Submission to Productivity Commission Inquiry into Caring for Older Australians

22 March 2011

This submission on the Productivity Commission's Draft Report draws on expertise I have developed in long professional experience in the adult protection field and from my current research into community care (for a Doctor of Social Work at the University of Sydney).

1. The draft report does not critically engage with the fact that large residential facilities – institutions – continue to be the primary model of residential care provision for the frail elderly. The report does not recognise that this ongoing practice is in stark contrast with residential care models for all but the frail elderly. In the case of people with disabilities, people with mental illness and children, large residential care centres have long been recognised as problematic because of the known inherent risks of abuse, neglect and inferior care in institutional settings. Thus, alternatives such as small group homes are used for these groups. Better models for older people are being explored and trialled for example by the Gay and Lesbian community. These models are more consistent with a human rights approach rather than the biomedical/institutional approach which has been transferred to the market, whether via private provision or charitable sector provision.

2. There is significant ageism in the draft report's uncritical acceptance of large residential institutions as the only option for our vulnerable frail elderly citizens who are no longer able to be maintained in the community. Yet a brief survey of submissions to the Inquiry shows significant concern on the part of recent consumers or their families about abuse, neglect and poor care encountered in residential aged care, and there continue to be media reports from time to time of shocking instances of abuse emerging in the sector. Most elderly people and their families fear entry to residential aged care in Australia because of its reputation and in many cases because of their own experience dealing with relatives and friends in residential aged care. Residential aged care "homes" continue to be described by the elderly and staff of such "homes" as "god's waiting room". It is this reputation and the associated therapeutic nihilism within the sector that has significantly fostered the popularity of the community care sector.

   Quality of care in many cases in residential aged care facilities is poor yet the industry and the Productivity Commission both take as a given that the residential aged care sector is **over regulated**. There is not sufficient attention in the draft report to the voices of dissent pointing out the inadequacy of regulation to drive care quality for vulnerable frail elderly citizens.

3. The principle of 'user pays' (in a "mixed" as opposed to "Universal" system) is also uncritically accepted in this document despite the fact that not all comparable countries take that view - as evident in the background appendix, C "International Experience" which is not included in the final draft report itself. It remains the case that in some countries the elderly are able to expect good care as their due as citizens, as in the case of Japan and some Scandinavian countries. In addition it is noteworthy that Australia pays a far smaller proportion of GDP on Long Term Care for its frail elderly than the majority of OECD countries and the question should be entertained as to why more should not be committed to long term care options for the elderly rather than less.

4. Accommodation bonds are an area of policy that needs significant reform. Aged care providers, in the case of people taking up residence as low care residents or at any level in an extra service facility, can charge any amount of bond based simply on the person's assets, only limited by the requirement that the meagre amount of $39,000 (as of March 2011) remains for their personal use, specialised medical and comfort equipment not required to be supplied by the facility, and important lifestyle expectations such as continued community access with assistance of a trained care worker. Thus bonds of over $2 million have been charged and the average bond is now about $500,000. **It is recommended that there be placed a cap on bonds of about $500,000 or that governmental guarantees only apply to bonds of $500,000 or less** for it appears that unlimited guarantees foster the charging of higher and higher bonds – often at a time when the person is least able to negotiate in their best interests because of cognitive and/or severe physical impairment. Such governmental controls will become even more critical if bonds are extended to high level care as well.

   Indeed, it is the experience of many social workers in aged care that frail elderly people and their families associate the prospect of residential aged care with being charged exorbitant accommodation bonds which could necessitate sale of their home, thus taking away all hope that they might one day return (as in fact can happen in some cases) and would prevent them from carrying out specific long held plans to provide for their children following their death. Such unexpected bond requirements can have an unexpected and catastrophic effect on vulnerable elderly people and their families/beneficiaries. In the adult protection field there are numerous instances of individuals choosing to remain at home with inadequate care or families insisting on caring for frail relatives when unable to properly do so because they do not wish to be faced with such a financial assault. Yet the frail elderly person commonly then is neglected, or self neglects, and at unnecessary risk, for funded support at home (often only up to seven hours per week) is often insufficient for the needs of the person.

5. Most residential aged care facilities are not staffed at a level sufficient to meet the needs of residents. Both staff and families attest to that and adult protection experience confirms it. Hence minimum staffing levels (including sufficient appropriately trained professional staff (nursing, paramedical and medical) as well as suitable, trained nursing assistants, need to be set at sufficient level to meet the need. Without such provisions there is an ever present risk of businesses cutting staff and/or replacing trained with minimally trained or inexperienced other staff for the sake of the bottom line, with negative consequences for our most vulnerable citizens.

6. The Accreditation system currently in place is not sufficient to ensure good quality care for elderly Australians needing residential care because of the risks inherent in institutional care and in the design of the accreditation system itself. My professional experience shows that the agency's typical three yearly visits focus on records and compliance but may well not pick up quality care/human rights issues. These include the fact that elderly residents can have serious, even life threatening skin ulcers due to poor wound care or the excessive use/abuse of restraint. My professional experience also shows that the use of covert and unauthorised restraint is common in residential aged care, in large part because of inadequate staffing to monitor the welfare of people at risk of falls or of wandering away. Such covert restraints include the abuse of fixed tray tables and people being seated in heavy chairs and then pushed to tables or use of deep

chairs from which a frail person cannot escape independently. This is a serious human rights violation.

7. The standard of general practitioner service in residential aged care is an issue of concern in my professional experience. People in residential aged care are usually seen very briefly by their GPs, who tend to rely on nursing staff to identify health issues rather than examining their patients thoroughly themselves apart from when a medical crisis occurs. A higher standard of service applies in the community. This difference is a function of the institutional care system and again raises the question of why this model is taken for granted by the Commission's draft report.

8. The draft report does not discuss the fact that the rapidly growing **community care sector** is in fact **unregulated as a whole, in contrast with residential aged care**. Governments monitor only those segments of the community care sector which operate as 'approved providers' of government care packages (including Community Options packages, Community Aged Care Packages (CACPs), Extended Aged Care at Home (EACH) packages or EACHD (EACH dementia) packages. Yet many care agencies operate independent of government (apart from the ATO) and many frail elderly people use these services despite the fact that their capacity to 'vote with their feet' is compromised: in the absence of governmental sector wide monitoring most agencies operate based on market principles and the assumption that the market will drive quality service. This is huge risk when the clients of these organisations are so compromised in their capacity to negotiate on their own behalf for good quality, affordable care.

9. Consumer directed care models are an important option for people with disabilities and for some among the frail elderly. However, any more extensive rollout of a voucher style consumer directed care model must include case management option, not least for the frail elderly or people with cognitive impairment. Any such system must also make arrangements for the industrial protection and insurance of care workers. These arrangements are in place for the Attendant Care Program in NSW but this is not open to other consumers. Most community care agencies (private and charitable sector) charge in the vicinity of 50% on the top of the cost of paying the care worker, for administration, recruitment, training and industrial and insurance entitlements. This is neither appropriate, nor affordable for an extensive consumer directed care system. Current agencies may agree to be funded to provide a minimum service option in order to enable people directing their own care to be protected from the risk of workplace injuries and the worker from not receiving their just worker entitlements.

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