HOME MODIFICATION

INFORMATION CLEARINGHOUSE

Monday, 21 March 2011

Australian Government Productivity Commission

agedcare@pc.gov.au

Re: Caring for Older Australians –

Productivity Commission Draft Report January 2011

Dear Commissioners

I would like to thank you for producing such an interesting and thought provoking draft Report. In particular, I would like to express my appreciation for the consideration you have given to the input provided by myself, Assoc Professor Catherine Bridge, and the Home Modifications Information Clearing House. I appreciate the opportunity to comment on the draft Report and would like to draw a few specific issues to your attention.

I am aware that you will receive a large number of submissions addressing all aspects of the draft Report, so will confine my comments to: Chapter 10 Age-friendly housing and retirement villages, and the related parts of Chapter 6 Paying for aged care; Chapter 7, Options for broadening the funding base; Chapter 8 Care and support, with particular reference to this aspect of assessment; and Chapter 11 Delivering care to the aged – workforce issues. Although there are links between age friendly housing and Assistive Technologies (AT), as a Director of the NSW Independent Living Centre, I know that they are forwarding you a submission specifically to address AT issues.

I will also raise some issues that have been clarified in recent, as yet unpublished, research on *"Home Modifications and their impact on waged care substitution"* which was funded by the Home and Community Care program in NSW through the Ageing, Disability and Home Care agency of the NSW Department of Human Services. A copy of the report will be available shortly on the Home Mods Information Clearing House website: www.homemods.info

Comments on Chapter 6 Paying for aged care:

In Section 6.2 *Who should pay and what should they pay for?,* it is not clear where payments for home modifications, even minor ones such as grab rails, would sit. Would they be included under 'accommodation services' or 'health care', because of the occupational therapy component, or under 'personal care', because they have the potential to replace or reduce personal care services?

Under Section 6.2 *How much should individuals contribute to care costs?,* it is not clear whether the costs of home modifications would be included in the calculation of an individual's contribution to care costs and their safety net or stop-loss limit. Given that some home modifications cost many thousands of dollars e.g. bathroom modifications, it is possible that home modifications could use up much of an individual's stop-loss limit if those costs were fully included in the safety net. One option here would be for the occupational therapy assessment costs to be included in the safety net as a 'health care' cost, but for the other costs of project management, tradesmen and materials to be counted as a personal contribution to the individual's accommodation costs.

Comments on Chapter 7 Options for broadening the funding case:

In Section 7.2 *Drawing on housing equity to pay for care costs,* there is no recognition of several facts:

- recent research[1] has indicated that an increasing number of older people may be accessing equity from their houses prior to their becoming frail: primarily to top up their pension/superannuation to meet living costs or replace critical items such as cars and large appliances. Therefore, the quantum of equity still available from their homes may not be the same as for current older Australians who have not used their home equity to any significant extent prior to becoming frail; and

- many older Australians live in areas with low, or falling, housing values, primarily remote and rural areas, and cannot access their housing equity through existing Reverse Mortgages. The extent to which their housing equity could be accessed, or, given the relatively low value of their housing, would assist, may be marginal. Would the proposed government backed reverse mortgage product accept a higher Loan to Valuation (LVR) ratio to enable older people from those low housing value areas to access their housing equity?

In addition, if older people were to use their housing equity to undertake modifications to make their home safer and more suitable for ageing in place, would that leave sufficient equity for them to also use that asset to contribute to their care costs? In many cases, the answer would be no. Therefore, this dual call on older people's major asset needs to be recognised and prioritised. For example, for access to home equity, would home modifications, where they had the capacity to reduce or replace ongoing care costs, be prioritised over the individual contributing to their care and support costs?

However, under the section *Is there a role for a 'public equity release' scheme*, it should be noted that one benefit from government backed reverse mortgage products could be that the protections and scale were sufficient to enable the interest rates on

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[1] Bridge, C., Adams, T., Phibbs, P., Mathews, M. & Kendig, H. (2010) *Reverse mortgages and older people: growth factors and implications for retirement decisions.* Australian Housing and Urban Research Institute UNSW-UWS Research Centre AHURI Final Report No. 146

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THE UNIVERSITY OF NEW SOUTH WALES

Level 3, Red Centre (West Wing)

UNSW SYDNEY NSW 2052 AUSTRALIA

Telephone: 1800 305 486

Facsimile: +61 (2) 9385 5935

Email: hminfo@unsw.edu.au

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these products to be reduced to the equivalent of a standard variable home loan rate, which could be up to 2% less than current reverse mortgage rates[2].

Comments on Chapter 8 Care and support:

Under Section 8.1 *Community education and Individual information needs,* it is correctly stated that older Australians and their families could benefit from information on a range of issues. However, it is not clear in this list where the provision of information to help them to assess the suitability and safety of their home for ageing in place would be available. At the moment this information is provided in a piecemeal fashion by Independent Living Centres in each state, occupational therapists and, in some cases, the local hardware store!

One model of early intervention to extend independence, and prevent accidents which lead to disability, is the Department of Veterans Affairs (DVA) HomeFront service. HomeFront aims to maintain clients' health and independence and reduce potential medical and hospital costs by reducing the incidence of falls and accidents in and around the home. It provides a free home assessment by a trained assessor who identifies hazards in and around the home, such as uneven floor coverings, poor lighting, wet/slippery floors, unsafe steps or railings and cluttered walkways. Recommended safety appliances, such as grab rails or non-slip surface treatments for floors are then installed by qualified tradespeople, often a HACC Home Modification service. Clients are also given information about other support services to help them to continue living independently in their homes. However, one issue with this program is that assessments are not done by an occupational therapist and there is a risk of inappropriate equipment being prescribed or incorrectly installed. Note that DVA includes minor modifications such as handrails in bathrooms, under Aids and Appliances (assistive technology) rather than under home modifications.

Under Section 8.1 Assessment, there is little awareness of the fact that current aged care assessments and assessment tools do not adequately assess the impact of external environments on people's capacity for independence. For example, the Ongoing Needs Identification (ONI)[3] tool, which is used by HACC services, contains no elements to identify or assess the enabling/disabling effect of the client's environment. This means that simple home modifications, such as the installation of grabrails which

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[2] Bridge, C., Adams, T., Phibbs, P., Mathews, M. & Kendig, H. (2010) *Reverse mortgages and older people: growth factors and implications for retirement decisions.* Australian Housing and Urban Research Institute UNSW-UWS Research Centre AHURI Final Report No. 146

[3] http://www.health.qld.gov.au/hacc/docs/pdf/onitool-allprof.pdf

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would enable the client to self-care, may not be considered until after the care plan is developed and the initial home visit is undertaken by the service provider for the OH&S assessment of the workplace for their care workers. Research into the use of home modifications to reduce/replace waged care services[4] has indicated that it is essential that assessment for the potential for enabling home modifications be carried out prior to allocating ongoing care needs as, in some cases, they may replace or defer the need for care services, particularly personal care.

There is also a poor understanding of the interaction of home modifications and assistive technologies (AT). Where either could assist the client, home modifications are preferable for chronic ongoing conditions, but not suitable for short-term, rapidly deteriorating or palliative conditions. However, due to long waiting lists or lack of access to AT, the two are often used as inappropriate substitutions for each other. There is little policy/practice guidance available to practitioners/assessors on what these trade-offs are and which option is preferred in any particular instance.

There are a number of different ways that people access home modification services. In NSW alone these include:

- Through a hospital or community based occupational therapist (OT)
- Through referral from another community care service
- Direct or self referral to a HACC Home Modification service
- Through the Department of Veterans Affairs HomeFront service
- Through NSW Lifetime Care and Support Authority
- Through the Disability Services Program, insurance companies, Workcover etc.

Each pathway may have different guidelines and funding conditions which may be differently interpreted and applied. This directly affects how large items of technology e.g. lifts, ceiling hoists and major bathroom modifications, are funded and supplied[5].

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[4] Carnemolla, P. & Bridge, C. (2011). *Home Modifications and their impact on waged care substitution.* Home Modification Information Clearinghouse, University of New South Wales. Available from www.homemods.info

[5] PricewaterhouseCoopers, *NSW Health – Review of the Program of Appliances for Disabled People*, June 2006.

In addition, it needs to be acknowledged that inappropriate prescriptions or poorly installed home modifications have the capacity to cause injury. The Australian Standards cannot be relied upon to ensure appropriate prescription/installation. This was exemplified in research conducted into grab rails[6], which found that, with respect to grabrails, AS 1428.1 is a poor guide to the needs of individuals in a domestic setting as optimal design is needed to accommodate individual difference. They noted that:

"Appropriate prescription and design of a grabrail affects successful outcomes. Successful use of a grabrail is achieved when the individual has completed the given activity in a safe and dignified manner. This includes minimising the risk of secondary disability due to falls or overuse injuries"

Current home modification services are also primarily geared around the trades involved, rather than the balance of home modification and care services for an individual. This means that aesthetics, emotions and alternatives are usually not considered in the assessment/prescription phase e.g. berming rather than installing institutional-looking ramps, which decrease the value of the client's home, and may increase their vulnerability by publicising it. Consequently, clients have been known to reject home modifications of poor design and aesthetic. Additional research and evidence and the involvement of committed architects is required to build a portfolio of solutions which meet self-care needs, cost constraints and aesthetics.

Ideally, all older people who need any level of personal care would receive an in-home assessment to identify opportunities to support self-care or reduce ongoing formal care needs prior to their care plan being finalised. A hypothetical layering for assessment and advice to replace/reduce ongoing care costs could comprise:

1. Low level client – has moderate arthritis and cannot prepare food:

    - Recommend purchase by client of microwave and press-to-pour boiling water jug so that client can make cups of tea and reheat pre-prepared meals. Supplement with weekly outings to a community meal with friends. *Result: no need for assistance with food preparation and client remains independent and self-caring.*

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[6] Evidence Based Research – *"Selecting Diameters for grabrails",* L. Oram, J. Cameron & C. Bridge; and *"Effectiveness of Grabrail Orientations during the Sit to Stand Transfer", (2006)* H. Seton & C. Bridge. Home Mods Information Clearing House

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2. Medium level client – has mobility impairment and cannot stand in shower or step over bath

    - Recommend removal of shower hob, installation of grab rails around shower and toilet and shower chair. *Result: No need for personal care assistance and client remains independent and self-caring.*

3. High level client following major stroke – cannot transfer without assistance, which prevents self care in bathing, toileting etc

    - Recommend reinforcement of ceilings in bedroom and adjacent bathroom to enable installation of travelling hoist; modify shower/toilet access to enable a single careworker (instead of two) to provide personal care. *Result: reduced ongoing cost of care as only one personal care worker is required and carer does not sustain injury trying to lift client.*

Comments on Chapter 10 Age-friendly housing and retirement villages:

Although the draft Report makes the key point that *"Universal design standards are increasingly being applied to new private and social housing",* these changes will have almost no impact on the capacity of older people to age in place as they mostly live in houses and communities which were not designed to support any level of disability.

One option often discussed, or assumed, is that older people, or people with impairment, will embrace a move to a more supportive/enabling environment. There is no evidence to support this assumption. In fact, the evidence available is to the contrary[7]. However, the housing design of people's homes does influence their decision of whether and when to move. Judd et al[7] noted that many respondents in older age groups spoke of problems that would or had caused them to move, or illness or frailty which made it difficult to cope with aspects of the house, such as stairs and household and garden maintenance. A typology has been developed which shows the relationship between housing design type and an individual's level of functional

[7] Judd, B., Olsberg, D., Quinn, J. Groenhart, L. and Demirbilek, O. (2010) *Dwelling, land and neighbourhood use by older home owners.* Final Report No. 144 Australian Housing and Urban Research Institute, Sydney Research Centre

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impairment, and, by implication, their need for ongoing care services and/or home modifications.[8]

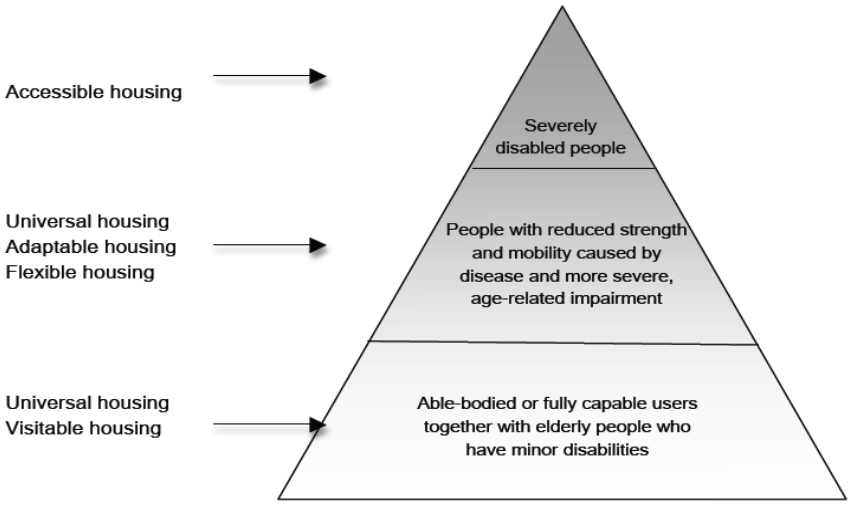

Figure 1: Pyramid comparing layers of design approaches (Source: Newman, 2010)

Typical Australian houses have at least several front steps, narrow halls and doorways and inaccessible bathrooms. Typical Australian communities have inaccessible shops, buses, trains and, often, poorly designed and maintained, or even no, footpaths. This is well illustrated in communities with a high number of motorised scooter users by those who divert along the roadway until they find a kerb ramp and can get back on the footpath.

New housing construction in Australia has remained relatively stable for many years at only a relatively small percentage change in overall housing stock. Indeed, changes in housing stock occur gradually over time through construction of new dwellings and alterations to existing homes. For instance, in the nine years from 1994–95 to 2003–04 an estimated 1.5 million new dwellings were completed in Australia (an average of 146,000 per year). These additional dwellings represent less than one-fifth (19%) of the

[8] Newman, R. (2010) *The Home is for Every Body? An Investigation of the Statutory and Strategic Planning Implications of Inclusive Housing Design,* (Honours thesis) University of New South Wales, Sydney. Australia.

7.7 million households in 2003–04, the same statistics underscore the trend to larger buildings with less occupants. [9]

While older Australians who live in public or community housing have access to modified or accessible housing, those who live in private rental or privately owned housing do not. Private owners can modify their homes, but often leave it too late to do so, e.g. after they have had a significant accident. Private renters have less choice and are more likely to be admitted to residential care[10]. Even if an older person were to sell their home to move to more suitable premises, there is a dearth of accommodation which is suitably accessible available in any community[11]. For example, new apartments may have accessible common areas, but the internal layout is not required to be accessible. In addition, the costs and the challenges of dealing with an Owners Corporation and local council to undertake any necessary modifications would be overwhelming for most people. In the absence of mandated requirements for private housing to be accessible to some extent, then home modifications will remain an essential part of providing community care.

As you noted in your draft Report, additional research is required to identify the effectiveness of home modification services in economic terms. In this respect, I would like to draw to your attention our recently completed research on: *"Home modifications and their impact on waged care substitution"* [12]. In this research, the major findings are that timely, appropriately prescribed and installed home modifications:

1. Facilitate ageing in place;

2. Maintain a sense of independence;

3. Reduce hazards in the home environment; and

4. Act as a substitution for assisted care services, thus reducing the need for care.

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[9] Australian Bureau of Statistics, 2007

[10] Bridge, C., Phibbs, P., Kendig, H., Mathews, M. and Cooper, B. (2008), *The costs and benefits of using private housing as the 'home base' for care for older people: secondary data analysis.* Final Report No. 115 Australian Housing and Urban Research Institute, Sydney Research Centre

[11] Judd, B., Olsberg, D., Quinn, J. Groenhart, L. and Demirbilek, O. (2010) *Dwelling, land and neighbourhood use by older home owners.* Final Report No. 144 Australian Housing and Urban Research Institute, Sydney Research Centre

[12] Carnemolla, P. & Bridge, C. (2011). *Home Modifications and their impact on waged care substitution.* Home Modification Information Clearinghouse, University of New South Wales. Available from www.homemods.info

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Therefore, the economic benefits of timely, appropriately prescribed and installed home modifications could include:

1. Reduced length of stay in hospital (timely discharge)
2. Reduced risk of and/or deferred admission to residential care
3. Reduced risk of injury to clients, carers and careworkers
4. Reduced, or even negated, need for ongoing care assistance.

The full report will be available from www.homemods.info .

Also, please note that in Box 10.5, you have not identified that a significant funder of home modification services is the Department of Veteran Affairs, often sub-contracted to HACC home modification services. For some HACC home modification providers in NSW, DVA clients may, in fact, be the majority of their clients. In addition, both the NSW Home Maintenance and Modification State Council and the Home Modifications Clearing House are HACC funded.

Comments on Chapter 11 Delivering care to the aged – workforce issues:

There are significant issues of costs related to workforce with respect to Occupational Therapists (OTs), the main assessors for home modifications. These include universities not having sufficient places to meet demand and being therefore unable to train all students graduating from Allied Heath courses on the many systems and forms which are required for effective assessment and prescription of home modifications. This leads to service gaps and inconsistencies.

Also, with the move to training on home modifications being provided at post-graduate level, rather than undergraduate level, most undergraduates would not have received sufficient training in this area and there is insufficient time now allowed in their courses for it to be acquired. Given the grave shortage of allied health workers generally, and OTs in particular, their motivation to undertake post-graduate courses would be limited. As trained problem solvers, OTs are also in demand as assessors, case managers and managers. This means that there is constant leakage of OT skills out of OT practice.

Conclusion:

The strengths of the draft Report would be enhanced by consideration of the issues raised in this submission. In particular, that:

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- the majority of older Australians live in housing that is not designed to support any but the mildest level of disability;
- the economic benefits of promoting self care supported by appropriate home modifications or housing choice and minimising ongoing formal care is the preferred policy setting for caring for older Australians;
- the potential cost savings of delaying or reducing ongoing care costs through the identification of appropriate home modifications are significant;
- the recognition that assessment for the potential for home modifications to reduce care costs is required at the initial assessment and care planning stage for all older persons requiring ongoing assistance and their carers;
- the recognition that there is a shortage of appropriately qualified allied health professionals to identify and prescribe home modifications; and
- recognition that the use of home modifications and assistive technologies intersect across the health, aged care and disability service systems and that restriction in one area can lead to inappropriate use of the other e.g. delays in discharge or purchase of assistive technologies to compensate for a disabling home environment.

I would like to thank you for the opportunity to comment on this draft Report and look forward to your final Report and the implementation of the proposed new care models.

Yours sincerely

Dr Catherine Bridge.
Associate Professor Faculty of the Built Environment
CityFutures Research Centre at UNSW

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