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The Productivity Commission
Review of Caring for Older Australians
CANBERRA ACT 2600

Commissioners

SUBMISSION TO REVIEW – CARING FOR OLDER AUSTRALIANS

I congratulate the Productivity Commission ("Commission") on its preliminary work on the Review – Caring for Older Australians ("Review").

I provide some comments in the following pages that I request be considered as input into the review. Rather than too much quantitative commentary, although there is some, these comments are largely based on qualitative observations from almost 30 years of experience gained from employment in the aged care sector.

A Table of Contents appears on page 2 of this submission.

I am available to attend any hearing that might be held in Perth (or elsewhere in Australia) to answer any questions on this submission.

Thank you and regards

Wayne L Belcher

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Grey Matters Advisory

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1 *Does the Review adequately address the matter of "Respect for Seniors"?*

The Review encompasses much about the current scope, provision, stakeholder and lobby group representations, funding, and regulatory components of ageing services in Australia. But does the Review adequately address the fundamental matter of "Respect for Seniors"?

What do I mean by this?

1.1 The Hospice Model

Since the earliest recorded beginnings of the hospice movement in the mid 11th century increasingly western, and more recently other, societies have been keen to provide hospice type services to seniors. Of concern, if only for the cost of capital, much of this increased focus has been away from the older person's own home.

The hospice movement can be summarised as follows, and includes notions of nursing homes that we have in abundance in Australia.

> The concept of hospice has been evolving since the 11th century. Then, and for centuries thereafter, hospices were places of hospitality for the sick, wounded, or dying, as well as those for travelers and pilgrims.
>
> Linguistically, the word "hospice" is derived from the Latin *hospes*, a word that refers both to guests and hosts. The first hospices are believed to have originated in the 11th century, around 1065, when for the first time the incurably ill were permitted into places dedicated to treatment by the Crusaders. In the early 14th century, the order of the Knights Hospitaller of St John of Jerusalem opened the first hospice in Rhodes, meant to provide refuge for travelers and care for the ill and dying. Hospices flourished in the Middle Ages, but languished as religious orders were dispersed.
>
> The modern concept of hospice includes palliative care for the incurably ill given in such institutions as Hospitals or nursing homes, but also care provided to those who would rather die in their own homes. The more modern hospice movement began to emerge in the 17th century. Australia was seeing active hospice development, with notable hospices including the Home for Incurables in Adelaide (1879), the Home of Peace in Perth (1902) and the Anglican House of Peace for the Dying in Sydney (1907).
>
> But many of the foundational principles by which modern hospice services operate were pioneered in the mid 20th century. "**Hospice**" today is a type of care and a philosophy of care that focuses on the physical, emotional, spiritual or social in nature symptoms of the person.
>
> *(Excerpts from Wikipedia [1])*

[1] Wikipedia, http://en.wikipedia.org/wiki/Hospice

1.2 The Development of Residential Aged Care in Australia

Australia has grown its nursing home provision slowly but steadily from the early part of the 20th century.

It was in 1954 that the first Commonwealth legislation supporting independent retirement living was promulgated as the Aged Persons Homes Act. This legislation was designed to socially engineer an affordable living alternative to retirees to free up housing to returned servicemen and their families post WWII and Korean War.

Almost exclusively pursued by church and charitable agencies, this legislation gave rise and substance to many of the larger well respected church and charitable sector aged care organisations that exist to this day.

The provision of housing, on a range of matched funding bases, by the Commonwealth, continued to be provided through until the early part of the 1980s. In addition however the implementation of aged care hostels during the second half of the 1960s was also developed under the provisions of this legislation. In latter years people with disabilities were also incorporated into a broadened Aged and Disabled Persons Homes Act.

A significant component of the current supply of residential aged care places arose out of the fundamental purpose of housing and accommodation, not the need for provision of advanced health care. To this day most of the providers of this form of "low level" aged care, provided through hostels for the aged, are owned and operated by church and charitable sector agencies.

Contemporaneous to the development of the Aged Persons Homes Act, but earlier than the development of Hostels under that Act, was the formulation of more rigour in the legislation in the National Health Act relating to nursing homes "C Class" hospitals. The early part of the 1960s saw a growth spurt in nursing homes across Australia, thus really easing up access to, and availability of, convalescent and health related care services to the older chronically frail cohort of residents that hereto had largely been only able to access State subsidies hospitals for the infirm, asylums, mentally incurable, and other such names that we recoil at today but were acceptable 100 years ago. A large proportion of all nursing homes is owned and operated by the for-profit-sector.

It is as if all of a sudden, during the mid 1960s through until the 1980s, there was another choice, a more appropriate choice if you will, of place to send Mum or Dad, or Aunt or Uncle, for the care that we felt we really were unable to provide at home. Not that we really wanted to, but at that time there was such a dearth of any sustaining home care service availability other than very limited home help, fledgling meals on wheels, and State subsidised home nursing services, still somewhat focused on child health care at home. Even the respective State based aged care homes began to revitalise during this period as updated research on care and accommodation options became more plentiful.

But, I contend, in those early years, the model of nursing home care was more closely related to a "hospice" model than perhaps what we see today. This view is largely coloured by the availability to funding to providers in those years. This view will no doubt be criticised by the omission of reference to care – quasi quality – standards that are in place today. I leave that commentary until later in this submission save to say that I accept sadly that the sector still suffers from an inability to meet all the desirable quality outcomes it strives to deliver.

1.3 More Choice

Although often shrouded with grief, embarrassment, or perhaps a sense of breach of promise, it was seen for many years that based on a feeling that we could no longer provide for our loved ones at home – safely, physically, emotionally, and economically – it was respectful of our seniors to have them admitted to an advanced care service.

It was not until the mid 1980s that the Home and Community Care ("HACC") Program came in to being. In fairly rapid succession, HACC programs, together with initially Community Aged Care Packages (early 1990s) and the various EACH programs (2000s) were developed as part of the broader community aged care mix across Australia.

It can be said that the effect of the actions of one generation will continue to be effected by the next. These same people, as children and younger family members of the elderly admitted to care in the 1960s, 1970s, and 1980s, before the development and advancement of a more broad community aged care system, are those suggesting to us today that they really do not want to enter into residential aged care.

Out of respect the admission of their seniors might have been their only realistic option to see good care delivered.

1.4 Change in Mental Model Required

But, out of respect to seniors can we not see that we might have to very quickly change our mental model and system approach to aged care in Australia so that we better serve frail elderly, indeed any person of any age who suffers from a chronic disease process that challenges accommodation requirements and day by day health, and personal care service needs provided to them by their family or other carers?

Helen Foster, recently presenting at EFA11, suggested "of the approximately 75 million baby boomers in the USA today, 79% want to stay in their homes." [2]

I suspect that if we surveyed our current residential aged care clients we would find at least a similar level of response to the question "before you entered into an aged care facility, where would you have preferred to be cared for, knowing that you needed a more comprehensive aged care service?"

In reality, we currently have only 5% or so of all people aged over 65 years in a residential care setting. But is that proportion perhaps inappropriately too high? If we believe so then even greater change will be in order.

I do not for a single moment believe that we can do away with all residential aged care, but residential care carries with it an incredibly costly capital component that may be verging on the unaffordable. Coupled with progressive recurrent defunding of the sector over the past decade, and the increasing inability to develop facilities at a reasonable, viable cost, the relative position of perceived quality and "place to be" is diminishing in the community's perception.

The problem, therefore, of changing the current mental model of an aged care service and accommodation delivery system – out of respect for our seniors – will likely mean an entire rethink of the aged care system we currently experience in Australia. That is, if we do believe that lowering our dependence on residential aged care services to be available to those genuinely most in need of care, in another's facility, there will out of necessity be a significant increase in the range and accessibility to community based care services. What if, for example, the current number of residential aged care places were fixed until the ratio was just 4% of the over 65 years

[2] Helen Foster, presenting at EFA11, is the Principal of Foster Strategy, L.L.C. The EFA website can be found at http://www.environmentsforaging.com/ME2/Sites/Default.asp?SiteID=4F2E80FF1A3D4635890466464EA028A5

age group? What does that mean for residential aged care supply, and refurbishment of current stock as opposed to new developments? What impact might this have on the matter of who pays for the cost of capital?

I am not sure that the Commission's Review has gone quite that far in its considerations, but neither do I believe it had the time to do so. I add some more discussion to these matters in the sections that follow.

We come back to the "paradigm question" that should be asked at every opportunity in every review or change situation:

> What is it that we are doing today that if we were doing better, doing differently, or not doing at all, would radically change and improve the range and quality of aged care services in Australia?

That single question should strike at the core of the purpose of the Review by the Commission.

2 *The Reliance on Residential Care at the Cost of More/Better Community Care?*

There is no doubt that there will be no time soon that we can reduce our dependency on residential aged care. But at our peril we cannot fail to do so.

That is, if we continue to just pursue the same funding models and their variants.

2.1 The Building Imperative

With an average cost to build rapidly approaching, or even exceeding, $200,000 per place, in an environment where from a qualitative perspective, if not societally equitable perspective, clients and their families are demanding single room ensuited rooms for their family members, the residential aged care sector is rapidly pricing itself out of reasonable existence. I note here that this cost is not all driven by the standard building regulations. There are building regulatory compliance requirements in residential aged care services that no other industry sector is required to meet. These regulatory requirements are set by the Australian Government's Department of Health and Ageing ("DoHA"). They are devised as a matter of "respect for seniors" particularly focusing on fire and safety matters, and design related to privacy and dignity issues. They add quality to the building design.

But these regulations also necessarily add to the cost of capital, for which residential aged care service providers are not adequately compensated in two main areas of operation:

- High care residential services; and
- DoHA's contribution to the daily cost of capital for supported residents – the proportion of residents that the DoHA regulates providers are obliged to have in permanent residency at their facilities.

We need to be very sure that providers are able to guarantee viable, and sustainably so, services from which these necessary residential aged care activities emanate. There is currently a hiatus in building activity in the residential aged care sector, driven by a combination of the matters in the dot points above, and the level of recurrent subsidy associated with the recruitment and retention of staff in our sector. This latter matter s discussed in following sections.

2.2 Discharges from Community Care Programs to Residential Aged Care Services

I note from a recent report from the Australian Institute of Health and Welfare [3] that there is a concerning level of discharges of clients from Community Aged Care Packages ("CACPs"), Extended Aged Care at Home packages ("EACH"), and Extended Aged Care at Home – Dementia packages ("EACH-D"). It is a real concern that the death of clients at home rates as a distant second in proportion to discharge or separation to residential aged care services as follows:

Discharge / (Separation) "Reason"	Service Type	Proportion (%) of all Discharges / (Separations)
To Residential aged care	***CACP***	***47.5 %***
To Residential aged care	***EACH***	***45.2 %***
To Residential aged care	***EACH-D***	***66.4 %***
Death	CACP	17.6 %
Death	EACH	34.7 %
Death	EACH-D	20.0 %

Why of so much concern?

One could say (I hope tongue in cheek) that the great community care program innovations over the past two decades have failed as they certainly have not stopped the relentless admissions to what one hopes is more advanced and appropriate care.

[3] AIHW. 2010. Aged care packages in the community 2008-09: A statistical overview

The reality is that there is a paucity of reporting on what opportunity cost these services have saved in terms of ultimate residential aged care services should these services not exist. Neither is there a great level of reporting on the qualitative outcomes of such services such that the questions:

- What more could be done in our community care service programs that would reduce – dramatically reduce – other than for the death of the client, the level of discharges from community care programs to residential care services;
- At what cost to the community, the Australian Government, and to families;
- Therefore, at what capital cost savings to residential aged care providers; and
- Are these costs adequately realistic so that eventually the ratio of residential care places allocated can be reduced as an overall proportion of all people aged 65 years and over?

need to be relentlessly pressed.

2.3 Can we consider Residential Aged Care Services being only for High Care Recipients?

I proffer an alternative solution to some of the thinking that the Commission has considered in its Review relating to high care residential aged care services.

I do not believe that an up front contribution to the cost of capital should be a single solution to the matter of the cost of development and building cost for appropriate facilities. I certainly am in favour of excellent built form services in which the delivery of high quality services can be provided. I am also highly in favour of there being a quality of service accreditation system for advanced community aged care services that are provided.

I take the view that the service delivery quality certification system should apply across both of the residential and the non HACC advanced community aged care sectors, with approved residential aged care providers having additional components of that certification based around their provision of built form facilities.

But surely the aged care system that the Australian community wants for its seniors is for those most in need of care to have that care subsidised. And, if that care requires an approved residential aged care service because the provision of (someone else's) accommodation is an integral part of the provision of an appropriate high quality service, then the appointed gate keeper ensures that access is indeed available to the most in need. For mine, I am not surprised of the discharge rate to residential aged care for people in the EACH-D programs. The AIHW has reported in each of its past two reports on residential aged care in Australia that the

proportion of residents in permanent care at 30 June of each of 2008 and 2009 had at least one diagnosis of dementia [4] [5].

Whilst there is no doubt some point at which one's dependency escalates to where residential aged care is inevitable, it is accepted that the disease process of dementia and its counterpart processes would be one of those afflictions that, unless another, more aggressive, life threatening, disease process intervenes, almost predicates an eventual admission into residential care.

Similarly I suspect that an individual afflicted with the following are equally worthy of admission to residential aged care once things become just too difficult for community care to continue to meet the needs, or if admission is direct from hospital for specific high care service provision:

- Behavioural disorders and processes;
- Neurological disorders and disease processes;
- End of life palliation; and
- Sub acute / transitional care.

I elaborate on the sub acute / transitional care form of service later in this submission.

2.4 Does the data support the rationalisation of High Care built form?

AIHW acknowledges that the DoHA aged care client database does not match admission data for clients entering either residential aged care or the range of community package services. This is an astonishing shortcoming given that AIHW's own discussion (see footnote 4 for reference, page 46) that "Coding of health conditions in the ACFI come from those used in the Aged Care Assessment Program and these codes map to equivalent codes in the International Statistical Classification of Diseases and Related Health Problems – Tenth Revision – Australian Modification (1998) (also known as ICD-10-AM)."

The Review should strongly recommend the collection by DoHA of specific data relating to ICD coding. It is this coding that can be used in conjunction with ACFI to demonstrate that the most needy, as determined by regularly reviewed ACFI, are receiving, or being targeted to receive the appropriate allocation of high care level aged care services – whether residential or community based services.

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[4] AIHW. 2009. Residential aged care in Australia 2007-08: a statistical overview. Cat. No. AGE 58. Canberra: AIHW

[5] AIHW. 2010. Residential aged care in Australia 2008-09. Aged care statistics series no. 31. Cat. No. AGE 62. Canberra: AIHW

What we know from the implementation of ACFI in March 2008 is that the rate of admission of residents with a high care assessment is now approaching twice that of residents with a low care assessed need. But the questions remain:

- Is it absolutely essential that all of these high care assessed residents need to be admitted to residential care, when greater attention given to the development of community high care services might assist to alleviate that high care admission rate;
- Is it possible to work towards removing the need of residential aged care for people with low care assessed needs, or, if not;
- Can the accommodation requirements of low care residential care clients be dismantled from the service funding components to effect more plentiful and appropriately designed low care accommodation / housing for seniors.

The housing and accommodation matter is discussed further in the sections that follow.

3 *The Dance around Recurrent Funding and Capital Revenue*

The relentless dance in motion continues, ever spiraling downward into a defunded pool of inability to achieve required quality outcomes.

3.1 Recurrent Funding

A current hospice service in Western Australia, a State in which private hospital type hospice services have shrunk over the past handful of years, receives funding for WA State Health initiative to provide end of life palliative care services for $716 per occupied bed day. The subsidy is paid at an agreed level of occupancy and there is an annual audit to adjust actual occupancy with subsidy paid.

Recent research shows that the daily cost for a metropolitan non teaching hospital in Perth, for the provision of the room and bed, with no acute medical or surgical intervention in the active care plan (that is either pre or post medical or surgical intervention) ranges between $1,000 and $1,200 per day.

The hospice service receives no additional funding for the cost of its capital employed in the service delivery. I do not know the level of additional capital funds allocated for the purpose of development, upgrading and / or refurbishment of a public hospital in Western Australia.

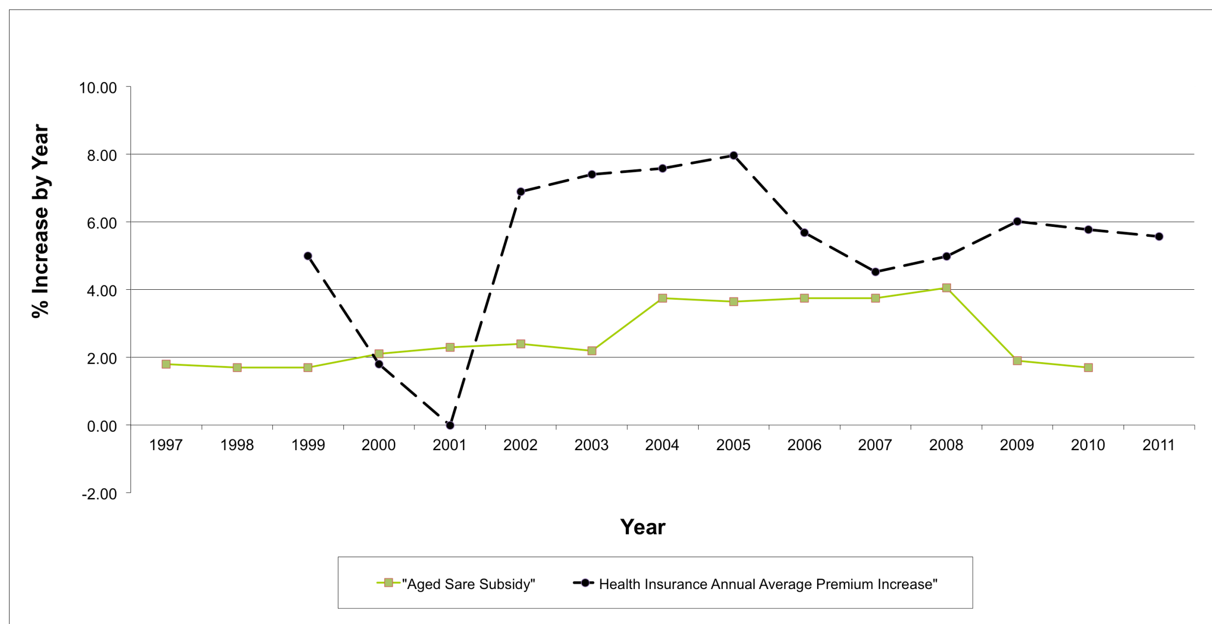
What I reasonably understand though is the considerable difference between the daily recurrent service income that aged care providers – both residential and community based – receive for the services rendered to their clients. This is something that the Commission understands but, as I read the Report, has yet to make any firm recommendations upon.

The difference between $250 to $300 maximum per day for a residential aged care service, and some $150 per day maximum for a community care based package service, are but a fraction of the palliative care contract price – a contract that provides for non privately health insured WA Government sponsored clients. Please understand my concerns here – this is not in any way to suggest that the palliative care contract is over priced or not worthwhile. The alleviation of pain and suffering in end of life care is a focus that should receive much more attention and equitable funding for aged care as well – whether in a residential care or community care setting.

I raise these comparisons to once more highlight the gross inadequacy of recurrent funding for aged care in Australia.

The recent announcement by the Federal Minister of Health on the average rate of increase approved for health insurance funds confirms the obvious, the obvious being a progressive defunding of the sector compared to reasonable comparators. Please note that the 2011 subsidy increase for aged care will possibly not be known until May or June 2011.

Chart – Comparison of "Aged Care Subsidy" to Approved Annual Average Private Health Insurance Increase

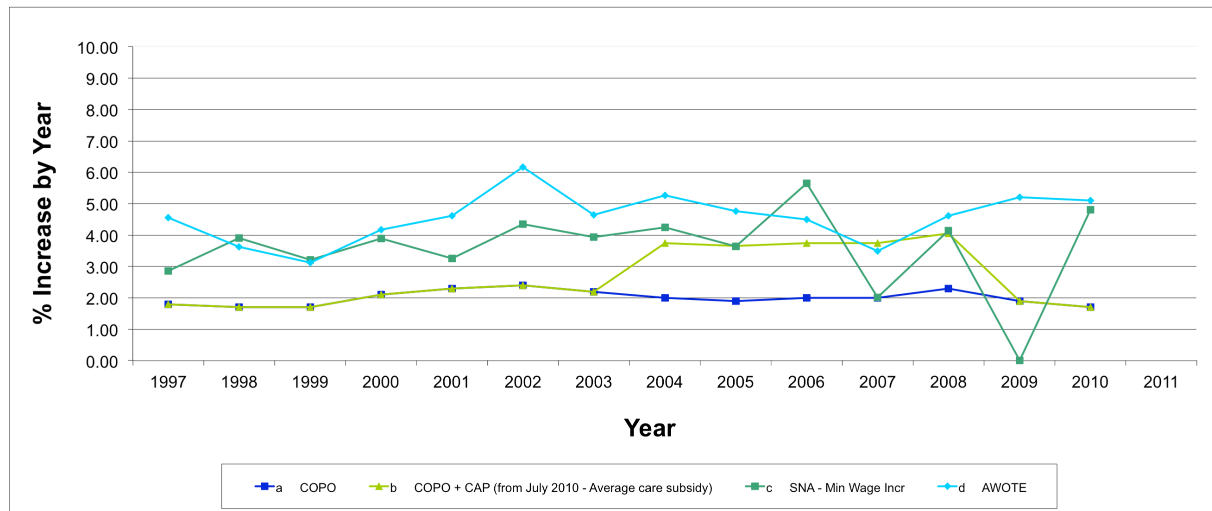


3.2 Recurrent Funding and Workforce

Benchmarking reports over the past decade or so suggest that a similar proportion of aged care organisational income is allocated now to costs associated with the aged care workforce as it has been through the past ten years.

If this is so, then due to the relative defunding of the sector as shown in the following chart, then surely the only reasonable solution that can be drawn is that compromise has necessarily been made in either the quantum of labour available to manage and care for our aged care clients, or the ratios of the mix of skills has been varied towards lower cost, hands on workers and away from skilled clinical professionals, or a combination of such factors.

Chart – % Increase in COPO, COPO + CAP, SNA - Min Wage, and AWOTE, on a year by year basis 1997 to 2010



After several decades of management science it is accepted that the payment of a reasonable salary is not the only driver of workplace satisfaction. But the absence of equity amongst peers elevates this salary satisfier [6] to a higher order requirement of satisfaction in the work life of an employee.

The aged care sector has suffered from a Cinderella perception amongst health care services for decades. It now struggles impossibly for recognition in a time of increasing funding disadvantage against its hospital and other health service peers.

This dissonance is having a practical effect in the ability of providers to attract, recruit and retain appropriate staff across their services.

In addition, the imposed funding regime drives for economic rationalism that strikes at the core of service quality. At a time when services are facing admission of greater numbers of high care recipients, a bias now towards a higher age of first entry into care, and a higher level of comorbidities being evidenced in residents, providers today can simply not provide to their clients the optimum level of care that one would want to see their family member receiving in end of life care and support.

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[6] Herzberg's Motivation-Hygiene Theory (Two Factor theory).
Herzberg, F, Mausner, B, and Snyderman, B B. 1959. The Motivation to Work (2nd ed). New York: John Wiley & Sons.

One can simply not do in care with $200 to $300 per day what one can do with $716 per day. But in terms of the advanced residential care and community aged care package services being delivered, those clients with measurably comparable hospital / health assessed care needs are more closely similar to end of life care recipients than we might think or want to believe. The acuity level and care needs presenting for staff requires a rethink by funders and providers alike if we are truly going to provide holistic end of life terminal care for our loved ones.

This will mean a renewed focus on use of registered nurses, greater application of activity therapies and activities, greater application of clinical governance requirements including additional medical, pharmaceutical and allied resources, and a renewed focus on the provision of spiritual support services for providers and their clients – at home or in home.

The recurrent funding issue as it applies to provision of workforce resource is two fold:

- More staff, and an improved variety of health professional services, are required to deliver higher quality care services; and
- An appropriate staff mix, and related up skilling of all staff, is required such that recognised end of life care principles can be pursued in delivery of service to clients.

3.3 Capital Funding

Whilst I am not necessarily against the use of refundable deposits, or other forms of capital contribution as payment for accommodation, I think this is a pathway that is not necessarily in the best interest of clients and provider alike – for high care service recipients.

I am more open to the notion of continuing capital contributions for people needing an accommodation based low care service.

I am a supporter of the unbundling of capital and recurrent funding as follows:

- I am of the view that the provider of low level care accommodation does not need to be the provider of the care that happens in such a facility, but as this is a form of congregate living in which care is provided, there should be some minimum building certification requirements that respect the increasing frailty of residents;

- This manner of thinking is in line with how we now fund community care – the certification required by the land owner / rate payer is that of the local council for a suburban residence, and most often the service provider is not the resident or the family (although it could be if this was the choice of the client, and appropriate accountability safeguards for consumer directed care provision are in place);
- Low level care housing provision could be met with a once off accommodation payment, a lease for life payment, a time share arrangement payment, or any variant of same; and
- However, similarly to a house in any suburban street, if the low level accommodation has actually been certified as appropriate to provide high level care to clients living in these services, then an appropriately discounted high care subsidy (care minus accommodation and hotel service cost) could be provided by the funder to the provider.

However, and the answer that I guess people are waiting for, I am not in favour of a bond for high care recipients. I am of the view that a refundable, sizeable once of payment, is a mechanism that complicates the delivery of care, and brings with it such (necessary for respect of seniors) bureaucratic prudential strings, that I ask, at what future cost?

I am of the view that there should be a two "broad banded" level subsidy for approved high care clients.

The highest level is a figure that includes an amount for the provision of the capital cost. If the overall figure is set at an appropriately high rate the risk/reward incentive for the provider is to prospectively develop a service for their prospective clients and repay debt from their income stream. The recurrent income from the funder will recognise, and be discounted based on the asset and means of the individual client and on a means basis set the additional cost to be reimbursed by the client to the provider. In instances of supported residents, the higher figure will recognise the Australian Government's contribution to the overall cost of care.

The lower broad banded range will be for provision of high care service where a care recipient is in situ and is not intending to move. Essentially this fee will be for care, recognizing that the cost of accommodation and hotel services will be, or have already been, met by the client and/or other stakeholder (such as a supportive housing authority). Such a payment might well have been an accommodation bond or variant of the theme.

4 *The Housing Dilemma*

One of the fundamental needs in life is shelter.

In the National Housing Supply Council, "State of supply report 2008" [7] it was reported that some 250,000 families are in need of affordable housing in Australia. In its second report [8] the National Housing Supply Council has suggested an updated shortfall of almost 500,000 dwellings that are both affordable and available for those people in the bottom 40 per cent of the income distribution across the nation. The following excerpt from that second report notes the attention seniors affordable housing is attracting:

> As the population ages and longevity increases, there will be a considerable increase in the number and proportion of older people seeking housing assistance, support to remain in their home, and transition to other housing options better suited to their emerging circumstances. The Council's projections of underlying demand for housing—while making no provision for changes in income, wealth, trends in affordability and access to home ownership in earlier age cohorts, urban development patterns, and housing preferences—serve to illustrate the challenge that population ageing presents to the housing industry and government policy at all levels.
>
> Maintaining independent living for as long as possible is an important priority for most older people. Meeting the housing needs of older Australians is as much about health, mobility and maintaining connections with friends, family and support as it is about housing, income and housing costs.
>
> The solutions, therefore, need to be found in a 'joined up' approach that views older households' housing needs as one element in a more holistic view of maximising their independence as and when their circumstances change and their need for support increases. This extends the challenge to society as a whole, including funders and providers of support services, health care agencies and families, to work in partnership with providers of housing and housing assistance to deliver high-quality and affordable outcomes.
>
> *(Page 148)*

National Shelter Inc [9], in their November 2009 report, advised government that in excess of 1 million Australians were in housing stress and 105,000 Australians are homeless.

In Western Australia in June 2009 a Social Housing Taskforce report [10] suggested that some 42% of those people needing affordable housing were people aged over 55 years. If we assume that up to 80% of those people aged over 55 years are indeed couples, then my maths tells me that we need 60,000 additional homes in Australia today just for those people aged over 55 years.

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7 National Housing Supply Council. February 2009. 2nd State of Supply Report 2008
8 National Housing Supply Council. April 2010. State of Supply Report 2010.
9 National Shelter Inc. November 2009, Housing Australia affordably
10 Social Housing Taskforce. June 2009. More than a roof and four walls

However, that report showed that only 20% were senior couples, indicating that perhaps **some 90,000 additional affordable homes for seniors are required across Australia today**. These seniors are, through whatever circumstance, not able to purchase a home of their own, but rely on the goodwill of the Australian taxation system to have Commonwealth and/or State governments, local governments and the private sector develop and construct their accommodation whilst they pay a pension based formulaic rental fee for a tenancy right. Based on those numbers, in Western Australia, we need 9,000 affordable seniors housing dwellings today to cope with the unmet demand.

Funds have recently been provided to aged care providers through the State Governments, by the Commonwealth, and via one of the Federal Housing Stimulus packages, to construct seniors' focused independent living social housing. The finished built cost of these units can be as low as $200,000 per unit. This means that the delivery of 9,000 such dwellings (assuming that they were all to be of an apartment type) is going to cost government/s at least $1.8 billion – in Western Australia alone.

I understand the caution with which government/s are dealing with what is a massive problem.

A key factor in delivering the much needed housing for seniors is building design. Well designed housing for seniors is good design. Shower recesses with no floor hobs, wider doorways, no thresh-hold at the house entry doors – all simple to build into the construction – these design principles can have a major mobility enhancement for old and young alike. If we are ever going to reduce our dependency on residential aged care we must start to think about more practical internal design that promotes the possibility of the older person to not have to move from home because of access, egress and internal accessibility in their own home. A well designed dwelling that can easily have assistive devices retro fitted, requires none or minimal fitting of ramps, can facilitate the latest in e-Health technologies, and where required is trafficable via wheelchair, shower chair and the like without capital fitment becomes ideal as an individual ages and/or becomes more frail and needs the input of more formal family and external care services.

I am not suggesting that there is (in my life time at least) going to be an abandonment of all residential aged care services. Other countries have meddled with almost that same scenario and have found it is just not the right balance.

But when one considers that with the requisite planning approvals and completed certification and public building requirements, the cost of each residential aged care place in Australia today now at or extending past $200,000 – per place – whether it is a “multiple bedded room” or a single room with an en-suite, we must think seriously about how we deal with the dependence we have arrived at on residential aged care services. In Western Australia we estimate that there is probably a shortfall of 2,700 residential aged care places – at a going rate for some $250,000 per place that equates to $675 million.

A unit or apartment called home, or a residential aged care place – some choice!

Residential aged care facilities are prohibitively costly forms of capital that providers currently find extremely difficult to drive a business case from. I hesitate to get into too much detail but the so called partnering between the Commonwealth Government and providers is farcical. A legislated requirement is that a certain proportion of residents be accommodated at a rate that is just under one half of the reasonable cost of today’s capital construction. Paid as a daily supplement, the cost of interest on a building project eradicates the worth of the payment. These clients are called supported residents as they have no income means other than a pension or equivalent, and insufficient assets from which a refundable deposit for accommodation can be contributed. They require affordable housing and fit into that category. Providers do accommodate people in such circumstances – some to a greater extent than others. The average proportion of supported residents that a provider must accommodate is around 22%. It depends on the regional geography. But if providers do not accommodate at least 40% of the total number of residents being supported residents, the providers get a penalty – a reduction in the supplement paid. The most odd thing with this is that the Commonwealth’s own data suggests only some 36% of all residents across Australia are considered supported residents. Now that doesn’t make sense! This and many other complexities with the legislation suggest to me that we do need the major re-think about aged care in Australia that is currently before the Productivity Commission.

Clearly residential care should be reserved for the most needy – perhaps mostly limited to those with advanced dementia or behavioural and neurological disorders, or for people with advanced palliative care needs. Situations where people are really unable to remain at home as there are no caregivers able to support or provide services to them in their own home. My personal view is that there is no disease or frailty process known to man that does not permit a person to be cared for at home. What is most often missing is the capacity and capability of a person to remain at home and be cared for, by willing and available family members. As a

society we need to revisit why and who we send to residential care, if nothing else to improve the range of services that can keep folks at home in appropriate, available, and accessible housing, and reduce our dependency on what really is very high quality, but nevertheless, institutionalised care. This willingness and need for more of us to care for our elders in other than institutionalised settings might be sorely tested in the not so distant future. Costs to government/s are driving that trend.

5 *The vexed matter of quality*

At least residential aged care in Australia has had an aged care accreditation system for approximately twenty years. Prior to 1997 the outcome Monitoring Standards system was in place. Post the implementation of the Commonwealth Government's Aged Care Act in 1997 the Australian Aged Care Standards and Accreditation Agency ("Agency") was created. It manages the accreditation system for the 2,900 or so residential aged care facilities across the nation.

In May 1997 I wrote to every then Federal; Member and Senator suggesting that we were embarking on an accreditation process that we could not afford. Whether or not the Agency achieves its regulated goals is for others to comment upon. I simply make the following observations:

- The Agency is an International Standards Organisation (ISO) certified organisation – its accreditation process are not;
- The process is expensive compared with alternate certification systems;
- How then does the process of continuous improvement processes get applied to, and by, the Agency and then passed on to aged care providers;
- Aged care providers who seek their own ISO certification as an internationally recognised quality certified and "improving" organisation will not have that ISO certification recognised by the Agency;
- The Agency's accreditation process is one of compliance measurement – a measure of 44 outcomes against 4 standards. The process however is not necessarily a measure of quality – either of the services the facility provides, or of the overall system of residential aged care in Australia;
- This however is not solely of the making of the regulator, as the certification / accreditation processes are a response to respect and service to frail seniors and others in care.

What we need is a paradigm shift about quality and change.

5.1 Quality Improvement of Care Services

Health care quality improvement has traditionally focused on the clinical aspects of care – whether the care is being provided in a nursing home, hospital, or in the home or other community care setting. In aged care in Australia, where maters of clinical governance are steadily losing priority due to economic rationalism, the focus has recently been more applied to regulatory compliance on structural matters of services. Much of the accreditation skips over the notion that quality starts with people. There is little room in our so over regulated compliance systems for a sense of "empowerment of people" to gain breath. But inspiring leaders are the key to quality improvement in the gamut of service provision to seniors and frail elderly.

In aged care we are so often now swallowed by the regulatory compliance requirements that we forget that there are real people who are receiving care, advice, or information to assist them in their ageing. Aged care is siloed and often the parts do not communicate with each other. This might simply be because the silos are all too busy following the plethora of rules that govern their respective domain/s.

Let me take even more from a colleague's article on healthcare quality [11] and compare aged care workers to fire fighters.

Both aged care workers and fire fighters experience burnout. Both experience very difficult, hard work, joy, and sorrow as part of their job. Yet the aged care worker suffers from burnout whilst people actually volunteer to be part of the firefighter culture. The firefighting culture includes the camaraderie and community of the firehouse where firefighters share, vent, cry, and laugh. They are considered heroes.

Yet aged care workers just suffer burnout. The stress they carry has nowhere to go so they take it home. Stress leads to poor quality, missed steps, and can endanger lives. This all on top of a reduction in relative means of staff directly due to the continuing relative reduction in recurrent funding by the funder of programs across Australia.

As commented upon earlier in this submission, Herzberg would say that when it comes to workplace satisfaction, money (in terms of wages and salary) is not everything. But it sure has to be a primary leveler of equity between sectors.

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[11] Cirillo, A. 2011. Healthcare Quality Improvement Starts with Culture Change. http://assistedliving.about.com/od/caringforclients/a/Healthcare-Quality-Improvement-Starts-With-Culture-Change.htm

5.2 The Leadership Imperative

At the end of this submission there is one question that remains unanswered – who is going to drive the change that is required in aged care today to pave the way for the delivery of greater capacity and capability of seniors' long term care and accommodation services in the future? Again, I rely on Anthony Cirillo's insights (see footnote 11 above).

Before we start to see any real clinical and service quality improvements we must first start with the culture of the organisations. The culture of an organisation can be the practice of the collective wisdom, mores, intelligence and behaviours. The culture of an organisation will beat (defeat perhaps) or outdo its strategy every time. So will the culture of an industry sector. The imperative for our leaders in this entire sector is to seek to lead change in the abiding culture.

Enlightened and visionary leadership can help expand the reach and benefits of culture change by improving the employee experience and work environment. To do so, Government, facility and industry leaders should:

- Recognize that educating the public about ageing issues is not just the right thing to do but also builds relationships;
- Know that changing the employee experience will change the resident / client experience and people will talk about it;
- Recognize that culture change is not the program of the day, driven by more rules and regulations;
- Use hard economic times not to batten down but to press the reset button, changing the rules of the game, redefining the work, and changing the organisation;
- Understand that empathy will assist in cultivating loyalty and an understanding that employees are not following the organisation down a blind path; and
- Realize that empowering staff with tools allows them to collaboratively solve problems. It helps creates context.

The bottom line is that trusted leadership recognizes the fragile life and death nature of ageing and allows staff to celebrate, grieve, and become empowered to change it – to make it better.

That is where clinical quality starts, and how aged care in Australia will change. There is no way that some form of quality certification and improvement process will be off the agenda for the aged care services we provide in Australia. Its here to stay.

But, if we can come up with something better, perhaps the sector can change how it works.

I ask the paradigm question once more:

> What is it that we are doing today that if we were doing better, doing differently, or not doing at all, would radically change and improve the range and quality of aged care services in Australia?

6 Why Sub Acute and Transitional Care?

Some years ago I wrote a paper suggesting the notion of an "aged care hospital" concept. Such a service is described as follows. It seems to me that aged care services that provide a holistic range of supports including residential aged care and community services can become a "one stop shop" for the type of services described in the following paragraphs. Whilst I specifically was using the name "aged care hospital" (a name (or similar) used in other jurisdictions), the services that would be provided from such a facility include all the types of services included in sub acute seniors care and transitional care programs known to the Commission from their Review.

Aged care hospital services can be defined as comprehensive (in-patient or ambulatory) care designed for someone who has an acute illness, injury or exacerbation of a disease. Aged care hospital services then "is a goal orientated treatment program provided immediately after, or instead of, acute hospitalisation to treat one or more specific active complex medical conditions or to administer one of more technically complex treatments. [12] " Generally, the individual's condition is such that the care does not depend heavily on high-technology monitoring or complex diagnostic procedures, rather, requires a more coordinated care approach of an interdisciplinary team including medical, nursing and allied health disciplines.

An aged care hospital service is generally more intensive than traditional nursing home (high care) but less than acute (hospital) care. It requires frequent (daily to weekly) recurrent patient assessment and review of the clinical course and treatment plan for a limited (several days to several months) time period, until the condition is stabilised or a predetermined treatment course is completed.

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[12] Definition developed by American Health Care Association (ACHA) and Joint Commission of the Accreditation of Healthcare Organizations (JCAHO).

A review [13] of national benchmark data for sub acute care has identified a number of general observations and future trends in the provision of sub acute care services:

- There is a preponderance of female patients aged 70+ years receiving sub acute care services, though the sector does treat a number of younger people;
- The greater the impairment, the longer the length of stay;
- The average length of stay per patient is 21 days;
- The majority of sub acute patients returned to the community after discharge; and
- The volume of rehabilitation episodes continues to increase over time, in part due to the ageing population.

And we recognise that there may be some significant merit in aged care providers – long term health care providers if you prefer – to shore up their business model and strength by offering these "new" models. We can but agree that there appears to be a race to position for the niche being created by the pressure to curtail stays in regular acute hospitals. As traditional acute care hospitals are pressured to shorten their length of stays even more – some are currently averaging four days or less – a new market niche is being created for just the kind of service suggested – post and sub acute care either in dedicated specialty hospitals or in special sub acute / transitional care units in residential aged care facilities and community service programs.

Long term care companies are in a unique position to provide lower cost care than traditional hospital settings for patients who hospitals really can no longer afford to keep but who still need 24 / 7 hour supervision or the services of special medical / nursing / allied health personnel, services, or equipment before they can go home. These post and sub acute care will provide higher profit margins for long term care providers as they position themselves to take care of the increasing number of patients being discharged early from hospitals.

Efficiency does it every time. Long term or aged care facilities and community services have traditionally had lower capital and operating costs than acute care hospitals, which is why they may be able to offer sub acute care at significantly lower costs than the traditional acute care hospital, sometimes 30 to 50 percent lower.

The strategy today for several long term care providers is growth and expansion through mergers and acquisitions as they jockey for position for tomorrow's consolidated long term and sub acute health care funds. But the growth is not only in residential aged care facilities but also in post and sub acute care units.

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[13] Simmonds, F. and Stevermuer, T. (2008). The AROC annual report: the state of rehabilitation in Australia 2006. Australian Health Review. 32(1). p85-110

7 *Summary and Conclusion*

I summarise my lengthy comments in this submission as follows:

- i As a society we give lip service to "Respect for Seniors" but the disconnect between community expectations and what can be delivered underpins the inadequate quality control seen in our aged care services.
- ii The compliance quality measures we have invested in have not improved the general public perception about residential aged care services;
- iii But all aged care providers, residential aged care and community aged care alike, are engaged in a sector that has been progressively defunded over the past decade or more – how much the deleterious effect of that has been on quality is difficult to quantify but is clearly being experientially expressed;
- iv We should give due regard to the complex health care needs of advanced high care recipients – whether residential aged care or community aged care based – as hospice care service recipients, and as equitably funded as their private hospital counterpart services;
- v Such service recipients require dramatically improved funding with such funding requiring an appropriate clinical governance model to be in place for the funded providers of care;
- vi Such funding should also include an adequate component of capital supplement for care recipients requiring residential care services;
- vii Given that the residential aged care data suggests that 89% of all residents in care at 30 June 2009 were Australian pension recipients , rather than focus on bonds or other form of capital contributions from the more wealthy and affluent, the Commonwealth Department of Health and Ageing should be focusing on how it can better supplement the true capital cost for supported residents in modern, high quality, fully certified, residential aged care facilities – residents it (the Commonwealth) requires providers to admit to care;
- viii Except for high care services, accommodation, hotel services and care services income streams should be uncoupled so that a fee for provision of care can be assessed/funded separately from the accommodation and hotel service charges;
- ix Once off capital contributions might still be a valid form of contribution but not ideal for high care services;
- x Recurrent funding for both residential and community based care needs to be dramatically improved to restore equity to care service roles, and improve the skills quantum and mix so that more comprehensive care services can be guaranteed;
- xi The subsidy level for care services should be more similar between residential and community aged care provision – same reason/ need for service but different location – same care subsidy.

xii The Department of Health and Ageing needs to ensure better data matching and availability of data for assisting the provision of high care services to the most in need;

xiii Residential aged care is a necessary, but capital intensive and costly, form of service infrastructure. We need to be very sure that we are not over supplying such facilities for high care recipients, and rather trying harder to deliver what will be required to enable the client to remain at home with their carers;

xiv Such facilities of course can be used as appropriate forms of housing, particularly for low care recipients who require housing;

xv The relationship between appropriate housing and wellness and perceptions about quality of life status is well understood. There is much work to be done by Governments of all levels across Australia, the industry leaders and providers in terms of more age and frailty appropriate affordable housing for seniors. This is not a matter of scarcity of demand;

xvi A culture change is required in the aged care sector. We have for reasons of economic viability changed the mix and quantum of labour resource available for caring. Have we irretrievably neglected our real clinical governance responsibilities to those as low as some of the major hospitals our clients come from;

xvii Our range of care services should be provided out of respect for Australia's most elderly frail people, applied with all manner of clinical, nursing, and allied therapy support systems, rather than being left to the increasing burnout and stress of over worked, underpaid, often under skilled workers, and the economic rationalism that has driven so much aged care policy and service development over the past 15 years;

xviii Multi service aged care providers – those with at least residential and community aged care services in "co-existing locations" – should be given encouraging access to sub acute and transitional care for the over 55s. Being more capitally efficient with building costs than most hospitals, the efficiency of the built form alternative may well contribute significantly to a reduction in cost of health care for seniors, and free up valuable bed spaces in hospitals; and

xix Finally, what is it that we are doing today that if we do better, do differently, or not do at all, would radically change and improve the range and quality of aged care services in Australia?

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