Response to the Productivity Commission draft report *Caring for Older Australians*

Mercy Health commends the Productivity Commission on their extensive review of Australia's aged care system and its future challenges.

We endorse the recommendations made in the draft report *Caring for Older Australians,* acknowledging that their implementation would be a significant step forward in reforming the aged care sector.

The draft recommendations were in line with 10 of 18 of those made by Mercy Health in our initial submission.

In making this response, Mercy Health also commends those responses made by Catholic Health Australia and Aged and Community Services Australia.

Workforce

While the acceptance of the Productivity Commission's recommendations would be a significant move forward for the sector, workforce is a key issue that the draft report has failed to adequately address and urgently requires review if the industry is to meet operating, community, legislative, government and resident expectations.

Draft recommendation 11.2 indicates the need to pay competitive wages to staff delivering aged care services, and we would welcome a funding model that enabled this, but attraction and retention requires a wider focus than remuneration.

Many organisations are paying above award wages for key positions such as Division 1 nurses and senior management due to market competitiveness, yet we continue to have difficulty attracting people to these roles. Attracting highly skilled people to Personal Care Assistant roles is even more difficult as they are paid less than the hourly rate of those working in a supermarket, when they will be tasked with the job of caring for the most vulnerable people in our community. People undertaking these roles are increasingly reflecting current migration trends and whilst deeply caring, often have skill deficiencies associated with verbal and written communication.

Other issues impacting on the sector's ability to attract staff include:

1. Demand, workload and acuity

The acuity in residential care has increased exponentially over recent years due to the impact of community care packages keeping people at home longer before entry to residential care. Currently within Mercy Health 70% of our residents require high care, a reflection of the industry. This acuity, compounded by punitive legislative measures, impacts on the industries ability to retain managers and nurses who prefer to work in the acute sector where they are surrounded by a supportive multidisciplinary team, faced with often less onerous legislation and accreditation measures, and are more highly valued by the community. In order to better support staff in the aged care sector we need to:

a. Improve access to specialists

Nurses working in the aged care sector are generalist. Given the increasing acuity, residential aged care facilities require improved access to specialist services.

If care and accommodation are to be separated, a flow on result should be the option to be a recipient of services such as Hospital in the Home (HITH), Palliative Care, Hospital Admission Risk Program (HARP), Community Rehabilitation and Psychogeriatric Services regardless of your accommodation setting. This would

provide for high level clinical nursing care by Division 1 nurses and other specialists, who currently tend not to be attracted to working in a residential aged care facility.

Such a model of care would result in a decreased number of acute aged in hospital beds, improved education of residential facility staff, and most importantly, improve the health outcomes for these residents.

Residential services should be seen as a true extension of the broader health network, not simply a ‘storage place’ for the frail elderly without any ongoing support.

b. Improve delivery and access to education

Nurses entering the aged care sector require further education pathways, and assurance that the sector provides career options for those with high aspirations. Various models of education need to be explored. To translate research into practice, mentoring learning models need to be implemented. These models would require the engagement of higher learning establishments and additional government funding.

c. Fund research

Research that directly impacts on practice is lacking in this sector. Dedicated funding needs to be considered to ensure that the research relates to practice and improves resident outcomes and staff ability to care.

Mercy Health, in partnership with Australian Catholic University, will later this year appoint a Professorial Chair in Aged Care. The Chair will be responsible for translational research within aged care through fostering a culture of research and academic leadership. This will contribute greatly to removing barriers to multi-disciplinary collaboration in the aged care sector. It is also in line with draft recommendation 11.4 and Mercy Health would welcome the opportunity to expand its position as a ‘teaching aged care service’ but this requires funding models that value research and teaching.

2. Staff Continuity

Driven by financial efficiency the majority of working shifts within the aged care sector are short shifts i.e. 4 to 6 hours, hence a high proportion of staff are employed on a part time basis. Currently 97% of staff working within Mercy Health aged care facilities are part time and on average work 33 hours per fortnight. This practice effects staff morale and most importantly, continuity of care with staff often employed at two different facilities part time. There is no time to improve relationships between carers, residents and their families or attend education sessions, elements which should prove rewarding in this sector.

Mercy Health acknowledges the need to balance part time and full time staff, and that time should be allocated for education, writing of notes and care plan reviews as is the practice in hospital settings. However, this would increase staffing with commensurate costs. Mercy Health believes that if the number of full time staff in this sector is increased more direct care staff would be attracted and retained.

The draft report also fails to address the largest portion of the aged care workforce, which is Personal Care Assistants (PCA). We recommended a move to registration of PCAs to establish a base line skill set nationally and to enhance the professionalism of this segment of the workforce.

Registration of PCAs would enhance the attractiveness of the role and provide increased assurance to families that their loved ones are cared for by registered professionals.

Government contribution for basic standard of accommodation

Draft recommendation 1.7 concerns Mercy Health, as it states that the average cost of providing accommodation for supported residents should be set on the basis of a two-bed room with a shared bathroom. This is a dated and unacceptable paradigm.

The norm is currently to build residential aged care facilities which provide single bed rooms with a private ensuite. Shared rooms do not provide people with the privacy and dignity they deserve, furthermore many residents will have high levels of acuity and may be receiving palliative care. With the prevalence of dementia in older Australians set to increase, shared rooms may be a more cost effective setting, but may also be an unsafe option for many residents.

A shift back to shared rooms would further discourage people to move from the privacy and familiarity of their own home into a residential aged care facility. It would also highlight the gap between rich and poor, with the choice, privacy and dignity of a single room taken away from those who are unable to afford it, who want to spend these remaining years in the forced company of a stranger. This is a retrograde step that reflects the aged building stock in Australian and a poor model of practice.

Deregulation of Bed Licences

The Commissions draft recommendations 1.3 and 1.8 call for the removal of regulatory restrictions on bed licences. While there is a need to provide people with greater choice and options in their selection of services, Mercy Health does not support the deregulation of bed licences.

The deregulation of bed licences, and the removal of the socio- demographic allocation model, is likely to lead to an increase in the number beds provided in areas of relative affluence, to the detriment of lower-socio-economics areas. Equity of access and quality of service should be a base principal of any model of allocative efficiency.

Accommodation costs

Mercy Health supports the overall intention of the Commission to improve consumer choice and flexibility in the payment of accommodation charges. We consider the equity release scheme is a positive initiative.

While there is still a significant amount of detail to be determined as to how the proposed scheme may work, we are concerned about the linking of accommodation charges to the cost of supply as indicated on page 172, especially in an environment where licences are deregulated.

Mercy Health submits that the linkage of accommodation charges to the cost of supply is an inappropriate measure that will not overcome the problems that are currently creating a downturn in new residential care development. Unless providers are given an appropriate balance of risk and reward in accommodation pricing, consumers will only experience a marginal increase in choice from the proposed reforms.

Mercy Health believes that accommodation charges should be linked to an appropriate return on investment for the provider that is commensurate with the risks undertaken to supply the service. These risks are not only related to the normal operating risks that providers have experienced in the past, but should now include additional risks associated with:

1. Declining occupancy levels with increased consumer choice through the potential deregulation of licences;
2. Increased working capital requirements and debtor exposure;
3. Increased funding requirements and longer term exposure for financiers as lump sum bonds fall in favour of periodic payments.

We believe that in assessing increased funding costs, it is critical for a weighted average cost of capital to be used rather than a simple borrowing rate. Most providers will need to source greater equity in the future, a task made harder by the increased risks associated with moving from a Government funded to a consumer funded accommodation model. The cost of equity, which forms a major part of the cost of capital, should reflect these increased risks associated with structural changes to the aged care sector.

A further issue associated with the Commission's recommendation to cap the periodic charge (draft recommendation 1.4) is how, and who might calculate an appropriate charge/bond that reflects the cost of accommodation. If it is about choice, settings of differing standards and quality may attract differential rates. The idea of capping the charge does not support this stated intent.

Australian Seniors Gateway Agency

Draft recommendation 8.1 would see the Australian Government establishing an Australian Seniors Gateway Agency that would deliver services via a regional structure. The concept of a single point of entry into residential and community aged care is welcomed. However, the reality of such a Government Agency being able to deliver the proposed services should be carefully considered. Learning's should be taken from the Primary Care Partnership (PCP) project that Victoria has been attempting to implement as this shares similar objectives as those outlined for the proposed Agency.

The potential inefficiency of such an Agency could result in roadblocks for people needing to enter and move through the aged care sector. We are concerned that the proposed triage and assessment process will not overcome the problems that are inherent in the existing system, but may add another layer to an already complex entry process. Mercy Health proposes that the following issues need to be explored if the Agency is to succeed:

Case management model: The case management model should be person centred and truly assist people through the system, not just refer people by giving them a phone number and a list which is a problem inherent in the current system.

Staff training: Staff within this Agency must be trained in triage through to case management. We believe this is a major deficiency of the current system. The Commission's recommendations should include the attainment of minimum knowledge and skill standards for Agency staff.

Improved information flow systems: The Agency needs to ensure that information flows out to providers in a manner that is timely and comprehensive. Currently information tends to be 'lost' or is so poor that carers often have to repeat information already provided.

This is time consuming and frustrating for carers, and can affect the relationship with the provider.

Mercy Health concurs that the entry system into the aged care sector is fragmented and confusing for people requiring services and that the establishment of a Gateway Agency may assist.

Assistive Technology

The Productivity Commission draft report has not adequately considered the potential benefits of assistive technology in the inquiry.

Greater use of smart technology would enable the aged to remain in their homes for longer, which is what the majority of people desire. Smart technologies offer the potential for early alerts, preventing the number of acute episodes a person experiences. Use of these technologies can provide substantial savings to the sector, including the potential to supplement workforce.

The 2010 report from the Australian Academy of Technological Sciences and Engineering entitled *Smart Technology for Health Longevity* provides valuable insight into aged care technology in Australia and Europe and the benefits they provide.

Mercy Health supports the recommendations made in the above mentioned report, and also those submissions made to the Commission by Australian Academy of Technological Sciences and Engineering (ATSA) in recommending an increased national focus on development and applying smart technology to enable the aged to remain in their homes and new models to fund the deployment of this technology.

Funding barriers associated with remote monitoring are a critical impediment to innovation, much needed for the take up of this technology and changes in practice.

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