Wayne L Belcher OAM
26 Strathalbyn Loop
CARRAMAR WA 6031

Wayne.Belcher@bigpond.com

0419 230 655

20 November 2019

Submission to the Royal Commission into Aged Care Quality and Safety

The following are the substantive comments I made in a recent submission to the Royal Commission on Aged Care Quality and Safety. As a very recently retired Chief Executive in the aged care sector, with some 37 years of continual involvement in aged care related matters, I feel I can comfortably comment upon my own research into matters around minimum levels of staff, and importantly how, I believe, the aged care sector has been left in a quandary as to how best to navigate through these troubled times due to funding constraints placed on (at least) the residential aged care.

1 Minimum / Mandated Staff Ratios

In the first half of 2018 this author[1] completed a literature review around the question "If implemented, how will regulated minimum staffing ratios impact on business viability and quality of care in residential aged care services?" Among other matters, the review included consideration of relevant nursing and aged care literature ranging from the 1980s to the present; a critique of quality care and the effectiveness of staff ratios; and an indicative cost impact of suggested reform of the law on minimum regulated staffing in residential aged care.

Some have suggested that a fixed staff ratio should not be supported,[2] or that there is inadequate qualitative/quantitative evidence to support a minimum ratio,[3] or indeed that a staff ratio is a blunt instrument,[4] and likely not appropriate in residential aged care in Australia.

In 2011 the Productivity Commission reported that in its view:

> 'while there are superficial attractions to mandatory staffing ratios, there are also downsides. An across-the-board staffing ratio is a fairly 'blunt' instrument for ensuring quality care because of the heterogeneous and ever-changing care needs of aged care recipients – in the Commission's view it is unlikely to be an efficient way to improve the quality of care. Because the basis for deciding on staffing levels and skills mix

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1 Wayne L Belcher, *Minimum What Ratios?* wlbelcher.com <https://wlbelcher.com/staff-ratio-review/>. Accessed 17 December 2018.
2 Aged & Community Services Australia, 'ACSA Position Statement: Staffing Ratios' (November 2015).
3 Senate Standing Committee on Community Affairs, 'Future of Australia's aged care sector workforce' (The Senate, June 2017), [3.76], 58.
4 Productivity Commission, 'Caring for Older Australians, Report no. 53' (Productivity Commission, 2011).

> should be the care needs of residents, it is important that these can be adjusted as the profile of care recipients' changes (because of improvements/deteriorations in functionality and adverse events, etc). Imposing mandated staffing ratios could also eliminate incentives for providers to invest in innovative models of care or adopt new technologies that could assist care recipients.'[5]

Largely based on the Productivity Commission findings, in November 2015, Aged and Community Services Australia ("ACSA") commented that whilst it 'supports sustainable staffing levels, and appropriate skill-mix, across the aged care sector' it does not support fixed staffing levels.[6] But in 2005, Buchan had already arrived at an almost diametrically opposite conclusion that staff ratios are 'a blunt instrument for achieving employer compliance where alternative (and often more sophisticated) methods of determining nurse staffing levels have not been effectively managed or have been ignored by policy makers.'[7]

In 2018 ACSA updated their position to recommend that 'Government work with key stakeholders and industry to develop … a suite of quality indicators (that includes a staffing ratio measure) that are evidenced based and focus on the quality of care and services that consumers receive.'[8] Leading Aged Services Australia, commenting on Spilsbury et al (2011),[9] opined that 'While care staff's input of time, effort, right attitude, knowledge and skill make a large contribution to quality of care, a focus on staff ratios fails to address all contributing elements.'[10] This is a somewhat misleading observation though as immediately below the Abstract from which that quotation is taken from Spilsbury's article, Spilsbury writes that the authors know 'Poor quality care has been associated with inadequate nurse staffing and poor skills mix'.[11] Spilsbury (2011) commented specifically that other 'staffing factors, turnover, worker stability and agency staff use, as well as training or experience of individuals may be influencing quality of care delivered to residents.'[12]

What we presume is a sea of difference between views of the merit of having a useful minimum staff mix and ratio that ensures quality of service and minimises potential neglect and abuse, all seemingly supported by robust research. However, even within what seems a significant difference of opinion, two further reviews are compelling:

- In 2009, in response to an online question 'Is there evidence for an "optimal" staffing ratio in nursing home settings and do staffing ratios have a meaningful relationship to measures of quality care in long term care?',[13] Howe responded, that in a 2000-2001

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5 ibid, 206.
6 Aged & Community Services Australia, above n 2.
7 James Buchan, 'A certain ratio? The policy implications of minimum staffing ratios in nursing' (2005) 10(4) *Journal of Health Services Research and Policy*, 244.
8 Aged & Community Services Australia, 'Submssion: Inquiry Into the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018 - Standing Committee on Health, Aged Care, and Sport' (ACSA, 4 October 2018), 6.
9 Karen Spilsbury et al, 'The relationship between nurse staffing and quality of care in nursing homes: A systematic review' (2011) 48(6) *International Journal of Nursing Studies*.
10 Leading Aged Services Australia, 'LASA National Workforce Forum: Background Paper' (LASA, November 2017), 8.
11 Spilsbury et al, above n 9, 732.
12 ibid, 748.
13 Carol L Howe, 'Staffing Ratios in Nursing Homes' (2009) 15(2) (August 2009) *Arizona Geriatrics Society*, 23.

two part study by ABT Associates on behalf of the Centers for Medicare and Medicaid Services,[14] the lower level threshold set as a ratio in USA, the recommended outcome was a 'minimum of 4.1 HRPD [hours per resident day] was needed to prevent harm to residents with long stays (90 days or more) in nursing homes.'[15] Howe added that by 2009 subsequent 'studies have employed different methodologies but few spell out specifically different quantitative conclusions'.[16] Howe comments on similar factors that Spilsbury referred to above, but views the single independent variable to such arguments as being 'staff ratio'. Howe's review suggests that the upper ratio of 4.75 HRPD offered by ABT Associates indicated a 'threshold of staffing above which little benefit accrues from adding more staff.'[17]

- In March 2017 British Columbia Health in Canada reported on a review of residential care staffing.[18] Their findings repeated from a 2008 review were that although 'Canadian researchers and professional organizations support the need for a broad focus on the factors impacting staff and resident outcomes', and they 'reject the legislated focus on staffing ratios and hours of care adopted in some jurisdictions in the United States',[19] they recognise that research 'in all jurisdictions consistently shows that higher levels of all types of staffing lead to better resident outcomes', and 'the recommended range is between 3.9 and 4.8 paid hours per resident per day.'[20] That range is almost identical to the recommendation by Abt in Howe's comments above.

Harrington et al describes some '150 staffing studies … documented in systematic international reviews', documenting 'a strong positive impact on both care process and outcome measures.'[21] From studies in her home nation the USA, Harrington observes that whilst there may well be a financial incentive for providers to overstate resident acuity, there has been an increasing trend for higher acuity of resident hospital discharge to nursing homes. Based on acuity levels driving the quantum of a staff mix, Harrington also advises a minimum standard of 4.1 HRPD, including a Registered Nurse on duty 24 hours per day, has been accepted by the American Nurses Association, the Coalition of Geriatric Nursing Organizations, and the National Consumer Voice for Quality Long-Term Care.[22]

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[14] Abt Associates Inc, 'Appropriateness of Minimum Staffing Ratios in Nursing Home: Report to Congress Phase II Final.' (Centers for Medicare and Medicaid Services, 24 December 2001).

[15] Howe, above n 13, 24.

[16] ibid, 25.

[17] ibid, 23.

[18] British Columbia Ministry of Health, 'Residential Care Staff Review' (Ministry of Health, March 2017), 35.

[19] ibid.

[20] ibid.

[21] Charlene Harrington et al, 'The Need for Higher Minimum Staffing Standards in U.S.Nursing Homes' 2016(9) *Health Services Insights*, 14; Ramona Backhaus et al, 'Nurse Staffing on Quality of Care in Nursing Homes: A Systematic Review of Longitudinal Studies' (2014) 15(6) *Journal of the American Medical Directors Association* 383-393; Jane E Bostick et al, 'Systematic Review of Stidues of Staffing and Quality in Nursing Homes' (2006) 7(6) Journal of the American Medical Directors Association 366-376; Nicholas G Castle, 'Nursing Home Caregiver Staffing Levels and Quality of Care: A Literature Review' (2008) 27(4) Journal of Applied Gerontology 375-475; Mary E Dellefield et al, 'The Relationship Between Registered Nurses and Nursing Home Quality: An Integrative Review (2008-2014)' (2015) 33(2) Nursing Economic$ 95-108; Spilsbury et al, above n 9, 750.

[22] Institute of Medicine (US) Committee on the Work Environment for Nurses and Patient Safety, *Keeping Patients Safe: Transforming the Work Environment of Nurses* (National Academy of Medicine, 2004); American Nurses' Association, 'Position Statement: Nursing Staffing Requirements to Meet the Demands of

The StewartBrown 31 December 2018 average from the 900 plus facilities contributing to their quarterly reporting showed the average HRPD for Registered Nurses, Enrolled and Licensed Nurses, Other Unlicensed Nurses and Personal Care Staff, and Imputed and Implied Agency Care Hours nationwide was at 2.89 HRPD (the top 25% of facilities are at 2.59 HRPD),[23] – a significant difference from similar jurisdictional regulated staffing provision.

In addition, there is now some international evidence that the lower amount of direct care hours per resident per day provided to residents in Australian residential aged care services likely results in an increase in missed care. An Australian study found that whilst differences between respondents from the three mainland States included in the survey tended to differ by State, the conclusion of the study was 'Resident care is missed in residential aged care with staffing numbers identified as a key cause.'[24] Of concern though is that Schnelle et al (2016) found that when residential care Nurse Aide hours per resident per day were at 1.6 HRPD, up to '38% of all scheduled care time was not provided by staff',[25] and one in three continence care events were missed. Schnelle adds that the simulations used in their research suggest that a range of 2.8 HRPD to 3.6 HRPD for Nurse Aides alone (Registered Nurses and Enrolled Nurses are additional) – depending on the acuity of residents – should maintain a rate of missed care below 10%. Is 10% missed care acceptable?

Whilst both authors comment on the limitations of their research, these are early, indicative reports suggesting that there is insufficient care being given to residents. Surely that means that when more care is provided and the missed care rate lessened, that outcome can only be achieved is by providing for an appropriate staff mix and contemporaneously creating an appropriate pricing model that enables providers to meet reasonable obligations for the care they deliver? At this time, it seems that providers are in a position, via the Funder, where it is difficult to not fail in service delivery.

Considering the above, I strongly recommended that a regulated minimum staffing ratio is an important requirement for residential aged care in Australia**.** If well planned and implemented, such a ratio would be likely to:

- improve quality of care and reduce allegations of neglect and abuse of care recipients[26];
- build the hours of service and expertise for all direct care workers;

Today's Long Term Care Consumer - recommendations from the Coalition of Geriatric Nursing Organizations (CGNO)' (American Nursses' Association, 12 November 2014).

[23] StewartBrown, 'Aged Care Financial Performance Survey Sector Report: (Six months ended December 2018)' (StewartBrown, 2019), 15.

[24] Julie Henderson et al, 'Missed care in residential aged care in Australia: An exploratory study' 24(2017) *Collegian*, 411.

[25] John F Schnelle et al, 'Determining Nurse Aide Staffing Requirements to Provide Care Based on Resident Workload: A Discrete Event Simulation Model' 17(2016) *Journal of the American Medical Directors Association*, 976.

[26] National Center on Elder Abuse, 'Nursing Home Abuse Risk Prevention Profile and Checklist' (National Association of State Units on Aging, 2005), 11; Haizhen Lin, 'Do Minimum Quality Standards Improve Quality? A Case Study of the Nursing Home Industry' (Retrieved from http://search.proquest.com/docview/1698621328/, 2010), 24; Joseph Liu, 'Protecting Essential Human Capabilities of Elders in Institutional Care' (Washington and Lee University, 2014), 19.

- include mandatory registered nurse cover for 24 hours per resident per day (HRPD), seven days per week, in all facilities where any one or more resident's assessed acuity exceeds a minimum point on the assessment scale;
- include a minimum of 0.75 HRPD cover by registered nurses;
- be based on an immediate increase of direct care staffing to 3.2 HRPD, with no permissible diminution of current HRPD provision per provider;
- improve resident care outcomes by increasing the minimum ratio to 4.1 HRPD over the forward estimates; and
- provide for additional funding from the Australian Government for each resident, based on their overall acuity assessment above a minimum benchmark.

It is further recommended that action should commence to amend the relevant legislation to reflect the above recommendations, determine the veracity of the initial minimum ratio and phased increase over time, make provision for funding in the forward estimates, and monitor improvements in quality of care and provider agency performance against the implemented minimum standards.

Since June 2018, there have been further comments regarding minimum staffing ratios in residential aged care, including recommendations to implement such an approach by a recent Australian Parliamentary Committee review[27] and a supporting advertisement in The Weekend Australian on Saturday 15 December 2018.[28] The latter was supported by a range of professionals.

It is important to note though that while a move to minimum staffing ratios is a matter to seriously contemplate, it will likely be impossible to implement the researched target ratio without substantial additional funding to the sector. A well-structured transition plan recognising the need to increase sector capability and capacity, including skilling and training of current and future workforce requirements, would also be needed.

Not only is there a need for a significant increase in funding to achieve such a minimum ratio, there is also a need for access to appropriate human resources, particularly registered nurses and allied health staff, to work in the aged care sector. While this is increasingly true in any geography, it is a pressing and urgent matter for rural and remote/isolated communities. It is almost reaching a point where one must bring entire families into a community to provide capability to run an aged care service. Any transition to a minimum staffing ratio model must take such difficulties into account and a punitive response (inclusive of closure of a service) should not apply simply because a "prescribed ratio" cannot be practically met.

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[27] House of Representatives Standing Committee on Health Aged Care and Sport, 'Advisory Report on the Aged Care Amendment (Staffing Ratio Disclosure) Bill 2018' (Commonwealth of Australia, Canberra), December 2018.

[28] 'Advertisement: Open Letter to Prime Minister - Staffing ratios', *The Weekend Australian* (Sydney, NSW), 2018.

2 Recurrent Funding of Residential Aged Care

The implementation of the *Aged Care Act 1997* (Cth) changed the nature of aged care provision as it was then known; and also changed over time the funding mechanisms upon which approved providers of care rely in order to fund their operations. It has been recently oft said that some 80% of all revenue in residential aged care services is derived through Australian Government funding sources.

In aged care in Australia:

- almost 240,000 people received permanent residential aged care in 2015-16;[29]
- the proportion of people aged 65 years or over is projected to increase from 15.3 per cent in 2017[30] to 22 per cent in 2061,[31] when one in twenty people will be aged 85 years and over;
- frailty of residents is increasing as people age in place in care or are admitted at an older age, with multiple morbidities; and
- a further almost one million older Australians receive some form of government funded care and support in their own homes funded directly via the Australian Government and care recipient co-contribution.

The overall funding mechanisms for both residential and community-based aged care services then become imperative for not only all Australians but for governments that fund our subsidised care systems. Federally, that responsibility falls to the Department of Health and the Minister for Aged Care (howsoever titled).

When the Aged Care Act was introduced on 1 October 1997, the majority of funding to providers came through the assessed need of residents through the Resident Classification System. Additional daily co-payments were payable to assist providers to meet the care and accommodation needs of residents. At 30 September 1997, the resident co-payment was 87.5% of the combined value of the aged pension plus supplementary benefit for nursing home care recipients and 85% of that combined total for hostel care recipients. On or about 1 October 1997, that became a standardised 85% of the value of the aged pension only. Income for care was already being restructured.

In the mid-2000s, various aged care providers and their peak bodies undertook work to understand the impact of (very) low level increases in annual indexation for aged care payments compared to similar industry or accepted social index comparators such as the Wage Price Index (WPI), Average Weekly Earnings (AWE) and health insurance premiums. The outcome of this work, meeting resistance with Government officials but often repeated by peak bodies and cited in different reports[32], shows the following:

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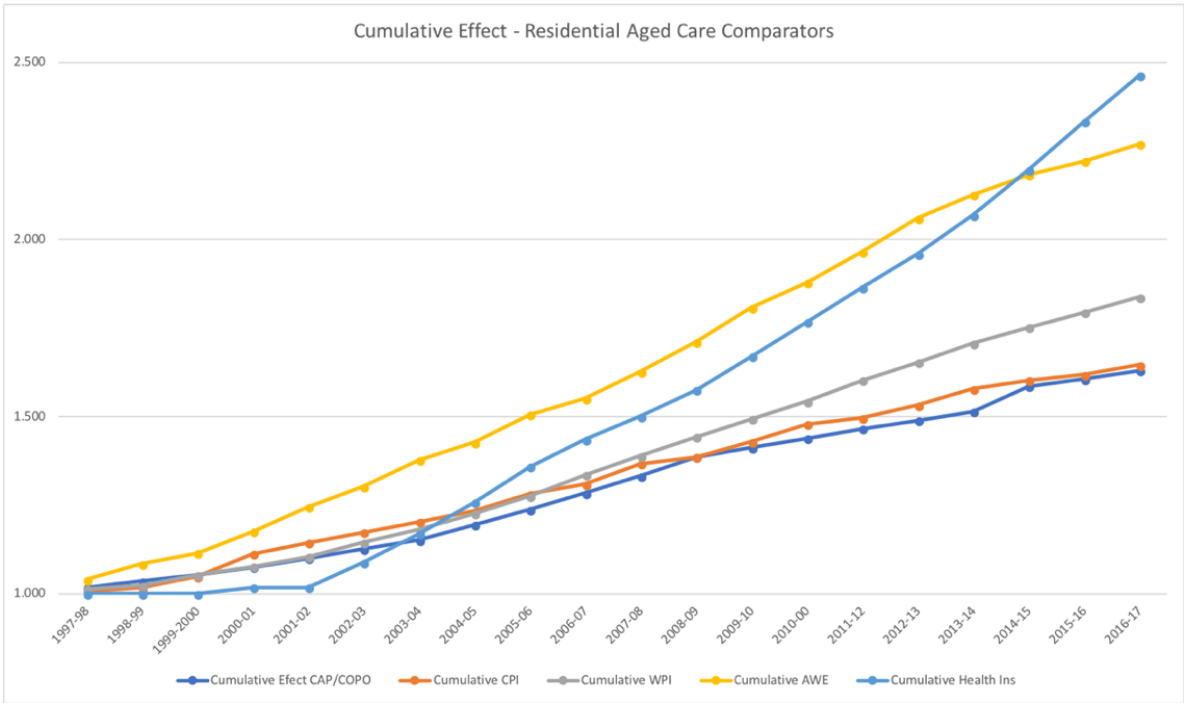
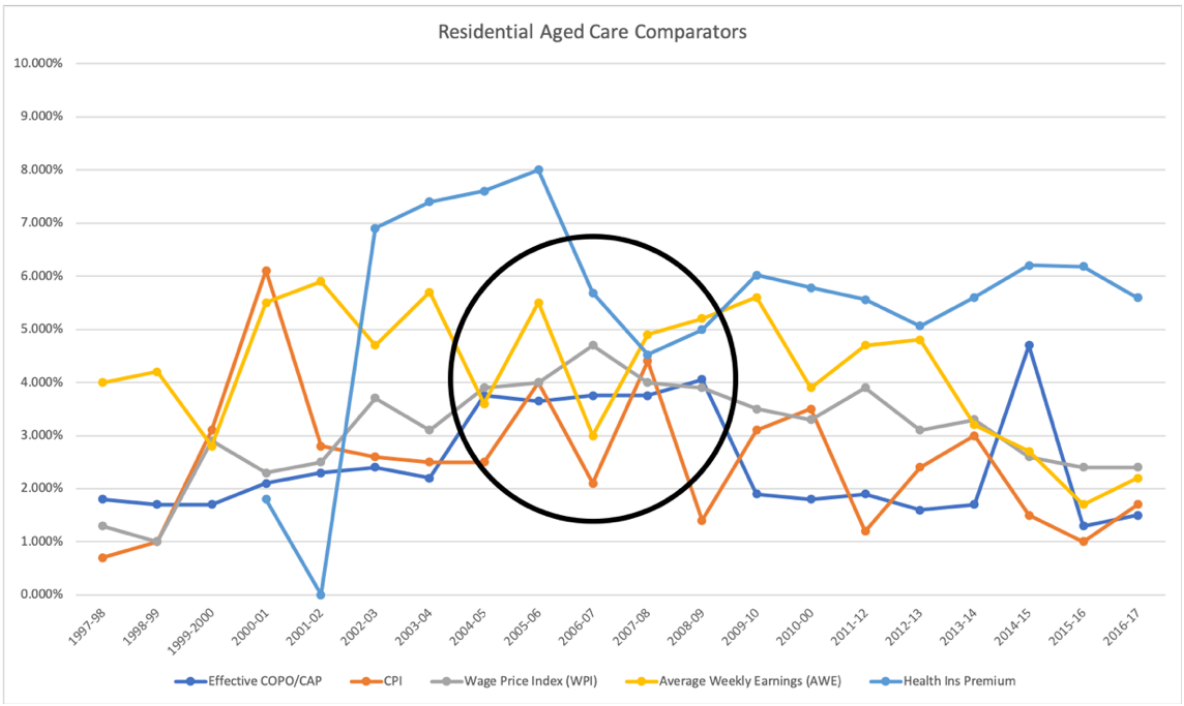
[29] Commonwealth of Australia as represented by the Department of Health, *2016–17 Report on the Operation of the Aged Care Act 1997* (2017), 19.

[30] Productivity Commission, 'Report on Government Services' (Productivity Commission, 2018), Table 14A.1.

[31] Australian Bureau of Statistics, 'Population Projections, Australia, 2012 (base) to 2101' (ABS, 2013), Series B.

[32] Standing Committee on Finance and Public Administration, *Residential and Community Aged Care in Australia* The Senate, Commonwealth of Australia <https://www.aph.gov.au/Parliamentary_Business/Committees/Senate/Finance_and_Public_Administration/





It is clear from the figures above that the annual indexation of aged care payments has fallen far short of that for comparable indices for the best part of two decades.

Completed_inquiries/2008-10/aged_care/report/c05>, accessed 18 December 2018; Productivity Commission, 'Caring for Older Australians - Submission DR759' (Australian Government Productivity Commission, 2011).

In spite of Government reluctance to accept this finding of consistent underfunding of aged care, in the Access Economics[33] review of the Conditional Adjustment Payment ("CAP") that came from the Review of Pricing Arrangements in Residential Aged Care (Hogan Review), a specific allocation of an additional 1.75% of funding was granted for each of five years circled in the chart above to make the level of funding more equitable for providers. That CAP funding underpins the residential aged care sector's insistence over time that the sector has been systematically defunded since the commencement of the Aged Care Act and continues to be so to this day.

Why might this bipartisan continued reduction in funding compared to other meaningful indicators be perpetuated? It could be as simple as the Australian Government being cognisant of the burgeoning growth in need for aged care services, and the limits to our overall capacity to pay for those services as and when needed. If that is the overwhelming and unsurprising rationale, then this should be transparently explained to the Australian public and the blame for decreasing ability to fund and provide high quality aged care services not laid at the feet of the providers alone.

Across the sector, providers are willing to do more with less, but there is a limit to their financial capacity to do so. That is highlighted with the 2017-18 financial benchmarking service conducted by StewartBrown[34] that, amongst other things, found:

- 45% of residential aged care facilities are failing to achieve sustainable returns;
- Some 21% of facilities are actually making a real loss from their operations. They are not receiving enough subsidies, supplements, and income from fees to actually cover their current day to day costs; and
- Indexation shortfalls in the home care sector have had a similar impact on home care and home support services, eroding the level of these services over time. For example, a higher-level home care package ("HCP") (old EACH) used to buy around 20 hours of service per week. Today an HCP Level 4 is much more likely to be around 14-15 hours per week. Additionally, in block funded programs such as CHSP (ex-HACC), erosion of the buying power of the grant levels through inadequate indexation reduces the number of hours of service that can be afforded.[35]

Significantly more recurrent funding is needed in the sector to address financial sustainability needs and the ability to provide high quality services that the broader Australian community expects.

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[33] Access Economics, 'Submission io the Review of the Conditional Adjustment Payment' (2008), 2.

[34] StewartBrown, 'Personal Correspondence with Data' (2018); StewartBrown, 'Aged Care Financial Performance Survey: Sector Report (2018 Financial Year)' (2018), 2.

[35] Productivity Commission, above n 32, Volume 1 125-126; Aged Care Financing Authority, 'Sixth report on the Funding and Financing of the Aged Care Sector' (Aged Care Financing Authority, 2018), 64-78.

3 Funding of Aged Care Into Australia's Future

With renewed focus on the sector through the Royal Commission into Aged Care Quality and Safety, we have a valuable opportunity to consider an appropriate funding apparatus for the future – the next generation of aged care services in Australia.

It seems reasonably clear that the Australian Government does not have the capacity to continue to fully subsidise all aged care requirements of a burgeoning care recipient population. Yet it does not seem that individual citizens have the capacity, or perhaps more so, the desire to completely cover the cost of their own future care.

However, Australia does have in place an ideal three-tiered framework from which it can collect, manage, and reimburse the cost of care for those who need it. The three components are our Medicare, Occupational Superannuation and current aged pension schemes.

The aged pension has been a hallmark of Australia's social policy for in excess of a century. One presumes that Australia will continue to invest in a social welfare payment system from which those with little or no recurrent wage at or during retirement can be paid a living wage to sustain them in their own homes as independently as possible until admission into a residential aged care setting or death.

The Superannuation Guarantee scheme (occupational superannuation) has been in place for almost 30 years. But it has the capacity to earn more and to support the aged care system. For example, a once off increase of 3% in superannuation guarantee charge, with the collected funds set aside specifically to meet ongoing long-term care needs as people age and become frail, would provide immediate relief to Commonwealth resources and shift the burden of payment and preparation for long term aged care to the prospective recipient of care.

Care recipients with little or no recurrent income and no asset base, would still be covered by the provisions of the regulations to the Aged Care Act that supports such care recipients.

Medicare may have a role to play in the management, collection, and disbursement of funds targeted for care based on existing entry practices into our aged care system. The 2011 Productivity Commission *Caring for Older Australians*[36] report did examine alternative funding options, including social insurance models, possibly overlapping into Medicare.

While the suggestion of a superannuation and/or combined superannuation and social insurance contribution seemingly focus on recurrent funding matters for community and/or residential aged care, it is possible that the revenue raised could provide capital development funds to create accommodation for "concessional" or "supported" care recipients. The cost of development of accommodation necessarily requires consideration. The Tune Review

[36] Productivity Commission, above n 11, Volume 2, 95-128 (particularly 116-126.

discussion and recommendations[37] on accommodation matters seem to us to be highly worthwhile of further consideration.

A different level of thinking and a shift from current practice is needed to achieve the necessary change to financing system design for the next generation of Australian Government-funded aged care.

4 A Person-Centred Approach to Caring for the Elderly in Australia

In terms of quality measurement, while the developing use of customer experience surveys in accreditation and contact visits is welcome, as recently as April 2018, Trigg (whom the Royal Commission did indeed seek evidence from earlier in 2019), found in a bilateral aged care system review that England, when compared with Australia, had a more person-centred approach to standards measurement that upheld the rights of the individual older person. In that system quality was expressed as a rating and there was a 'Mum test'[38] of customer experience conducted as part of the regulatory system. By comparison, in Australia, the system was compliance-based, driven by the measurement of provider processes against the standards and assessed on a pass/fail basis.[39]

Schedules 1 and 2 of the User Rights Principles of the Act provide for the Charters of Care Recipients Rights – Residential Care and Home Care respectively. Lacey commented that the 'relegation of the Charter of Rights to schedules rather than being in the body of the Act is emblematic of the "lack of priority given to those rights under the legislative framework"',[40] and that the Aged Care Complaints Scheme focused too much on complaint resolution rather than on enforcement of (human) rights of the recipients,[41] inclusive of elder abuse prevention and response units.[42]

Of the total number of people using the aged care system, almost one quarter of a million people are in residential care each year.[43] Of this number, well in excess of 50% are living with at least some measure of cognitive disease process, mostly due to the impact of dementia associated with ageing.[44] But such disease processes do not diminish a person's intrinsic human rights or value. Any person receiving care and support from any human

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37 David Tune and Department of Health Australia (issuing body), 'Legislated Review of Aged Care 2017' (2017), 93-106.

38 Lisa Trigg, *Improving the quality of residential care for older people: a study of government approaches in England and Australia* (PhD Thesis, London School of Economics and Political Science, 2018), 125.

39 ibid, 125.

40 Wendy Lacey, 'Neglectful to the point of cruelty? Elder abuse and the rights of older persons in Australia' (2014) 36(1) *Sydney Law Review*, 125.

41 Rae Kaspiew, Rachel Carson and Helen Rhoades, 'Elder abuse: Understanding issues, frameworks and responses' (Australian Institute of Family Studies, 2016), 24.

42 John Chesterman, 'Taking Control: Putting Older People at the Centre of Elder Abuse Response Strategies' (2016) 69(1) *Australian Social Work*, 121.

43 Commonwealth of Australia as represented by the Department of Health, above n 27.

44 Suzanne M Dyer et al, 'Diagnosis of dementia in residential aged care settings in Australia: An opportunity for improvements in quality of care?' (2018) 37(4) *Australasian Journal on Ageing*, E155.

service, particularly our vulnerable and frail elders, should have 'a right not to be exposed to violence and abuse, cruel, inhumane or degrading treatment, poor hygiene and neglect, indignity, and invasion of privacy.'[45]

I agree with Barnett and Hayes' statement that, as well as 'social, legal, medical and economic challenges, there is a moral imperative that Australia should take all appropriate measures to encourage and protect its elderly citizens and provide them with opportunities to live happy and meaningful lives because the elderly as a group have contributed to the history, advancement and prosperity of the nation.'[46] That, I venture to suggest, will cost more. Accordingly, either the Australian Government or the consumer or, better, a combination of both, must pay more for appropriate levels of well-regulated care. Just as the Australian Government has for decades required a minimum level of publicly funded places be made available for assessed consumers of residential care, it would be appropriate for a capped level of return on investment for publicly funded care and services.

Conclusion

I keep cycling back to the importance of funding an appropriate person centred service system of support and care. When we objectify elderly vulnerable and frail people as care recipients, we can quite quickly turn to a depersonalised commodity-based business mode that too quickly trades out human value and rights for excessive profitability margins. To provide appropriate and well-regulated levels of care, Australians must recognise the value and inherent rights of older human lives. Without trading out our humanity, we must strive to create a better aged care system that meets the needs of all elders, current and future.

However, I recognise the need for accountability and transparency in such funding as the vast majority of any provider's operating income is derived from the public purse. I believe it to be within the wit of man to work this out. As a past provider I do not believe quarterly or similar reporting of staffing levels to be a significant hurdle for providers to demonstrate. After all, there is so much regulation now, and organisations manage that.

Surely the balance of the income derived is a reasonable level of transparency and accountability upon which the confidence of the Australian community can be built into the system supporting our frail elders.

Nice chatting.

Wayne L Belcher OAM, MBusLaw, MMin, GradDipHealthSciences (Gerontology)
WLB:WLB [1911]

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[45] Michael Barnett and Robert Hayes, 'Not seen and not heard: Protecting elder human rights in aged care' (2010) 14(1) *University of Western Sydney Law Review*, 45.

[46] ibid, 50.