Productivity Commission of Inquiry into Aged Care

2010

Inquiry into Caring for Older Australians

- examine the social, clinical and institutional aspects of aged care in Australia, building on the substantial base of existing reviews into this sector

The best way to alienate or marginalise a sub sector of the community or social structure is to single them out. If we are to value add to our existing social, clinical and institutional aspects of Aged Care; we would do well to frame our discussions deliberations and debate with the respect and integrity we want for the end users, i.e. older people themselves.

Years of social research gives us evidence of our ageing community being non-contributing and a burden on others; including the public purse. By portraying our 'baby boomers' in a similar light; sets up intergenerational warfare further marginalising those who through no fault of their own are simply ageing.

Investing monies into researching modes and therapies extending the life of older people is foolhardy, delusional and at best wasteful. Investing money into pain management for older people to palliate them should they require it is a much better investment in to care. Investing into health promotion disease prevention including early life/better health programs is a much more practical and moral investment into what constitutes care along life's continuum.

It appears tokenistic to introduce an extension of retirement age to alleviate or postpone the inevitable. Aged Care Reform cannot be discussed maturely without also including social and taxation reform. These discussions and those charged with the responsibility for seeking a manageable future for Aged Care need to come to the discussion table as equals not any player having more sway simply because they have more status.

The private sector currently engaged in residential aged care is incompatible with the holistic notion of care. No one would invest in residential aged care unless it was a lucrative option. The bottom line is about profit not care despite the all the vision mission and values statements. I recommend that existing private sector providers meet strict criteria for the provision of care; this may include double the number of care staff on each shift.

Seek to move all government funded beds to the not for profit sector over a 10 year time frame with built in incentives for the charitable sector to engage. The evidence shows overwhelmingly that these groups reinvest in care rather than seek to provide better dividends for shareholders.

The sector has raised issues of concern in the associated costs of care and these need to be listened to with the view of partnerships in care with the Commonwealth Government.

Provide monetary incentives for excellence. Hammond Care has spent years improving the care of people who live with dementia and their carers. Give them more resources to pursue pain management in the same way.

Finally, any admission to an acute care facility for a frail older person with dementia has the potential for a catastrophe. Residential aged care should be able to manage most acute issues other than trauma. They need to be funded for such and resourced for such.

- address the interests of special needs groups

Special interest groups within Aged Care have been lost within their own specialisations. The funding and provision of Aged Care should be predicated on the demonstration of the provision of care for a ‘cross section’ of the community that best represents the local ‘flavour’ of the community in which they are placed. An example would include Inner City Aged Care would have provision for ageing homosexuals; trans-sexual etc. Stratified areas or localities that have a strong ethnic contingent in that community should make up the majority of users of those services. Staff should also represent that ethnic mix. The Aged Care Standards and Accreditation Agency must have provision to inspect, audit and examine special needs specific services; staff training; recruitment for clients and residents. The Aged Care Standards and Accreditation Agency should have its powers and responsibility extended beyond the Residential Care Sector.

It would be wise to understand that the recruitment of workers from other cultures do not necessarily have the older populations (relatives) that live a long life. They are not used to the very old. They do not understand dementia yet we have hundreds of poorly paid overseas trained/educated (mainly female) workers who cannot adopt a working understanding of what it means to provide care for someone with dementia.

The care of ageing carers is still as fundamental today as it was 10-20 years ago and there is little to support them in their capacity to remain healthy and focussed.

- develop regulatory and funding options for residential and community aged care (including the Home and Community Care program)

Giving notice of an accreditation audit is problematic; there are too numerous accounts of imported furniture; painting and taking people off restraint not to mention increased staff numbers to present a better picture. The Aged Care Standards have been in place for 10 years. It is now time to let the industry know they have had time to mature into what has been expected of them. Remove notice; expect the standards are being met; put sanctions on those that don't; close or remove funding from those who won't.

Lessens learned from the past 10 years should be the feature for the future; moving beyond the Standards to Aged Care Excellence.

Many older people can and do pay for their care. Many can't afford care and often cannot access timely and appropriate care because of their perceived lack of means.

Ideally GPs would be part of a comprehensive assessment along with an ACAT type body (or practice nurse type) that can undertake an over 65 assessment and delegate a 'fit' on a pathway.

- The pathway could mean a chronic disease management model or health promotion model or
- For those who require greater intervention they could get allocated a 'fit' on a pathway to supported care.
- Both of these could include a continuum of care model.
- Both options come with incentives for improved outcomes.
- Both could come with unit/s cost.
- Both could come with consumer choice of care provider.

I mentioned earlier that the Aged Care Standards and Accreditation Agency could incorporate Home and Community Care including Packages under its principles. This would have to mean a change in the Aged Care Act and Grant Principles….not an impossible task. We seek continuity, quality and opportunities for aged care not the current body of aged care providers all freaking because of a visit from the Agency.

- examine the future workforce requirements of the aged care sector

In order to attract a suitable, contemporary and proud workforce we must place the care of the Aged in just as an important position as the delivery of

trauma services. We must remunerate these specialist workers accordingly. Current places at tertiary level should be aged care specialist places only.

Low and high care should be mixed. Why someone who requires high care should be denied the opportunity to continue to engage as a human being due to their physical needs is beyond debate. Segregation further tells all that you are of less worth from a human perspective.

I do understand the need to care for those at risk and this can be taken into consideration.

- recommend a path for transitioning from the current regulatory arrangements to a new system that ensures continuity of care and allows the sector time to adjust

  - Grant principles will need to be adjusted to accommodate the continuum.
  - To receive any funding or bond for care provision the community sector (like the residential aged care sector) they will be required to establish them more effectively.
  - This will mean economies of scale will interfere with 'home like' services in the city.
  - It will mean amalgamations and joint initiatives for small operations.
  - It will require a timed approach.
  - The aged people themselves will have more choice in the city perhaps unless large groups like Catholic Community Care or Baptist Community Care can take their services into homes in small towns across the country.
  - It will require tight definitions of care language
  - It will require no ambiguity because services will be measured within regulatory arrangements.
  - They will require identification of special interest groups and directed funding. e.g. aboriginal & Torres Strait Islanders; Gay and lesbian communities, hearing impaired, sight impaired, ethno specific etc.

- examine whether the regulation of retirement specific living options should be aligned more closely with the rest of the aged care sector

Cashed up retirees who pay high prices for accommodation in 'over 50's villages/resorts' soon require the need for care services too. Regulation of this sector will see the abandonment of the 'for profit' providers of this resort type accommodation to the NGO charitable sector. Lifestyle programs are costly and the 'extras' that come with some of these places creates a two tiered system.

Ideally those who can pay for services from the private sector should do so. Not at the expense of a diminishing workforce that already pays such appalling salaries. People who cannot afford the luxury of private care should not be disadvantaged with a poorer standard.

Again this discussion and debate needs to take place in light of Aged Care Reform, social and taxation reform.

My view is that this component of the sector needs to be reigned in now before too many of them are out there asking exorbitant prices for 99 year leases..

- assess the fiscal implications of any change in aged care roles and responsibilities.

I am not in a position to discuss. However what ever investment is made will mean we have an aged care sector that becomes the envy of other nations. I ask why not?