary analyses suggest that, on average, those discharged into residential care may have longer length of stay in hospital than those discharged to the community. This pattern, however, appears to be affected by client age, with the disparity in length of stay more marked at younger ages. The combination of the two datasets also allows for the analysis of the impact of diagnosis while in hospital on subsequent care needs in residential care, which provides a useful basis for future policy development work and planning.

References

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