ACSA
Aged & Community Services Australia

POLICY PAPER
A Framework for the Aged Care and Healthcare Interface during COVID-19

About ACSA

ACSA is the leading national peak body supporting not-for-profit church, charitable and for-purpose providers of retirement living, community, in-home and residential aged care for more than 450,000 older Australians.

Background

What is the aged care and health care interface?

Aged care is the system through which subsidised care and support are delivered to older Australians as they age. However, the aged care system is not the only system through which older people have their needs met. Aged care sits alongside and interacts with a variety of other government systems as well as the open market that deliver services and supports that older Australians need and want.

One of the most important systems for older Australians is the healthcare system, through which they receive medical care and support. The healthcare system includes primary healthcare (General Practitioners), as well as the hospital system which provides acute medical care and subacute rehabilitation services.

The interface between aged care and healthcare describes the way these two systems interact to provide seamless care and support to older Australians to meet their ongoing care needs.

What is ageism?

Ageism is prejudice toward a person because of their age. It is largely driven by fear and negative beliefs about what it means to grow older.

Ageism is perpetuated by negative stereotypes about ageing and older people in the media and other areas of daily life. In many cases, ageism leads to discriminatory practices, both implicit and explicit, that prevent older people from fully participating in our community as members of equal value and worth.

The Benevolent Society's 2017 *Drivers of Ageing* Report highlighted how ageism is effectively discrimination against our future selves that becomes a self-fulfilling prophecy, leading to damaging internalisation and reinforcement of negative attitudes toward ageing.[1]

The Aged Care Royal Commission stated in its Interim Report that:
"As a nation, Australia has drifted into an ageist mindset that undervalues older people and limits their possibilities."[2]

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[1] The Benevolent Society, *The Drivers of Ageing,* September 2017, page. 9: https://d3n8a8pro7vhmx.cloudfront.net/benevolent/pages/393/attachments/original/1538977356/Ageism_SummaryReport_Final.pdf?1538977356

[2] Royal Commission into Aged Care Quality and Safety, Interim Report, Volume 1, November 2019, p. 1: https://agedcare.royalcommission.gov.au/publications/Pages/interim-report.aspx

Ageism during COVID-19

The COVID-19 pandemic has created heightened risks to the health and wellbeing of older people, who medical evidence suggests are more susceptible to the disease than younger people. Disappointingly, the susceptibility of older people to the coronavirus has led to the expression of a great deal of ageist sentiment in the media, with commentary stating that 'it only affects the elderly' exposing a cavalier attitude to the health and wellbeing of older Australians.

The Prime Minister has made some welcome comments that all lives are of equal importance in the approach to containing the outbreak of COVID-19 across Australia, arguing that "*Every Australian matters. It doesn't matter whether they've just been born or they are approaching the end of their life. Every Australian matters.*"[3]

However, there have been some troubling developments throughout the pandemic overseas where ageist beliefs and attitudes have become part of policy-making and decision-making around rationing of scarce health system resources such as ICU beds and ventilators.

In Italy, for example, there is a great deal of anecdotal evidence that suggests older people have been turned away and denied medical treatment by overwhelmed hospitals, with younger people being prioritised for treatment simply due to their age.[4] In the United States, Emergency Room physicians in New York reported having to make extremely distressing decisions about rationing access to ICU beds for elderly patients presenting with COVID-19.[5] And in Britain, the lives of older people were not even being counted in the official death tally of coronavirus until recently.[6]

Australia is not immune to ageist sentiment creeping into individual medical decision-making and system-wide health responses to the COVID-19 pandemic. There has already been one instance of an older Australian having a Do Not Resuscitate order listed on her treatment notes against her wishes when she was hospitalised for COVID-19.[7]

The aged care response to COVID-19 in Australia

Australian residential aged care providers have prepared exceptionally well for potential outbreaks of COVID-19 in aged care homes. This is exemplified in the low numbers of fatalities in Australian aged care homes compared to similar international jurisdictions, such as the UK, the United States and Canada.

Measures such as stringent infection control procedures, staff testing and limited visitation schedules have all been implemented across homes in various ways to help prevent outbreaks.

Some aged care providers are also taking steps to establish 'Special Care Units' within their facilities to provide care for residents diagnosed with COVID-19 separately from the main population of the home. For example, NSW not-for-profit Warrigal, a provider of residential care, in-home care services and

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[3] S Morrison, Press Conference, Parliament House Canberra, 3 April 2020: https://www.pm.gov.au/media/press-conference-australian-parliament-house-act-030420

[4] The Independent, *'We are making difficult choices': Italian doctor tells of struggle against coronavirus,'* 13 March 2020: https://www.independent.co.uk/news/health/coronavirus-italy-hospitals-doctor-lockdown-quarantine-intensive-care-a9401186.html

[5] New York Times, *'I'm an E.R. Doctor in New York. None of Us Will Ever Be the Same,'* 14 April 2020: https://www.nytimes.com/2020/04/14/magazine/coronavirus-er-doctor-diary-new-york-city.html?

[6] ABC, *'Coronavirus has infected 2,000 UK care homes but their deaths aren't included in the daily tally',* 16 April 2020: https://www.abc.net.au/news/2020-04-16/uk-aged-care-home-hit-by-coronavirus-outbreak-covid19/12149024

[7] Daily Mail, *'Grandmother, 71, says she was marked as 'do not resuscitate' while in hospital battling coronavirus - despite telling doctors she 'wasn't ready to cark it''*, 17 April 2020: https://www.dailymail.co.uk/news/article-8228167/Lorraine-Lewis-hospitalised-coronavirus-wrongly-labelled-not-resuscitate.html

independent living accommodation, has taken steps to establish Special Care Units to both provide care to people within their aged care homes, independent living facilities or home care customers.[8]

Warrigal's Special Care Units will operate separately from their residential aged care homes and will be available in instances where people are not able to be transferred to hospital. These arrangements will serve the dual purpose of providing care to those diagnosed with COVID-19, while helping to contain the spread and hence protect other residents, staff and the community from the outbreak.

These measures are essential to managing the outbreak of a highly infectious condition to which we know older people are susceptible. Given the nature of aged care homes, in which many older people live in close proximity, measures that enable providers to contain the spread of any potential outbreaks and keep residents safe need to be fully supported by government.

ACSA's policy position

Guiding Principles

It is vital that Australia's system-wide health response to the COVID-19 pandemic be completely devoid of ageist attitudes or beliefs. This is crucial to ensure ageism does not impact treatment of older Australians at an individual level.

ACSA calls upon all governments, state and federal, to ensure that the following principles be embedded into system-wide responses to the coronavirus:

1. All human life is equal, and all people should be able to access healthcare and live with dignity, regardless of their age, expected longevity or where they live.
2. Politicians, the media and others in public life must be aware of and combat negative messages and ageist stereotypes that are persisting throughout the pandemic.
3. Decisions made about rationing access to lifesaving health and medical care, should the system reach capacity, must be based on a triage process that is free of conscious or unconscious bias against older people due to ageist attitudes.
4. The rights of individuals must be balanced with consideration of the welfare and wellbeing of others, particularly at a time when there can be severe consequences to life if adequate infection control measures are unable to be fully realised.

A transparent and coordinated aged care/health system interface

The interface between the health system and the aged care system will be a critical juncture throughout the COVID-19 pandemic, given the susceptibility of older people to the virus.

Successfully containing the spread of the coronavirus in aged care facilities and treating those aged care residents who do contract it depends on the ability of each system having a clear understanding of their roles and responsibilities, and stepping up to fulfill them.

Aged care providers have clear responsibilities under the Aged Care Act to provide suitable accommodation and appropriate care to older people as their care needs progress. This includes the delivery of a variety of day-to-day clinical care outcomes, as well as preparing and implementing infection control measures to manage outbreaks of infectious diseases within their homes.

Aged care providers must have sufficient clinical resources to hand to enable them to implement infection control measures and to provide treatment for residents who do contract infectious conditions.

[8] Message from the CEO, Statement on Warrigal's COVID-19 Action Plan, 29 April 2020: https://www.warrigal.com.au/images/random_images/COVID19_MESSAGE%20FROM%20THE%20CEO_Special%20Care%20Units_PUBLIC_APPROVED-merged.pdf

So while it is appropriate to expect aged care providers to deliver a variety of high-quality clinical care outcomes for their residents, and to have the ability to implement infection control measures, in line with their scope outlined in the Specified Care & Services Schedule they cannot themselves provide the kind of high-level and complex acute care akin to what can be delivered in a hospital setting.

Residential aged care is not an acute setting and has never been funded in such a way to enable high-level acute care to be delivered. Comparing the funding provided for acute hospital care versus residential aged care illustrates this – the average national cost for acute hospital care per day is $1,300, compared to an average aged care bed cost per day of just over $300.[9]
Residential aged care facilities are homes, not acute medical facilities. They provide a home-like environment to their residents, and do not have the medical resources required to deliver acute care, such as doctors and other clinicians, medical equipment or sufficient levels of personal protective equipment to cope with a significant outbreak.

Professor Joseph Ibrahim of Monash University has highlighted the difficulty of delivering stringent, hospital-grade infection control and PPE use in the home-like environment of an aged care home as they are currently construed and funded, stating:

"It's not as straightforward as everyone thinks…Let's say there's 30 staff, and they've got to see a resident three times a day. That means they have to put on and take off PPE 90 times, which is 180 conditions of use. So, if they follow it right 90% of the time, then there's still 18 breaches."[10]

Given the nature of residential aged care and its funding model, it is unreasonable and unsafe to expect that aged care providers should be responsible for the acute care of their residents who contract COVID-19. We have seen in an outbreak situation that State Public Health Units and the Federal Government surge workforce steps in to assist. These are needed and valuable resources.

However, what is unclear and unplanned for is the protocols and clarity of roles of how the different health bodies will work together to achieve the best outcomes for residents who test positive for COVID19, while protecting those who haven't contracted it. While there will be differences to the ways an outbreak plays out depending on the exposure, the resident profile, care home design and service model, the work should be underpinned by clear arrangements that are known to a large extent ahead of time.

ACSA calls for federal, state and territory governments to develop and adopt clear protocols for the management of the interface between the aged care system and the health system, particularly residential aged care and hospitals, during the COVID-19 situation.

These protocols would:
- ***Ensure aged care residents can access their right to acute care in hospital, or another location that is well set up to manage infection control and treatment, if they clinically require it;***
- ***Ensure aged care residents at a facility where an outbreak occurs are not put in harm's way by any obstacles to transferring aged care residents diagnosed with COVID-19 to the appropriate acute care setting;***
- ***Develop clear guidelines for the additional support measures to be provided by the health system should an outbreak require the establishment of "hospital in the home" arrangements in an aged care facility.***

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[9] Independent Hospital Pricing Authority, National Hospital Cost Data Collection, Australian Public Hospitals Cost Report 2014-2015 Round 20, p 37, and Aged Care Financial Performance Survey, Six Months to 31 December 2019, StewartBrown, Jan 2020
[10] The Weekly Source, 'Professor Joseph Ibrahim says aged care residents who test positive for COVID-19 should be sent to hospital,' 12 May 2020: https://www.theweeklysource.com.au/professor-joseph-ibrahim-says-aged-care-residents-who-test-positive-for-covid-19-should-be-sent-to-hospital-because-it-is-too-difficult-to-prevent-ppe-breaches

ACSA also calls for consideration to be given for the inclusion in these protocols of a mandatory procedure that for the first index case of COVID-19 among an aged care resident cohort be immediately transferred to hospital. This would ensure aged care providers can remove the known active case from the premises to an appropriate acute setting and focus on preparing for a potential outbreak by:

- ***Initiating infection control procedures, particularly cleaning of the facility;***
- ***Obtaining adequate PPE;***
- ***Arranging immediate testing for all residents and staff;***
- ***Preparing any Special Care or isolation units as planned for.***

ACSA welcomes SA Health's recent indication that it plans to move any aged care resident in South Australia who tests positive to COVID-19 immediately into an acute hospital setting.

Remove potential regulatory roadblocks and introduce funding measures to enable the establishment of Special Care arrangements by aged care providers

There are many different types and styles of aged care home design and models which impact on how they will be able to manage positive cases or outbreaks. For example, household models are vastly different to older facilities with shared rooms and bathrooms.

All providers have looked at how they can manage COVID19 circumstances and numbers of them have identified special care and isolation arrangements ahead of any outbreaks. For example, the establishment of Special Care Units has the potential to save many lives by effectively isolating known cases of COVID-19 and preventing further spread, while providing targeted treatment to those affected.

For example, if a home has a resident or residents test positive to COVID-19, the home should be able to, as part of its infection control plan, temporarily rearrange the living arrangements of residents within the home to ensure those residents who have not tested positive do not come into contact with those who have. This is a sensible infection control measure to limit the spread of a potential outbreak following a confirmed case of COVID-19.

However, Security of Tenure regulation could potentially present a roadblock to the effective establishment of these types of infection prevention arrangements. Under current aged care legislation, aged care residents are guaranteed security of tenure over their room when they are admitted to an aged care home and cannot be relocated to a different room without their express agreement. This means if a resident or their substituted decision maker does not agree to the relocation, aged care providers are currently unable to require them to move, effectively preventing the implementation of this infection control procedure.

While there is some flexibility within these provisions for emergency situations, providers need certainty from the Commonwealth that they will be able to operate Special Care Units and relocate residents as required throughout the COVID-19 situation. This may include moving residents who test positive to COVID-19 to Special Care Units and away from the general population of the home, as well as moving residents who have tested negative out of an area where other residents have tested positive in order to isolate those cases.

Clearly, this is a case of needing to strike the balance between the individual rights of residents to maintain security around their accommodation on the one hand, and the need to protect the safety and welfare of other people living and working in the same residence on the other.

While these considerations are never straightforward and require careful deliberation on finding and maintaining the balance between individual rights and the welfare of the cohort more broadly, the consequences of failing to facilitate aged care homes with the necessary options to manage infection outbreaks are severe.

Furthermore, the establishment of Special Care Units or other arrangements – where heightened clinical measures are put in place to cope with the outbreak of an infection – is resource-intensive and not adequately covered by current aged care funding mechanisms. This means providers who seek to take the initiative to establish these sorts of proactive responses to the COVID-19 pandemic must do so from their existing operating revenue, which is simply not feasible for many aged care homes operating on thin margins.

ACSA calls for the Commonwealth to consider whether Security of Tenure regulations are sufficiently flexible to provide for temporary arrangements throughout the duration of the COVID-19 pandemic, allowing aged care providers to establish isolation arrangements to cope with outbreaks of the disease and implement clear protocols for their operation. ACSA also calls for the Commonwealth to develop funding mechanisms to support their development and utilisation.

A national COVID-19 triage tool

It is vital that age is never used as the sole decision-making factor about a person's capacity to benefit from treatment for COVID-19. While it is true that comorbidities and frailty are more likely to be experienced by older people, these should be assessed independently of a person's age.

A person's age alone, or expected longevity after treatment, should never be grounds to deny them access to potentially lifesaving medical care.

Furthermore, Advance Care Directives or other such documents in which an aged care resident expresses a desire for reduced or no medical intervention should not be used as a rationale to prevent a hospital admission from residential aged care. The location of where instructions from an Advance Care Directive wishes are performed (residential aged care or hospital) should be flexible during a pandemic, provided that the wishes expressed in the Directives are maintained.

In some cases, an acute hospital setting may still be the most appropriate venue for an older person with COVID-19. This may be the most appropriate for the individual to receive palliative care, even if they opt not to avail themselves of ventilators and other treatments. It may also be the most appropriate for other residents concerned about the presence of a COVID-19 case onsite in their home.

ACSA calls for federal, state and territory governments to develop and adopt a national COVID-19 triage tool.

The triage tool would be agreed upon and adopted by all hospitals operating ICUs across Australia for use in the instance that they reach operational capacity and are required to ration access to ICU beds, ventilators or other lifesaving medical treatments for people diagnosed with COVID-19.

The core purpose of the triage tool would be to maximise the number of lives that can be saved by apportioning scarce medical resources to people who are most likely to respond to medical treatment.

The triage tool would:

- ***Individually assess a person's capacity to benefit from treatment;***
- ***Take into account a person's comorbidities and frailty independently of their age;***
- ***Based on the above criteria, provide a decision-making process by which people may be excluded from medical assistance; and***
- ***Ensure decisions made about a person's access to health and medical care are made based on sound medical reasoning, free of any bias that may otherwise preclude older people on the sole basis of their age or longevity of life following treatment.***