COMMENTARY

on

PRODUCTIVITY COMMISSION REPORT

on

CARING FOR OLDER AUSTRALIANS

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INTERPRETATION OF PRODUCTIVITY COMMISSION REPORT on CARING FOR OLDER AUSTRALIANS.

THIS REPORT SETS DOWN IN THE TERMS OF REFERENCE FOR THE NEEDS OF AGED AND PROSPECTIVELY AGING PROPORTION OF THE AUSTRALIAN POPULATION.

AS A CURRENT RESIDENT OF A RESIDENTIAL CARE INSITUTION AND HAVING BEEN A RESIDENT OF ANOTHER, I BELIEVE THAT I HAVE SOME CREDENTIALS IN COMMENTING ON THE SYSTEM FROM THE INSIDE OR AS A RECIPIENT OF THE TREATMENT AVAILABLE.

SUMMARY

DEMAND. THE REPORT DOES NOT FORECAST SIMPLY IN UNDERSTABLE FORM, THE DEMAND AND FORM FOR AGED CARE IN AUSTRALIA.

WE NEED IN AT LEAST THREE AGE BANDS (65+, 75+ AND 85+) THE CURRENT SITUATION AND THE FORECAST 10 YEARS AND 20 YEARS IN THE FUTURE. THE NEEDS FOR AGED CARE IS AN URGENT ISSUE AND THE MIXING OF AGE BANDS IN DIFFERING

PARTS OF THE REPORT MAKES IT DIFFICULT TO ANALYSE THE DATA QUOTED.

THE IMPACT OF MEDICAL PRACTICES AND TECHNOLOGY ARE NOT IMPOSED ON THE FORECASTS. WHILST MANY OF THE CHALLENGES ARE ADDRESSED IN DETAIL, THE PRODUCTIVITY COMMISSION REPORT PAYS INSUFFICIENT ATTENTION TO THE MAJOR BUT NECESSARY KEY RESOURCES ISSUES OF WORKFORCE AND PHYSICAL FACILITIES AVAILABILITY. THE LIST OF STRENGTHS AND WEAKNESSES (SHOWN ON PAGE XXXIII) ARE GENERALLY CORRECT.

FUNDING. THE HIGHLIGHTING OF THE FINANCIAL INEQUITIES IN THE SYSTEM IS NOT METHODICAL. THE SECTOR LACKS A FRAMEWORK WHEREBY PARTICIPANTS (OR THEIR CARERS) CAN DECIDE WHAT QUALITY AND QUANTITY OF CARE SUITS. THIS NEEDS A RATING MECHANISM PROVIDED BY AN INDEPENDENT ORGANISATION, SIMILAR TO A STANDARD & POORS WHICH APPLIES IN THE FINANCE MARKET.

THERE IS A NEED TO IMMEDIATELY REMOVE THE CAP ON THE NUMBER OF INSITUTIONS AND JUST AS DIRECTLY THE NUMBER OF PLACES. CURRENT METHOD OF ASSESSING FOR ACCEPTANCE INTO FIGURE 6.3 CANVASSES THE OPTIONS FOR FUNDING.

IT DOES NOT PURSUE THE USE OF THE TAXATION SYSTEM TO OVERCOME THE LACK OF NEW FACILITIES TO MAINTAIN AND BUILD NEW FACILITIES. THE ABILITY OF CHARITIES TO FIND THE FUNDS FOR ADDITIONAL FACILITIES IS LIMITED. THE MODEL OF THE PRIVATE SCHOOL SYSTEM COULD BE FOLLOWED TAPPING INTO A BUILDING FUND/S AS A SOURCE OF FUNDS SPECIFIC FOR INDIVIDUAL FACILITIES.

RESIDENTIAL CARE IS TOO RIGID IN ITS ADMINISTRATION. FROM FIRST HAND EXPERIENCE I ENTERED THE SYSTEM AS HIGH CARE BUT MOVED UP TO LOW CARE AND WILL SOON BE ABLE TO TAKE ON INDIVIDUAL CARE. GETTING INTOTHE SYSTEM IS TOO SLOW AND ONCE IN THE SYSTEM, RERATING BY THE ASSESSMENT ORGANISATION (e.g.ACASS) IS TOO BUREAUCRATIC. IT IS NOT POSSIBLE TO EASILY MOVE BETWEEN CLASSES OF RESIDENTIAL CARE. IT IS NOT POSSIBLE TO LEAVE THE SYSTEM FOR WHATEVER REASON AND TO ALLOW EASY REENTRY SHOULD THIS BECOME NECESSARY IN THE FUTURE.

THIS SUBMISSION DOES NOT ATTEMPT TO DISCUSS ALL ASPECTS COVERED BY THE DRAFT REPORT. IT ADDRESSES ONLY STAFFING LEVELS AND TECHNIQUES TO ACCESS CAPITAL OUTSIDE OF TRADITIONAL SOURCES.

A. WORKFORCE

SECTION 11 (page 346) INTRODUCES THE SUBJECT OF FORECAST DEMAND INCREASE FOR AGED CARE WORKERS,FORMAL AND INFORMAL, PLUS IT HIGHLIGHTS THE NUMBER REQUIRED TO MEET THE INCREASING POULATION IN AGED CARE. THE RESIDENTIAL AGED CARE SECTOR PLUS THE RELATIVE AVAILABILITY OF INFORMAL CARERS WILL NOT BE MET WITHOUT GOVERNMENT INTERVENTION TO COMPLETELY RESTUCTURE THE PROVIDERS AND THE TAXATION SYSTEM.

AS THE UNIVERSITY OF MELBOURNE STUDY ON EMPLOYEES IN THE AGED CARE QUOTED IN THAT REPORT ON PAGE 361 STATES...

THE PRELIMINARY FINDINGS IN 2010 "44.5% OF PARTICIPANTS HAD LEFT AGED CARE AT THE TIME OF THE STUDY CITING WORKING CONDITIONS, INADEQUATE STAFFING LEVELS, POOR STAFF RESIDENT RATIOS, TOO MUCH PAPERWORK OR POOR PAY AS THEIR REASON FOR LEAVING. SIGNIFICANTLY THE STUDY ALSO FOUND THAT POOR WORKING CONDITIONS HAD DRIVEN SOME STAFF TO RETIRE EARLIER THAN THEY WOULD HAVE DONE HAD WORKING CONDITIONS BEEN BETTER..."

IT IS NOTED THAT (table 11.2) THAT THE NUMBER OF ALL RESIDENTIAL CARERS (ON A FULL TIME BASIS), HAS ONLY RISEN BY ONLY 1,760 IN THE PERIOD 2003 TO 2007. DURING THIS PERIOD THE NUMBER OF THOSE NEEDING CARE HAS INCREASED BY THAN THAT. IN FACT THE INCREASE IN THE NUMBER OF CARERS IS PRINCIPALLY DERIVED FROM PERSONAL CARERS. IN THIS SAME PERIOD THE NUMBER OF REGISTERED NURSES HAS DECLINED.

THIS DECLINE IN REGISTERED NURSES IS DESPITE THE NUMBER OF 'ENROLLED' NURSES BEING APPROXIMATELY 70% OF THE NUMBER OF GRADUATE NURSES. IF THEY GRADUATE WHERE ARE THEY GOING? WHO ENTER OR STAY IN THE AGED CARE SECTOR? WHAT IS HAPPENING WITH THE ENROLLED NURSES

AS IDENTIFIED IN SECTION 11. DO THEY FAIL TO FINISH THEIR COURSE? IF SO, THE NUMBER OF NURSES IN TRAINING SHOULD BE INCREASING UNLESS THE NUMBER OF EXISTING NURSES IS DECLINING DUE TO 'RETIREMENT' OR ARE THEY GOING ONTO PART-TIME EMPLOYMENT. THE REASONS FOR 'RETIREMENT'ARE SET DOWN IN DOT POINT 5 ON PAGE 345. THE PARTICIPATION RESIDENTIAL INSTITUTIONS FACE INCREASED DEMAND FOR FORMALLY TRAINED NURSES AND SUPPLEMENTED BY INFORMAL CARERS. IT IS A FACT CARERS REGARD GOVERNMENT REMUNERATION IS NOT AN INCENTIVE TO CARE FOR FAMILY, NEIGHBOURS,ETC. THE BUREAUCRATIC DEMANDS ON CARERS MAKES IT TOO HARD FOR THEM TO PROVIDE THAT FORM OF CARE. A PERSONAL OPINION UNTESTED WIDELY IN THE SECTOR IS THE NEED FOR MORE REGISTERED NURSES, POSSIBLY ONE NURSE PER DAY AND AFTERNOON SHIFTS AS THE FIRST STEP TO PROVIDING SPARE TIME FOR MANAGERS TO BEING MANAGERS.

WITH AN INEVITABLE INCREASE IN THE NUMBER OF AGED AUSTRALIANS, PLUS THE QUALITY AND SIZE OF RESIDENTIAL CARE INSTITUTIONS THE CURRENT SHORTAGE OF NURSES IS GOING TO BE EXCERBRATED. THIS SHORTAGE IS WORSE FOR HIGH CARE THAN LOW CARE INSTITUTIONS. IT IS POSSIBLE THAT THE NUMBER OF REGISTERED NURSES WILL CONTINUE TO DECLINE TO ONE PER SITE AND WILL BE REPLACED BY LARGER NUMBERS OF ENROLLED NURSES.

THE NEED FOR PERSONAL CARE IN HIGH CARE IS AS THE NAME IMPLIES. TOILETING, SHOWERING AND FEEDING REQUIRES FAR MORE ONE ON ONE ATTENTION THAN FOR LOW CARE. IT REQUIRES A LEVEL OF KNOWLEDGE OF INDIVIDUAL PATIENTS WHO OFTEN ARE UNABLE TO COMMUNICATE THEIR NEEDS BECAUSE OF THEIR MEDICAL CONDITION. THIS REQUIRES NURSES AND EMPLOYED CARERS TO BE AT A RELATIVELY HIGHER RATIO THAN FOR LOW CARE.THIS DISCREPANCY MUST BE ADDRESSED IN THE FUNDING OF CARE TO ACKNOWLEDGE THE DIFFERENCE.

THE OVERALL SHORTAGE OF TRAINED NURSES WILL REACH CRISIS LEVELS UNLESS THERE IS A STRATEGY TO INCREASE THE STATUS, PAY AND MANAGEMENT OF NURSES IN THE PROFESSION. GOVERNMENT HAS TO AT LEAST ACKNOWLEDGE THE PROBLEMS OF THE SECTOR (PERHAPS MENTAL HEALTH AS WELL) RATHER ONLY GRABBING HEADLINES WITH HOSPITAL FUNDING.

THE ONLY SOLUTION CURRENTLY BEING USED BY THE MANAGEMENT IS TO TAKE ON RECENT IMMIGRANTS AND/OR THEIR FIRST GENERATION OFFSPRING AND ENCOURAGE THEM TO ENROL IN PART TIME NURSING TRAINING WHILST EMPLOYED ON THE REMAING PART TIME HOURS AVAILABLE. THIS LEADS TO THE USE OF JUNIORS WITH OR WITHOUT YEAR 9 STANDARD EDUCATION. THIS BACKGROUND OFTEN LEADS TO

LANGUAGE PROBLEMS, ACCOMPANIED QUITE REGULARLY WITH SOCIAL INEXPERIENCE FOR OLDER PATIENTS.

TRAINING HAS TO BE MADE SIMPLER. WITH TODAY'S USE OF PC'S AND VISUAL TUITION THIS COULD BE EASIER THAN IT CURRENTLY IS. THE SET UP OF TRAINING MODES IS ONE SOLUTION WHERE TRAVEL EASE AND TIME WOULD BE LESS DEMANDING. TRAINING COULD BE CENTRALISED INTO, SAY, FIVE INSTITUTIONS IN EACH OF MELBOURNE AND SYDNEY ETC., WHICH COULD BE AT INSTITUTIONS THAT HAVE A REPUTATION FOR EXCELLENCE AND THAT WOULD BE WILLING TO ALLOW STUDENTS TO BE TAUGHT 'HANDS ON'. A COLLEGE OF AGED CARERS COULD COVER REGISTERED NURSES, ENROLLED NURSES AND CARERS. THIS COLLEGE WOULD BE DIRECTED BY HANDS ON NURSES RATHER THAN MANAGERS.

THERE IS CURRENTLY A DIFFICULTY IN RECRUITING STAFF FOR RESIDENTIAL HIGH CARE PATIENTS WHERE ALSYMERS, DEMENTIA, PALLIATIVE, ETC ARE THE REASONS FOR CARE BEING BEYOND THE SKILL AND ABILITY OF CARERS TO PROVIDE A 24 HOUR SERVICE.

LOW CARE IS LESS DEMANDING WITH SHOWERING, FEEDING, LAUNDRY AND PARMACEUTICAL DISPENSATION BEING THE MAIN ISSUES AND IS CONSEQUENTLY EASIER TO RECRUIT AND RETAIN STAFF.

THE FINANCIAL REWARD (WAGES AND HOURS) FOR ALL TRAINEES AND GRADUATES MUST BE ADDRESSED.

IN IS NOTICABLE THAT A REPORT BY THE PRODUCTIVITY COMMISSION DOES NOT ATTEMPT TO MEASURE THE PRODUCTIVITY OF THE MANAGEMENT AND EMPLOYEES OF THIS IMPORTANT SECTOR OF THE COUNTRY.

SETTLING THIS BY RELYING ON SUPPLY AND DEMAND WILL NOT WORK. WITH THE SECTOR BEING DOMINATED BY RELIGEOUS AND CHARITABLE ORGANISATION THERE IS ALWAYS GOING TO BE STRUGGLE TO RECRUIT AND RETAIN STAFF IN THIS SERVICE PROVISION.

THE RECENT DECISION BY THE AUSTRALIAN GOVERNMENT AND THE STATES FOCUSSES ON MAINSTREAM HOSPITALS BUT OVERLOOKS THE FASTER RATE OF DEMAND FOR FUNDING OF THE AGED CARE (AND MENTAL HEALTH) SECTORS.

GAINING A POSITION AS A PATIENT IN A LOW CARE CONCESSIONAL FACILITY, WITH MODERN FACILITIES SUCH AS ENSUITE BATHROOM IS EXTREMELY FRUSTRATING AS MY PERSONAL EXPERIENCE PROVED.

IN SETTING BUDGETS FOR AGED CARE PROVIDERS THE ITEMS IN ORDER OF IMPORTANCE OF ISSUES ARE CAPITAL FOR BUILDINGS NEW AND UPGRADES FOLLOWED BY FOOD, ELECTRICITY, ETC.THE SHORTAGE OF BEDS/PLACES IS NEEDED TO BE SOLVED.THE CAP MUST BE IMMEDIATELY REMOVED AND NEW NON-CHARITABLE CORPORATIONS ENCOURAGED TO BUILD

IT IS A FINANCIAL/STATISTICAL ISSUE WHERE THE MAIN TWO ISSUES ARE (a) OPERATING EXPENSES AND (b) CAPITAL TO FINANCE ADDITIONAL FACILITIES OR EXPAND EXISTING UNITS.

CAPITAL WORKS

THE AGED CARE SECTOR IS DOMINATED BY THE RELIGOUS AND CHARITABLE GROUPS. THERE IS ONLY ONE KNOWN PROFESSIONAL GROUP. IT IS BLUE CROSS, WHICH IS A JOINT VENTURE BETWEEN LEND LEASE AND PRIME LIFE.THE LACK OF CAPITAL FOR NEW OR UPGRADING BUILDINGS IS A BYPRODUCT OF THE PAYMENT STRUCTURE WHERE RETURN ON INVESTMENT IS NOT AN IMPORTANT CRITERIA.

THE RESULT IS MORE AND MORE AGED CARE FACILITIES ARE SEEKING SUBSCRIPTION TO ACCOMMODATION BONDS WHICH ARE USED TO FINANCE THE CONSTRUCTION OF NEW AND SOME EXISTING UNITS.

THE ACCOUNTING FOR THESE BONDS IS LIKELY TO HAVE THE RISK OF FAILURE DUE TO AMATEUR MANAGEMENT WHO ARE MOTIVATED BY THE WRONG REASONS.

THIS RISK OF FAILURE OF A POORLY MANAGED FUND GOING INTO ADMINISTRATION IS REAL. ALL BOND SCHEMES SHOULD BE REQUIRED TO BE AUDITED, THERELY REDUCING THIS POSSIBLY.

AS A SUGGESTION TO ENCOURAGE THE BUILDING OF NEW FACILITIES, THE MODEL FOR FUNDING OF PRIVATE SCHOOLS' BUILDINGS SHOULD BE CONSIDERED. THIS REQUIRES NO CASH OUTLAY ON GOVERNMENT BUDGETS. INSTEAD OF RELYING ON CASHFLOW WITHIN AN INSTITUTION FROM ARMS LENGTH OR CAPTIVE INSTITUTIONS. THE SUMS SUBSCRIBED SHOULD BE 100% DEDUCTIBLE IN THE YEAR OF OUTLAY. A BUILDING FUND SHOULD BE SET UP FUNDED BY THE FUNDING OFFSHOOT OF ANY INSITUTIONS THAT HAVE AN INTEREST IN THE AGED CARE SECTOR. THESE FUNDS SHOULD BE PROHIBITED FROM BORROWINGS AND SHOULD HAVE REPRESENTATIVES OR THE LANDLORD MANAGEMENT ,WITH CONTROLLING VOTE ON THE BOARD OF DIRECTORS. THE FUNDING THAT RESULTS FROM THIS INNOVATIVE FORM OF FUNDING WILL RESULT IN THE RATIONALISATION OF SITES OFTEN AT A HIGHER LEVEL OF FITOUT.

AS A GUIDE TO RESIDENTIAL CARE PROVIDERS A MINIMUM ECONOMIC SITE SHOULD BE SET. AS A GUIDE A 50 BED RESIDUAL CARE SITE SHOULD BE A MINIMUM. THIS WOULD INCREASE THE ABILITY TO SPREAD THOSE FIXED OVERHEADS OVER THE SITES' PARTICIPANTS' FEES. THE MIXING OF HIGH CARE, LOW CARE AND INDEPENDENT LIVING IS DESIRABLE, BUT NOT ESSENTIAL. THIS SHOULD SEPERATE THE MANAGEMENT OF EACH LEVEL OF CARE ON THE SAME SITE BUT WITH EACH BEING SUBJECT TO THE MINIMUM OF NUMBER OF BEDS. THIS ECONOMIC MINIMAX APPROACH COULD BE A FINANCIAL DISCIPLINE WHERE THE FACILITY OWNERS HAVE TO NEGOTIATE WITH THE FACILITY USERS UNDER A LEASE ARRANGEMENT.

BUILDING FUND FINANCING WILL REQUIRE A MANAGEMENT THAT IS MARKETING EXECUTIVE. PRESENTLY THE CAP ON BEDS DOES NOT REQUIRE ANY MARKETING. INSTEAD THE DEMAND FOR A PLACE IN A GOOD FACILITY EXCEEDS SUPPLY.

THE POSSIBILITY OF HAVING THE THREE FORMS OF CARE ON THE SAME SITE IS NOT NECESSARY. A RELATIONSHIP BETWEEN VARIOUS CARERS SHOULD BE ENCOURAGED SUCH THAT MOBILITY BETWEEN CARE LEVELS IS EASY. THE PROPOSED SENIORS GATEWAY AGENCY WILL FACILTATE THE MOBILITY AS INDIVIDUAL'S NEEDS CHANGE.

Curriculum Vitae-Rob Roeder (B.Sc., MBA)

Patient at St Vincent's Nursing Home with 'high care'.

Currently at St Joseph's Aged Care with 'low care'.

Spent 2 years recovery from 'golden staph' infected at St Vincents hospital during orthopaedic procedure.

Have 25 years experience as investment banker, working for government and private clients.

Have undertaken sale of private hospitals.