

The Australian Royal Commission into the Aged Care Industry 2019

Peter W. Harvey^{1,*}

¹Conjoint Clinical Professor, Deakin University, School of Medicine, Faculty of Health

Abstract

In the light of various complaints about the quality of care provided by and operation of aged care facilities across Australia, the Commonwealth Government has announced a Royal Commission into the activities of the sector. As the proportion of Australians over 65 continues to grow with the ageing of the 'Baby Boomer' generation, more Australians are seeking secure aged care arrangements to meet their increasingly complex living and healthcare needs.

We hear much comment today about the concept of healthy ageing and the importance of older people staying connected to and active in their communities. Not only does this ongoing connectivity support better lifestyles and health status, it provides an avenue for older people to contribute to the support of others once their more formal working lives are concluded. Unfortunately, the gap between the rhetoric and the reality of ageing in Australia is strained and it appears that much about the operations of the aged care sector today is less than satisfactory.

While some well-funded retirees can afford comfortable and fulfilling living arrangements, many others are left in less ideal circumstances. With aged care organisations currently building the next generation of 'hotel' style living arrangements for cashed up self-funded retirees, others are being left behind financially and in terms of the quality of their care. At the same time, maltreatment and abuse of residents is coming to light, as in the 'Oakden Nursing Home' situation in South Australia, for example. Consequently, the Federal Government has now launched a formal inquiry into the activities of organisations running aged care facilities in Australia. The inquiry is designed to assess the operation of this industry with a focus on the economics of aged care centres, the quality of care, the food and recreational activities provided and the challenge of staffing these facilities to keep residents safe and well as they age in dignity.

Corresponding author: Peter W. Harvey, Conjoint Clinical Professor, Deakin University, School of Medicine, Faculty of Health, Email: p.harvey@deakin.edu.au

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Background

In previous generations, the retiree cohort in Australia comprised a small proportion of the overall population. They did not live relatively long into their retirement as a cohort and many lived with their families or in their own homes in their old age. Today the situation is very different with the retired population making up an increasingly large proportion of the overall Australian population and with more and more ageing Australians living in institutional care. In 2016–17, almost all (97%) people in either type of residential aged care (respite care or permanent residential care) were 65 years of age and over: some 232,000 of these people used permanent residential aged care and some 57,500 used respite residential aged care. In 2017, one in seven Australians (3.8 million) were aged over 65 years of age with 1 in 3 of these people being born overseas, many in non-English speaking counties [1-3]. Projections are that by 2057 around 25% of the Australian population will be aged over 65, with an increasing number of people needing institutional care.

The incidence of chronic and complex illness in this group of Australians is also growing as people live longer and often with multiple chronic conditions (diabetes, COPD, cardiovascular, musculoskeletal disorders, mental health problems and dementia [4]. The cost to the country of maintaining this ageing population is escalating as are the costs to the individuals who fund their own retirement living arrangements. Indeed, some aged care organisations are building multi-million dollar 'hotel' style apartments to meet this emerging market for some residents who are choosing to sell their family homes and move into this style of living while they are still relatively young. Others become asset rich, but cash poor as they attempt to retain their family home as they age and as their superannuation funds are depleted over time.

Many older people are ageing in healthy and active ways as well, as positive approaches to ageing in general are promoted in society and older people are encouraged to remain active and continue to participate in and contribute to the culture. Older people have much to offer and, if they can maintain their health status and wellbeing, are able to remain active and productive members of the community [5-9].

Unfortunately, there are many who, through no fault of their own, do not fit this positive stereotype of healthy and active ageing in Australia.

The aged care industry is also becoming a much larger business from the 'high end' accommodation and residential facilities it provides to the lower end, government funded independent and supported living arrangements and the more secure management facilities for those who are unable to care for themselves. As the industry grows and hitherto charitable organisations move to a de facto 'for profit' business model, there is increasing pressure to run facilities more efficiently. At the lower end of the market this translates into people having less access to support services and poorer quality lifestyle options, food and care due to downward pressure on staffing and facilities. Aged care facilities, like our schools and hospitals, need to operate within tight budgets. Accordingly, it is not possible to pay the staff in these organisations at the premium that they may deserve. There are too many staff in these industries as a proportion of overall working Australians. If staff were paid better, schools, hospitals and aged care facilities alike would become unsustainable under the current operating models. If these places were staffed well with highly qualified and well-paid practitioners, they would cost too much to run and neither governments nor private consumers would be prepared to pay this price, especially in a 'for profit' driven economy.

In the aged care sector, keeping operating costs down is the key to financial success. The industry creates considerable revenue from the turnover of real estate in the form of its independent living apartments and intensive care units due to the entry and exit, management and refurbishing fees that gradually reduce real resident equity in these places over time. Hitherto not for profit providers like church organisation with major real estate and land holdings are turning this real estate into profit, possibly to balance the deficit side of their social commitment ledger. This process locks the consumer out of accrual of capital gains in the aged care market while at the same time, the day to day management and care of the more dependent residents is closely managed to avoid recurrent cost over-runs.

Nurses, carers, allied health workers and

domestic staff in aged care are required to work around the clock in some facilities in order to ensure resident comfort and safety and this situation is expensive to sustain. Many of the staff in these institutions, however, currently have limited formal education or qualifications, with the proportion of well qualified nurses and allied health workers to lesser qualified general carers and support workers being very low. Consequently, many workers are unable, due to work demands and their limited training and skill, to offer residents much more than basic support and care which, ostensibly, meets minimal standards for this sector. There are also, due to work pressures and skill constraints, increasing numbers of incidents of sub-standard treatment and abuse of elderly residents who become frustrated with their situation and difficult to manage and placing increasing demands and stresses upon already overworked staff.

The Main Areas of Concern in Summary

Staffing Levels, Staff Training and Quality of Care

The main problem here is the need to keep salary costs as low as possible while putting enough staff into facilities to meet best practice standards for the industry. Most notably, residential carers and support staff have minimal training of a few months at certificate level in Technical and Further Education (TAFE) courses. Many do not have the language skills and cultural competencies to communicate effectively with residents while the residents feel that they are not being treated as humanely and politely as they would like despite rhetoric from the organisations to the effect that they always 'put the client first'.

Food and Recreation

Many older people in care are not able to eat normal meals and need their food processed in some way for them to be able to eat. At the same time, this does not mean that the quality of the food going into these purees should be compromised. Also, for those able to eat normal meals there is a concern that the quality of food offered to residents of aged care facilities is below par in terms of nutrition and taste. Whilst notable advocates of healthy foods and lifestyles such as Maggie Beer [10] and Jamie Oliver [11] champion access to better quality and healthier foods for patients in hospitals and aged care facilities, the trend is not

taking off on a large scale. This is probably due to the cost of sourcing fresh, good quality ingredients regularly and in large volumes at cost effective prices.

Mal-Treatment and abuse of Residents

Evidence is emerging across the board of poor treatment of residents, especially in supported living and intensive support environments [12]. The pressure on staff to manage large numbers of residents (moving, washing, feeding, exercising, cleaning) within limited time frames and with minimal assistance in place to do this means that sometimes tasks are missed, skipped or overlooked while stressed staff may cut corners causing frustrated residents to become dissatisfied with their care options and difficult to manage.

Over-Medication as a Management Strategy

In the situation outlined above, medication management may be compromised with residents receiving incorrect doses of medication or medication being over-used as a strategy for controlling otherwise difficult and demanding residents because insufficient staff members are available to ensure that all individuals are treated in a way that respects their needs and their desire to be treated decently and with compassion and care. Medication irregularities also contribute to falls and other related accidents for older people with many of these incidents being preventable [13-15].

Diverse cultures and communities

As outlined above, today around one in three older Australians were born in non-English speaking countries. Many of these people eventually find their way into one form or another of the aged care support facilities available in Australia to be cared for, often by other people who are themselves from overseas countries. The language and cultural barriers here are significant. We are learning how to provide care for Aboriginal people in culturally appropriate ways by supporting living arrangements that link people to their culture and their community. Perhaps some of these lessons could be applied in our aged care facilities where currently we find Asian residents alongside Australian and European residents being cared for by carers from Africa and the Philippines, for example. Whilst this multi-cultural environment is enriching and exciting, there may be cultural and language issues

involved that hamper the provision of effective care and support.

Financial Arrangements that Drain Residents' Capital

There is a wide range of options available to residents in aged care facilities for people who are completely independent in their living arrangements to those who are totally dependent on others for all their care needs. In hostel or unit accommodation, some residents own their units and pay a small service and maintenance fee while others essentially rent their accommodation using their aged pension as their main source of income and financial security. Every facility will have different arrangements in place to meet the needs of their clients. Some return more of the value of a home unit to families when their loved ones pass away than do others. Essentially, families of residents receive a proportion of the capital value of a unit when it is sold, while the organisation holds back a refurbishing fee to prepare the unit or home for the next occupant.

In general, significant capital value is lost to the occupant of a home unit and their family over time under these arrangements. The fact that there are so many different financial plans and options in place for these purchase or leasing arrangements suggests that a more uniform approach is needed for all organisations so that the consumer can be clear about what is available to them and that they are sufficiently informed to make good decisions about their care options. Perhaps the whole industry should be nationalised rather than privatised and all aged care facilities tightly controlled by the Commonwealth government, which currently provides most of the resources for this sector, to prevent organisations taking advantage of consumers at vulnerable times in their lives. A key principle could be that owners of these living spaces are able to enjoy capital growth, regular maintenance and refurbishing notwithstanding, that is commensurate with the non-institutional home market.

Outside the Square

As the aged care landscape changes and more members of the baby boomer generation reach retirement age, this group may choose not to buy the current models of care; may not surrender their capital to an industry that is clearly targeting more privately funded retirees in their business models now that the

landscape of the industry is changing. If the boomers do not subscribe to this model, things will change [16]. Perhaps institutional aged care will revert to its original stance where the core business of providing good quality support and care to people who are unable to secure this in the private market becomes the status quo.

Some consumers may be able to bypass the aged care institution phase of their lives by arranging their own supports in their homes or in accommodation that is shared and managed privately by them, their friends and their families. In this way, consumers could keep control of their cash and their capital while ensuring that they get access to the government community care support packages that provide high quality and affordable care more directly to the consumer. By cutting out the middle provider; the aged care juggernaut that is currently emerging, consumers able to do so would get better value for their money while retaining ownership of their capital rather than losing this to the plethora of 'for profit' aged care management companies currently descending upon this lucrative market opportunity. In our local suburb in Adelaide alone there are now three major new facilities targeting the high-end consumer with luxury aged care and hotel style retirement living at prices designed to facilitate the transfer of capital from substantial family homes to the balance sheets of the aged care management organisations involved. A reverse mortgage arrangement that keeps people in their own homes may be another option, also, although tighter rules for how this process operates and what might happen if interest rates and home values change substantially over time will need to be developed to protect the consumer in these situations.

At the service provision level, a more integrated service offering or care plan; the kind developed for the management and coordination of care for patients with complex chronic illnesses, for example, might improve participation, service provision and health outcomes for residents of aged care facilities [4, 17, 18], but this would need to be tested by appropriate research. The idea of 'one size fitting all' in aged care is as irrelevant and inadequate as it is for people with chronic illness or for those with learning difficulties in schools. The benefits of coordinating services and linking these to the needs of the individual consumer of health care in the

community have been demonstrated [4, 18, 19]. The aged care sector should be no different and individuals in it should be treated as individuals with unique and specific needs and managed according to these needs and the complexities of their stage of life.

Conclusion

Things are changing rapidly in the health care sector today in Australia and in the aged care provision and management business specifically. More and more Australians are finding themselves either living at home with the support of aged care packages or living full time in structured care, either as independent residents or as patients in intensive care management situations. So much has changed and so many anomalies have emerged in relation to aged care, that the Government has initiated a Royal Commission into the functioning of the aged care system in order to better regulate and refine the activities of the sector to meet the needs of the individuals concerned and set the context for a sustainable, affordable and responsible model of care for the future.

Concerns have emerged in relation to the standard of care offered in these establishments, the quality of food and recreation facilities and even direct abuse of residents in care. The question remains however, can the system deliver high quality and affordable care to a growing proportion of our ageing Australian population? Do organizations have the staff with the skills and knowledge to be able to provide what is needed or are we looking at re-shaping this industry in major ways? Does the explosion of high-end residential care offerings threaten the retirement and home equity status of ageing Australians more generally and, if so, what needs to change so that we can guarantee the health and financial security of our ageing population? Should the aged care industry be more closely managed by the Commonwealth government; its major funder, and should the sector return its focus to the provision of care for those who are unable to afford private arrangements for their old age?

All these questions and more will no doubt be addressed as core terms of reference of the emerging Royal Commission and, as the work of this review gets underway, perhaps there are some lessons to be learnt from the work Australians have done in the past

generation on the management and self-management of chronic illness in our community.

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