SUBMISSION TO THE AUSTRALIAN GOVERNMENT PRODUCTIVITY COMMISSION ON CARING FOR OLDER AUSTRALIANS

I am making a submission to the Productivity Commission on Caring for Older Australians, based on my personal experience as a general practitioner over the last 30+ years. I have visited and continue to visit many aged care facilities, care for many aged patients at home and in hospital, as illustrated by my Medicare data. Most recently I am assisting in caring for my now 96-year-old mother, who lives at an aged care facility.

Many of the issues that have come to the fore have been gleaned by my years of medical and personal experience.

Aged care needs have changed dramatically in the last 30 years that I have been in practice. When I first started in practice, aged care facilities were in general what we would today call "hostel type care"? With the advances in medical science many older patients are living a lot longer and are becoming much frailer needing prolonged periods of high care. This has placed great demands on the facilities in which they live, the country as a whole and their families that support them.

One area that I think needs to be addressed is 'aging in place'. Once a person has been admitted to an aged care institution, it is wrong that they need to be shifted from one place to another on the basis of their care needs. It is a misconception to imagine that someone aged 75 will be able to remain in the same state of health that they are in when they are admitted for the next 20 years, and yet realistically they may well live for the next 20 years and beyond. It is important that aged care facilities have the capacity to accommodate the aging patient. Patients feel secure in one institution, as do their families.
The patient needs to be able to be cared for in continuity at the same facility. Patients over time build up trust amongst their carers and their carers likewise get to understand the patient's idiosyncrasies. The patient's health care needs can then be seen in continuity and not as fragmented sections of their lives.

It is important that the distinction between low care (the former hostel) and high care (the former nursing home) be a thing of the past. Both types of facility require both levels of care for their residents. Staff need to have nursing experience and I think that the whole gamete of services should be available within the aged care facility.

Aged care facilities need assistance in infrastructure if they are to remain affordable to all Australians. Bathrooms and floor covering take a severe beating in day-to-day care and need replacement at a far greater frequency than in everyday life. This assistance would go a long way towards making institutions more homely. Currently these costs are around A$2000.00 per bed with GST payable in addition. Removing GST from these costs would be of assistance to the aged care facility in keeping the facility looking friendly, not smelling of urine and showing stains of faeces and the chips of paint on the walls from the last resident.

The current categories of high care and low care are in themselves somewhat misleading and the current scramble that goes on in nursing homes to fudge figures so that patients can be classified with as many diseases as possible to get maximum funding is both an insult to the patient and an insult to the medical profession who it is expected wil provide the evidence and to the patient. The patient 'who has more wrong with them'[1] is more valuable to the institution in which they are being cared.

Within the next 50 years, aged care in Australia will change even further. With the increase in immigration both voluntarily and involuntarily into Australia the number of people of overseas origin, African, South East Asian, Ceylonese, Afghans, etc is going to place great strain on the current arrangements. Our aged care system has to date, not catered well for those of European extraction; it will cater even less adequately for those of mixed ethnic origin.

The second area I would like to address is that of medical care and nursing care within aged care facilities. I attend, currently, one aged care facility at which the nursing ratio per patient is dangerous if not outright negligent. It is no longer realistic to have one registered nurse for up to 80 patients. The patients that are being cared for have multiple problems, are often profoundly demented with multiple diseases, have families who are anxious and families who on many occasions who are unable to provide the niceties of care that they would like to be able to deliver because of their own life commitments. Registered nurses working in aged care have long been the "poor relation" in the health care system. With lower pay and little recognition. In reality the nurse working in the aged care sector has needed to be able to provide care for residents with multiple health problems without the backup of onsite medical practitioners. They are and do provide "holistic "care of residents and relatives in the end stage of life.

We of the so called "sandwich generation", that is having aged parents and young children and grandchildren are pushed from either side and it is becoming increasingly difficult for us to provide the aged with the intimate care that they need. It is important that the nursing sister in an aged care institution is not purely someone who is assigned to an office, to fill in documents in order that the aged care facility can receive their maximum government support, she needs to be ' on the floor ' in the time honoured tradition of the Nightingale nurse, soothing the sick, caring to their needs not reading the handover notes when the doctor arrives to do his round. With the severe shortage of registered nurses in aged care it is increasingly difficult for the registered to spend time out on the floor where she /he should be. Often there is one registered nurse on duty for over 50 residents. Increasingly the duties of the registered nurse are being taken over by carers with very basic nursing skills, this includes the administration of medications, wound dressings, enteral feeding and diabetic care to mention just a few basic activities

The rules for accreditation have become onerous and at times irrelevant and once again at the aged care facilities that I have visited and visit it does seem wrong to me

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[1] It is not an in frequent event to be asked by a nursing home to state that the patient is depressed, so that the institution will receive extra funding. Patients with lesser disability are on occasion refused admission by nursing homes because the nursing home knows a higher worth patient i.e. a patient with more maladies could be found.

that at the times of accreditation there is great haste to make every I dotted and every T crossed in order to gain accreditation. The care in some institutions maybe very good but not fulfilling the dotting and crossing that is demanded of them by government regulators and they fail to be accredited. All aged care facilities must be accredited and achieve and provide proper care and services to our frail aged. It should also ensure the staff that provide this care are properly trained and that there are adequate numbers of staff to carry out the work required. Accreditation has an important role in ensuring proper care and services are provided. Each year the expectations of how this care and service is provided increases without any logical reason. More time and effort is put into preparing for the accreditation than into the every day running of the home.

Aged care is not popular with general practitioners. They're a number of reasons for this; firstly the remuneration is poor, secondly the amount of troublesome contact that is had by the practitioner with the pharmacy[2], the aged care facility and relatives is all unremunerated. This level of interruption is not feasible in a busy general practice. If aged care is to become truly a commitment for general practitioners it must be recognised for what it is; a commitment, a vocation and a passion and be rewarded accordingly. The current SIP initiative is little short of an insult.

The current system does not adequately reward doctors who have provided continuous aged care support for their patients in an appropriate manner. Comprehensive Medical Assessments or CMAs, which are demanded by the institution to be completed by the doctor, do little to enhance the care of the patient. It is yet another form to be completed for there is little to be gained in day-to-day practice. The same applies to Aged Care Assessments, which in theory sound a good idea, and have been and continue to be rorted by corporate practices. An old style practitioner such as me in general practice took the time to know the circumstances of his patient and did not need yet another form to complete to tell him/her what he/she should have already known.

Aged care facilities often have staff who are inexperienced and often do not know the institution in which they work. One may question why is this? It is because they are amongst the lowest paid individuals in the land and only recently when the minimum wage was reset and raised to a more appropriate level, a comment was made by the aged care industry that this may push many aged care facilities to the brink, clearly

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[2] Let me illustrate the unsatisfactory system that exists in relationship to medications. The patient needs urgent medication. The doctor prescribes, the pharmacy dispenses. So far so good. The pharmacy needs a script for the medication, which must be written on paper to be signed by the staff at the aged care facility. In an efficient model the script should be electronically relayed from the doctor's computer to the pharmacy saving all the middle work of printing, and signing. If the medication is a schedule 8 drug e.g. a narcotic the doctor must not only print it but also hand endorsed by him and then faxed to the pharmacy if urgent. This requires the doctor's time and staff's time to complete this transaction. The time taken for such an interruption in the doctor's schedule from time of phone call to completion of transaction can be up to 10 minutes. Remuneration received for this service is nil. A lawyer would have received 2 units of remuneration i.e. $70 as would the plumber who has arrived to inspect the underlying problem.

illustrating that workers in aged care are poorly remunerated, poorly qualified and unrecognised for their worth. This must change if the quality of the carer and care is to improve.

Another area that I would like to comment on is the self-funded retiree.
I am acutely aware of the inconsistencies that exist in the financial arrangements for the older Australian. If an older Australian is in superannuation, they are paying a vastly different tax bill than one who isn't. If not in a superannuation fund, either DIY or from an institution the tax obligations are onerous, complicated and bewildering for elderly folk. To be able to manage his or her affairs someone such as a family member has to assist. This is not uncommon issue is becoming increasingly onerous as family themselves are often senior citizens.

Over the year that my mother has been in care she has developed her own style of care. She has been classified as high care, yet also employs a carer to visit her and do the little things that make her life so much better. This is an interesting model. It is a relatively new model and one that is recognised by some as probably providing the best of both worlds; 24-hour care with a personal touch and at an affordable price. The cost of prolonged i.e. over years, 24-hour care at home is only available to the super wealthy and thus is not feasible for the vast majority of older Australians. Personalized aged care in an institution is a model one that I think needs to be seriously entertained for many other older Australians and to be supported by government.

The question of regulation is all-important. Regulation does need to exist in aged care. Institutions need to be regulated to ensure that they provide the care, for which they are paid. This must be real not fudged, not just trumped up for the acreditors when they arrive on the accreditation day. The regulations must also allow creativity and difference to exist between aged care institutions so that families of different ethnic origins do have some choice for the elderly so that they feel comfortable in their own environment.

The current system is too confusing. There are so many acronyms for the various services that no single person can remember them, let alone remember all the other things that they have to in their professional life. Currently both local, state and commonwealth governments provide services. This is admirable, but it does need to be more uniform and clearer for the user to understand.. Some shires provide services that other shires don't. Some state governments provide services that other state governments don't and so the level of confusion continues and grows.

The principal objective of aged care must never be forgotten, that is to provide sound respectful, loving attention to the elderly who have contributed so much to the strength and to the wealth of this nation. Currently the elderly are seen as second class citizens, as a burden upon society, as a nuisance, as a group of people using up valuable resources. It is easy to forget that without the hard labour of these older Australians, the current, younger Australians would not be able to enjoy the lifestyle that they do.

In the arena of Veterans Affairs, the contribution of the past generation is recognised but the contribution in civilian life of many aged Australians, is sadly forgotten.

My suggestions are:

- Accepting the importance of aged care as a valued occupation at all levels of the industry from cleaner to General Practitioner
- Realistic staffing ratios in aged care facilities
- Putting the nurse back 'on the floor' and out of the office
- Infrastructure support e.g. painting, bathrooms &floor coverings etc
- Aging in place to be driven by need and compassion and not all based on funding of the those with the most illness model
- Accreditation that is relevant and not driven by bureaucracy
- Incentives in general practice to make aged care medical services more accessible and reducing the useless bureaucratic hurdles
- Removing the inconsistencies that exist in self funded retirees income sources
- Uniformity across the country in what services are available and what they mean to the recipients and their families
- Personalized aged care in aged care institutions

I trust that my comments on aged care are of assistance to the commission and I would be happy if so needed, to make any personal comment on any of the issues that I have raised. I hope that when we require aged care that desirable services incorporating some of the suggestions that I have raised will be available.

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