6 May 2020

Response to Consultation: Aged Care Visitors Access Code

Aged Care Crisis is less concerned by the details of the draft code than by the approach taken to the management of COVID-19 and to families and communities.

In large part, the issues are a consequence of major conceptual issues, in policy, in the structure of the system and in the relationships, or rather the inadequacy of the relationships between providers and the communities they serve.

We also have reservations about the approach taken:

1. Excluding workforce representative groups from the group considering the draft code is unacceptable. These are the people who have the most training and knowledge. They will be most impacted by the proposed code, along with residents and family members.
2. Funding announcements regarding COVID-19 payments to aged care homes fail to require transparency in how additional money will be spent.
3. Previous Consultations were managed and maintained by the Department of Health's "***Consultation Hub***"[1] website. We do not understand why this was outsourced to National Aged Care Alliance (NACA) members COTA Australia and industry? Will the submissions be published? If not, why not?
4. In the spirit of transparency, we would like to have our submission published and available for public discussion.
5. The short time frame of one week to respond is restrictive, especially given that some people may not have access to a computer and may need to rely on traditional mail, which has proven to be very slow throughout this pandemic.
6. Accessibility of Consultation: Provision to making contributions other than online should be made available. Many people, especially those in aged care, are unable to help themselves and some do not even have computer access. Their vulnerability may also preclude them from being active participants. Those who cannot participate may be among those most directly impacted by the outcomes of this consultation.

[1] Department of Health, Consultation Hub: https://consultations.health.gov.au/

We make the following points regarding the draft code principles

1 Our aged care homes are not equipped to cope with the problem

1. Sections of industry and members of the pro-government think tank, Menzies Research Centre, have been boasting of industry's success in controlling COVID-19 and have used that to attack those who have exposed the widespread failures in the system and to denigrate the findings of the Royal Commission. This suggests that there are too many in government and industry who don't live in the real world and are ill equipped to deal with the crisis.

2. The majority of COVID-19 cases in Australia have come from overseas or cruise ship arrivals, which are readily identified and contacts traced. There has been much less community spread, particularly in asymptomatic citizens. This was quickly controlled by social distancing. The main reason why relatively few Australian nursing homes have been affected thus far is likely to be a function of low infection rates generally.

3. When the infection did get into our aged care homes, it spread very rapidly as happened in Tasmania and Sydney. This does not suggest effective control within the facilities.

4. We are not suggesting that staff did not do their best. The simple fact is that we do not have the staff or the skills in our aged care homes to cope with a major outbreak requiring sophisticated and skilled nursing and infection control. Perhaps this is why some aged care homes took draconian steps to isolate residents.

5. Our aged care homes are more understaffed than other countries and most staff do not have the skills needed. They are poorly equipped to deal with the crisis.

Even though they are better staffed, European and USA nursing homes have been unable to contain spread coming from heavily infected communities. In Europe and in some US states, nearly half of all deaths have been in nursing home residents.

a. On average, residents in US nursing homes receive twice as much care from trained nurses and a third more nursing care overall. The research done for the Royal Commission by Professor Eager (Research Paper 1) confirms the poor staffing in Australia.

b. Between 70 to 80% of nursing staff are Personal Care Workers who do not have the necessary training and create a high risk situation. Infected residents, even if not symptomatic, require skilled nursing by well trained nurses who are part of a skilled medical team.

c. Australian nursing homes are at greater risk than other countries and the Royal Commissions interim report confirms this.

6. Regular testing of all staff and residents is necessary. There can be a high incidence of asymptomatic cases among residents and staff who spread infection within nursing homes. In Maryland (USA) they did not have sufficient testing kits and could not control the rapid spread of the virus until they identified these cases. They found a high incidence of asymptomatic cases among the elderly residents[2].

7. It would be desirable to move all infected residents to a hospital or other facility staffed only by trained nurses, move all possible contacts including staff to a facility where they can be properly isolated, and then thoroughly clean and sanitise the facility. Tighter visitor control and support for families and staff could be optimized using well trained staff. Residents and staff should only return after they are cleared and only if the facility is now free too.

2 Setting a code and expecting everyone to follow it is unrealistic

8. There are wide variations in each situation and *'a nationally consistent visitation policy'* will inhibit the flexibility needed to respond appropriately. General guidelines would be useful.

9. The structure of each aged care home, its staffing, resources and skills have to be considered.

10. The risk from the local community visiting the facility will depend on their socio-economic status and their level of education, as well as the number of symptomatic and asymptomatic cases in the community.

11. Taking a centralised managerial approach is the same mindset that we have seen in the design of the unpopular, centralised 'one size fits all' approach of the MyAgedCare system. You cannot manage the complexity of our humanity, our diseases and our lives with managerial processes and tasks. It requires relationships and individual responses. While mentoring, guidance and support build capacity. Central control undermines it. This sort of imposed control can be very frustrating. Guidelines are useful, but good decisions can only be made locally.

12. The Prime Minister's condemnation of providers for exceeding guidelines was Trumpian and unwise at this time. It illustrates the problem.

13. Aged care homes do not have the skills to manage this sort of outbreak. The misconception that *'age is not a disease'* and that *'nursing homes are not hospitals'* has been used to argue that there is no need for skilled medical or nursing staff. This has been exposed as fantasy.

14. Maryland in the USA had already identified this problem. It had started decentralising its system. Nursing homes and local hospitals had formed close relationships. Hospitals in the state had teams who were already working in and with nursing homes. When the virus broke out in aged care homes, these teams immediately moved in to support and enable.

---

[2] Keeping Nursing Home Residents and Staff Safe in the Era of COVID-19: A Webinar National Academies of Sciences, Engineering and Medicine (NAS) 22 April 2020 https://bit.ly/2Vvl0CG

Although stressed themselves, they mobilsed staff and resources to support and work with the facilities. Their problem during the early stage of many rapid infections from community sources was a lack of testing kits and of large numbers of asymptomatic infections among staff and residents.

15. We urge the industry to prepare for more outbreaks by building working relationships with local hospitals so that their infectious disease teams are ready to come in and support. That sort of approach should be adopted as policy. Permanent working relationships should be established.

3 Relationships with citizens and families have been shattered and there is intense distrust

16. The unhappiness of families and friends about the isolation procedures adopted exposes a major deficiency in the philosophy that underpins the current aged care system. This is not their system. They don't have any sort of ownership or trust in it.

17. The current free market policies of government and industry have their origin in a number of neoliberal economic and libertarian movements as well as a US philosopher who contemned traditional professional and community values.

All of them condemned 'the collective' (communities and society) because they were seen to impede individual freedom, which was expressed principally through the market. This negativity has left a legacy which has seen the erosion of civil society and its involvement in protecting and working to support its members. The *Aged Care Roadmap* is a good example of this failed philosophy.

Government's distrust of community and its views were expressed at an international business meeting by Peter Shergold in 2016. He said that *"government is concerned about a public backlash from people who believe that aged care should be a community service and not motivated by profit"*. He had become chairman of Opal Aged Care[3] in November 2014. He subsequently retired as chairman of Government's Aged Care Sector Committee in March 2015.

Without the support of a knowledgeable and involved community, family members and residents are at a distinct disadvantage. They are disempowered as a result.

18. The marketing of glowing lifestyle images to citizens when the ultimate reality is very different (most will become ill and die), is deceptive. Providers do not have the capacity to deliver anything like those images. This creates disillusionment and ultimately distrust.

19. This distrust is also reflected in the way in which government and industry avoided transparently collecting hard data about outcomes, even after promising to do so in 2003 when a review criticised them for not doing so.

20. This free market philosophy is unsuited to the sector. It creates perverse incentives. The focus on competition and consolidation rather than on cooperation and relationships compounds the pressures and drives people apart. The Royal Commission has uncovered the consequences.

---

[3] New Opal chairman says innovation is key to better aged care, Financial Review, 25 Nov 2014: https://bit.ly/2zXQHw8

21. Citizens as social beings have responsibilities to one another and particularly for the vulnerable in our society. We would argue that everyone of us and every community has a responsibility for the frail and vulnerable in their communities.

Anyone providing that care is our agent and should be responsible to us. Communities should be involved with their agents in providing that care and ensuring that it is what they and their vulnerable members need and want. They need to be involved in decisions and so develop some ownership of those decisions. This has been taken away from them by the sort of competitive free-market created. That is an issue which should be addressed during this pandemic and then adopted as policy.

4 Addressing the problem of community unhappiness

22. The problem of unhappiness about isolation should be addressed by involving community and families in the decisions and the ongoing management of the contact between families and residents. This ensures a sense of ownership and trust.

a. Local government and local community groups should form a group or committee that includes some citizens with medical and/or nursing experience to work with the families, residents and providers.

b. Representatives from this group should be involved with management and hospital experts in developing policy so that they know what is happening.

c. Someone with some expertise and the capacity to adopt infection control practices should work with staff and residents to see how they are going, to reassure or warn families about the care provided and to arrange for controlled, supervised and supported visiting. Local people from the community who connect regularly are seen as independent and trustworthy. Someone distant (eg from OPAN) is too easily seen as part of the system.

d. Clearly regular visitors and all staff should be tested frequently regardless of symptoms.

5 Concluding remarks

Warnings: During the 1990s politicians were repeatedly warned that the sort of market and the sort of regulatory system they were proposing would not work. It is time to accept that it has not.

For the last 20 years of his life, the late Professor Hal Kendig, a distinguished academic researcher in the sector has been pressing for the management and oversight of care to be decentralised to local councils explaining the many advantages. For over 10 years, Aged Care Crisis has been urging aged care related inquiries to adopt a very similar approach. We have put a greater focus on citizen involvement and ownership of the system.

Clearly if a community is dissatisfied with the way its agents are working with them or the way they are meeting their responsibilities, then it will want to find a new agent to carry out the task. The system should be structured so that this can be done without disrupting the care and the lives of residents. It is this capacity of citizens supporting one another to choose who will provide services that ensures that a market in vulnerable sectors works. The current system prevents this from happening.

The COVID-19 pandemic has exposed the weaknesses and problems in the sector. The changes proposed to address the current crisis should be the first urgent steps in a progressive reform agenda and we should build on that.