We need structural change and money, not more regulation

THE KNEE-JERK reaction to bad things happening is often more prescriptive regulation. It allows government and the community to think that something's been done. However it often doesn't work and it sometimes makes things worse.

Aged care, especially residential aged care, is one of the most highly-regulated industries in Australia. Will adding more regulation eliminate or significantly reduce the incidence of the examples of bad care coming to the royal commission? I doubt it.

As I have said before, within the current regulatory and financial environment there are providers who perform with a high degree of excellence and whose services are in high demand; and those who don't but who survive because of the restraints the

Ian Yates, chief executive of COTA Australia

current regulation of aged care places and funds imposes on good providers.

We need structural change – abolishing the Aged Care Approvals Round so good providers can expand and squeeze out poor ones. We need to give the government subsidy to the consumer, not to the provider, just as we do in the National Disability Insurance Scheme, Medicare and home care packages.

And we need to toughen up requirements to be an approved provider and give the Aged Care Quality and Safety Commission a wider range of compliance tools.

We also need to fund home care packages so no-one waits more than three months; then modestly increase government funding for care costs and introduce a robust, equitable and compulsory means-testing regime to increase user contributions. If we don't do the latter, then the increase in government funding will need to be bigger.

The commission needs to be tougher on appropriate staffing mixes and government needs to ensure funding covers this, but we don't need government setting arbitrary and industrially-driven nursing ratios, which for many residents will do more harm than good.

We need the right nurse numbers and skills for clinical needs, but we need lots of well-trained, empathetic care staff for people with dementia and experiencing isolation, and research is showing nurses are contra-indicated for this.

We need governance and management that does not operate hierarchically but is committed to a culture of consumer, family and community engagement and co-design and skilled at achieving this.

More prescriptive regulations won't make all this happen. New architecture for the system and cultural change supported by smarter regulation will enable it to happen. ■

Clear strategy needed to achieve care based on evidence

THE AGED CARE royal commission is certainly putting the spotlight onto the sector and the related news headlines and submissions are showing us the gaps in the system and in our knowledge.

It has become increasingly obvious how little research evidence we have about care of and with the older person.

There is a limited amount of research about caring for older people with complex chronic multi-morbidities and those wanting palliative care. And there is even less about models of care – how we structure our staffing, staff-to-resident ratios, or how allocation and supervision of caring tasks impact on experience and quality of life.

This is not just a national gap but an international gap in evidence. We need a clear strategy to make progress in improving care based on evidence.

One key strategy is to have a framework to guide the allocation of resources including funds, time and effort. The World Health Organization's Decade of Healthy Ageing 2020-2030 framework includes 10 priorities, which could provide direction.

The key premise is that while longer lives is one of the greatest achievements of modern life, we need to translate this into healthy longer lives.

The WHO however, does not define healthy ageing as absence of disease, but 'fostering the functional ability that enables older people to be, and to do, what they have reason to value'. Combating ageism underpins the three key recommended areas for action and all the recent focus on the aged care workforce suggests this would also underpin an improvement in status, recruitment and retention for the sector.

The areas for action – age-friendly communities, community based social care and support and person-centred integrated care – can provide a framework for addressing research gaps.

A focus on age-friendly communities can develop evidence about how older

Associate Professor Christine Stirling, president of the AAG

people can be supported to remain active in their communities wherever they reside. And understanding how best to deliver community based social care and support will ensure the focus remains on enabling older people to do what they value.

Last but not least, a focus on how we can best deliver person-centred integrated care could improve how we meet the healthcare needs of older people.

Quality assessments and access to experts such as dentists, dieticians, physiotherapists, nurse continence and wound care experts in a team approach are all ways that integrated health care can deliver healthy ageing.

Research is also needed to understand interventions around chronic needs resulting from incontinence, frailty and dementia.

To deliver on these research ambitions though, aged care organisations, the health workforce and researchers need to come together to trial and evaluate new ideas. Research funding bodies need to ensure they support research methods that are best suited to increasing knowledge about complex conditions and health services, as these are different to traditional disease focused research methods.

I hope we can all plan to deliver on some of these needs over the next decade. ■

AAG Australian Association of Gerontology