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TRANSCRIPT OF PROCEEDINGS

PRODUCTIVITY COMMISSION

INQUIRY INTO CARING FOR OLDER AUSTRALIANS

MR M. WOODS, Presiding Commissioner
MR R. FITZGERALD, CommissionerMS S. MACRI, Associate Commissioner

TRANSCRIPT OF PROCEEDINGS

AT MELBOURNE ON MONDAY, 21 MARCH 2011, AT 8.40 AM

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MR WOODS: Ladies and gentlemen, welcome to the Melbourne public hearings for the Productivity Commission inquiry into Caring for Older Australians. I'm Mike Woods and I'm presiding commissioner on this inquiry. I'm assisted by Commissioner Robert Fitzgerald and Associate Commissioner Sue Macri. The commission has been requested to undertake a broad-ranging inquiry into the aged care system with the aim of developing detailed options for a redesign which will ensure that the current weaknesses are overcome and that the future challenges can be met.

In developing the draft report the commission travelled extensively throughout Australia holding 150 visits and receiving nearly 500 submissions. I would like to express our thanks and those of the staff for the courtesy extended to us in our travels and deliberations so far and for the thoughtful contributions that so many have made already in the course of this inquiry.

These hearings represent the next of the inquiry and the final report will be presented to government in June this year. I would like these hearings to be conducted in a reasonably informal manner but remind participants that a full transcript will be taken and made available to all interested parties. At the end of the scheduled hearings for the day, there will be an opportunity for any person present to make an unscheduled presentation should they wish to do so. I welcome to the hearings our first participants from Australian Unity. For the record, could you please state your names and the organisation you are representing.

MR McMILLAN (AU): Derek McMillan, chief executive officer of retirement living, Australian Unity.

MR PUTAMORSI (AU): Robert Putamorsi, general manager commercial, Australian Unity retirement living.

MR WOODS: Thank you very much. Do you have an opening statement you wish to make?

MR McMILLAN (AU): Yes, thanks, commissioner. There are probably two or three key points I'd like to make. The first is in relation to wellbeing and I congratulate the Productivity Commission for their strong emphasis on wellbeing of older Australians, in particular in your first draft report. There is a way that we can easily measure wellbeing and the Australian Unity Wellbeing have identified that in the report as a measurement tool that's been operational for over 10 years now and has 70-odd publications to its name. So that's a tool I'd encourage the commission to review.

There are two or three key points I'd like to spend most of my time on, one

being in relation to stimulating retirement or age-friendly housing and I think that there is two or three levers which we could use to help to stimulate the development of more age-appropriate housing. The second is in relation to accommodation charges and accommodation bonds. They are the two areas that I'd like to spend most time on, if that's okay.

MR WOODS: Please, proceed.

MR McMILLAN (AU): All right. So perhaps if you in your pack turn to the schematic representations which are the Venn diagrams. I would just like to make a couple of contextual comments in relation to these. The first is that we've represented the age accommodation services in this manner. One point I would like to make in page 3, which is the asterisk, the star, we have surveyed, since the first submission that we made, our retirement residents, of which there are almost 2000, and of those about 30 per cent of those residents are receiving actual home care, either HAC or CACP or EACH packages. So there is a substantial overlap there between those two sectors and it's our proposition that in fact that is a much more efficient way to deliver those services to those people.

On the next chart, page 4, I'd like to just touch on those overlap areas a little further. The first in the overlap between retirement villages and home based care and I have identified there that retirement villages increase the efficiency of service delivery. They help to defeat loneliness through the community living aspect of retirement villages, which is actually quite important. I will provide these with our more formal submissions but there are several studies now which have been published which associate loneliness with both increased morbidity and also increased mortality, including an increased risk of Alzheimer's disease as well. So I will include references to those in our full submission.

MR WOODS: Thank you very much.

MR McMILLAN (AU): Of course retirement villages promote wellbeing by giving people the opportunity to do a range of interactions, not just relationships but also achieving in life and so forth. But they are a very good tool for allowing equity release from the family home through to downsizing and essentially releasing equity which generally, in our experience, residents release in the order of 150 to 300 thousand dollars when they downsize. That money often goes towards, not only just lifestyle but also paying for other health care costs and so forth as well.

MR WOODS: We would be interested in discussion then to get your views on our proposals as to how people may maintain their pension as well as have some equity release and what that might do for the industry, so if you can keep that in mind.

MR McMILLAN (AU): Yes. The second overlap is the co-location between retirement villages and residential aged care. In our experience our co-located sites, where we have some villages which are stand-alone and some which are co-located with aged care, the co-location is a preferred model for residents, particularly those that are couples, where one is ageing more quickly than the other, but it also does allow a more efficient delivery of a range of services, not just funded services but also user-pay services as well and we would encourage the commission to promote that co-located model.

The third is something, just to explore a little further as the commission identified in relation to additional services such as rehabilitation and palliative care which can be provided. I have also included in there a triage service which is not something I know a lot about, except that I am familiar that a lot of older people end up in emergency where they don't need to be in emergency, that's not the best place for them, particularly if they're ill, leaving an aged care facility, the operators need to send them somewhere, it's probably not the most appropriate place for older people to go. There may be a model - I'm not sure if there are in other countries - of triage-type services where older people can go to a more, I suppose, geriatric-friendly location for triage where it may or may not require full emergency services.

MS MACRI: Can I just say some hospitals now in fact are triaging and have set up their emergency departments in various places for older people, so they're separating - they have actually triaged paediatrics, geriatrics from the mainstream. It is starting just to happen a little bit.

MR McMILLAN (AU): Yes. The keys that I would like to make, the first is in relation to increasing the supply of particularly retirement and other purpose-built communities - so this is page 5 in the summary document. So age-friendly housing does cost more to build than a traditional residential development. They cost more to construct because of the additional costs for accessibility and adaptability within the home. It has slower sales rates because the market is clearly much smaller than a conventional residential development. It is more difficult to finance these developments because of a number of factors, including non-binding deposits under the Retirement Villages Act. The deposits are fully refundable, so that makes it more difficult to receive bank finance. Alternate uses, sometimes the land, particularly for villages half constructed - it is difficult to then, if the village hasn't gone on to completion, to onsell the rest of the land. There is a fair bit of community infrastructure that is required and there are fewer lenders in that market.

So when you put that all together, as well as the fact that most older people need to be closer to shops and closer to public transport, it says it is more expensive to develop retirement than it is other sectors and that is why there is an enormous

number of players in the market. The proposal that I am putting to you today is on the next page, which is page 6. So there currently exists, if you like, a GST distortion, I've called it, on the construction of retirement villages where charitable operators are able to develop those GST-free. Non-charitable or tax-paying operators, such as ourselves which are a mutual, not-for-profit but a mutual organisation, independent living units are input taxed when it comes to GST, so that adds an additional 10 per cent to the cost of the development. That is an inhibitor to retirement village development, there is no doubt about that.

I can also accept that some retirement villages are not particularly focused on the older cohort and some are more lifestyle villages. So what my proposition is - the first dot point is that any village which is co-located with serviced apartments or residential aged care facility is clearly one which is focused on service delivery to older people. The GST taxation treatment of that should be changed, such that it's consistent with the other accommodation services for older people.

An alternative or maybe even a supplementary model could be in order to stimulate more affordable housing that operators/developers could be given the option to say that that GST which may paid, in a normal development instead of paying that GST they could build affordable housing for their equivalent contribution for that GST, so that then increases the supply of affordable housing in the market. The third point is that both the federal and state government has extensive land holdings and the highest and best use is often a term used for consideration of disposing of government land. I would contend that the highest and best use should also consider the social use. Governments do put aside land for schools, for libraries, for other community infrastructure, that they should also be asked to consider requirements for social and aged housing as well before they dispose of government land. I am happy to take any clarifying questions on that. Does that make sense?

MR WOODS: I think if you make your presentation and then we will come back, that is probably the best way.

MR McMILLAN (AU): Okay. Accommodation charges and bonds. I have tried to illustrate the fact that this equivalence - and I do congratulate the commission on looking at ways we can both extend accommodation bonds and also provide more flexibility in payment, I think that is a very positive model. However, there are a number of issues that need to be considered in establishing this equivalence. Firstly, is the availability of debt. At the moment most aged care facilities are being constructed using essentially consumers' capital to help to fund those. If the market moves to more accommodation charges, then we're going move from capital to debt and we're going to need debt to fund those.

MR WOODS: Like most of the economy.

MR McMILLAN (AU): That is correct. One of the interesting issues with that is do the financial markets have the capacity to add another 20 billion or so of debt into this sector when there is relatively low returns on capital in the sector? So equivalence is not just, of course, the construction costs but also the costs of the land, the financing costs, fit-out and an appropriate return on equity as well. I have an illustrative example here. So if we assume an aged care facility of 100 beds with no concessional places - just to make the maths easy - this is not atypical so land and construction of $20 million, equity funding from the provider would be around $5 million, being a 75 per cent LVR for debt funding of $15 million.

Over the page we will see what happens when the residents start to move in. If they are all bonded beds at an average of $250,000 each, which is around the average in Australia at the moment, accommodation bonds would comprise $25 million which would enable the principal and interest to be repaid out of the bonds, there would be a retention of some bond amount for working capital, particularly for allowing redemption of future bonds and so forth, which would leave $5 million which the operator could then recycle that 5 million from that facility into another facility and start the process again, so every two or three years a provider could do that.

The second scenario would be 50 bonded beds, 50 with accommodation charges. I have assumed at that $250,000 equivalence being at 6 per cent indexed rate which is about, I suppose, a term deposit rate means that 50 beds provides $750,000. So if construction funding is approved under this model, then the operator would be required to pay down that LVR from 75 down to 25 per cent, so the accommodation bonds that are received would then provide that opportunity to pay down the principal and the interest and then we would have an ongoing debt of $5 million. That debt at 8 per cent would then - to service that debt would take about $400,000. The operator would need to inject an additional $2 million on liquidity and working capital. So in this scenario the operator would have $7 million retained, trapped in the aged care facility, earning about 5 per cent return on that equity, which wouldn't be enough to attract most external equity providers or, if they wanted to recycle that equity, then it would take then over 20 years to enable them to recycle that equity.

MR WOODS: Can I just clarify, with your 20 million for land and construction, what do you see as the rough split between land and construction now that the - - -

MR McMILLAN (AU): A 100-bed aged care facility would be around one million or two million dollars for the land and the rest would be construction.

MR WOODS: I'm not quite sure why you would be repaying the principal on the

land giving that it's an ongoing and in fact appreciating asset in the balance sheet.

MR McMILLAN (AU): So we would borrow 75 per cent of the cost.

MR WOODS: I understand paying the debt charge on the land, but I don't understand why you would repay the principal on the land given that it's an ongoing and usually appreciating asset in the balance sheet.

MR PUTAMORSI (AU): Typically for a development a bank would require that that principal gets repaid. If you talk about external debt - - -

MR WOODS: But I'm talking about the equity component. It would just sit there and it would be in fact an appreciating asset.

MR McMILLAN (AU): Yes, so what I'm saying is that we would have $5 million, we could either retain that $5 million in the facility which would be the cost of the land plus some of the - or most providers, I think, would rather recycle that capital into another facility.

MR WOODS: Well, recycle - it's an interesting description of the process but, yes. Thank you.

MR McMILLAN (AU): Of course, it could stay in there if there was adequate return on the equity.

MR WOODS: You could be borrowing against that appreciating piece of equity as well for your future developments. Anyway, I understand what you've done.

MR McMILLAN (AU): Yes. So then on page 9 the releasing housing equity. So the pensioner of one scheme, I think that's a terrific thought and it does tap into the concept of how do we get around this issue that people lose the bulk of their pension when they downsize and release capital from their home, turn that into a sort of a liquid asset. I think one of the key issues is that that should be available also for older people, not just moving into residential aged care.

MR WOODS: Yes. We will explore that, but it's not intended to.

MR McMILLAN (AU): Right. The report didn't specify one way or the other, I wanted to make the point that I think this is valuable, not just even for retirement accommodation but also for other accommodation as well. The second point on equity release is that if there are some sort of government bank - - -

MR FITZGERALD: Sorry, just to clarify, the bonds scheme is available for use

for any purpose whatsoever, as long as you're an aged pensioner. It's the equity release scheme that's only available for formalised age care, so they're different concepts. But if you sold your house, the bonds scheme is available for any purpose.

MR WOODS: It's your equity, it's your wealth - - -

MR McMILLAN (AU): Yes.

MR WOODS: - - - you can apply it in whatever way you wish. The only point of it is to protect the person's entitlement that they already have to a pension.

MR McMILLAN (AU): To the pension, yes.

MR WOODS: So if you're not an aged pensioner, you don't have that option - - -

MR McMILLAN (AU): Yes.

MR WOODS: - - - because there's nothing to protect in that sense. But it is your wealth that you have had embedded in a home, you can then choose to either purchase an asset of equivalent value, another home or something or you can downsize, you can choose to pay rental rather than purchase your next piece of accommodation. This is your wealth and you can apply it in whatever you want. So the bond scheme is only focused on sorting out the pensioners. It has very little to do actually with aged care rather than to facilitate people moving to accommodation that best suits them in their changing circumstances.

MR McMILLAN (AU): Thanks for clarifying that. I didn't read it that way in the report but that's - - -

MR WOODS: We will make sure the report is clear on that process.

MR McMILLAN (AU): The equity release products. Leasehold relationships in retirement villages, I'm a little concerned that if those products were to be available in a retirement village setting. Two points: one is that a retirement village operator may end up with eight or 10 different valuers coming through every six months to value the units if the equity release product is provided by a financial institution. Presumably they will need to value those units to make sure that those units are still maintained, so there will be quite an administrative burden on providers.

Secondly, that if there are affordable housing units or maybe in regional markets, so some of our retirement units that we operate are only 150, 200 thousand dollar units. If there's consistent low property growth because of their age or because of the location, then the deferred management fees already diminish equity. It may

be that there is not a substantial amount of equity to release further equity from those units and if there is a decline in property values, we could find that residents or their families end up with nothing. So I think we just have to be cautious about applying this in the retirement setting. They were the key points that I wished to raise, so I am happy to take questions on those.

MR WOODS: Thank you for that and thank you for the submissions that you have previously provided. It has been very helpful to understand this sector and your contributions have aided in that process. As a general point what we're trying to achieve is to ensure that the care is delivered in the accommodation that people choose. So we're separating out care from accommodation and your Venn diagram showing the intersections of care delivery and retirement villages and independent living units and the like, we would see that those overlaps would in fact increase over time. So certainly a very key philosophy for us is that if people choose to live in their current home or choose to go to an ILU or a retirement village or serviced apartment, whatever, that is an accommodation decision which is separate from a decision about what care do they need.

So in that context I know that there have been projections about retirement villages and what part of the market they will occupy and the projections going from 5 per cent to 8 per cent et cetera but under the reforms that we're proposing here, do you think that that would at least support that rate of growth and in fact could it have an impact on increasing that rate of growth in the retirement village/ILU-type market?

MR McMILLAN (AU):   I think the pensioner bond scheme will really help to increase interest in the retirement sector. One of the most common reasons that people who are part-pensioners face is actually 50 to 300 thousand dollars is the general difference in price between their home and the unit that they purchase, so that can have a significant impact on their pension.

MR WOODS: You can only spend so much on an overseas trip.

MR McMILLAN (AU):   Yes. Two issues: the day-to-day reduction but, secondly, they say that, "Well, okay, even if our pension produced for 10 years then it will increase again when my savings have been depleted but my asset base is much smaller then if I wish to do this again." So they maybe feel trapped, so I think the pensioner bond will be a really important tool in this regard. The second is having more flexibility about the delivery of care will enable people to stay in their unit longer or make a choice about particularly a co-located site where, if they are a couple, they have more comfort that they could receive care for longer in their unit, one or the other. Both of those, I think, would have a stimulatory impact on the retirement sector.

MR WOODS: You talk about encouraging congregate living, social housing and the like. You make a specific point about the GST impact on ILUs but are there other policies that might be an unintended barrier to the development of social housing at the moment that you would identify?

MR McMILLAN (AU): The one that we come up against the most is this highest and best use for land where there is generally no zoning favouring or use favouring when it comes to purchasing land. Retirement villages have for many years found themselves only being able to afford, because of the lower returns, land on the fringe of urban rather than actually where people want to live. If retirement villages were able to get access to land closer to where people actually want to live, then that would allow, I think, more people to access that type of product.

So that means governments actually thinking about the social fabric of that suburb, rather than just what is the highest and best use, if you like, or highest use and I think that is probably the key. So it doesn't mean necessarily saying that something has to be zoned for retirement only but they have to be given that opportunity to compete on an equal footing.

MR WOODS: Robert.

MR FITZGERALD: I just want to clarify, your concern in relation to our recommendations about the accommodation bonds and user charges, do you accept that the accommodation bonds should better reflect the true cost of that accommodation, firstly, and secondly, I gather from your submission your concern is more about the shift to daily charges or periodic charges.

MR McMILLAN (AU): Yes.

MR FITZGERALD: The first proposition is: do you accept our proposition that the accommodation bonds should more accurately reflect the true cost of that accommodation, including a return on investment?

MR McMILLAN (AU): Yes. So if it does incorporate the full cost, then that is, I think, acceptable. I think we all have to face the fact that most operators are taking higher accommodation bonds because they are unable to spread that across the entire resident base. So being able to charge bonds or a like product to all residents would enable the average bond value to be essentially maintained for that facility so it takes the peaks from larger contributions. So that proposition is sound, I don't have any real argument about that but it has to be the full cost, which includes a return on equity.

MR FITZGERALD: Sure.

MR WOODS: We do note other issues that you have raised there, but I don't think we have any particular need for clarification on them. You're going to provide a final submission?

MR McMILLAN (AU): Yes, we'll provide then a final report in the next couple of days.

MR WOODS: Certainly we're very conscious of your wellbeing index, and I think there is opportunity for us to integrate that further into our report.

MR McMILLAN (AU): Terrific.

MR WOODS: So if you have no further comments you wish to make?

MR McMILLAN (AU): No.

MR WOODS: Again, thank you for your early and ongoing contributions to this inquiry.

MR McMILLAN (AU): Pleasure, thank you. Thanks for the opportunity.

MR WOODS: If I could ask the next participants, Benetas, to come forward, please. Thank you very much. Could you please, for the record, state your names, the organisation and the role in which you appear in?

MS HILLS (B): Yes. My name is Sandra Hills and I represent Anglican Aged Care Services, which is known as Benetas, that's our trading name, and I'm the CEO.

MR GRUNER (B): My name is Alan Gruner, I also come from Benetas, and my role is research and development manager.

MR WOODS: Thank you very much, and thank you for your participation already in this process. We have been grateful for your earlier submission. Have you got an opening comment you wish to make?

MS HILLS (B): No, just to - I know that we're under the pump today, so thank you for the opportunity.

MR WOODS: No, that's fine.

MS HILLS (B): But we did make a full submission, you should be aware - - -

MR WOODS: Yes.

MS HILLS (B): - - - and we do hope to have something into you by - a final submission by the end of today. We participated in a range of responses. So, for example, our peak body is ACCVU in Victoria, and also Anglicare Australia, of whom we're a member. We haven't gone into some of the comments that they've made in their submissions, we've spared you that. So anything to do with regulations or finances we've kept well clear of because there are six areas that we want to pull out from our original submission to you that we will emphasise today and hopefully leave some time for some questions from yourselves.

MR WOODS: Please.

MS HILLS (B): So over to us first. The first thing I want to talk about is this issue about public attitudes towards older people and ageing. You'd note from our submission that we've started to do quite a lot of research in this area with Deakin University. Currently, we're in our second longitudinal study with funding from an ARC grant. Our research shows, even though its early days, that the Australian population is rife with ageism. Now, the commission might believe that this issue is actually outside the scope of what you are doing, but we'd like to convince you otherwise.

MR WOODS: Well, you'll have noticed that we changed the name of the inquiry from sort of an Inquiry into the Aged Care System to Caring for Older Australians.

MS HILLS (B): Well, if we have a small impact on that, that's fantastic. We believe that there is ample evidence that supports the benefits of older people, if they are actively engaged members of the community. This in turn impacts on their confidence and their capacity to choose where and how they will live, including taking a proactive approach to planning for their future. So these sorts of things really pick up the objectives of your inquiry and we really think that this is a huge area. Certainly local government in Victoria - I can't talk about in other states - have done a lot in this area, but we think it needs a higher profile. In our opinion there needs to be a national policy on ageing which puts forward strategies for engendering a positive viewpoint by Australian society of older people and ageing. I'm now going to hand over to Alan. He will go through a few other areas, and I'll finish up at the end. Thank you.

MR GRUNER (B): I'd just like to make a few points on the special needs area, particularly I think - and it was very pleasing to see in the report, draft report, about the recommendation for extra support for indigenous people and people from CALD backgrounds.

We want to raise the point about people from homelessness backgrounds, particularly in community care and the difficulty there is in engaging with people from this sort of background, most of whom have drug and alcohol problems, mental health problems and challenging behaviour. To undertake the task of bringing these people into the service system, where they really need those services, is extremely difficult and it's not acknowledged at the moment within the funding, the way it's put forward. In terms of doing costing for care I think it's really important to acknowledge the special needs of the homeless people, given their backgrounds.

Also I might the point too we're very pleased to see the draft report mention the EACHD and its inability to capture the cost, particularly relating to behaviour, again from people often from homelessness backgrounds. But we'd like this to be taken a little bit further too, in terms of the challenging behaviour needing to be fully costed and taken into account in a scheduled set of prices, when that's actually done.

We would also like to mention too about the baseline standard, which I know has received a lot of comment already in terms of the supported category of accommodation for people. In your draft report you mention the standard being set at a two bedroom with a shared en suite. We believe it has already been covered a number of times - - -

MR WOODS: We have heard many, many comments on that one, yes.

MR GRUNER (B): Yes. So we do want to emphasise again and the necessity to bring in, I think, a standard which meets - we believe at least a single bedroom with an en suite, which is the standard at the moment for design and construction of buildings. It is really important - we believe this area - to prevent a two-tiered system, so that people on low incomes are not given a raw deal.

We would also like to bring up the issue about the tradeable obligations in regard to the - at the moment to get the full supported payment you need 40 per cent of residents. In the draft report there is mention of that being tradeable and then put on a regional basis. We have some concerns about this in terms of the possibility of setting up ghettos within regions - if they're tradeable - and particularly in large regions where trades are made. All of a sudden there's only a few facilities left with a large number of supported residents. That, in our view, really restricts the choice for people and goes against your principle of equity and access in the draft report. So we would just like to bring that to your attention for further consideration.

We would like to just make a couple of points too, moving away from special needs into the research and evaluation area. Again, we were pleased to see the recommendation about aged care data being made public and a type of clearing house being set up. We would like this to be expanded to undertake - a clearing house for research findings beyond just pure data but actually evidence-based research coming through, particularly in terms of ageing and service evaluations. That would be of great assistance, we believe, to the industry to share that sort of knowledge. As I said, rather than just raw data actually putting across the evidence based on the findings from research.

MR WOODS: Do you not think that that's sort of sufficiently encompassed in the text that we have around that topic in the report? If not, then we would be happy for you to expand on that a little, and then we could incorporate. Certainly our intention is that not only the raw information but there should be much more open exchange of findings an analysis, but if we haven't covered that sufficiently then you could pick that up in your final report.

MR GRUNER (B): Good. No, thanks for that. Yes, the way we read it we thought it was more the raw data released, like from the Commonwealth - - -

MR WOODS: Well, that's certainly the foundation of it, but we would want it to go further.

MR GRUNER (B): I think too, there's a great deal of research being done at the moment, particularly in clinical issues. We'd like to look at the research being expanded in that area, particularly looking at the areas Sandra mentioned, quality of

life for older people and issues such as social isolation - some funding streams being available for that, as well, obviously, the important areas of clinical care.

I would just like to mention briefly too in terms of housing, as people are well aware, the level of home ownership, even amongst older people is dropping, and the lack of affordable housing is well documented. One way we would like to address that is to open up the housing market to aged care providers, rather than having to register as housing organisations which is quite arduous and difficult in many organisations. We believe that would enable aged care providers to take a more active role in the provision of accommodation. I would also like to mention - it has probably come through already - about the independent living units.

At Benetas we have nearly 200 units, all of them are in poor condition and there is no funding available for refurbishment or to bring them up to service standards. When the independent living units were first established, there were grants from the Commonwealth government to assist particularly not-for-profits to set these up but then the funding was withdrawn and we're left with a housing stock. Our concern is not just for ourselves but for other not-for-profits particularly that housing stock would be lost to the market and there would be less access to affordable housing for people from low incomes. It is an issue that is not so much about new housing, but it's actual loss of housing that is already in existence which is of concern to us.

The final point I would like to make before I hand back to Sandra again is the gateway which we support and is a great concept. We would like to just emphasise, not so much within the gateway but certainly within the assessment, realise in your draft report it's not your role to go into details but we would like to emphasise the importance of case management, even in those early stages, particularly dealing with people with complex care needs, they do need a lot of assistance, particularly if someone can negotiate on behalf of themselves and we believe this is a role for case management and it should be hopefully give a bit more emphasis.

MS HILLS (B): So I've fast-forwarded right to the end, the implementation. Commissioners, you would be aware that the report so far has garnered quite a lot of support from the industry but being a person who implements things, obviously that is the hard bit, I believe. I suppose I can't but look at this more, to me I've undertaken a lot of cultural change projects and I think this is the big one. I'm not saying it lightly, I think it is, and I think there are a lot of people with a lot of invested interests in this and everybody, of course, will say that it's about improving services for clients and potential service users, older Australians generally. But the reality is that we have investments and commitments and we have ideas about getting bigger and better and how we want to survive; it's just a natural human situation and response.

So having said that, I think that - part of the process, most providers know, is that we need to get support from politicians and certainly we have the smarts on that, that it's not just about - people, I think, are well aware of the process. You can report back to government, as you will do, but it's up to a range of people to get their skates on - and I'm going to Canberra again on Wednesday and many people are doing that as well. So I think that there is huge commitment from the industry but we haven't got a lot of experience of working together and it's a new ground for us and we've all got some quite different ways of approaching things. Of course, I can't forget the Department of Health and Ageing. There is a government department that is looking at some future changes - you're smiling, I know why you are smiling. But it is a huge change.

We have in our submission and I know others whose submissions I've already seen, the responses have called on an implementation task force to be independent and we would absolutely support that. Who is on it, that is going to be a hard call. I think it's pretty obvious who need to be on it but I think it does need to be independent. The other thing I would like to say is that it has already been alluded to the issue of cost of care and cost of accommodation and the national peaks ACRA and ACSA are already looking at doing some work in that area, which is fantastic; it is a really crucial piece of work. But I think that in any change process I have been through it is important to look at what is needed and think through and commission pieces of work that will inform you and move people with you and I think that that costs money and time but I think that there is certainly the generosity in the industry generally to actually do that.

So I think that there is a lot of research that is required, not just costs of care and costs of accommodation, but models of care, some of the transition issues. There are lots of things we haven't even thought of, you know, business rules, all those sorts of things, ACCV have called for an industry fund. I think that is a great idea. But these are some of the things that we need to work through. Five years is probably ambitious but there are some things that we can start working on sooner rather than later. I think that is it. Thank you.

MR WOODS: Thank you for that. You have traversed a range of issues. If I can work backwards through a couple first. Implementation we do agree is absolutely fundamental, both in our report and subsequently, to have a clear implementation path. We invested sufficient resources to demonstrate that it was achievable in the draft report but we didn't want to go too far until we knew that there was general agreement to the architecture. But as that unfolds, that will allow us then to spend more time sketching that out. Obviously an implementation task force would need to consult with the key stakeholders, whether they are actually on the body and part of the decision-making is a separate question and ultimately government must take

responsibility, so we may not see quite eye to eye on that particular issue but that is a small one, as long as there is open and regular consultation I think they can deal with it.

Care coordination case management, it certainly is intended to be a strong part of our process. The care coordination function, if an older person receives most of their services from a single supplier, then that function will just be an integral part of delivery by that provider. If they choose to have multiple providers for a range of services, then a care coordination function by default is given to the gateway so that it doesn't get lost in the process and we see case management as a separately funded service that is required for the more intensive and complex cases. So again if we haven't sufficiently spelt that out in the draft report, between now and when you lodge the submission, maybe you can work on it tonight and put it tomorrow instead. But that would be useful if you, in looking our draft, felt that there is some strengthening or clarity needed on that particular one. I don't think there is a disagreement between us on what the intention is but if there is some contribution further that you want to make on that, that would be useful.

On supported residents, we certainly don't want to talk about a dual standard. What we see is that there will be a multiplicity of accommodation that people choose and for those who receive public support in their living in the community generally through supported accommodation systems program or whatever that particular program is, that they would continue then to receive public support for their accommodation in their later years when they're receiving care services. But for the rest of the population, they choose a whole range of lifestyle decisions as to what wealth they have available to them and what standard of accommodation they want to have for some of that wealth and we would envisage that they would continue to make that diversity of choices and in fact not be constrained by an aged care system that tries to impose certain limits.

On the particular issue of the standard for supported residents, of course, there are several balances that need to be achieved. Yes, there is the question of what is the actual standard of accommodation that they would receive but then there also the cost to the taxpayer generally of delivering that standard of accommodation. There is also the question of what is the appropriate accommodation for all older people in all the circumstances. It may not be necessarily for everybody to have a single bedroom, single en suite environment, that some may choose or prefer or would be better suited to having some other options that don't create unintended social isolation. So there are a whole range of mixes, but if you could, in any further remarks that you want to make, reflect on the balance of these issues?

MR FITZGERALD: Can I just raise a question? At the moment the funding is based on 1.5, not one for one. So we've got an industry which at the moment

produces single bedroom en suite, yet they are only funded for 1.5, which means there's a mix of single rooms - - -

MS HILLS (B): That's right.

MR FITZGERALD: - - - and dual rooms. It seems very curious that in fact you'd only be funded for one type of model but produce an entirely different product and then say the government under-funds it. So I'm just wondering in your services why would you not have a mix of services between a singe room with en suite, between two rooms and an en suite, between two separate bedrooms with a shared en suite? We're starting to see that model. So whilst nobody likes our proposition of two - you know, a shared room - on the other hand a one for one, that is, one bedroom with an en suite, seems to me not necessarily appropriate. So what is the right basis upon which government should fund the supported residents? If it's not two, what should it be?

MS HILLS (B): No, look, it's interesting. We are just about to start upgrading two facilities, fairly new facilities. We're actually extending wings on them. I think it's an issue about the market research that you undertake, and you look at your competition in the surrounding areas and you look at occupancy. At any time you look to see what the competitors are building, and you look to see what the vacancy rates are like. At any time it's - you know, if you're - a number of our facilities are at the end of their life. So when we do that piece of work we do have people sharing, you know, two people share - we do have a number of those facilities, particularly in high care. Our apportioning is two-thirds low care, one-third high care. So it is about the competition. So when we look at building these extensions or any new facility that we might build, we will do that piece of market research. It is the risk you take if you don't - I hear what you're saying in terms of government not funding that, but it's a risk you take. Will you risk building a facility that you don't think you're going to be able to fill?

MR FITZGERALD: Sure.

MS HILLS (B): But we also know that a number of people who are disadvantaged, particularly economically - and just with my past experience in previous jobs, not everybody prefers to have a single bedroom. We know that.

MR FITZGERALD: Sure. So what are you suggesting to us in terms of - what should our recommendation to government be in relation to the base for the Commonwealth funding of supported residents? What is it?

MR GRUNER (B): Yes. I guess our concern is that the baseline is, at the moment, set too low, which will create a sort of dual-system almost, in terms of supported

residents.

MR WOODS: The baseline we're proposing, as distinct from the baseline that currently is 1.5?

MR FITZGERALD: The 1.5?

MR GRUNER (B): Yes, that's right, yes. So we're proposing that the benchmark be raised. We're again, not suggesting that - we would never suggest actually, that there is a single room with an en suite. But again, that's not - particularly that could be provided, it's more the costing for that in terms of accommodation for the standard to be set. So what we're actually saying is that the pricing for supported residents as a benchmark should not be different to anyone else, so there's not a two-tiered system.

MR FITZGERALD: But just to finish off, at the moment it's 1.5. What are you recommending?

MR GRUNER (B): We're recommending 1.

MR WOODS: But if you are then saying that you wouldn't necessarily always build it in that structure, because it doesn't suit anybody, then we're not going to be recommending that government fund you for a higher standard than you're actually going to deliver. So it strikes me that there's - somewhere between - at least either stick with 1.5 or move towards 1, but I wouldn't have thought 1 in itself would be the government-funded proposal from you.

MS HILLS (B): But can you see the dilemma of the provider in terms of - - -

MR WOODS: Absolutely.

MS HILLS (B): Going back to my market research comment, you know, it is a risk if you actually do your work and you find out that in certain areas - in certain areas you will get away from, in perhaps some of the rural and regional areas - but in some of the areas where we're doing our research and we're building, you will be looking at single bedrooms.

MS MACRI: Can I ask you though, in your market research also - I mean some of the issues that have come across to us are around - perhaps a single room with an en suite is not always the most appropriate environment to care for certain people, that they do become socially isolated, that they don't do as well in a single room. In your market research are you doing anything about having a look at what is the best environment or care environment or what is the best room configuration for certain

people, as opposed to just going out - everything with a single room and an en suite. I mean that would be really helpful for us in terms of - because the other argument often coming up besides the cost is also what is the best environment to care for certain people with certain conditions.

MS HILLS (B): No, we haven't done that, and you're right, it would be a good piece of work to do. I mean clearly low care and high care is different in terms of - you know, it's obvious if someone is in high care and has high-care needs, actually the question is asked many times: does it really matter if they're in a shared room? But we know that we're not selling that to the older person who has the needs, we're actually selling the facility and services to the family. Certainly there are some opportunities, and I'm sure many people have picked this up in terms of being a bit more creative, about the living space and how they design buildings, because people don't - exactly what you're saying, Sue - - -

MS MACRI: Yes.

MS HILLS: - - - in terms of people being in their rooms all the time and encouraging people to go out into the shared area. But we know is that in the future predominantly there will be a significant move to high care more than low care. So there are all those challenges. We're looking at a number of areas specialising in palliative care and subacute care, for example, I mean that gives us another challenge.

MR WOODS: Yes, and that comes through in your submission.

MS HILLS (B): That gives us another challenge in terms of does the room look any different.

MR WOODS: So if you could elaborate - sounds like it will be a late night but if you could elaborate on that as well, even if that does require you to come back a little bit later with something more thoughtful; but we are looking for the evidence in relation to care as well as trading off issues of cost.

MS MACRI: Yes, and not just the competition in the market but - - -

MR WOODS: No, what is actually the care that's needed for people.

MS MACRI: Yes, and looking forward, because the residential aged care facility going forward and the clientele in it is going to be quite different, and that's increasingly happening now.

MR GRUNER (B): Yes, that's true.

MR WOODS: Could I move to the issue of homelessness? You are quite right to focus on that as one of the special needs that does require careful and thoughtful analysis. You've identified that the behavioural management side may not be adequately funded, but the question is what sort of numbers are we talking about and is it possible to extend this sort of ACFI, CACFI-type framework for them? Are there alternate ways of looking at it? Should there be a particular group of people who are supported by a range of providers - which you're one, and various others in this space - where a block funding model might be more appropriate? Don't start sort of getting the cash register sort of clunking away but we are interested in what is the best way of supporting these people.

MR GRUNER (B): Yes. No, I particularly like the idea of the block funding, because it is a very specialised area and there's not that many organisations who really target that group of people, and those that have are the ones that are bearing that cost. It's difficult to do it on an individual basis because obviously needs vary so much. But coming through very strongly is that there is an extra cost involved just engaging with these people to try and work them through to the system. Once they're into the system then that's when the ACFI comes in, I think, in terms of the funding within the system. So what we would be looking at is actually the pre-entry area of people, so going through even before they had an assessment, just that engagement with that group of people is time consuming. So the idea of a block funding would be very good because it wouldn't specialise what area you have to do it, it's more the actual work itself.

MR WOODS: The reality is that although there are some facilities that specialise once a person is willing to accept living for a period of time in a facility - and that in itself is most of the challenge - but, you know, some facilities would only have a few people and it would be on an occasional basis but other facilities are more dedicated so the funding models would need to adapt to those situations. There are also already, as you well know, various programs that do support care workers who specialise in this field, so we wouldn't want to duplicate that but if there is some way where that whole bundle of related services could be integrated in a more seamless way, any views you have on that would certainly be helpful.

MR GRUNER (B): Certainly the Commonwealth funded ACFI program is an excellent program but again it's very - I was going to say poorly funded but there's not much of it around in terms of the spread of the services.

MR FITZGERALD: Just one final question. The issue about tradeability of the obligation to provide accommodation for supported residents, we appreciate absolutely that the definition of the region is critical and many people since the draft have indicated that to us and we're very conscious of that and at this stage in the draft

we haven't indicated what those regions have been but going forward we would want some principles to guide government in relation to that. But there is a more fundamental issue and that is trying to see your view about this. Should the general public policy approach be that all providers and all services have a mix of supported residents and non-supported residents or would you contemplate a situation where some providers would in fact be largely a provider of supported residents and some facilities potentially would in fact have no supported residents? So that notion of whether you have a social mix or not, if you could just give me your views about that.

MR GRUNER (B): My views are that, as I mentioned before, it's a very specialised area, so I think there is an argument to be made that some facilities with the proper block funding and so on could take on that role and then other facilities with other particular focus may not have those sort of people. So I guess it's a balance again but it's making sure people have got their choices in terms of where they can go as much as possible. But in today's market too there are obviously a number of facilities people can't afford to go into and that's a reality. We're not saying that should change but it's more that people from homeless backgrounds with particular special needs do have access to a reasonable amount of services and facilities.

MR FITZGERALD: But moving beyond the homeless and those with special needs which we understand is a special cohort of people, generally supported residents are low income people and don't have any special needs other than they don't have much money or wealth. What about that group?

MS HILLS (B): If I can just say, in an organisation like, mine, Benetas, the organisation was founded to actually look after older people who were homeless - at risk of homelessness - and moving into the other group, my board always challenge me and say, "What are we doing differently than anyone else is doing? Why are we in this business? Why don't we hand it over to someone else?" Of course, these discussions were had some years ago but I'm being up-front with you because they see it as being one of their key roles to do the social good and they're very conscious of that. So they would always, and rightfully so, live out their mission that they should always be providing for people on low incomes.

But if you look at the whole picture, it is about financial sustainability. So we would always see it as our role to provide to that particular group but we have to look at the big picture. Alan talked about the 200 ILUs, we're currently looking at what we're going to do about that and there were some really exciting opportunities.

MS MACRI: And the difficulties in terms of the community care would be really useful.

MR WOODS: Thank you for your presentation. We look forward to your response but we have also targeted a couple of other areas where we would encourage you to come back to us with further detail and if that does that take a few more days, we full understand and look forward to those contributions. Thank you very much.

MS HILLS (B): Thank you very much.

MR WOODS: Ethnic Community Council, if you could come forward, please. Thank you very much for coming and thank you for the previous submission that you have made and your contribution to this inquiry. For the record could you please state your names, the organisations and the position that you hold in them?

MS LAU (ECCV): Good morning. My name is Marion Lau and I'm one of the deputy chairs of the Ethnic Communities' Council of Victoria and I'm also chair of the council's aged care policy committee. My two colleagues here is Irene Bouzo who is working specifically on our aged care policies and programs, she is our aged care policy - - -

MR WOODS: Just for the tape, if you could introduce yourself, please.

DR BOUZO (ECCV): I'm Irene Bouzo, aged care policy officer at the ECCV.

MR WOODS: Thank you.

MS LING (ECCV): My name is Kate Ling and I'm the HACC project officer at ECCV.

MR WOODS: Thank you very much. Do you have an opening statement that you wish to make?

MS LAU (ECCV): Yes. Firstly, I just want to thank the commission for giving us this opportunity to present our report to the draft report. We have examined the draft report closely and we agree that it is a good document. From a cultural diversity perspective we believe that it is positive and hopeful. The commission has obviously listened to what we have said in our initial submission and we are pleased to see that you have incorporated a number of our key points and we certainly appreciate that.

MR WOODS: Thank you. Do you wish to elaborate on any in particular that you think will be helpful to the groups that you represent?

MS LAU (ECCV): We would like to. Firstly, I'd just likely to stress that the Ethnic Communities' Council of Victoria, which is known as ECCV, has a very strong history of ethnic aged care advocacy. We represent the views of a wide range of organisations with an interest in aged care. As you have acknowledged, we have sent to you our response with some suggested solutions for improvement in nine areas. We would like to see aged care reforms that really work for our multicultural nation. We have examined the forms around a particular point of view, as well from the 21st century overview. We believe that it does make sense to link the reforms with new policies and population trends such as Minister Chris Bowen's new multicultural policy, the National Compact and the Third Sector and diversity as a

core business which is driven by population changes.

Today we would like to stress on three main points. We would like to talk a little bit more in detail about them. Firstly, the gateway reform; secondly, the role of not-for-profit organisations and third, the reform implementation. With regards to the gateway reform, the gateway agency has an important role in community education on health, ageing and services information. We believe that that requires a cultural competency approach. Not-for-profit organisations have a strong role to play. It is also crucial that the gateway keeps a bilingual face-to-face component, such as home visits for assessment, and the Ethnic Communities' Council set model for initial contact with non-English speaking clients.

Our second point that we want to put is the non-English speaking background providers in the not-for-profit organisations. Ethnic Organisations have spent many years providing culturally responsive aged care to non-English speaking background people. We believe that we have the expertise and the experience. This is about providing choice, preferences and meeting cultural expectations. We strong believe that reform should recognise and build on this expertise of ours. Not-for-profit organisations can provide greater choice of provider and aged care services, especially in the Victorian HACC program. I'm sure Kate would be happy to talk a little bit about it in a while. We feel it is very important for reform to create opportunities for the ethnic and multicultural organisations in the not-for-profit sector to be come aged care providers with a broad range of service delivery. We believe in forming partnerships as well, especially with local government organisations.

Looking at the reform implementation, we welcome many of the suggested draft reforms on cultural awareness training, language services and diagnostic tools. The proof however, is in the careful and effective implementation, and I've heard some of the comments from some of our colleagues earlier on. We are concerned that different aged care providers interpret cultural diversity policies differently, sometimes too generally. I have been told strongly by some mainstream providers that they are caring for their aged care residents, "because we have a lot of Asian residents, we have a rice cooker". Another one said to me, "Look, we have a lot of Italian residents so we have spaghetti three times a week." That's not acceptable. This is not right.

We would like to avoid a general tick-the-box approach without any real changes. We believe that non-English speaking background people belong to the mainstream. Diversity is a mainstream issue. We do not one to be put into a box and be treated as an addendum. We feel the reforms and the implementation processes need to be sufficiently regulated so that older non-English speaking background people can genuinely continue to live at home with quality lifestyles they deserve.

The other thing that we believe strong about, and myself very particularly, is the term "special needs". We get boxed into that. We, the non-English speaking community, get boxed into that. Each time that we have a non-English speaking background person we tick that box and say "special needs" and we say, "Look after their language and look after their food." It's all they're interested about us. It doesn't really matter if we are disabled, we have an acute heart condition or whether we have diabetes or any of the other conditions that an older person, regardless of what country they come from - we all have the same physiological concerns and difficulties and troubles. But to box us in as just language and food and forget all about our other needs - I would like to see somewhere in documentation and references that we are all the same but with additional needs, because the words "special needs" is just putting us into a box and marginalising us, and this is not good.

We are appreciative of the cost of aged care services but we feel that the safety net for low income earners is very important. We are also very concerned about the impacts of bonds on extended family members. Now, as you know, many of our migrants come in with no extended family and they're on their own, so we just need to be looking at some of the bonds, because many of our non-English speaking constituents are from refugee backgrounds, so they do not have bonds. Again, I agree with the comment that we do not wish to be treated as second-class citizens. While we may be disadvantaged, while we may have differences, we also pay rates and as ratepayers we also expect to be treated fairly and equitably. Irene, would you like to comment a little bit?

MR WOODS: Please?

DR BOUZO (ECCV): Would you like me to add something?

MS LAU (ECCV): Yes.

DR BOUZO (ECCV): Of course I support everything that Marion said. I'd just like you to know that this response that we sent you was done in consultation with a very broad-based group of peak bodies, ethnic organisations and multicultural migrant resource centre organisations. A wide range of personnel came along to our consultations - CEOs, managers, people working on the ground - so it really represents very broad views.

MR WOODS: Thank you.

DR BOUZO (ECCV): We have really tried to capture this, and then we ran it past everyone again. So it's not just the views of our organisation, we represent these

views. One thing that I did want to add: we appreciated very much the focus on language services in the draft recommendation, however, cultural responsiveness and culturally diverse aged care services really go beyond language services. The people we consulted with felt very much on the language services issue - we appreciated the fact that you put in something about the cost of this type of service, but they felt very strongly that some sort of regulating comment should be put in the recommendations tying the cost of language services and interpreter services with the requirement for interpreter services, because the way it looks at the moment if somebody was an aged care provider and saw that that's an extra cost, well then, you might not really feel driven to do that fully. So we felt that there needs to be a little bit more of a link with regulation for interpreters and the cost factor.

MS MACRI: Can I just ask you how you would see - in terms of that regulation, I mean that's a fairly broad statement.

DR BOUZO (ECCV):   It is, yes.

MS MACRI: So can you just - - -

DR BOUZO (ECCV):   I know that there's a lot of work being done on compliance and standards in community care and also the accreditation process in residential care was recently reviewed and so on. We feel that that's where the regulation should like.

MS MACRI: Okay.

DR BOUZO (ECCV):   Not just in terms of residential care accreditation, not just as one of the 44 expected outcomes, but some kind of cultural diversity response right across all the standards.

MR FITZGERALD: Could I just ask - firstly, I welcome your comment about being regarded as having additional needs rather than special needs. I think we will take that on board. We struggled with that. In some of our reports we talk about additional needs and some, special needs; but I think your point is well made and we appreciate that. But there is a conundrum, and that is that the vast majority of people with ethnically diverse backgrounds will in fact be in mainstream services.

DR BOUZO (ECCV):   Yes.

MR FITZGERALD: Clearly, going forward, there is provision for specific language groups to be catered for by their own providers if you so wish to. In other words, community providers might hold out as one of their advantages that they are specifically available for Italian-speaking people or Arabic-speaking people; same

too with residential aged care. But the majority of people are cared for in the mainstream. It goes to that issue about cultural competence. I'm not quite sure how far we can go further than we have. In other words, what specifically in mainstream services the government can do. Clearly the providers should in fact be trying to have culturally competent organisations, absolutely. We support that and we say it. But once you get beyond saying it, what is it that you'd actually want us to say beyond that which we've actually said?

MS LAU (ECCV): We'd like to see more of our community programs being allocated to ethnic-specific organisations. At the moment we are struggling as a peak body to encourage and work with - I did indicate earlier on that we tried to work in partnership with local governments, because there are some local governments and there are other local governments that find it very hard for us to work with them and to get the equal opportunity and equal allocation of funds and resources to help support our ethnic-specific service providers. We have a large number of them. We're all working as volunteers. We're all putting in hours to try and ensure and subsidise the programs and services that funded providers, mainstream providers, are giving to our communities.

MR FITZGERALD: Sure, but just talk me through, what are the services that - let me go back. Going forward, anybody who gets approval and accreditation will be able to be a provider of services to older Australians, whether it's in the community care area or residential care going forward. Most of those will be funded through entitlements. The consumer will take that entitlement. Some of those will be ethnic-specific services, some will not be, but there are a group of services that provide information, advice, support, peer support, all those sorts of things; community support. What are the sorts of services that you are particularly concerned continue to be block funded, given that the actual HACC program is likely to disappear across Australia even though in Victoria that is not yet resolved?

MS LAU (ECCV): Daycare and socialising programs - they are the programs that we feel are of very good benefit to many of our non-English speaking groups, and this is where the funding has been reduced. Our planned activity program groups is one of those programs. What used to be called the adult day and support programs, those are programs that will benefit a lot of our community groups. So if we could increase funding - looking at that - and work with our communities and work with our ethnic-specific organisations. We have a number of ethnic-specific senior citizens' clubs. They're all struggling. They're all working through - and they're all meeting in very second-rate and very broken down buildings or sometimes in the back of somebody else's garage or having to share space and having to share programs with other groups.

MR FITZGERALD: Can I just ask one final question in relation to that? Are

those services available not only to older people but also to a range of people with different needs in the community? So in other words, these services, these daycare and socialisation programs, do you see those are being specifically for people that are ageing and their carers or do you see them serving a broader range of people from non-English speaking backgrounds or CALD backgrounds?

MS LAU (ECCV): I'd like them to be block funded.

MR FITZGERALD: Yes.

MS LAU (ECCV): I'd like them - because again, they have additional needs.

MR FITZGERALD: Sure.

MS LAU (ECCV): One of the socialisation programs like singing and dancing and music is quite across the board because everybody understands and all that, but there are some other activities in it that is language specific and culturally specific. There are some older men and older women not wishing to be - participating in similar programs. So we need to be very careful about that. So I am supporting a block funding concept for some of these programs.

MR FITZGERALD: But the target consumer, the target client for those services is largely aged or ageing Australians?

MS LAU (ECCV): That's right, the aged Australians from non-English speaking backgrounds.

MR FITZGERALD: Yes, okay.

MR WOODS: You talked in your first submission about - that there are programs under HACC and community aged care and the like. Do you see that our proposed model of care whereby each individual being assessed would then be able to draw on a range of either basic support or personal care or other services will better assist the groups that you represent by not being tied to sort of individual packages?

MS LAU (ECCV): Kate, would you like to respond to that?

MS LING (ECCV): Yes. I mean certainly an increased choice would benefit our user group, but it's really important that there is special support or there's support for people from CALD backgrounds to make those choices and to understand the system. That's something that we - we are working on a program at the moment called the Supported Access Pilot Program, which provides that specialised support from bilingual workers in the not-for-profit sector to help people not only access the

services but then remain within the services so they don't drop out prematurely because they don't feel that the services are appropriate for their needs. So there's certainly a kind of informal advocacy role that I think can help mainstream service providers provide a more culturally appropriate service, but also to give the support to the consumer as well to stay within the system. So there's a kind of triangular relationship there.

MR WOODS: There are a number of programs that come and go and get a bit of funding for awhile and get used and then sort of morph into something else or an election is held and then government wants to re-badge something or amend something. In your particular areas of interest that seems to be perhaps a bit more prevalent than in some others. Is there a way in which there can be sort of an integration of various initiatives? I mean we still want pilots, we still want to analyse them properly, we still want to see what learning can we get from them and then make them more mainstream, where they're appropriate. But do you have a view on how to bring together a range of these sort of disparate small initiatives that seem to arise and live for a while and then get submerged again?

MS LAU (ECCV): I believe that - and again, it goes back to my concept of the special needs notion, that if we are all considered to be older Australians with all the needs as required of them and then some of us that - as the needs require, then we have additional needs. It's just like an ordinary person. We're now looking at gender balance. We cannot be considering - but we then now need to look at recognising the lesbian and gay community also as residents of Australia with additional needs. Their additional needs are - I'm just looking at and going back to the two bedroom concept. I would hate to think how the female - part of the two gay gentlemen would feel if he or she is placed in a double room with another - - -

MR WOODS: We understand your point.

MS LAU (ECCV): So this is what we're doing. But then that doesn't mean that we're not interested in having additional pilot programs. Again, like the general population we work with the government of the day and we work with politicians and we are part of the political football being thrown around - to give voice to different politicians at different points of time. So we're happy to do that. But we do not want to be marginalised, put in with a tick box. Then if we follow this party our tick boxes will have a full 10 out of 10, but if we move to the other we only have five out of 10 and then we lose the rest of it. So I don't want to see us do that. So again, the challenge is for the commission to come up with an instrument as to how you can enshrine these needs into your report, your final recommendations, without us losing out.

MS LING (ECCV): We would welcome a move away from pilots to a longer-term

approach.

MR WOODS (FRDC): Sure. Permanent pilots are not satisfactory.

MS LAU (ECCV): No.

MS LING (ECCV): Yes.

MR WOODS: Pilots have a role to explore a new concept and to then properly evaluate it, but then a decision should be made, not just have permanent pilots.

DR BOUZO (ECCV): Just as a matter of interest I know in South Australia their version of the supported access program has been running for 25 years now. It's a good example of what can be achieved when there's a really long-term, committed approach . You know, the work they've been able to do joining it with the mental health services and things like that is really encouraging.

MR WOODS: Do you have any final comments you wish to make?

DR BOUZO (ECCV): Yes. I just wanted to offer some specific solutions to Mike's questions and Robert's questions. Mike, you mentioned the one-off programs and so on in the ethnic sector. One very valuable outcome out of just about all of those is partnerships: partnerships with the mainstream, partnerships with local government. They really do succeed. By putting in this extra one-off funding, whatever, they really do succeed in forming very good partnerships which is part of the cultural competency training that you're recommending in the recommendations for mainstream aged care. So that was a very good outcome.

I think Robert asked about specific components of ethnic aged care service delivery. Traditionally, what has been very successful, as my colleague Marion said, is the ethno-specific social support programs that have been run by ethnic and multicultural organisations. What we would like to see is more ethnic and multicultural providers becoming aged care providers with a much broader range of services that might even include assessment, care coordination, delivery, the full range of domestic services. Kate gave examples of the Supported Access Pilot Program, the bilingual supported access program. Now, there are lots of ethnic organisations that do have the capacity to deliver a full range as aged care providers and they really have not been recognised as such until now. They are given social support, these individual programs, or apply for CAPS packages. So we would like to see - we see these reforms as an opportunity to provide individuals not just with preferences of services, as Mike said, but choice of providers as well.

MR WOODS: Thank you very much.

MS LING (ECCV): Thank you.

MR WOODS: Appreciate not only your evidence today but your ongoing engagement with this inquiry and all the work that you've put in in consulting and drawing together various views. So thank you very much.

DR BOUZO (ECCV): We appreciate the opportunity.

MR WOODS: We will adjourn for morning tea and resume at 10.30. Thank you.

MR WOODS: Thank you, we will resume the hearings. Our next participants are the ANF. Could you please for the record each of you state your name and the position that you hold.

MS THOMAS (ANF): Lee Thomas, federal secretary.

MS CHAPERON (ANF): Yvonne Chaperon, assistant federal secretary.

MR BLAKE (ANF): Nick Blake, federal industrial officer.

MR WOODS: Thank you. Thank you for your submissions to date, both your initial one which was very extensive and that I scribbled all over it as I read through it and came up with a whole range of views and thoughts, and for a summary of your final submission which you prepared for us preceding this hearing today. So we're grateful for also the other meetings that we have held with your organisation during this process and your contribution to the inquiry and for 26,000-odd - I haven't counted each one, so I can't verify the precise number, but in the order of 26,000 signatures on a petition which I received during the morning tea break. Do you have an opening comment you wish to make?

MS THOMAS (ANF): Yes, thanks very much and thank you to all of you for seeing us today. We know you've got a very busy day. We just did want a couple of opening statements if we're able to, broadly in support, I guess, of the gateway. We've had discussions with the three of you previously about the concept of a gateway. Our position is that we are broadly supportive of that and see it as an excellent way of providing, coordinating care into the future and we're looking forward, we're hopeful that that will remain part of your recommendations in the final report and we're looking forward to obviously putting some more flesh around exactly what that's going to mean.

I think the other thing, of course, that we're broadly supportive of and you've gone to in your initial report is the use of nurse practitioners in aged care. We think that there is no doubt that the use of nurse practitioners, along with a range of other care providers, allied health workers et cetera is absolutely appropriate. But, of course, one of the issues that we face in terms of nurse practitioners is getting then through and authorised. But certainly I think the future is for nurse practitioners. We think that aged care is absolutely one of the most beneficial places where nurse practitioners can operate the full scope of their practice.

I think broadly there the first comments that we would like to make - we know that your time is limited - and there are two issues that we would like to address today. The first one is the issue of wages and in your preliminary report you've made some recommendations about nurses and assistants in nursing competitive wages

and, of course, the issue there for us is the mechanism. You have indicated in your report that the pricing agency, for want of a better description, would have to take regard of that following their recommendations around cost of care. We think working out cost of care is absolutely vital. Frankly, it's a wonder it hasn't been done to this point. So we're absolutely on song in terms of working out costs of care.

We're concerned though that the mechanism that you have suggested, at least in the preliminary report, and the agency would take a reasonable period of time to set up and we're concerned about wages in the sector continuing to fall behind. So what we have done - and in discussions with you and with our branches - we are trying to move to a position where we can make some suggestions to the commission for their final report about a mechanism. That is really why I have asked our federal industrial officer to attend with us today. He has been in negotiations, I guess, with some of the peak aged care providers around what we are calling a set of principles, that is, a national framework agreement that addresses the wages issue.

Look, it is fair to say, commissioners, that at this stage this is only a set of principles and they're before you but really what we're looking at is that there's a commitment by employers and unions to agree and to establish competitive wage rates that allows employers in the sector to effectively compete. The second principle is that employers and unions agree industry-wide changes that will improve the sector and make it more attractive. In terms of the government, that would then see a flow of money from the federal government and that employers would reach enterprise agreements at the enterprise level with their employees that would bridge that wages gap.

Now, as I said, it's a set of four principles at this stage. Our negotiations are very new and really are very much in the developmental stage at this stage but we do believe that if we can get agreement around that set of principles, that there is no reason why they couldn't be operationalised to actually form, like a tripartite agreement between unions, providers and the federal government to actually bridge that wages gap. Nick, is there anything you want to add to that?

MR BLAKE (ANF): Just to make the point that in our view any industrial instrument that is developed which intends to close the gap between the wages paid to our care staff in aged care and those paid to other comparable employees in the hospital sector needs to be transparent in terms of how it works in practice and it needs to have some form of acquittal so that the funding body, which is the Commonwealth, is clearly satisfied that if they do make additional moneys available to the sector for that purpose, then those moneys will reach their ultimate destination.

We're also very keen to take the opportunity as part of this process to work with industry to support what we'd say are significant industry-wide efficiency

changes that we think the industry has suffered in the past because at an enterprise level they have the capacity to bring about such changes and we've put into the draft national framework agreement some examples of the changes industry-wide that we think would make the industry more attractive to potential labour but also, I think, be attractive to the Commonwealth in terms of getting some overall value for their additional funding.

So whilst we are in the earlier stages of having discussions with national providers, we do think there is industry support for bringing about some of those changes, so they tend to be a transferrant exercise, an accountable exercise but also one that brings about benefits to the industry generally. Thanks.

MS THOMAS (ANF): I'm just wondering whether you wanted to ask us any questions about that.

MR WOODS: On that part before we then move on to your second part which would deal with skilling and skill mixes?

MS THOMAS (ANF): Yes.

MR WOODS: It is probably useful to divide the conversation. The first point is that through the National Aged Care Alliance process you collectively agreed to the phrase "fair and competitive wages" which we picked up in the report. I notice in your draft proposals to us that it also appears as comparable and as commensurate with and you didn't actually get to parity but I was wondering if that was over the page - I didn't quite find it. I think there is a common understanding that it is necessary to provide wages and other conditions and career structures that will not only deliver quality care to older Australians but will attract a sufficiently trained, competent and committed workforce to deliver that care in association obviously with family friends and other informal carers who provide the bulk of day-to-day and I'm not just talking in terms of the workforce of the RNs and the ENs but the totality.

So I think there is common understanding that unless there is that level of remuneration, terms and conditions that attracts the workforce, then the care can't be delivered. The question then is, "What's the vehicle?" and you're proposing a national industrial framework and you've shared with us some of your thinking in that. There is the other side, of course, that there is a cost to taxpayers as well a cost to those receiving care and the two must balance out somewhere in the process. But one particular issue that you do raise is this one of accountability. Many of us are old enough to remember CAM and SAM and the forms of funding preceding that. Are there elements of that that you are thinking of drawing on or where does this transparency of if more money is paid, an appropriate price is paid for care, how does the workforce receive adequate and appropriate remuneration as part of that process?

So where is your thinking on that accountability transparency?

MR BLAKE (ANF): Commissioners, the starting point for us is to have further discussions with the national providers to establish agreed industry rates which will be different in each state and territory because of the history of the award system and bargaining over the last two decades. I think that on the basis that we can reach a general view across the industry as to what those rates ought to be - and I think there is guidance in terms of the existing enterprise bargaining outcomes, in terms of the payment of aged care nurses employed in the public sectors in some of those states and territories, what's the market for the work that they do? I think we can reach agreement around what ought to be the industry rate.

In terms of accountability, our strong view is that that accountability can only be delivered if it's through an industrial instrument that is certified under the federal industrial laws. We are very keen to recognise and have discussions with providers abut the recognition that we are in a decentralised industrial environment and ultimately the agreement will reflect the views of the employer and employees at the workplace, but in terms of the wages, we want to have some national discussions about what those wages out to be and then the particular changes or the efficiencies that need to be put in place at the enterprise level can be done at the enterprise level. That is generally how we see some form of transparency and accountability.

MR FITZGERALD: Can I just have a point of clarification. Does the new framework that you're all referring to also cover nurses and nurse practitioners and others that are involved in the community based care or is it exclusively in relation to residential aged care facilities? Because going forward, as you know, by 2050 three million Australian will receive care in the home and 600,000 are likely to receive care in residential services. So is this framework just residential aged care or is it the community as well?

MR BLAKE (ANF): No, it's the community as well. We do negotiate industrial outcomes with employers that have activities in both parts of the industry so, yes.

MS MACRI: Can I just ask you, in looking at that and one of the issues that has come through in the last couple of weeks is the - and I'm just wondering if you've looked at the salary sacrificing issue for the not-for-profit sector as opposed to the for-profit and some of the private sector providers in that competitive environment again around competitive wages, comparable wages, I'm just wondering if you've had a look at that.

MR BLAKE (ANF): Salary packaging is a common feature of enterprise agreements in the residential aged care sector. It has an impact on individual workers differently, depending on their own particular circumstances. We support

the issue of salary packaging. There has been a key mechanism for providers to keep and attract labour. But we don't see it as being the, I suppose, panacea for the problems in aged care because of the nature of its application. It's very difficult for a union to have any confidence that a salary packaging agreement in a particular workplace will have a general benefit to the workers, but we do see it as an important feature.

MS THOMAS (ANF): Something that's a very important feature, and one that those people who are able to have access to and then take up that choice, see great benefit. But having the choice and the take-up rate do not equal each other. That is the case across the board by and large, it's certainly in our industry.

MR WOODS: But do your members express a view of preference for working in say the not-for-profit sector with the attended FBT arrangements versus in the for-profit sector? Does that actually play out on the ground or is it a theoretical exercise?

MS THOMAS (ANF): Well, you know, I've worked for the union for 13 years in a row in a variety of roles now and I can't ever remember a nurse working in aged care ever raising those issues with me.

MR WOODS: Does that mean those who receive it accept it and say nothing, and those who don't understand that it's not available to them, and therefore it's not raised?

MS THOMAS (ANF): Yes. I think that that may be the case, but I think in even working in the not-for-profit sector where it's available I think you would find the take-up rate is low.

MR WOODS: Do you know if there are statistics on that that we could track through and whether it is an issue that does need to be pursued?

MR BLAKE (ANF): We could certainly provide some data about the existence of salary packaging clauses in enterprise agreements. We could provide that, but I don't think we have looked at it any more closely in terms of how it flows through the workforce.

MS MACRI: Yes, it's interesting. Just quite often the private sector have said that they can't compete in the marketplace, and probably more at the senior management - you know, the director of nursing, deputy director of nursing level when you can see the offsets of salary sacrificing; and what can happen in the church and charitable as opposed to the private sector. So I mean that has come through to us a couple of times. I'm just interested in - you know, because we haven't seen it in

your submissions.

MS THOMAS (ANF): No.

MS MACRI: We're just interested in - - -

MS THOMAS (ANF): I mean I think our position would be that where salary sacrifice is available it's an option for those workers to buy-in or not. It's purely voluntary and not seen by us as being a - it's an extra benefit, if you like.

MR FITZGERALD: Can I just - it may - I think it's in relation to this matter. As you're aware, we've recommended the removal of the distinction between low and high care and ordinary extra high care. We also see that taking place quite quickly. We can argue about what that time frame - from previous discussions you've indicated there are some industrial difficulties with that. I was just wondering whether you've - without going into a lot of detail, are they able to be overcome in a reasonable period of time such that that transition to just simply a generic residential aged care facility could take place?

MS THOMAS (ANF): Yes, thank you for that question. The issue for us is that we have, over a period of time in two or three states, now have certified industrial instruments that hang off the high care distinction, which allows in those states for there to be the maintenance of a registered nurse where there are high-care residents. That has been seen by those state branches as indeed - in fact, in some cases the only way to keep registered nurses in residential facilities.

The question you ask is about - and I might say that that is not the only thing. There are, in many states, drugs and poisons regulations that are also attached to those distinctions albeit, and as we have previously discussed, it may well be artificial, but in terms of those two quite meaty and important things are nonetheless attached to that distinction. I can't say to you that we could unpick those industrial instruments in a particular length of time. Nor could I say that the issue around the drugs and poisons regs could be unpicked easily either. That is a state government issue, in fact.

MS MACRI: That's a state issue, yes.

MS THOMAS (ANF): So I'm certainly not going to go there. In terms of industrial instruments I'm just looking at my industrial officer here about unpicking that.

MR BLAKE (ANF): I suppose if the final outcome was there was a requirement for providers to provide a level of nursing care outside of the enterprise agreement

then you could then sit down and renegotiate your agreement. But historically we have had situations where we've been able to secure agreements requiring providers to provide nursing care where there are high-care residents. Historically that hasn't been the case in the low-care sector.

MS THOMAS (ANF): So I guess the short answer is anything is possible. But we would need assurances that if those industrial instruments were unpicked away from the distinction of high care - we would need assurances that there was some other mechanism, a mandated mechanism, for ensuring that registered enrolled nurses and assistants in nursing were able - however titled were remaining in - and particularly registered nurses were remaining providing care for high-care residents. So it would have to be some sort of different arrangement.

MR WOODS: That might be an appropriate segue into the next issue of skills mix and staffing levels, because part of that debate is the underlying issue of ensuring that the quality of care that is being delivered is appropriate, particularly when we're then talking as specifics drugs and poisons, administration and management and some of those very important underlying issues of ensuring proper care. Do you want to make an opening comment on that issue?

MS THOMAS (ANF): For some time now the union has been lobbying for a minimum number of care hours. We say that a minimum of 4.5 hours of care per resident per day is something that would be suitable. We have provided for you our rationale for getting there. Frankly, commissioners, there are a range of ways that you could arrive at that total. The issue for us is not only should there be minimum care hours provided for each resident but there should also be the workforce available in the right numbers with the right skills to provide that care, because as you've quite eloquently said in your draft report we know that the numbers are going to exponentially rise over the next several years.

We see staffing levels and skills mix as integral to providing that care. You would be aware that we're about to embark on a project which aged care providers, other unions and ourselves - federal funded - to try and ascertain what a particular cohort of aged care residents might need in terms of care hours and who is best placed to provide that care. That is a 12 month project. It's a shame, in fact, that we're not going to have any data ready for your final submissions in June. But we are very clear that provided that that project goes the way we assume it will, and there is some reference back to the aged care funding instrument - and we think there's some opportunities there - that in fact we can come out at the end of it with an agreement and a way forward for staffing levels and skills mix in the sector.

With that said, I think that it is very important that I return to my initial point, which is minimum care hours per resident per day, and we're saying 4.5 is a blunt

instrument, there is no doubt about that. Some of my colleagues might in fact, as you round, argue for a range of different outcomes that equal 4.5 such as staffing ratios. All of these things are blunt instruments. We absolutely understand. But the foundation of this is about providing quality care now and into the future by registered and enrolled nurses and assistants in nursing for a group of people that we know are going to be more frail, older and have more complex medical conditions into the future and we're already starting to see that now. I think I might leave it at that and take your questions.

MR WOODS: All right. Let's pursue that because I notice in developing your framework agreement there's a possibility of entertaining such concepts as greater flexibility in working arrangements, the multiskilling with the objective of increasing the skills of employees to undertake a greater variety of rewarding functions but compatible with their base role. We share the common aim of how to deliver quality care by people trained efficiently and effectively to deliver that, so we're not talking about over training people, we're not talking about people who are trained to a higher level delivering skills and services that others could more efficiently and economically provide and there is this question of the ratio being a blunt instrument and it's a matter then of what are the ways of ensuring care.

In our draft report we have put forward the concept of the need to transparently assess the cost of delivering care for different types of care needs and one of the absolutely essential components of that is what are the labour inputs, to put it in its generic sense, at what levels of skill would be required to deliver that care. You can turn that into language more eloquent to suit the professional nature of your area but in its generic sense that's what we're talking about. So that's one way through which would allow a more considered approach. Your research project - and it is a great pity that the timing is such that it's been delayed and will not be available for us before we present our final report but at least if we could stay in touch and watch its progress during our next couple of months. That's also trying to understand what is this care requirement and what labour and other inputs at what levels of skills and competence are required to deliver it.

So you would understand my natural reluctance and I think share by my colleagues of the blunt instrument approach that we do strive to find some way of identifying the evidence that demonstrates that this level of care requires this level of input. Robert, do you want to expand on that or do you want to comment first?

MR BLAKE (ANF): Sorry, commissioner, I think the starting point for us is that whether it's a blunt instrument or whether something more sophisticated, the starting point for us is that there is a requirement that nursing labour be provided in each facility that has a resident. How that is mixed and the proportions of different types of nursing care is something that I think the industry has worked through and

grappled with for some time. Historically, the classification structures that were legally required to be in place in aged care facilities were not dissimilar to the acute sector and for those agreements that we have been able to provide with the large providers like Blue Care, Silver Chain in WA, we've had the opportunity to discuss with those employers different approaches to the skills mix, the numbers of staff and how that care is provided because I do think there is a recognition across the industry that providing care in the aged care sector, although the acuity levels are high and the care needs are great, is somewhat different than hospitals.

So we have worked around the structures that may suit particular enterprises. The National Framework Agreement seeks to take it one step further in terms of having an agreement with national employers to have some serious discussions about how that work in practice. How do you develop appropriate classification structures, job definitions, how do you recognise that you potentially would have a much larger group of assistants in nursing in particular facilities than you would, say, in a hospital at this point in time.

MR WOODS: AINs or equivalent I think is the phrase we often use.

MS MACRI: However titled.

MR WOODS: However titled is the other phrase.

MR BLAKE (ANF): How do you develop appropriate structures that will deliver the care needs to the residents and also provide a reasonable career path for employees that want to work in aged care and provide reasonable remuneration arrangements. Those types of discussions I think have been sadly lacking in this sector and I think most organisations believe there is some opportunity to have some serious discussion around that.

MR WOODS: Can I just pick up a point that Robert raised earlier though, also that care increasingly will be delivered in the community setting and again you referred back to residential aged facilities, so I understand why that is where you have come from in large part, but not in total. But when we're looking at this debate into the future, it is all about delivering care in a range of accommodation settings, of which residential care facilities in fact will be proportionately smaller and smaller. So if you could keep that in mind also as you address these issues.

MS THOMAS (ANF): Certainly the project, commissioner, is not only residential care so it's across the board. We absolutely recognise that community care is critical to the survival of residential care almost. So we acknowledge the point that you are making and clearly you're absolutely right, we have been campaigning in aged for some time now and I guess we do inherently talk about residential care. That is not

to say that we don't understand and acknowledge the issues in community care and know that in the future community care is going to be even more significant than it is today.

MS MACRI: Could I ask you, Lee, just in terms of looking into the future and the complexities and it is going to be more complex in residential and the community, but I'm just wondering, if I come back to residential for a minute and look at it in terms of the complexity of that care and the capacity for people to perhaps bring in particular skills which doesn't happen at the moment which would be great in the future, so I'm talking about palliative care, specialised wound management, you know, stomal therapy, whatever it is. So that in your framework are you looking at how some of that specialised care, because there is absolutely no need for it to be perhaps on staff 24/7 but there certainly is the capacity to me to co-opt and bring in some of that care from time to time.

MS THOMAS (ANF): Absolutely. The role of nurse practitioners I think is a perfect example of that. We wouldn't see necessarily that there is - unless it is a significantly large residential facility. But in fact our federal budget submission recently had a proposal to the federal government specifically around nurse practitioners in aged care and we looked at a one in four to five-type arrangement, so one nurse practitioner for, you know, geographically close residential care facilities or over one group in a particular area. I think that is the sort of thing that you're getting at.

MS MACRI: Yes.

MS THOMAS (ANF): So if you're asking does our project go to that, look, to be frank, I'm not sure that it goes necessarily to that point. But I think we all recognise that from time to time specialist care of that level that doesn't need to be on staff at all times is something that we all recognise is probably already happening; probably very clearly already happening.

MS MACRI: Not as much as it should.

MR WOODS: Can I pick up a related issue, and that's the role management plays in the best use of staffing and the ability to provide very localised terms and conditions. We made some point in our draft report about how a lot of nurses, many with many years of sound experience, suddenly find themselves as directors of nursing of facilities, and it's a much broader role than providing clinical expertise. We also have our own personal anecdotal evidence by going around the countryside that when you enter a facility or go to a provider of community care and you ask about agency staff they say, "No, we don't need agency staff. We have our core staff and we have others who we call on intermittently as required." You talk to the staff,

"Oh, the rosters are great, they're sorted out each week. Yes, we've got good professional development courses." Mind you sometimes the owners then bemoan that their good staff get moved and taken away because the opportunities and their horizons expand so greatly. But what role does management play and how can we promote better management, many of whom do come from in fact the RN and field?

MS THOMAS (ANF): You're hearing evidence tomorrow from a range of Victorian aged care nurses. You would be best placed to ask them that question, I think, because I think it's their view that would be most informative for you. However, what I will say is that if you're asking whether there is a need for increased foundation education when somebody moves from a registered nurse providing care at the bedside to the deputy director or director of nursing, I don't think anybody would disagree that it's vitally important. It's a change in role, and of course whenever you change a role it's important that there is some education that's put in place to support that person in that role. But it goes beyond education, frankly. It goes beyond the whole culture of the environment. I think that if that's your question then yes, we would support front-line management-type skills. There are some courses out there already that are specific to aged care, but beyond that I would, with respect, ask you to ask our members.

MR WOODS: Entirely happy. We will be following that question around as we go around all the states and territories, because it does seem to be part of - the total environment that your members work in is so dictated by the quality of management, again, in some cases, having come from your membership base.

MR FITZGERALD: Can I ask a more general question, and you may or may not be able to answer it. As you'd be aware, both Michael and I were the commissioners on the inquiry into Australia's health workforce.

MS THOMAS (ANF): Yes.

MR FITZGERALD: A number of those recommendations the governments of Australia are implementing, in full or in part. One of the issues for us there was the very large number of health trained professionals who were in the health system, in particular in nursing but not exclusively so. I was wondering to understand whether you see any movement in terms of the attraction and retention of nurses generally and its flow-on effect in relation to aged care, because they're absolutely symbiotic. You can do a lot in aged care but in a sense it's the whole of the health work - states or territories are in fact starting to significantly improve both attraction and retention or re-engagement, more significantly, in this field or not.

MR BLAKE (ANF): Commissioner, the view we have is that generally in Australia there is not a shortage of nurses but rather there's a shortage of decent

nursing jobs. That's why you have up to around 10 per cent of your registered workforce who choose not to work in the sectors because there's a lack of decent jobs providing rewarding working lives and decent remuneration. We do now know that where there is a willingness by employers to introduce better remuneration arrangements, better working conditions - and I refer to the Victorian hospital sector, the public hospital sector, and in Queensland and in Western Australia that nurses will come back to the workforce. They will come back into nursing and remain in nursing.

We hear that in terms of the aged care sector that it's not all about wages and it's not all about industrial outcomes. But the fact remains that remuneration is important. People do look at remuneration as being an important issue, not the only issue - and working conditions, rosters, workloads, staffing mix. I think there is a body of evidence now that does demonstrate that where those things are addressed then there will be a positive response from people who have previously opted to get out of the workforce, but also in relation to - new entrants may well look at nursing as being more attractive.

MR FITZGERALD: Can I just ask very specifically, in relation to the three states you've nominated Victoria, Queensland and - - -

MR BLAKE (ANF): Western Australia.

MR FITZGERALD: - - - WA. The evidence is now clear that practices introduced in those states are now starting to have demonstrable effect.

MR BLAKE (ANF): Particularly in relation to the workload arrangements, that nurses or potential nurses can see that if they go to work they have a reasonable workload and they are prepared to come back into the workforce. I think the Victorian government has noted that over 4000 people have re-entered nursing in Victorian public hospitals as a result of their nurse to patient ratio, for example.

MS THOMAS (ANF): I think that's the best case study that you can find. When the introduction - and over the years post introduction of ratios in the Victorian hospital sector, the attraction back from nurses who were already registered but had made a decision not to work in the sector - as Nick said, about 4000.

MR FITZGERALD: Can I ask another question then I'll stop, but is that demonstrated - is the same effect occurring both in the government and public sector and the private sector? I know the story was always a little different in both sectors but are we seeing comparably in those three states both in the public and the private sector?

MR BLAKE (ANF): Principally, commissioner, it's in the public sectors. The larger private acute hospitals have reasonable conditions and workloads but they very heavily on agency staff and 457 workers to meet their staffing needs. In the public sectors, who are the major employers of nursing labour in the country, there has been a return to the workforce in large numbers as a result of changes to their industrial arrangements.

MR FITZGERALD: Good, thank you. Sue?

MS MACRI: No, I haven't got anything.

MR FITZGERALD: We're out of time.

MR WOODS: Do you have any final comments or are you - - -

MS THOMAS (ANF): No, just thank you all very much for today. Thank you for coming and collecting the petitions. You will receive our final submission.

MR WOODS: In the near future?

MS THOMAS (ANF): Yes.

MR WOODS: Good, thank you very much.

MS THOMAS (ANF): Thank you.

MR WOODS: We appreciate your ongoing support.

MR BLAKE (ANF): Good, thanks.

MR WOODS: Carers Victoria, if you could come forward, please. Thank you very much. For the record, could each of you introduce yourselves, your name and the position that you hold in your representation today.

MS MULCAHY (CV): Sure. I'm Caroline Mulcahy. I'm currently the CEO at Carers Victoria. With me, I have Margaret Baulch.

MS BAULCH (CV): Margaret Baulch. I'm a volunteer with Carers Victoria.

MS MULDOWNEY (CV): And Anne Muldowney, policy adviser with Carers Victoria.

MR WOODS: Thank you. Thank you very much for your contributions already to this inquiry and in fact your early submission as well. We appreciate the time and effort that you've gone to assisting us during this inquiry. Do you have an opening statement that you wish to make?

MS MULCAHY (CV): I just wondered if you wanted some background on Carers Victoria.

MR WOODS: We do have a fairly good understanding but if you do want to give us an introductory short comment.

MS MULCAHY (CV): Okay. We're a statewide peak organisation representing those who provide care for people that they care about. We represent more than 700,000 family carers across Victoria but there's people caring for ageing parents, children with disabilities and partners with mental illness or chronic health issues. Carers Victoria also provides a range of direct services to family carers, both statewide and through our auspice of the Commonwealth Respite and Carelink Centre in the western metropolitan region of Melbourne. We're a member of the National Network of Carers Associations and the Victorian Carer Services Network. We're a not-for-profit association which relies on public and private sector support to fulfil its mission with and on behalf of caring families.

Our vision is that caring will be a shared community responsibility and so our mission is to lead change in services, systems and supports for caring families. We're a membership organisation. Our members are primarily family carers like Margaret who play an important role in informing our work, contributing to advocacy and strategic aims and distributing information to other carers.

Our presentation today will address the interdependent needs of older Australians and their families as part of care relationships, the need for entitlement to a range of family-focused supports based on the assessed needs of the care

relationship and that the building blocks of caring family supports must address the dynamic and interrelated needs of individuals and families during the caring journey.

We would like to thank the commission. So far in the draft report, we're pleased to see that the report addresses the overly complex and discontinuous nature of current aged care assessment and service delivery. It provides substantial recognition that the majority of support and assistance for older Australians is provided by families and friends and recommends nationally consistent assessment of family carer needs via the proposed Australian Seniors Gateway Agency. However, we're a little disappointed that despite the evidence presented to the commission of compromised carer health, wellbeing and social participation, a functional view has been taken of family carers as resources who require services that aim to support their capacity to continue caring. We would submit that a more preventative focus is needed that will enable families to undertake the caring journey without compromising their own physical and emotional health and social participation in life outside of their caring.

So why are we focused on caring families? These are the people that have the person with the care needs at their centre and include those family members and friends who care about the person and who may provide care for them. A focus on caring families recognises interdependence of needs, particularly between the person with care needs and any primary carer. Importantly, it also recognises other family members who provide direct support for both the person with care needs and, if required, for the primary carer themselves.

A focus on older people as being independent or dependent ignores the realities of many people's lives and does not adequately capture reciprocal care and dynamic changes in caring journeys within families. Carer needs have become narrowly defined and there is frequently a lack of distinction in carer policy between caring about someone, the relational aspects of care, and caring for someone, the functional aspects of care.

A focus on the separate support needs of family carers over the last two decades is partially a consequence of inadequate and rationed services for people with care needs. Adequate support services for a person can create a respite effect, relieving families from a range of care tasks while also supporting them to maintain a caring relationship. So a shift to an entitlement approach to the care of older Australians is an opportunity to (1) bring the focus back to the interrelated needs of older people and their families; (2) reduce competition for resources and support between older people and their families and (3) design an aged care system that is both person centred and family focused.

My final comments relate to the lack of recognition in the draft report of the

role of specialist peak organisations. The draft report recommends that carer support centres should be developed from the existing Commonwealth Respite and Carelink Centres but the role of specialist agencies that provide information, education and training or advocacy, such as Alzheimer's Australia, care associations such as ourselves, are only mentioned briefly on page 41 of appendix B.

The commission has also identified the need for independent consumer advocacy services, recommending that an expanded system of aged care consumer advocacy services be funded. We submit that specialist services and independent advocacy will be key roles for peak bodies in a reformed aged care system. Indeed, we anticipate there may be a greater need to support an advocate for family carers and moves towards greater consumer choice and control.

We therefore propose the following roles for peak bodies and a reformed aged care system could include advocacy, both individual and systemic; specialist information and education for caring families; support for caring families to implement their consumer-directed care; accredited and professional development education for the aged care workforce to support cultural and practical change; conducting and supporting evidence based research on support for caring families and dissemination of good practice in family support and inclusion to the aged care workforce. I'm going to hand over to Margaret.

MS BAULCH (CV): I'm here in the capacity of a former carer and as an older Australian already linked into services. Family carers must be recognised as experts, not in health or aged care, but as those who know the older person best. Service providers must work in partnership with clients and carers. I applaud the single entry point mechanism because it's much easier only having one assessment. Workers must appreciate what a strain different assessments can place on clients and families.

The concept of the telephone interview raises other issues. Some clients will play up their disabilities, others will play down. There needs to be a clear definition of standards. What precisely is meant by feeding oneself? In-home personal interviews can alert the interviewer to observe unrecognised needs and also observe tensions. At the commencement of care needs or the point of diagnosis, all family members who wish to provide care should be offered education on the condition of the person, how to provide care effectively and safely, how to care for themselves, and I would add that I think this should be almost made compulsory. For example, training of care of a person who has had a stroke, how to dress and shower the client, may reduce the need for an outside careworker to come in. However, families must always be made aware that they have the choice not to perform care tasks that they find beyond them and that formal support is available.

There is little recognition that the needs are not necessarily linear. More care

may be required at an earlier stage, particularly with people with dementia, and more support for their family carers, especially clients who are more physically active. Choice, flexibility and continuity are key points. For example, I refused a package because the provider wanted to place my husband in a day centre 12 kilometres from home when he had just settled into one three kilometres from home. There was the distance and transport costs and I also would not have been able to get to know the staff who would be working with him.

Affordable maintenance and alteration. A properly designed accessible shower could extend the time a client remains a home and such aids being incorporated in the care package would enhance independence and reduce risk of injury to client, carer and service providers.

On the matter of enhancing equality of care: as well as improving remuneration there needs to be some basic health and competency standards, especially for personal carers who may have sole care of a client, for instance, a carer who could have an asthma attack while looking after the person, a diabetic who has a hypo, and any client who needs assistance with medication help needs while the sole worker is caring for a client in their home.

What is the interface between aged care and support and disability care and support? Conditions may be age related but sometimes they are disease related and I'm particularly thinking of those with early onset dementia and early strokes who somehow fall between two playing fields. I support the idea most sincerely the user pay according to means. However, I am concerned that if residential payments are not carefully adjusted, it could leave the remaining partner dependent on the state. I would question have the recommendations been tested against a wide range of possible scenarios because we're dealing here with people who have many situations.

While most people's care needs would be accommodated within the framework suggested, there needs to be an opening for flexibility for the different case. All caring families are different. Thank you.

MS MULDOWNEY (CV): Mine is the last. Thank you for the opportunity to present some of Carers Victoria's responses. We have contributed via the national network of carers associations to the Carers Australian written submission and you will also shortly be receiving our written submission. Carers Victoria has worked systematically over many years to draw attention to the needs of family carers in both residential and community aged care and to promote the need for service providers to work in a more family inclusive way. So we have developed frameworks for the assessment of carer needs and for the practice of carer support work. We have developed resources for residential aged care facilities on family-carer friendly practice. We have studied the experiences of relatives and

friends of older people who live in residential aged care.

We have made a range of recommendations over the years to the Department of Health and Ageing on family-inclusive changes to the Aged Care Act, the principles, the standards, the ACFI, the guidelines for packaged care and the charter of resident rights and responsibilities. We've developed accredited and professional development training for the aged care workforce on working effectively with family carers and we've conducted consultations with carers about their experiences of and preferences in consumer-directed care.

So I would like to address three points this morning: a framework for the assessment of the needs of the older person and the needs of family carers as well as the needs of their care relationship. I'd like to spend a little time reframing respite care as family support and also some of the building blocks of family support through the transitions of caring journeys. So the draft report recognises some of the support needed by caring families such information, education, respite, peer support, counselling and advocacy and we support the recommendation that carer assessment is a key role of the proposed gateway agency. However, I reiterate Caroline's point about a functional view as carers as resources who require services that support their capacity to continue to care.

We submit that assessment should focus on the care relationship so the needs of the family carer and the older person are equally considered, that service is aimed to support them both and importantly their differing needs and priorities are acknowledged and made explicit. This will underpin in our view a reformed aged care system being able to effectively balance the needs of both individuals and families. We recommend that older people and their family carers are offered separate needs assessment to enable each the opportunity of an honest appraisal of their own needs. Family carers can feel particularly constrained discussing someone's declining abilities and their own ability and willingness to provide care in the presence of the older person.

Our written submission will address the recommended domains but we believe that gateway assessors should establish things like, "What are things like for you?" in each of these life domains, "Have there been major changes since taking on a caring role and what are they? How do you feel about the current situation? Are there difficulties? If so, what do you see are the ways you could bring about positive change?" It is our view that comprehensive assessment will also highlight risks to the continuation of the care relationship, such as a deterioration in care health and wellbeing or multiple care responsibilities.

We note that the draft report has not made any recommendations about redeveloping respite care, awaiting the outcome of the National Carer Strategy. We

submit that the commission must address reforming respite care as fundamental to a more person and family-centred service system. The paradox of respite care is that it is a service provided to the older person but is in often viewed in policy terms as a support for carers. An alternative definition of respite provides a means of encompassing this dual focus and I acknowledge the Victorian Carer Services Network for this definition, "Respite is support and assistance to people in a care relationship that enables them both to participate in the community."

So I will move to an entitlement approach which aims to ensure that more of an individual's aged care and support needs can be met by formal services will actually create a respite effect which will benefit many families. But in addition to this, other family support must be delivered flexibly and we recommend that all caring families should have an entitlement to funding that can be used flexibly for a range of in-home day activity and overnight support. We further recommend that the current entitlement of 63 days of subsidised residential respite be retained based on assessed level of need.

I refer now to the layered funding model approach to the needs of older Australians outlined appendix B. Carers Victoria supports a building block approach to assessing and delivering entitlements with different levels of support available at basic and complex care need levels. However, once again a less functional and more preventative view of the needs of families is required. Family care risks that have been identified at assessment should entitle caring families to an additional funding supplement in order to reduce any risks of further harm to the carer's physical or emotional health, breakdown of the care situation and premature entry of the older person into residential care.

The modelling also appropriately identifies a range of care supports as areas of need that are not always directly related to functional impairment or conditions of the older person and these include home modifications, aids and equipment and carer support. However, all older people and their families may have needs related to information and education about the health condition and its management, individual and group peer support and emotional support and counselling to develop coping skills in dealing with change, loss and grief. These aren't just supports for carers. The commission must consider an entitlement for both older people and families to choose these services.

Finally, all families must be entitled to a range of additional time-limited practical and emotional support at times of key transition in their care journeys and we particularly identify the commencement of caring, at any time when support needs change, especially the transition to residential care and for families who are bereaved following the death of the person.

A couple more things. We would asks the commission to also make recommendations for both a reformed age care system and the industrial relations system to accommodate the needs of family carers who are participating in the paid workforce. We also ask that you make recommendations about the interface between aged care and disability support where families are caring for more than one person with support needs, for example, a woman who may be caring for a child with a disability and a parent with dementia. So we trust that you consider these points in your final report so that Australia can build a genuinely more person-centred and family focused aged care system. Thank you for listening.

MR WOODS: Thank you. That covered an awful lot of territory in those opening comments and answered some of the particular questions that I had in mind. Just one initial reaction. I was interested in a sort of anecdote that you added in in your presentation about refusing a package because the particular provider was offering a daycare service that didn't meet your particular needs.

Hopefully with our reforms it will be your entitlement that you take to different providers and that you negotiate with the one who provides the services that best meet your particular needs. I mean that's a very good demonstration of what we're trying to achieve in the reform process - so I hope that comes through in our draft report to you, and it will certainly be coming through in our final report - that you're empowered to then go to the different providers, and if one is offering one 12 K away who you're not going to know and relate to and understand and another says, "Oh, but we've got this facility here. You can come along and we'll make sure that you understand what is being provided and meet the staff," and things, then you will have that power to choose. So you won't give up the package, you will choose the provider who best meets the individual needs. So hopefully that will address what would appear to be a seemingly simple issue but under the current constraints doesn't happen.

MS MULDOWNEY (CV): I would just like to comment on that, that through our consultations with families about consumer-directed care, they identify that they do need substantial support in order to be able to exercise their entitlements and rights as consumers. They would often see that that support should come from organisations like ourselves or other peak bodies.

MR WOODS: Yes. No, we understand it is more than just sending them out the door with an entitlement that they have to - (a) that there is sufficient information available to them but then they have to be able to interpret it and make a responsive choice in reaction to that. Your questions about respite and the re-interpretation into family support and the like, what views do you have on how to draw on a supportive environment more broadly? Why I raise that question is that there are providers who are approved providers of respite - as it's currently termed, although I'm interested in

pursuing your thoughts in that area - but should we be broadening the definition of who constitutes an approved provider both for scheduled and emergency respite or at least for emergency respite, so that if there is a neighbour with whom there is a good relationship or another third party and who can provide safe and proper support in those situations that they could also be included in the range of people who are constituted as providers of that care?

MS MULDOWNEY (CV): Yes, it's certainly our recommendation that assessment should consider both informal and formal supports that are available or that could be available to the family. It's also our recommendation that at the point of contact with the gateway agency that all families should have an emergency care plan completed that will outline what people wish to have occur if the carer becomes suddenly unavailable, and that one of key transition points, I suppose, in the caring journey actually occurs well before the commencement of care; that we would recommend that families have support to be able to work out amongst themselves ways of managing care within family and friendship networks, and that there's some planning that goes into that prior to the commencement of care.

Of course that's easier said than done, but we feel that that's important in the consideration of advanced care directives, powers of attorney et cetera - that those are important conversations that families need to have. It's our view that the formal support system could do more in that area to enable more sharing of care between different family members and friends rather than - I hesitate to use the word "burden" but the responsibility falling primarily on one person.

MR WOODS: You didn't raise specifically the issue of cashing out of parts of entitlements and particularly say either emergency respite or even scheduled respite. Now, some groups have come to us saying, "No, we're happy to operate within the process of approved providers." Some are saying, "Well, we'd want the approved provider definition to be much more broadly based, particularly in certain circumstances, to draw on a range of supports." Others, not many, but some, say, "Well, we'd actually just like the" - in effect the cash and to then be able to pay people to provide that support when it's required. Where do you sit in that or do you have a particular view or don't need to have a particular view?

MS MULDOWNEY (CV): We do. We have prepared a range of discussion papers around the issue of consumer-directed care and we certainly believe that that should be a choice available. It's our view that it's a choice that only a minority of families would wish to exercise at this point in time, but those who wish to make steps towards being able to direct more of their care and support are asking for support to be able to do that. We also have expressed some concerns about the commodification of family and friend care.

MR WOODS: Yes.

MS MULDOWNEY (CV): Our view is that the payment of family and friends to provide care should be treated with caution.

MR WOODS: I can fully understand those views, and they align fairly closely with where we've come to in our draft report. So thank you for putting that on the record. Robert?

MR FITZGERALD: I just want to go back to your opening point in relation to the carer support centres. One of the things that in discussions with your national body we've clarified is that we are saying or should have said that the carer support centres would come within the national carer support program. But just the point - we recognise the important role of peak bodies, and perhaps in the final we need to do more of that as you've indicated, and the unique functions. On the other hand, we also recognise that some functions will in fact be part of those centres which the government will, as it does now, tender out. Some of those are already operated by carers associations around Australia, some are not.

So we would see a distinction between the role of the peak bodies and the centres, which may or may not be run by the associations or Alzheimer's associations or any other numbers based on a tendering process or whatever process the government puts in place. Does that accord with your view or do you want a view, a more strict view, that the peak bodies should, as a matter of right, have the capacity to run those centres? Not exclusively, but there is a difference, because the peak body has a role. Whether or not they actually run a centre is a different issue. So I just wanted to just explore that issue.

MS MULCAHY (CV): We have both those roles currently. We'd like to continue with that. We believe we're the experts in delivering carers services. What we've thought about internally is trying to separate out those two services. We may need to consider that in the future. We've certainly talked about that with our board and there is tension sometimes between being a peak and a service provider and we're just trying to tease out some of those tensions at the moment.

MR FITZGERALD: It would be helpful from our point of view if you could actually define what you think are the roles of a peak body and separately the role of what an integrated support centre might be. Could I just say one other comment on that. It would be envisaged that these care support centres would be dedicated to the support of carers of people that are ageing but also people with disabilities, people with mental health conditions and people with significant medical conditions. So we are in fact trying to go just beyond the aged care. We're trying to look at a coordinated or an integrated set of services that would meet all of those.

Now, the way you enter those will be different and the funding will be different but I just want you to give some thought to the separation between the peak body functions as distinct from what an integrated carer support - - -

MS MULCAHY (CV): We can certainly articulate that very clearly. We're very clear on the differences between those.

MS MULDOWNEY (CV): But I would just also like to question then your view of the functioning of the carer support centres so that you would suggest that the older person would have an entitlement to choose from a range of service providers but that carers would get their support from carer support centres?

MR FITZGERALD: It depends on the nature of the support. What we are looking at the moment and seeking your feedback on is there are some services that lend themselves to an entitlement, for example, we think at the moment planned or scheduled respite is one of those and a number of other functions. There is then a group of services - you have indicated those, training, peer support, information to advocacy - which are much more likely to lend themselves to direct allocation or block funding and we're just trying to work out that. So we would welcome your views, some entitlement, some would be block funded to the agency.

MS MULDOWNEY (CV): Okay.

MR WOODS: Excellent. Any final comments from yourselves?

MS MULDOWNEY (CV): No. Thank you for inviting us today and allowing us have our say. We look forward to your report.

MR WOODS: Thank you for your ongoing contribution, and I stress the ongoing. We look forward to your - - -

MS MULDOWNEY (CV): We have another submission.

MR WOODS: - - - to you completing your homework and pursuing those matters for us. Thank you very much.

MR FITZGERALD: Thank you.

MS MACRI: Thank you.

MR WOODS: If I could invite the Royal District Nursing Service, please. Thank you, could you please for the record, each of you state your name and the position in the organisation that you are representing.

MS HINTON (RDNS): Georgina Hinton, executive general manager for new ventures for RDNS.

MR SMITH (RDNS): I'm Mark Smith, general manager of external relations for RDNS.

MR WOODS: If I could invite Sue Macri to declare your interest in RDNS.

MS MACRI: Yes. I just need to put on the record that I'm a director on the board of RDNS. Thank you.

MR WOODS: Thank you very much. Do you have an opening statement that you wish to make?

MR SMITH (RDNS): Yes, commissioner. I just wanted to provide some background to add to the context in which our submission is being made. Royal District Nursing Service Ltd is a major provider of community based care in Australia. We are the largest home based nursing and health agency in Australia. Initially in the Melbourne area only and over the past few years we now provide service in New South Wales, Tasmania and over in New Zealand. On any one day we have over 9000 clients on our books with 70 per cent of those being 70 years of age or older. Most of our service is provided by a team of over 1000 nurses, but we also have a small team of personal care workers and allied health professionals.

We provide a lot of service to people within their home around support and maintenance but we're also funded to provide specialist services through many different streams which allows us to put us a perspective on what you mentioned in terms of in reach into residential aged care. We already provide some of that service but also very strong links with the acute hospitals, all areas of primary health care and, of course, local government, a major care provider here in Victoria also.

So from that perspective there were just a few key elements of the draft report which we wanted to provide our feedback on. The first of those was the Australian Seniors Gateway Agency, particularly because RDNS back in 2005 established its own customer service centre here in Melbourne which provides that same central point of intake and information and that has now been spread across all of our other services. The main focus behind that was to provide a consistent response to all of our callers and a flexible response by being able to take an overall high level look at the organisation and where there was capacity and particularly skill. It runs 24 hours

per day and has a fifty-fifty staff mix between clerical officers and nurses. So at any time where there is a particular clinical need there is an escalation process so that a nurse will in fact be able to take that call.

We were very particular that we would call it a customer service and not a call centre, given the demographics of our client base but we have made sure that we have built into it all of the call centre disciplines but to provide a human personal response to every single caller. We would value the opportunity to show to the commissioners and to the commission the technology and processes that we have in place if time were to allow. As with the gateway, initial assessment is done by phone but our experience shows us that quite often what you get in terms of the initial response over the phone can be very different to what the nurse will find when they continue the assessment in the home, both in terms of the physical environment itself and also in terms of the functional capacity of the client and/or their carer.

So we would certainly support what was said in the previous submission about relying purely on telephonic information, you will risk having an overemphasis in terms of what they can do and also providing less than they are actually able to do for themselves. The other major experience we have had with that is that although we started it back in 2005, it was something that we rolled out across our 18 sites in Melbourne in a staggered approach because we found that as we developed further, things kept changing. So it was much better to do it in a contained manner rather than introduce it across the board and then have to implement changes that would affect the whole of our workforce. So we would recommend that it's something that should be refined and piloted, rather than being something that is implemented across Australia initially.

Of course, there are also some other examples out there. We, for example, run the Access Point Service for the whole of Tasmania. So it should really build on those services that are already available. One of our other concerns is dealing with capacity and capacity at two different points: firstly, those people who contact the agency but aren't able to go through the formal intake process because capacity within the gateway is met at that time, what happens with them in the interim. But also importantly once the initial assessment has been done and need has been identified and the entitlement has been determined, there is still a very great risk that there will be a time lag between the time where the client or carer is provided with the information around service providers before they can actually be admitted into one of those. What will happen with those clients in that interim period? Who will become the default carer? Will it be the gateway and, if so, will they have the capacity to actually undertake the direct care role?

One of the other issues that we have been talking about in many forums here in Melbourne is also the risk of cherrypicking of clients and what will be put in place to

ensure that the complex clients who are most in need of care aren't rejected on the basis that there are other clients who are less complex and therefore more cost-effective to care for, what actual processes will be put in place for that.

One of the questions we've also looked at is once the gateway is up, whether there's potential to integrate other services into that capacity and we would certainly see that there is the capacity for that. Within our customer service centre, we have our central intake but we also provide DVA Veterans Home Care. So we can see that there are some very great synergies there. One thing we have mentioned though, particularly with DVA, there's a high level of expectation from that particular cohort about the service that they actually have provided. So there will be need for lots of checks and balances and a lot of education if other services were to be integrated.

Another one of the points I just wanted to touch on was the notion of the restorative approach or re-enablement. At RDNS, we have had some experience with that. Here in Victoria, we've worked on the active service model with the Department of Health and we've certainly seen some benefits from that, so we would certainly encourage that approach. But also across the Tasman in New Zealand, when we entered the market there as a new provider, we were able to, right from the start, embrace the restorative approach. We found, even in the short time that we've been providing services there, that we have had significant outcomes when we compare to other existing providers who haven't yet embraced the restorative model. So still early days but certainly we have a much higher rate of discharge from service and we have a higher rate of clients going from a higher level of care down to a lower level of care.

MR WOODS: Have you documented that and have got a body of evidence in support of that?

MR SMITH (RDNS): There is actually some work under way for the University of Auckland and we understand that there will be some publications coming out in the next couple of months that do support the findings that we have anecdotally found within our service.

MR WOODS: That would be good when we get it, but in terms of timing and that, if there's any raw data from your own administrative records that we could also get hold of, the sooner the better on that.

MR SMITH (RDNS): We'd certainly be able to provide that, yes.

MR WOODS: That would be excellent.

MR SMITH (RDNS): We would be more than happy to provide that. But I guess

just in closing about the restorative model, one thing that's certainly been found in New Zealand is that it isn't for everyone. There's no point in putting intensive resources into everybody unless they have had an appropriate assessment that shows that there is a great likelihood that by putting in extra resources initially, you'll be able to reduce or delay the level of resources into the future. Thank you.

MS HINTON (RDNS): Thanks, Mark. I'd like to talk a little bit just on your area of paying for aged care. RDNS believes that as the cost of health care rises, co-contribution will probably be inevitable for those that actually have the capacity to pay. However, whether older Australians actually will understand the financial reality to that remains to be seen.

One issue we do have in this area is whether the cost of efficient care will actually recognise the additional costs associated with value-added services to the system; for example, 24-7 service delivery or specialist IV care. Value-added services, I suppose as we all know, come at a cost and sometimes at a high cost and in some circumstances are absolutely critical to enabling efficient best-practice service delivery. We believe the system must be sufficiently resourced to remain flexible, contemporary and, more importantly, able to embrace change in the future.

Our biggest concern, however, is that the one efficient price approach could lead to cherrypicking of clients which Mark mentioned before. The more complex clients, those clients that are more vulnerable and require more intensive service delivery, could be overlooked potentially by service providers for those that are simpler and more cost-effective to serve. So we are concerned as to who will look after these complicated clients. We suspect that unless there are specific measures that are put in place that these clients will deteriorate and get lost in the system.

We recommend that the proposed AACRC liaise not only with service providers but also with expert clinicians when setting the price structure to ensure that a realistic price is set that reflects the true cost of quality service delivery. The price will need to reflect a quality person-centred model of care which embraces the overall health and wellbeing of the client in a restorative approach. The price will also need to reflect the e-health reality being faced by this industry. Providers will need to have the capacity in the not too distant future to actually act as e-health savvy providers and this will come at a cost, not only in terms of infrastructure but in terms of ongoing resources. If the set price doesn't reflect the true quality of service delivery for a customer based in different geographies with different service requirements, it may actually have the opposite effect to what is being intended and customers may not be faced with a diverse group of quality service providers offering innovative and different service delivery options but a few providers offering the bare minimum.

In conclusion, we at RDNS believe that the draft report is a significant positive step to improving the current service system and we would welcome the opportunity to be part of the proposed implementation task force. At this present time with changes happening not only in health and in aged care but also in disability, we believe it's important that the reforms are linked and staged so they're aligned. We also believe that consideration must be given to the capacity of the industry, so funders, consumers, providers and regulators, to embrace the magnitude of change that is being proposed in this report, otherwise greater fragmentation and confusion on behalf of care recipients could actually occur.

In the area of consumer choice which Mark touched on, we believe that the move to a customercentric model where consumers have more choice - we view this positively. We are concerned as to who will choose for those clients who can't choose for themselves. With respect to the gateway, we have found that our centralised access point through our customer service centre has been beneficial to clients in terms of their ability to access services and has ensured a coordinated approach across our organisation. Our concern with the implementation of the gateway is with actually coping with the workload and ensuring that it actually doesn't add time to the already time-consuming assessment and reassessment process. The issue for who cares for clients who can't find a service provider to actually accept them and take them on needs to be addressed. We would therefore like to see a piloted and staged implementation as Mark mentioned of the gateway to ensure that the systems and processes are tried and tested before a complete national rollout.

In the area of price, our concern lies in whether or not it is actually possible to set a single price that reflects the true cost of quality service delivery for a diverse customer base in different geographies across the country. We do not wish to see any clients left behind in this process. Thank you.

MR FITZGERALD: Michael just has to go and fly back to Canberra. So it will be just Sue and I. Can I just take the last point. At the moment, in a range of services, for example, DVA, there is a price set. So in the contract that you have to deliver veterans' aged care services, they say the price for or the funding for a particular service is X amount per hour, whatever that figure is in the schedule. Going forward, the price is still set but now we've got an independent regulator advising on that price, and you're right, we're trying to get an efficient price. So the question is let's assume we get the price right just for the moment: what mechanism do you think should be implemented in relation to community care to ensure that the cherrypicking doesn't occur? Clearly in residential, we have a quota which we've maintained for support of residents. The way in which that quota works is a matter for obviously ongoing discussion. In community care, there are no quotas. So how do you think - if the price is set correctly, just assume that, what do you think the

mechanism could or should be to ensure cherrypicking doesn't take place?

MR SMITH (RDNS): That's a good question.

MR FITZGERALD: Yes, I know that's why I'm asking it. You don't have to respond now but we have thought about this issue. It is all very well to say you get the price right but, of course, cherrypicking takes place. It takes place by not-for-profit, for profit and government providers and we know that. But coming up with a mechanism that minimises that is actually much more tricky in the community care area.

MR SMITH (RDNS): I think something we have seen elsewhere is setting targets in terms of the mix of different types of clients to ensure that in reporting back data it can be assessed that they are taking an appropriate mix of clients with different needs over time and that's certainly something that we have seen over in New Zealand, for example.

MS MACRI: I was just going to ask you, and it comes on a little bit from that, in terms of when you talk about the cost-efficient care and then looking at the value added, again it's having a look at how do you add on the cost of the value add because lots of people will have the cost of care as it is, say, currently through a CACP or an EACH if we go up to that. How do you then identify the additional value adds and where they're appropriate and how do you cost those? I mean, I think - - -

MS HINTON (RDNS): It's not easy.

MS MACRI: Is that something that your organisation - - -

MS HINTON (RDNS): I think we would welcome the opportunity to participate in - whether it is a workshop or a discussion point around once the price is set, how do you then value some of the - well, what are the services that actually should have a value placed on them and, you know, how do you actually come to a realisation and that can then be implemented in a transparent way across the industry because that is something as well. So RDNS has some advantages in terms of our scale and our size and through our customer service centre, we now have a huge transparency in terms of data that we can draw upon but we completely recognise that a lot of players don't have that mechanism so, therefore, it becomes very difficult for you to actually provide some regulation and mechanisms around this.

MS MACRI: That may stop the cherrypicking.

MS HINTON (RDNS): Yes.

MS MACRI: If you have your cost of care and then if there is a value add - I mean, it's a little bit like what we have looked at with ACFI where the added for oxygen and added for others so it may be a way around the cherrypicking.

MR FITZGERALD: The building-block approach which you're largely supporting, is that correct, in terms of the assessment?

MS HINTON (RDNS): Yes.

MR FITZGERALD: One of the aims is to ensure that the levels of complexity and the natures of complexity are taken account in that assessment phase. So that as I understand the way this operates is that you look at a particular need and then you look at the intensity of that need from low through to high so in a sense this efficient pricing is based on having identified the actual complexity of need required. You're right to say, however, that one is never going to get that perfectly correct and, secondly, agencies by nature choose different types of clients, they always have and they always will so we didn't want to take that into account.

But surely the fundamental starting point is to make sure that building-block approach is as comprehensive, yet as - and I hesitate to use the word "simple" because it's not - simple as possible.

MS HINTON (RDNS): Absolutely, I would agree. I have a concern in terms of the loop and as the needs change, the ability to be able to then come back. So this isn't just - - -

MR FITZGERALD: Sure.

MS HINTON (RDNS): As you have recognised in your report and how that feeds back and how the needs change and how those needs then get implemented is very complex.

MR FITZGERALD: We do see that as a responsive system where either the person that is ageing or the carer or the case coordinator can in fact reactivate the assessment at any stage.

MS HINTON (RDNS): Yes.

MR FITZGERALD: So it is actually a very responsive system but it is very responsive in the way you have indicated and we actually hope that sometimes the needs go down and you need less services. Can I ask this very strange question: what would an entitlement to a re-engagement or restorative approach look like?

What is it? I can identify what you need in terms of cognisancy, I understand personal care and washing and showering but what do I actually get as an entitlement to a re-enablement-type service? What is it?

MR SMITH (RDNS): The philosophy behind it is to acknowledge that it is quite simple and very time efficient to go in and provide care to someone. It will take more time to go in there and support them to actually do more of the care for themselves. So it requires more education, longer time up-front to actually encourage that person to become more independent and more confident and competent in providing care for themselves rather than going in for a shorter period of time more often to just do the job and then get out.

MR FITZGERALD: You operate that specifically in New Zealand as well as here but how is that funded in New Zealand, can you tell me that?

MR SMITH (RDNS): It's something that a number of a district health boards are taking up. So Auckland District Health Board, where we have a contract, because they were renegotiating the way in which they provided home based support services did indicate that all of the providers would need to move to a restorative model of care where it was appropriate but because we were a new provider coming in, we basically did it up-front. So the other providers aren't yet required to do it which is why we have some actual good data to compare because it was something we initiated up-front. So that's built in to the costing of the care that we provide.

MS HINTON (RDNS): We can provide some further information if you require that.

MR FITZGERALD: Yes, very much so. In your submission you talk about the greater use of interdisciplinary teams. One of the things that we have mentioned but not fully explored in our draft is the desire to see the further development of aged care health teams which are interdisciplinary and integrated. I was just wondering if you have any comments about that.

MR SMITH (RDNS): It is certainly something that is required. There are examples of where that is actually happening where there is a team and each of the people in that team has a general role but also they will be called on specifically for things from their own profession but it is expected, for example, that any one of that multidisciplinary team can do the initial assessment, it will just be if there is a particular physiotherapy need, that the physiotherapist will be called on. So, once again, there are already some good examples of where that is currently happening and hopefully with the change to curricula and universities now and a bigger push to be interdisciplinary throughout that course it will be easier to implement and more recognised in terms of the benefits of it in coming years.

MR FITZGERALD: Any other final comments?

MS HINTON (RDNS): That's it for us.

MR SMITH (RDNS): Thank you very much.

MS HINTON (RDNS): Thanks for the opportunity.

MR FITZGERALD: Thanks very much. We're dead on time, so we'll just adjourn for lunch and come back at 1 o'clock. Thank you.

(Luncheon adjournment)

MR FITZGERALD: If we could have the National Ageing Research Institute. Grab a seat, grab a microphone. Good. Okay. If you could just give your names and the organisation you're with and the positions you hold.

MS DOW (NARI): Thank you for the opportunity to present this afternoon. My name is Briony Dow and I'm the director of the health promotion division at the National Ageing Research Institute.

MR FITZGERALD: Good. And your colleague?

MS DOYLE (NARI): I'm Colleen Doyle, principal research fellow and director of the service development and evaluation division.

MR FITZGERALD: Okay. If you've got an opening statement or some comments, that would be terrific.

MS DOW (NARI): Thank you. As we're from the National Ageing Research Institute we're going to mainly focus on ageing and aged care research in our discussion today. There's three main areas we want to cover: funding for aged care research; translation of research into practice, and building capacity in the aged care research workforce. I'm going to cover some of those things and Colleen is going to cover others. But I just wanted to mention also I'm on the board of Carers Victoria. I know you heard from them earlier this morning.

MR FITZGERALD: Yes.

MS DOW (NARI): But if I have time I'd like to make a couple of points just specifically about services rather than research. First of all I'd like to welcome your report and congratulate you on the great job that you've done. We feel that if the recommendations were acceptable we'd have a far better and fairer aged care service system than we have currently. There is recognition throughout the report of the need for a sound evidence base for policy and practice in this area, but at the moment there are really only two specific recommendations relating to research and building an evidence base. I guess we'd like to just see this addressed a bit more extensively in the final report.

So we welcome the recommendation that the Australian Aged Care Regulatory Commission act as a national clearing house, and also the recommendation of that timely release of research reports, but we'd like to see further recommendations regarding funding for ageing and aged care research, mechanisms for a translation of research into practice, and some incentives or other mechanisms to support career researchers and to develop the aged care research workforce. As you probably know, the main source of funding at the moment for research or initiated research into

ageing is the National Health and Medical Research Council and the ARC, one of which focuses on health, and the other focuses on more social, psychological and other issues.

The NH and MRC is really the main area for ageing research, and that focuses mainly on biomedical research; looking at specific disease entities, so cancer or cardiac disease. Anything to do with health is not funded through ARC. Ageing research really doesn't fit well into these two models, particularly the disease specific model, as ageing affects all bodily systems, as well as psychological and social functioning and so on. So research into ageing requires a more holistic and multi-disciplinary approach which is not easy to reduce to these more positive scientific models. In 2009-2010, only .9 per cent of the NR and MRC budget was devoted to gerontology and geriatrics, but we do acknowledge of course that much of the other disease focused research is of benefit to older people.

That's about ageing. Research into aged care, so model systems of care is also difficult to fund via these mechanisms. In 2010 only 4.7 per cent of funding was devoted to health services research compared to 47 per cent on basic science and 33 per cent on clinical medicine and science. It means that research, such as the evaluation of the recommendations of your inquiry, is actually difficult to find in the current environment. So where we want to look at new models of care, system changes, it's actually quite hard to fund the evaluation of that. We think there should be some strategic prioritisation of funding according to priority areas, such as ageing, and some consideration given to the proportion of health care expenditure and potential impact of research, when research funding is allocated. So if you're researching into aged care, obviously there's a huge health and aged care budget of which there's no percent that goes automatically into research and development.

There may also be a need to fund research into ageing outside of the NH and MRC model, and there are some examples of that at the moment with the Dementia Collaborative Research Centres and cancer research. That's about funding. I'm going to hand over to Colleen now who is going to talk about translational research and workforce development.

MS DOYLE (NARI): Thank you, Briony. Yes, we noted there's a prevalent interest that the Productivity Commission had already made a recommendation about in-reach into residential aged care from health services, and one of the areas that we would like to emphasise is to have better translation of research into practice and a stronger link between the aged care sector and the research sector. While the teaching hospital model is well established - and we know that the teaching nursing home model has been around for many years and that the Commonwealth is interested in developing that - we feel as though the government could be more proactive and facilitate that link in a much stronger way than it has up until now. We

think there are a number of advantages to this on both sides. From the researchers' point of view, the opportunities are for a better quality of research and more groundedness in their research, and from the service providers' point of view, there's opportunities for quality improvement and better consumer participation in research.

At present the researchers don't have any government support or encouragement in approaching service providers to be involved in their research. Service providers don't really have any great incentive to spend the time and money in being involved in research. We feel as though the government could provide some facilitation in improving that link; especially the opportunities we think around quality improvement and regulation that participation in research is not a part of the regulation systems in aged care. We feel as though there was an opportunity there to develop that in a stronger way. But the services themselves also need adequate compensation for participating in teaching and research, and again that's where the government could encourage services to be involved in teaching and research in a stronger way. We feel that, as I said, there's benefits on both sides of that.

Another way that we think that the links between the research sector and the services sector could be improved is in evaluation of programs and services. We would welcome an evaluation strategy, as Briony said, for the changes recommended in the Productivity Commission, but we noted that while there was a large evaluation of the dementia initiative there haven't been similar sorts of exercises undertaken, for example, with community aged care packages or in community care. We feel that the government could encourage this link between services and researchers by also strengthening the evaluation into randomised control trial models rather than the preposed sorts of evaluation models that are currently being undertaken by government programs.

The next main point that we would like to make is about capacity building in ageing research. We feel that teaching and research about ageing continues to have a low profile in Australian universities. That's an attitude that flows on to health professionals working in this area. We think that the government needs to consider ways to encourage all the tertiary sectors to really forcefully promote working in aged care as a valuable career path in order to grow the aged care workforce. We think there was a good example of that in the dementia initiative which encouraged work and research in dementia care through a push from government. We feel that that sort of model could also be translated across into health ageing as well. As we know, the majority of Australians age without dementia and there's great improvements in health and welfare that can be gained from communicating about the latest evidence about health ageing. So we think that by encouraging an ageing initiative from the government in association with the changes associated with the Productivity Commission recommendations, that would encourage more activity and help to raise awareness in the community about ageing issues while we are changing

the structure of the aged care sector.

So ageing collaborative research centres or ageing training study centres could facilitate the growth of ageing in the tertiary sector and we think that an associated communication strategy around these changes that we're putting in place to the framework of aged care could inform the population as a whole at the same time about healthy ageing and that would then improve awareness and reduce the stigma associated with ageing issues.

MS DOW (NARI): Yes, that just gets me onto the issue which is a broader point around health promotion, just to add to that, that there is a lot of epidemiological evidence that the adoption of healthy lifestyle habits, healthy diet, regular physical activity and social engagement can delay or prevent the onset of diseases associated with ageing, diabetes, cancer and even dementia and so therefore obviate the need obviously for some people for care. I suppose I just thought as a general point it would be good to see your building-block framework actually start a little bit earlier, start with some of those health promotion activities and services.

So finally I suppose from a NARI point of view I would just like to say a little bit more about what we do and how we see that we might be able to help. We're one of the Australian Association of Gerontology collaborating research centres and the AAG does bring together a number of collaborating research centres on a regular basis to collaborate on aged care research. So what I'm saying we could do, we could do in collaboration with others. So we feel that we could help, apart from what we're already doing, which is a lot of original research and evaluative research, we could actually help the government to identify what the key research direction should be in ageing and develop a national strategy for aged care research. We could also help and we think that there should be an evaluation strategy for the changes recommended by the Productivity Commission and we could help with that.

With the data clearing house, we think that there is a need for the research context to be made available as well as statistics and feedback to the sector. So what I am imaging is going to happen there is that there will be reports back to the sector from the statistics that they feed in but there probably needs to be some context put around that so that they're more comprehensible to the people receiving them. If I have time, I would just like to make a couple of comments more generally about aged care services, if that's okay.

As you will have heard over and over again a major problem that older people and their families have is getting information about aged care and then navigating the service system. It is such a complex system and I'm sure many of us have had personal experience of that as well. The seniors gateway seems on the surface seems to be a great solution to that problem, a single point of call where people can get

information and I guess the thing that I think is needed and I'm not sure whether that is in your thinking around the seniors gateway, is some sort of navigator for older people. People come in and out of the system at different points in time and there are different people at the moment with whom they come in contact, it might be the hospital social worker or the ACAS assessor. But it seems to me there is nobody that they can go back to when they're confused or they've been given a whole lot of information but, "What do I make of that for me in my particular circumstances in my particular area with my particular needs?"

So I just think the idea of somebody who can be there on an intermittent basis, not as active as a care coordinator but more as a navigator of the system I think would be of real benefit. The other issue that I come across again in my interactions as a board member of Carers Vic but also my research is just the issues that carers face when the designated care recipient goes into care or dies because they will have been assessed for services pretty much based on the needs of the care recipient but they may be interdependent and both have needs and actually both be getting support from the package of care or whatever they're getting. So they get to a situation where the person is admitted into residential care, they then lose their financial support, their services, as well as dealing with all the issues of admission to care and they often have to start again. They lose the case manager that they're familiar with, they have to start the system again in their own right. I would just like to see some sort of mechanism where that doesn't have to happen, where the care needs can be considered more as, I guess, a family or dyad and the carer can continue to receive help without having to start the whole system again. That's it from us.

MR FITZGERALD: Thanks very much.

MS MACRI: A couple of things, if we just go back. I think the research thing is a real issue. I know of a number of people, even last year, who put in projects to the NHMRC that didn't get anywhere. Do we know how many applications there are around aged care on a - - -

MS DOW (NARI): It's very difficult to tell because people will tick the box gerontology or aged care perhaps for cancer research. Do you know what I mean? It depends how you cap it. I think someone has claimed that 30 per cent of the research is to do with ageing and it may be that that condition is more prevalent as you get older but it's not the sort of ageing research we're talking about which is more whole person research.

MS DOYLE (NARI): Obviously the NHMRC would have figures about the number of applications with "aged care" as key words but it's difficult to analyse those sorts of figures when we're sitting outside the NHMRC. We feel as though there is a case for developing a body of research outside the NHMRC. There used to

be a Research and Development Grants Advisory Committee that produced a service development and evaluation series of papers in the government that was very valuable and specifically addressed issues about aged care and the service sector, the sorts of things that didn't seem to be covered specifically by the NHMRC and without that model now there seems to be a gap as far as a stronger focus on aged care and evaluation.

MS MACRI: Just quickly on that, my other questions - your feed back on this would be good too - a lot of people doing masters by research or PhDs there is a lot of good stuff out there that just does not get published, that you just don't know about. You talk about the government or the Department of Health and Ageing putting a proportion of budget in for research projects, would you see some of that being appropriate in terms of encouraging people that have done research because it's a little bit about when you talk about translation and getting it out there. I would be really interested in - it seems to me a lot goes on but we don't know about it.

MS DOW (NARI): In our written submission we have talked about some of the mechanisms that we think that could occur for that. There are number of questions in what you say. There is the whole issue of getting all the research that has been done known about which is a huge challenge but also it's about having some sort of formal mechanism where someone has that responsibility for finding that out and then feeds it into government through some sort of formal policy advisory mechanism which I think would be really beneficial and it wouldn't just be the minister for ageing, it would be a range of different ministers because ageing is so multidimensional.

MS DOYLE (NARI): By developing stronger links between the industry and the researchers, the students who are doing the masters and PhDs and so on, then it becomes a more immediate and stronger way to get the research out straightaway. So with the Dementia Collaborative Research Centres, just for example, there is an annual forum where students and other researchers come along and talk to the industry about research that's going on, has been happening that year, and other conferences obviously like Alzheimer's Australia have similar sorts of mechanisms for students to get their work out to the industry straightaway. So if we can develop stronger links between the aged care sector and researchers, I think that sort of communication, two-way communication, can really start to flow a lot more easily.

MS MACRI: So it's a bit about harnessing too, it's not just about new research.

MS DOW (NARI): Yes, absolutely.

MS MACRI: So, to me, it seems like it's twofold: one is about initiating new research and the other part is about harnessing - - -

MS DOW (NARI): Yes, and the third part is getting other people who need to know it, whether it's service providers or government or whoever - - -

MR FITZGERALD: Can I just deal with that. One approach is to establish a new research framework, entirely now, probably for ageing and disability, because many of the issues you've raised are similar in the disability area.

MS DOW (NARI): Yes.

MR FITZGERALD: The alternative is to increase and specify funding both in the NHMRC and the research cooperatives. In other words, do we use the current mechanisms that ensure there's an allocation of funds specifically for ageing or do you think that those mechanisms are in fact not appropriate?

MS DOW (NARI): I think there would need to be some adjustment to the current mechanisms because, for example, the NH and MRC did have a panel for gerontology and geriatrics which wasn't there in 2010, so that would obviously need to be reinstated. Yes, it's a difficult question to answer. It's such a limited pie and maybe it's not going to grow, and there's lots of really good research being done in a whole range of areas. I think they probably fall within the existing structures to allocate more into ageing research.

MR FITZGERALD: I mean, it may well be that you have to put in additional funds into those, into the NHMRC and the ARC systems, and allocate those specifically. But I was just trying to get from you whether or not you think the actual mechanisms, the two approaches, could be made to work or you actually do need to go to an entirely new research framework in this area.

MS DOW (NARI): I think that there are limitations to the current model which are that it's all based on scientific merit, and where you get areas that are less well developed in terms of their scientific merit, it is actually harder for them to get funding. Where you're looking at multidisciplinary and multisystem approaches, it's actually very hard then to reduce the variables down in the way that the NH and MRC are happy with, so it would need to be probably adjusted, I think, to get the outcome that we're looking for. Do you want to comment?

MS DOYLE (NARI): Perhaps this is not a question that we can answer immediately off the top of our heads but there are other models that could be used as examples. In other countries, for example, the USA, has a National Institute on Ageing specifically for ageing research, so that's another type of model that we could go down the track of, and obviously we don't have the research funding that they do. But that in itself, by establishing a separate model that sits apart from other

biomedical and health research, if you like, says to the community that this is a very important area that we want to focus on in our research. There is very good research going on outside the NH and MRC system currently, for example, dementia research and so on. So we do already have a sort of dual system, if you like, but what we're saying is we'd like to see some formal recognition for ageing research as a very important focus.

MR FITZGERALD: The last point is just in relation to a clearing house for research currently undertaken. The AIHW in its own right but also on a contracted basis is a clearing house for research in the indigenous area, for example, and a number of other areas. Again, do you have a view about whether or not that would be an appropriate way? We're talking about a clearing house for data coming through the regulator, not necessarily research. But there are a number of clearing houses that are funded by the Commonwealth government; as I said, some are with AIHW, some are independent of that.

MS DOYLE (NARI): We've said in our written submission that we would certainly welcome the greater transparency that comes with having a clearing house. We would like to see the addition of looking at and some systematic monitoring of the reliability and validity of the data that's being collected into the clearing house and some ongoing evaluation and monitoring associated with that because we have some concerns about the quality of the data. There's no point pulling it all together if it's just garbage in garbage out, kind of thing.

MR FITZGERALD: Sure. Anything else?

MS DOW (NARI): Just on the data, there's a lot of data that's been collected by a whole range of different organisations, Medicare, DVA - - -

MR FITZGERALD: We're trying to bring that together.

MS DOW (NARI): - - - and there's still a need to pull it together.

MR FITZGERALD: The point I was trying to make is that we're certainly clear that we want to good quality data in, good quality data out.

MS DOW (NARI): Yes.

MR FITZGERALD: At the moment it goes in and doesn't come out.

MS DOW (NARI): Certainly.

MR FITZGERALD: The second thing is independent of that which is research

and evaluation and how you best handle that.

MS DOW (NARI): I guess that I was imagining that potentially the clearing house could do both those things.

MR FITZGERALD: It can. Some people have said to us that it shouldn't, but that's a matter we can have a look at as we go forward.

MS MACRI: Just the other comment on the carer, where you talked about when the care recipient either passes away or goes into aged care, the carer generally needs to renavigate the system.

MS DOW (NARI): Yes.

MS MACRI: One of the things that we have built in in the report is about the care recipient when they are assessed and there's care coordination and case management, the carer is also assessed in terms of their capacity and their ability to undertake the care of the care recipient. I guess this is one of the things we might go back and have a look at in terms of making sure that rather than the carer, when the person does die or goes into residential aged care, that they in fact don't have to renavigate the whole system but it's part of that care coordination because when the care recipient needs to go into residential aged care or passes away, the care coordination goes on until that point in time. So one would suggest and hope there would be a reconnection with the carer in terms of how they go forward, but I take your point around that, yes.

MS DOW (NARI): In addition to that, to your focus which is on their capacity and ability, it's really about their care needs in their own right.

MS MACRI: Absolutely. That was why we built into the system that the carer also had some form of assessment. Part of that ability or capacity is also around where they're at in terms of - - -

MS DOW (NARI): Yes.

MS MACRI: But it's a good point.

MR FITZGERALD: Any other comments?

MS DOW (NARI): No.

MR FITZGERALD: Thank you very much for that. That's terrific. Thank you.

MR FITZGERALD: Can we move to Elder Rights Advocacy. I should say normally we stand up, greet people, talk to them and be pleasant, but because this has got so many participants today, we're formally just sitting here. If you could give your name and the organisation and position you hold.

MS LYTTLE (ERA): My name is Mary Lyttle. I am chief executive officer of Elder Rights Advocacy.

MR FITZGERALD: Great. If you could just give us your opening comments.

MS LYTTLE (ERA): Basically I haven't made an extensive submission; it's about time frames, as with everybody, and the size of our organisation. However, there's a few key things that we as a organisation wanted to comment on around funding, the need for advocacy, which may not surprise you, and also some issues around diversity and special needs. We had a brief comment about the policy research - I don't have a problem with supporting that - and regulation. So those are the main areas. I am happy to describe who we are a little bit first if you'd like me to do that.

MR FITZGERALD: Please.

MS LYTTLE (ERA): We were established in 1990 and our original auspicing body was called the Older Persons Action Centre Inc, who received the money from the Commonwealth Department of Health and Ageing, so that's where the funding grant comes from. They auspiced us for 12 years and then in November 2002 we became incorporated separately as an organisation. Some of those people stayed on our committee with us. We then began operating as a trading name of Elder Rights Advocacy because we just don't cover residential care, we cover any of the Commonwealth funded programs, so CAPS in each program also. We're part of the National Aged Care Advocacy Program which is funded a similar way around the country by the Department of Health and Ageing, so we assist the person receiving the care service and their family member representing their interests as they go through the system, and anybody who has been assessed as eligible. So once they get into the ACAT assessment process they can become our client. Fortunately not too many of those people call us, so we hope that they deal with information from our web site or that sort of area.

Our service in Victoria - and it's similar around the country - is managed through a volunteer committee of management, many of whom are older people. Mostly they have an interest and an expertise and have policy input into aged care. One or two of them actually live in a retirement village and are daily involved with people in residential care and home care. In Victoria we've got six full-time staff to cover the state. I guess the issue about us is not whether we're a large service but that our service is fairly unique in that we are a service that focuses very much on being

beside the person - that's our aim and that's what we're obliged to do - their rights and interests as they receive the care services, so a very rights based function, and being an independent advice and information and support service in that way.

Last year we reached 5765 people with our advocacy in this state through information, education and direct support, distributed around 17,000 products, and 220-odd thousand hits on our web site. So all of those ways are ways that we use to spread support. We work on an empowerment model of advocacy, so the more we can assist people maybe to have the confidence and the information to go forward for themselves or their relative, that's an even better way to go. Basically the whole of the program, NACAP, the National Aged Care Advocacy Program, is nine services across every state and territory, and the reason I guess I'm drawing your attention to that is I think that's part of our strength that we are a network, we're all operating on similar guidelines and we have the capacity to therefore be responsive to the differences in each state and territory. Again we're all working to the same framework, protecting older people's rights and wellbeing, working towards their social inclusion and helping them to raise their voice.

Canadian health economist Evans talked a long time ago about - there's two options in the health system; one is exit and one is voice. Exit is usually not an option for most people, especially at the residential care end where it's a limited option, and so voice is really important and that's where we would see ourselves assisting people. We also would say that the program and advocates assist the government to meet their obligations under UN conventions - the rights of older people with disabilities and all of those areas. Across the country we get 2.582 million in funding. We're currently on yearly funding grants and have been for all except three of our 20-plus years of existence as programs around there, and we're dealing with around nine and a half thousand contacts a year and 37 to 38 thousand people that we speak to with education. So we do do a more proactive thing, we're not just simply there to solve problems, help people with complaints. We do a lot of education with staff and information sessions for people getting services.

My other colleagues in other states do a range of things which again we would see as part of the function that any of us could adopt. They work with people going to tribunals, they work with people getting HACC services. Here in Victoria we don't have HACC advocacy; there isn't any. We would like to do, but it doesn't happen. In most of the other states the same service that provides the Commonwealth's aged care advocacy, also provides HACC advocacy.

MS MACRI: So your service only looks after people that have been ACAT assessed. I'm familiar with the New South Wales model, TARS, which I would assume is a - - -

MS LYTTLE (ERA): They don't do HACC advocacy either but they do retirement villages.

MS MACRI: No, they do retirement villages.

MS LYTTLE (ERA): Yes.

MS MACRI: Do you do retirement villages?

MS LYTTLE (ERA): No. They get state government money for some of those things. You'll find, if my other colleagues are speaking to you in other states, they get state government money for elder abuse programs and prevention programs and various things like that - disability: Tasmania gets mental health money, all of those things. Here we're purists, if you like; only managed to attract one set of money. So certainly all of those things happened in other places. We don't have a problem with doing them. In fact Advocacy Tasmania did a pilot project with the Commonwealth government where they travelled alongside the person with dementia to be accessible to them for advice, information and support in their journey, and the person could then - a little bit like some of the stuff you appear to be envisaging in your report. The person was able to access support they needed as they went along. That's now being continually funded through the state government. The Department of Health and Ageing didn't refund it, but it was a very successful model.

We'd see advocacy very much in that way; not that everybody needs it but having access to an advocate as an independent person just focused on your rights and interests - perfectly feasible in the model that you've described is some of what we already do and could be enlarged upon. So accessibility to a service, like the National Advocacy Program is, I guess, what we would be arguing is reasonable. I think the disability advocates get 18 times more funding compared to aged care advocacy. Just as the general program as an accessible service, that's not been seen in the same way. Perhaps we've argued for our clients a little better than we have for ourselves as a program.

We think the gateway approach, to look at some of the structures you've addressed in your report, is a good one. We certainly hear a lot of comments about the confusion that people have on entry; people who ring us or looking to enter. Anecdotal comments will say there will be family members who say, "I'm quite good at what I do. I've actually got a sophisticated job and I'm pretty competent at it, and I find the aged care system complex, confusing and, you know, I don't seem to be getting anywhere even though I took a week off to do this. I've still got to figure out a bit more." So it shouldn't be as complicated as that, one would argue, and I think the gateway idea is a good way of pulling that entry point - for whatever service you getting, community or residential, is a good idea. Also separation of the regulatory

function into the AACRC from the department I think is also a necessary component of your proposed restructuring.

I think there's certainly a perceived and often at times real conflict of interest there and that's a way to pull it out and separate it. I think some of the issues around the funding and the changes to the increased - making people pay. I suppose that's the short version, isn't it? Make the users pay more. Removing the high, low care distinctions to enable the bonds - if that's what people choose to do - to travel right across the system. I'm not exactly sure how that is going to totally assist with promoting independence, wellness and consumer directed care. It might be me but in reading it I'm seeing a focus on the capacity to pay, enhancing the choice and then the freeing up of the market forces eventually as a way to ensure that. Please correct me if I'm wrong but looking at it in that sense I do not have the belief that this is a true marketplace in the way that you would describe other marketplaces. So I think that's a tension or a danger that needs to be carefully worked through. We are providing end-of-life care for vulnerable older people in the system. This isn't just staying at the Sofitel or those other choices that any of us have. It's not even staying at the retirement village. The residential end of things is very much - while there may be some choice of where you go, particularly if you're lucky and you do have some money, it's limited certainly and is premised around what your key needs are, particularly as you see the sector changing and more people staying home, going in at a later age.

This is an area with over 10 billion currently of resident loans into the system. I am told on approximate levels, if nothing changed, it would amount to approximately 22 billion by 2014. My version is the residents own the system at this point because that is more than the government is putting in but then again, I am a consumer advocate. I would argue for regulation and particularly around who becomes an aged care provider. For me it ought that ought to be about demonstrating your ability to provide sustainable, quality aged care for life to the people who come into your facility. The residential side I see is perhaps the most vulnerable people potentially - not everybody is like that but the potential for vulnerability is there. I notice there has been some talk of linking this to the notion of how the private rental accommodation market operates. I think if you're average age at entry around 85 and you have a limited choice of options around your chronic health needs, it isn't the same. It simply isn't the same kind of thing.

I don't therefore think that general market protections are sufficient because of the exit issue. That usually isn't a choice for people. I think there is a need to ensure that there is a strong consumer voice hear but also that there's a strong rights based framework that goes along with that. I don't see choice as a thing that protects consumer rights or human rights. I have fairly strong views about that which might be obvious. But I think the need for people therefore to have a secure home and be

treated with dignity to get to those options that you were talking about, those outcomes, needs this sort of framework around it.

So my concern is the eventual even removal of those supply limits, particularly in the residential care area. I'm concerned about there becoming a two-tier system of aged care and that's rather what we have in Victoria with the supported residential services and frankly you've seen the reports on some of that, the Office of the Public Advocate has a lot of issues with that. The Human Rights commissioner came back some years ago and spoke about the issues. There have been a lot of cleaning up - to their credit - with the state government around the area but it's still very much a two-tier system. I'm not sure that that's what we want to put in place. Again, we've had the experience and because I had had some interaction with them we've had the experience of the Macquarie Bank and others coming in and thinking this was a great new sector to move into and marketplace model. I sat opposite the quality manager who came down and spoke to me after some comments I had made who assured me they were in it for the long haul. That hasn't proven to be the case. So I think we need to be careful about that.

We have been involved in places that have closed down in Victoria through providers allegedly taking the money elsewhere, the facility having to close down, being unable to be sold, it wasn't worth what the bonds were in for et cetera, a whole range of problems like that and last time I think we had a perfectly lovely facility that they couldn't sell, the people had to move. There was a 94-year-old, I think, on YouTube saying, "This is my home." Didn't work, didn't stop it, but very hard to - we've seen that trauma at close hand. To stand up there as a resident advocate even and say, "I'd love to protect your rights but frankly I can't do anything except ensure you get a decent process of moving out," is pretty bad. Those residents were, although physically frail, were fairly clued up. There were 85-year-olds saying, "Can't we do a resident buy-out with the staff," et cetera. The way the financial affairs had been handled and the level of the bonds that was in there which were eventually guaranteed by the guarantee scheme meant that was not possible.

I think also the national care co-contribution for the same reasons - have to look at who has money, who doesn't have money, what their choices and their purchasing power is going to be. There is already a bit of an issue around about that. As with anything in life, you have more choices if you have more money - to a point. I have still had to argue for people having 15 minutes a day support to maintain their walking to go to a meal when they had $950,000 bond with the facility and extra service. So it doesn't always work that paying more means you will be able to have your wishes met, but we did negotiate it.

I think also there is an issue around people thinking of their home as an asset, particularly while they're still living in it. Most older Australians don't think of that

and so again that's about bringing people to this way of thinking, providing them really good advice about the kinds of options that they may have. I'm not saying it can't be done but that's going to need information, education and advice. The equity release scheme, again the same, I would say protections and safeguards are needed for that. To build consumer trust and public trust in the system it needs to meet standards of financial probity and be fully explained to people. People have had all sorts of experiences with reverse mortgages et cetera.

MR FITZGERALD: We just need some time for questions, so if you have other big points or do you want us to raise some issues?

MS LYTTLE (ERA): I would probably still have an issue about the charges being able to rise as people go through the system. Again, most of us don't expect that too much. People go in with some sort of framework about their money, their superannuation and what they have as income. Again, that needs to be monitored and carefully thought through. I had thought about the gateway agency whether, again because of all this duplication, can the electronic health record - which we hope may come one day - be linked into that and then perhaps something like a Medicare or HECS-type card system that says, "I now have access to certain things. I have a card that works to help me access it," so you get an endorsement, if you like, which then avoids some other problems.

Catering for diversity I think is important and I didn't seem to see an immense amount about dementia and dementia care and as that's a huge area and that will be the rising group of people, then I think more attention to that is going to be important. One other thing that was very important to me was the financial disclosure. You proposed changes to the prudential standards allowing on-request disclosure of compliance with the standards and letting people know about the liquidity standard and how people are going with the bonds. I don't agree with that absolutely. I think if people are obliged in other areas of commerce and business - and if this is the business part of the aged care area - then why should the onus be on the person to ask? It should be on the provider to disclose. I was there when some of that was developed. I was on the working group and that was a tension and I don't think we should give away anything in there. We have all this money in the system. The residents, as I said in my view, own the system. Why should they not be able find out how sound and how viable the system is. Thank you.

MR FITZGERALD: Thanks very much, Mary. You have covered a huge amount of area there, as you should. If I could just ask a couple of questions and make a couple of comments as well. You're absolutely right, this is an unusual market and hence you're absolutely right to stress the need for both rights and safeguards to be built into the system. We acknowledge that. Indeed, it's not a free market at all, it is a highly regulated market and under our proposals that continues because of the

equity issues and because of the safety concerns for people who need to access this service.

Can I just take this point: one of the things we have tried to do in relation to residential care is to maintain the quality standards through a new regulatory system and we have also tried to ensure that low income and disadvantaged people are well catered for through the maintenance of the quota system and increased funding so they get adequate care.

So the freeing up of the stock, your concern about that, we would have thought that's to the advantage of consumers generally, people that are ageing. Yes, they have greater choice. Some services will close, some will open, some will grow, some will change. That part of it is part of the market mechanism but I would have thought, in a sense, if we can maintain the quality controls, ensure that people only pay according to their needs, then in fact the freeing up of the stock would actually be a positive rather than a negative, even if that does mean from time to time service providers do in fact leave the system or in fact change the way they operate.

MS LYTTLE (ERA): Yes, I think the amount of how frequently that might happen or the loosening of the system to the point of non-viability would be my concern.

MR FITZGERALD: Sure.

MS LYTTLE (ERA): We've seen a lot of restructuring for other reasons, for the rebuilding of stock in Victoria. I mostly attend those meetings at night and it's not fun to explain that to people, to say, "No, it's all going to be better," and you can see on their faces they think, "But not for me, I won't be here for that." All they can see for their family member is that they have to move now. Sure, that's improved the system and overall there's been a benefit, but I've faced people who have had to move three times.

MR FITZGERALD: Yes. We appreciate - both Sue and I have been involved in this sector in various capacities - so we're acutely aware of what you're saying. On the other hand, one of the dangers is to have a system where everybody stays in the system, even the poor providers. At the moment, there's a real danger that you've got quite poor providers being supported in the system and we would think that that's not a particularly good outcome either. So you want a system that's more responsive, but you're right, that does in fact mean, at least for some people, some movement.

MS LYTTLE (ERA): Difficult.

MR FITZGERALD: It is. The second thing - and then I'll ask Sue for her

questions - is in relation to the quota for supported residents. We've made a recommendation in that that it could possibly be trainable within a particular region. In other words, some service providers might choose to provide services for a larger percentage of supported residents, others for a lesser group. Some people have said that creates the two-tiered system that you've referred to, others say that's not the case. I'm just wondering whether you have a particular view about how we should deal with this issue of the quota for supported residents in residential care.

MS LYTTLE (ERA): I think it's difficult because it can be better to say this is a slice of the community, you know, in a given area and they're scattered into three facilities or something; there are people who have a lot of money and others who don't have much. It's the community as it is. I thought there had been an amount of scooping - whatever word you want to say - in more supported residents in some areas when the quota system came in originally. I am told there was a point where you couldn't find a concessional resident, as they're called, in certain areas at one point. There are providers who will also have a mission to people who actually have no money or no assets et cetera as well and they will probably, as with people we know at Wintringham Aged Care, for instance, be providing a very specific model of care. But, yes, I think it still needs to be balanced across very carefully and you would need to look at how far apart these areas were et cetera because I think the more residential care is, broadly speaking, reflective of the community that it is in, the better.

MR FITZGERALD: Certainly there's feedback to us that the setting of the regions, if you are going to have tradeability of quotas or even setting of quotas, is absolutely critical and that's been a consistent message we've been receiving.

MS LYTTLE (ERA): That will be an issue too in country areas. There are already people who can find it difficult to access places and access concessional beds and there was certainly a period where people got sent out to what I'd call holding pens, somewhere an hour away, which appeared extremely unfair. So it needs to be especially looked at, I think, in those areas, where you're not cheek by jowl with another option.

MR FITZGERALD: Certainly.

MS MACRI: You've probably covered most of my questions, but I'd just make the comment that our understanding is, in talking with the peak industry bodies, the support of resident ratio at the moment really has no basis for where the 40 per cent came from or how it was arrived at and certainly hasn't been well defined in terms of demographics, assets, home ownership, all of those sorts of things.

MS LYTTLE (ERA): Yes, that could well be true.

MS MACRI: So one would hope in going forward looking at those sorts of ratios that they will better reflect the assets and the wealth of particular regions.

MS LYTTLE (ERA): Yes, that would be rational, wouldn't it.

MS MACRI: Yes.

MR FITZGERALD: Can I just raise one question in purely the advocacy issue. In the draft report we've indicated there should be an increase in funding for advocacy, individual advocacy. You've indicated that you are part of the national network of nine services across Australia which receives around $2.5 million, give or take, but it's about right. What's your advice to us about this area in terms of advocacy? Should advocacy funding be spread more widely? Should it be concentrated into organisations like yourself? The second thing is, how would we know what the right level of advocacy funding would be? Now, I'm not going to ask you to come up with a figure, but advocacy is as expandable as you like or as constrained as people want to make it. Just your view about this: what's the best way that the government can get value for its money going forward, if it is to increase the available funds?

MS LYTTLE (ERA): We're certainly asking them separately to increase it, so that it won't be a surprise to the existing program. I wouldn't see why at least an increase in an existing program wouldn't be reasonable. We've all been going for over 20 years; we can demonstrate good outcomes and quality information and knowledge of the system and for everybody except ourselves a broad range of services. That doesn't stop some other people at various points being funded to do that. I guess all we would say is we have a very particular focus which is around the independence - while working to guidelines that we're given, of course, as we always do - but being that independent role in the system. So I guess that's the particular kind of advocacy we promote which is often needed in a health system where other people have an interest or a view.

MS MACRI: It seems to me that it also would be worthwhile looking at - there seems to be a great variety between what the advocacy services do from state to state or territory to territory in terms of coverage. Would you see there being a preferred model in relation to those sorts of advocacy services, otherwise again they become a little bit siloed in terms of - I know for instance TARS in New South Wales gets quite involved in contracts for retirement villages and making sure that older people understand and have proper access to legal advice in terms of contracts before they sign them, so there sort of seems to me, in terms of advocacy for older people, it just doesn't begin and end once you go through an ACAT or an ACAS, as it's called in this state.

MS LYTTLE (ERA): No, that's really only the NACAP part of the program, the national aged care part of the program.

MS MACRI: Yes.

MS LYTTLE (ERA): As I said, the others take on the broader system which is what your report is doing also. I guess because we know that this program around the country is able to do some of those other things, we would say we could provide that as a group of services to be alongside the person, particularly in the health sector - debate about how much of the retirement villages issue is done - but as someone traverses the health sector while ageing to get that range of services which may be HACC or community or residential or dipping in and out of some of the hospital in the home processes, that sort of thing, that having someone alongside you possibly that you could use - it's not that everybody needs someone - but to be able to access the information provided, at the very least, or to get a bit of direct advice again in that navigating way that NARI providers were talking about. We think that's an expertise we all have and we have it across that range and I guess that ability of someone to navigate the system alongside you, coming from your perspective, is the important one that we would see.

MR FITZGERALD: We're out of time. Are there any final points?

MS LYTTLE (ERA): No, I think I've given you mine.

MR FITZGERALD: Thank you very much. I'm sure we will hear from your sister organisations around the countryside.

MS LYTTLE (ERA): Thank you very much for the opportunity.

MR FITZGERALD: Pleasure. Greg, how are you? Come and join us. Good to see you. If you can give your name and if you're part of an organisation or not.

MR MUNDY: My name is Greg Mundy and I'm not part of any organisation.

MR FITZGERALD: After many years.

MR MUNDY: After many years.

MR FITZGERALD: Over to you for some opening comments.

MR MUNDY: I want to make 10 key points, some big, some small, based on the written submission of mine which is on the web site about some of the things that will need to change in our aged care system in Australia if we are to realise the vision that is set out in the interim report which I thought was a fine document and very thorough. I think I have read nearly 400 pages. I wouldn't swear to the last 120 in detail but I have had a bit of time to look through.

I think one of the big challenges we have is to make sure that we work on the resources at our disposal if we are to go ahead and effectively turn the aged care system on its head, which not in those words at all I think is what this interim report is recommending and I think that's a fine thing. Then we need to think about what other things might we need to do in order to make that a doable task. My written submission and what I came to say today really addresses that point.

It is well known that aged care is a very diverse industry. There are, at last count, nearly 2800 outlets for residential aged care provided by about 1600 organisations. I put in my submission that there is an estimated 4000 organisations providing care at home which is an old estimate that I was involved in a few years ago and I came across a new one though just last week in a Commonwealth government department document which said 5900 organisations doing community care. If the government is telling me, it must be true. There is a lot.

I guess the point that I draw from that is that we don't start the journey towards a client-centre aged care system with a client-centre architecture. You're actually starting with a system that's structured around programs and providers and we have some distance to travel, that's why I say we have to turn it on its head to make it genuinely client centred. I think we should do that. I think we can do that but if we go into it with our eyes closed, then we will probably get stuck somewhere on that journey. There is a lot of aged care organisations that only do one thing. There are a lot of residential care organisations that only do residential care and some that only do high care. That is the opposite, if you like, of being able to offer the whole range of services to meet the individual needs of people. There are even more by number

community care organisations that only do one thing. There are lots of single-purpose NGOs - more in some states than others - that what they do, which is absolutely a fine thing, provide community transport or provide meals on wheels or to provide social support services, friendly visiting, neighbour aid, those sorts of things, all done separately. So it's organised around the stream of funds, the providing organisation, it is not actually organised around the needs of the individual.

That is why I support the notion that is in the report of the gateway. Some of my former colleagues in the provider world - I used to represent the aged care providers - have been muttering about extra layers of bureaucracy, "Why do we need that? What do those people know?" et cetera et cetera. But what I think we have to grasp is that because we have the opposite of a client-centred service delivery architecture, we need a mechanism that works out what people need and can shop for them in this plethora of organisations. So we don't start with a client-centred structure.

The second point I want to make is that the recommendation moving more to a market based system I think is a sound one. What we currently have is a bureaucratically based system that has been planned - with some care - but planned at a distance from the point of service delivery giving people more say, more choice over what services they get and how they get them I think is the right way to go but we will need to watch things as they develop. We're not used to operating in a market system. There are some characteristics of the provision of aged care that will never meet the full characteristics of a market. We just need to be wary of those and to keep an eye on things, as it were, as the market forces come into play.

For example, I think the notion of variable charges for accommodation according to its standard and according to people's relative pay is a reasonable policy basis to go with, that's how do accommodation at every other stage in people's life cycle. I don't think there is a particular in-principle reason why it should change. But we do need to be wary about cherrypicking. There is a fair bit of that goes on currently of aged care providers selecting residents on the basis of their ability to pay. People who are concerned about the development of a two-tier system ought to have a harder look at the system we have now because it has very strong elements of that in it already and I think we need to have a capacity to monitor that and take corrective action that it doesn't get out of hand. I will come back to that example in a second.

How do we ensure that everyone who needs a place in either residential community care gets a place and it's partly about setting the right financial incentives in terms of government pricing and so on and but it's also partly about checking that they're right and making sure that they're doing their work. I think we need to be

careful and I think having an independent body setting prices is a really important thing to do because it is very easy to set unintended incentives with pricing systems. I was reading something this morning that was a set of questions and answers that the aged care industry associations had put together and put on their web sites - it is a fine document. But it contains a suggestion that we ought not make care at home too attractive, we need to make sure that there is still a need for residential aged care.

At one level that is absolutely true. There does come a point in the trajectory of many older people, and that includes my parents and probably some of yours too, where residential aged care is the right option but setting financial incentive to support that is quite tricky because one of the things that wasn't in the providers questions, if you like and needs to be factored in, is that it actually costs more anyway to stay at home. One of the consequences of receiving aged care in your own home is that many of the costs are fully privatised to you, the cost of your roof, the cost of your food, the cost of all the unpaid volunteer time that comes from your family and friends. It is more expensive anyway to receive care at home and setting the bar too low and saying, "Well, the government will pay up to here and then if you still want to stay at home, be it on your own head," the point I want to make is that in most a fair bit of that cost is already on the head of those consumers. So we ought to allow a margin, if you like, rather than a direct equivalent. It shouldn't be the business of the pricing system or anything else to drive aged care business to residential care.

The third point I wanted to make - and I have summarised it here very crudely - is to say are we sure we've got the cattle to produce this new system. One of the consequences of the structure of the industry that I outlined before is that we actually don't have a deep management echelon in aged care. There are a lot of separate organisations, relatively small, they only have two or three people in key management roles in many cases and we're asking people to turn the system on its head, do things completely differently. Doing things on a day-to-day basis and getting it right and not making mistakes is a hard job. Taking that and turning it upside down and turning it into something else is a significant management challenge and we don't actually know what talent we have out there in order to do that work.

We have collected data about other parts of the aged care workforce, the nurses, the personal care workers, the community care workers, et cetera. We don't know how clever and competent the managers in the aged care system are and they've never been tested in a way like this report recommends. They have been running a steady ship, it might have been difficult, it might have been hard at the margins, but it's been the same ship for as long as I can remember.

So what this means for the future isn't that we should throw up our hands in

horror and say, "It's all too hard and we shouldn't even start to change the aged care system," because I think we should, there are some things that we need to do. If we're going to move from a service provision industry that's structured along program lines, service types to one that is built around the need of consumers with a relatively thinly stretched management cohort. What things do we need to do? I think there are things that government needs to do. They need to resource the change. I think there will be a need to monitor what happens in particular parts of Australia with the mix of services that's available to people. I mean, the price setting - on day 1, we need to make sure that the full range of care services that people might need are available, not just in general, not just Australia-wide, but in particular localities where people live. We need to be aware that there is, in my view, a sort of permanent and ongoing constraint on the ability of a market mechanism to deliver what we want in aged care.

That's partly about what people call information asymmetry - like you can't know all the array of options. Even people in the system don't know that. Certainly people like GPs don't know the array of aged care services, and aged care services don't really have that good an idea about what GPs do in some cases too. There's that level of information asymmetry. But aged care is a very sticky product - and I think you were having part of that conversation when I walked in the door. Once you're in a residential aged care service you've made a huge investment of mental energy and financial resources and so on. You can't actually go to the place next door easily. You can't just leave that service because you don't like it or it's not up to scratch and go somewhere else without paying a very high price personally for exercising that choice. I'm not saying that's either a good or a bad thing. I think it's a feature of the type of care we're talking about, but we need to recognise there will be an ongoing need to keep an eye on what it is that market forces throw up so that the incentives for that market can be adjusted should the need arise.

I might just cover a couple of things. I've already talked a bit about the need to keep an eye on what I've called cherrypicking, and that's selecting clients - be they residents or community care clients - on the basis of the pricing structure rather than the needs of those individuals. I can give you an illustration of how that can happen. You may all know that the funding system for residential aged care was changed about two years ago - it might be coming up for its third anniversary. It introduced the ACFI system. In my view the ACFI system is a much better way of measuring the need for residential aged care than the one that went before. It measures it more accurately at the expense of some arithmetic complexity. But one of the things that it did - and it was a deliberate matter of policy to do it - was to target residential aged care more towards the higher end of care. It puts more resources in at the top end of residential aged care and less at the low end of low care.

Now, that was regarded as a sensible - and it was a deliberate policy decision

by the federal government to re-target or to adjust the targeting of residential care upwards. That's not a bad thing, provided you backfill with more community care and particularly more of the higher levels of community care. But I've come across instances since then that I don't recall ever having been discussed in the policy - what do you do if you've got a married couple one of whom is high care and one of whom is low care; one of whom is therefore financially attractive to an aged care provider and one of whom is going to cost them money. Can you simply rely on the market forces in the pricing to generate what I think is the only conceivable right outcome in those circumstances, and the answer is, no, you can't. The reason I say that is because someone rang me and told me about one of these stories. I thought, yes, it's all very well having these things in principle and looking at them from an individual point of view, but all of these services intervene into existing family structures. Individuals are not atoms, they are linked in molecules, if you like. No-one actually put in any sort of mechanism, any sort of pricing mechanism, to encourage aged care providers to take a loss on one half of the couple in order to keep them together.

What that means is - I don't want to labour the point - you get people being together for 40 years until they get to aged care, and because the price is too low for one of them, "Sorry, you can't come in." Now, there's interesting questions in that, like, whose fault is that? Is it the fault of the government setting the wrong financial incentives? Is it the fault of the aged care provider being mercenary and calculating? There's no answer to either of those questions. The thing is that it makes the point that you have to be really careful how you set financial incentives that you don't prevent good outcomes and encourage bad ones accidentally.

So I do think we need to look at the mix of services on the ground. I think the government, once it has made its mind up about the review, is it needs to tell people to roadmap an industry plan so that people know what's expected of them, because people will follow those sorts of incentives. When the government decided we had too many manufacturers in Australia - I think it was the industry's commission that might have come up with that report back in the 70s - John Button got up and said, "We've got 12 car plants, we need three. You've got 10 years to sort it out," and after that the tariffs had gone. A lot of the adjustment was then done by the industry because they had been given a clear message about where they needed to go and how they needed to achieve it. I think something like that would be useful.

Aged care services have got a responsibility themselves to do lots of thinking about where they're going to go, how they're going to plan for the future and how they are going to fit into a client-centred service system as opposed to the program and service-centred one we have now.

Two final points: I think in all of this, one agenda that's certainly mentioned in the interim report and I think is particularly important - although the importance is a

little bit on the potential side - is around e-health. We need to be cognisant of the fact, I think, that even aged care broadly conceived is only a subset of the types of services that older people will need. They will need aged care, they will need to go to their GP, they will probably need to go to the pharmacist and they may be in and out of hospital. There's a whole range of services that people need and over one little subset "aged care", I think the title of the report, The Care of Older Australians, is the right title. But what things do we need to actually link all those different parts together and make sure that A knows what B is doing, and B knows what A did. I think the e-health agenda that is in the process of being developed is actually particularly, potentially useful and pertinent for the care of older people; things like the person who controlled electronic health records.

If there's one group of people in Australia that really stand to benefit from a development like that is older people have lots of things - talk to any geriatrician and they will say, "The thing about geriatric medicine is there's never one thing, there's always layers of things going on." Having a record of what different people are doing, they can all look at, that's the sort of thing we need to encourage the industry.

Finally, I think this is a fantastic opportunity. I've been involved in aged care for a long time - I think it's 19 years. I know people in the Productivity Commission have been working on it for well over a decade. I think the first report I read from the commission is 1999 - the nursing home review. I think it's high time that we did take an aged care system and improve it and build a better model for the 21st century that's built around the needs of individuals, gives people more choice at the expense of maybe some greater financial responsibility. I think that's a fair trade. I think it's a bold proposal and I think we need to work with it. Thank you.

MS MACRI: Thanks, Greg. I guess to ask you - and also make a comment around the workforce and where you talked about turning the industry on its head, and do we have the capacity, the management skills, to cope with that. I would make a comment and ask you a question: one of the things is that in terms of workforce, aged care has been deemed to be not an attractive place to work in the general health care system per se, and I just wonder what your thoughts would be around this. I agree that it's going to take enormous resources to turn an industry around, but I also wonder whether you've got some thoughts around the fact that this may attract new players into the system that weren't attracted to aged care before.

MR MUNDY: Yes, I think that's a really good point, Sue. I think opening things up to market forces will give things a pretty healthy shove. I think if you want to get the ball rolling, that's probably the way to do it and it will help. I think you're right that aged care is already a very rewarding and interesting place to work, otherwise it wouldn't have those - was there 265,000 people work there, or something like that?

MS MACRI: Yes.

MR MUNDY: It wouldn't have those. But I think the change process will attract new talent, because it will be interesting and exciting and people would see it as a worthwhile mission, if you like, in the narrow sense of the word. I mean we've done lots of research, lots of people have done research on what makes people work in aged care and they basically do it because they like it, they find it rewarding, stimulating and have supportive work environments. I mean yes, people complain about the pay but still 300,000 people still do it for lots of other reasons.

I think it will make - I think the reform process has the potential to make everyone's working life better, so the managers, the staff. But I think it also has the capacity to make the work of the administrators and regulators more interesting, more rewarding and more pleasant. It can't be fun doing what they're doing. It couldn't possibly be, you know. That's because of the way the system has been set up. If we play our cards right we could make aged care a really highly - much more highly desirable place to work than it is already. We've done research. People who work in aged care like working in aged care otherwise - they wouldn't do it for the money - and that's a good thing. So yes, I think there's definitely an upside. I'm not - I'd still emphasise the challenges, because if you don't face the challenges you won't overcome them, but there's huge opportunities, no question. The whole IT agenda is something that really people find - it brings in new people to apply their skills and insights into our business and you get some creative products out of doing that.

MR FITZGERALD: Can I go back to a couple of points you made? One is in relation to this notion that you are suggesting that some in the sector may be looking at, that is, that you have to price community care in a way that doesn't detract from going into residential care.

MR MUNDY: Yes.

MR FITZGERALD: This I don't understand. On our projections going forward we're going to increase the number of people receiving community based care from around 800,000 to three million. But we're also going to increase the number of permanent residents in residential care from something in the order of 160,000 close to 600,000. So we're talking about a growth industry in both community and residential care.

MR MUNDY: Yes.

MR FITZGERALD: I find it almost inconceivable that a person couldn't develop a business plan within this environment that is both sustainable and viable if they were

relative competent operators. So I don't quite understand what this fear, if it is that, by some providers that in fact their residential model is going to be threatened by community. So I don't think - you understand this industry better than I do but that seems to me to be an irrational fear in the long term. I'm not suggesting around transitional issues but going forward.

MR MUNDY: I personally don't think it's a fear that policy makers should entertain. I think globally it has no place. I think people need the care they need in the setting that's the most appropriate to get it. But where we're starting from is that a large proportion by number of the current providers of aged care services only do one thing, and some of them have been doing that only that one thing for 20 or 30 years, and they have been and continue to be resistant to offering other options. Like if you're a multi-functional aged care service - many of the bigger charitable groups, people I understand were in front of you this morning , it's not a problem. Already there's some residential care, some community care, they provide some housing, they're dealing with disability services, they have some HACC services. Not really a big problem for them. It's just they do more of this and less of that.

But if you've only ever done the one thing, if you've only ever provided meals on wheels, community care, or if you've only ever done residential care or residential high care, then for that particular organisation you are asking them to change their DNA and they are resistant to do it; because of - and I don't want to go too deeply into the content of the culture of aged care - because it has always been a client of the government there is a bit of a view that the government owes the industry a living, and that it shouldn't change the - I'm putting this very harshly. Probably just for clarity's sake, I don't think that's a valid assumption. It's not going to last as an assumption and I don't think it's correct in the first place. So globally I don't believe there's a problem but there is a challenge that individual providers feel that they have.

Now, my advice to them has been and would continue to be, "Well, there's two ways you can look at this: you can look at yourself as a global provider that's going to grow big and do a little bit of everything and offer people choice and meet the whole range of needs," you can go down the Myers and David Jones type route, if you like, "or you can be a niche boutique provider of one particular thing. That's probably a sustainable business model too. Don't worry about it." You know as long as you're agile enough to work out what it is you want to do, how you fit in the market, how that fits with other people in the areas that you operate in. I don't see that as an insuperable challenge. But it does require people to develop a business strategy and a business plan that they have never had to do before.

No-one has had to worry about the business that comes to you door, it comes. People are now worried about occupancy levels and residential aged care dropping from 96 per cent to 92 or down to the high 80s. If you're a hotelier, occupancy levels

that never drop below 88 per cent think, "My God, what is this?" It's not that it's impossible to do but it's a new thing that people will have to learn. That's a pretty long answer to your question.

MR FITZGERALD: No, that's fine. The second one is this issue about cherrypicking. It's come up already this morning. It will come up throughout these hearings, and we're very conscious of it. But right at the moment people are not forced to take any particular client.

MR MUNDY: No, they're not.

MR FITZGERALD: That's true in aged care as it is in many others. That's not true in all services. Some community services the government requires you to take everybody, anybody who comes, but that's not true in residential aged care. So I ask you there is your fear - well, not a fear but you've raised the issue that pricing could create that. You've used the example of a couple, one of whom the service would be willing to take because it's attractive financially and one whom they would not be. There are a couple of ways forward. One is sort of to regulate it and say you've got to take everybody. That, we wouldn't have thought was a appropriate way to go.

MR MUNDY: No.

MR FITZGERALD: No-one is suggesting that. But the second thing surely is to make sure that the assessment of needs and the financial arrangements attached to that assessment is in fact adequate. So now, theoretically you shouldn't have a situation where a person goes in that's costing the service greatly. Now, I know in reality that will happen and people develop needs and behaviours that sometimes are unpredictable. But is the issue about cherrypicking based on price or based on finance to make sure you get both the needs assessment correct and the financial correct?

MS MACRI: I mean the other cherrypicking we have talked about today is about complexity of care. I suppose that comes back to the pricing, about which is the more cost-effective person to look after.

MR MUNDY: And which is the more cost effective for your organisation give your staffing models and all those of sorts of things. I think it probably needs a combination of factors. I do think looking at family units as well as individual needs is a relevant thing for a gateways agency to do. If it's going to take an extra $20 a day to keep a couple who have been together for 40 years together for the next 10 years, I think that could be a reasonable use of public funds myself. There might also be a role for advocacy groups - I know Sheila was here before - to help make the point for people, because the problem in our current system is that people who aren't

residents have no rights. You can't make a complaint to the complaints investigation service if you're not a resident. You've got not standing under the act. So if you're the excluded partner, sorry, there's nowhere to go; well, except the media or whatever or people like Sheila.

So I think it's going to be a combination of having some flexibility to make sure that the obviously correct outcome is feasible. I think maybe that sits in the hands of the gateway agency in the first instance. I think there's a role for advocacy groups to act as an avenue to say, "Hang on a minute. This isn't right. What's happening here? Can't we do something about it?" It suggests to me, perhaps, a different sort of relationship between the administering agencies, the regulatory ones and the funding ones and service providers. There is no scope in residential aged care really for negotiated outcomes, whereas there is in lots of other human services. There's no scope under the Aged Care Act to sit down with an aged care provider and say, "Look, this isn't right. How can we make it right?" There's lots of other areas of human services where there's sufficient discretion where you can do those sorts of things. It's such a clean sort of purchaser-provider type model that if you don't set the incentives right, the wrong things will tend to happen because there's nothing else you can do.

MR FITZGERALD: There's a couple of things about that. In the new regulator, we're envisaging a new complaint handling and review process which we're welcoming participants' views on. We think we've picked up most of the themes from this review but obviously people have specific views about what we've proposed. One of the issues that we did see was a dispute resolution sort of focus within that body in order to negotiate outcomes.

MR MUNDY: Yes.

MR FITZGERALD: Is that going to aid or assist that or are you actually saying that the financial arrangements and the regulatory arrangements are so rigid that in fact in a sense, getting negotiated outcomes, the structure doesn't really facilitate that?

MS MACRI: It might not be enough on its own. To the extent that it is true - and I think it is - that there is a class of people who would have been low-care residents before the act came in, that now the subsidy does not cover - they get a zero subsidy in many cases and even with the contribution for the pension, it's less than the standing cost of having that person in an aged care facility, such that to have them there might mean you've got a loss of, let's say, $10 a day. That's a figure I've discussed with people and no-one has argued significantly about the order of magnitude. Can we have a system that require providers to lose $10 a day and we're thinking perhaps not, and can we have a system that allows providers to separate

couples that have been together for 40 years? Well, of course we can't do that. So we've got to do something to make sure that we don't set impossible financial barriers. Now, you could say a big rich organisation should be able to cover $10 a day and I'd agree with you, but can government compel them to do that? Probably not. So there might need to be a financial solution as well as a negotiated solution or a financial component might need to be part of the negotiated solution in that particular case.

MR FITZGERALD: You didn't raise an issue - therefore you may not want to comment on it, but it will probably be in your submission - have you got any views in relation to the quotas for supported residents and how that should be treated going forward? If you don't have any views, that's fine.

MR MUNDY: I think the quotas have actually been a success in public policy terms. The government decided that they wanted 40 per cent of all residents in residential aged care go be concessional residents, and how many do they have? 40 per cent. It's rare for things to come out so neatly. People will take concessional residents because if they don't have enough, then they lose money effectively. So to me, it looks like an early example of a market solution to a social problem that actually has worked reasonably smoothly. The notion in the report of trading those allocations between providers I think has got pros and cons. I come down on the pro side. I think that's a sensible idea. Forcing people to take concessional residents when they really don't want to do it I don't think is sustainable long term, and I don't think it's consistent with the sort of culture you want to build into a client-centred system. You want providers and their clients to want to be together. You don't want a class of people being forced in there.

Yes, it has elements of a two-tiered system and actually we have a two-tiered system now, it's just obscured by a whole lot of mechanisms. We have a two-tiered system in health which is pretty obviously two tiered, but we do have it aged care too, it's just we don't have the price signals to match. So I think the notion of setting a target so that you can tell whether you're doing a good job by supported residents or not; the notion of financial incentives to take them on I think is also good; the notion that you shouldn't compel everyone to do it if they really don't want to do it is also good. The most significant thing that I think may be wrong with the current system is that it is not true that there are 40 per cent of people in every planning district here in Australia who have that need. I mean, of course there aren't. There might be 40 per cent in Canberra but there aren't in Queanbeyan. That's an absurd proposition and I'm surprised that it's lasted as long as it has.

I think a quantitative target - I've sort of touched on that in the broader sense with the notion of targets. Like, what would you expect an aged care system in this region to have? Does it have it, yes or no. I think the 40 per cent, some percentage

is - - -

MS MACRI: It will change too now with the means testing of assets because currently the 40 per cent is based around only means testing of income.

MR MUNDY: It's also very sensitive to geography. I did some work on this a long time ago. We looked at the regions in Victoria and found that on indexes there was no difference between the regions; because regions were so big, every region had like a Ringwood and a Toorak in it.

MR FITZGERALD: All right. As you're aware from the report, we do believe that the aged care system will be a regional system. The question is: what's the principles behind setting those regions? Sue, have you got anything else?

MS MACRI: No.

MR FITZGERALD: Any final comments?

MR MUNDY: No, I've finished.

MR FITZGERALD: Thanks very much, Greg.

MR MUNDY: Thank you.

MR FITZGERALD: We'll now break for afternoon tea and come back at 3 o'clock. For those that are interested, we have six participants after afternoon tea. We will finish just before 6 o'clock this evening and resume at 8.30 tomorrow morning. So afternoon tea and we will come back at 3 o'clock.

MR FITZGERALD: Could you give your name and the organisation and positions you hold within that organisation for the record, that would be great.

MS LYONS (VM): Thanks, Robert. I'm Valerie Lyons. I'm CEO of Villa Maria Society.

MS RAUFER (VM): I'm Beryl Raufer. I'm chief operating officer for Villa Maria Society.

MR FITZGERALD: Okay. Over to you for an opening comment.

MS LYONS (VM): We're very pleased to have the opportunity to talk through some of the issues. We'd like to take a fairly informal approach to this afternoon across the three hours. Sorry, I wish it was three hours. Just to give you a bit of a backdrop, I myself have been in the sector now for 20-plus years and heavily involved, currently CEO for Villa Maria for three years, and previously CEO of Southern Cross Care. Beryl has also had a long and diverse experience in the aged and community sector. We're very involved through ACCV, ACSA, Catholic Health Australia, and NDS; National Disability Services.

With that backdrop, I'd just also like to give you a bit of an insight into Villa Maria. Villa Maria is an organisation that provides services from some 42 sites, principally across Victoria. We have a wide range of services across both disability, and senior services, and education. Our senior services involve residential, community, and also retirement in those structured sectors; it certainly keeps us very busy. We have 950-plus staff, we support over five thousand individuals. So we have a good insight into the challenges that are facing the community of seniors into the future.

If I could just refer to the summary of draft proposals that you've done, for simplicity, for reference purposes. Just working through that systematically: in regard to funding, the key issue up top, we'd just like to indicate that as an organisation, Villa Maria, we do support the separation of care, and living expenses and accommodation; we're strongly in support of that. Following on from that, we do support the principle of open-market concept in regard to regulatory restrictions on community care packages and residential aged care bed licences. We do believe that both of those should be opened up. We also support the removal of the restriction of packages and bear this distinction between high care and low care. We think it's important for that to be removed.

Moving on then to the regulation restrictions on residential accommodation payments, bearing in mind that we do support the distinction of the three different groupings, we again support the allowing of accommodation bonds at all levels. We

do have some questions in regard to the abolition of retention charges; we do question whether that's the appropriate approach. We do think that needs to be worked through in terms of the financial modelling implication, and obviously the conclusion factor in terms of the bond equivalent will come into play then.

In regard to the choice of periodic charge and accommodation bonds, again we support that there is the choice to do that for potential clients, but we would also raise concerns that any arrangement that is put in place does not discourage the use of accommodation bonds. The reason we say that is that accommodation bonds and the capital flows that come from that do enable significant financing for the development of residential facilities. What we would be concerned about is that availability is undermined in any way and some of the challenges around that.

If I can perhaps go through it. We are concerned that if there is too much of a push to accommodation charges then we may find that the availability of capital resourcing through appropriate bank debt financing may be limited, because we're very conscious that in a global market the availability of funds may not be what it is or has been in the past. Into the future it might be a different story. We've had a real example of that with the global financial crisis and the consequences of that; we all saw the constraints of financing. So we believe that is a real issue at a macro level that the Productivity Commission perhaps needs to gives closer scrutiny to, and we would encourage further modelling in regard to that.

I would also raise for consideration, from Villa Maria's and others' perspective, that the big question is, if in fact we move to a situation where we have recovery of capital outlays across a 20, 25-year period, organisations might be more hesitant in terms of their commitment to such investments, because of the risk issues related to it. Those risk issues are not just financial, they are also related to political risk, in that the government may change its position and, obviously, sovereign risk as a consequence of that. The other thing that we need to question is whether or not the community is prepared to pay a premium for increased costs as a consequence of long-term financial modelling, rather than short-term. I think there's been, certainly, figures floated around in the sector, from banking circles, that their me an impost of 3 per cent. I can't give you any substantiation for that, but that's certainly the figures that have been floated.

They're the principal concerns, but, again, some very good thinking behind it. We would make the point too, in regard to the basis of two-room, shared en suite as being the framework for reference for the accommodation charge, that we would question whether that's appropriate. We think that it should be based on a one-bedroom model, and that's principally around the issue of equity of access and equity of service delivery, if in fact we can sustain that as a community.

Moving over the page, in regard to co-contributions across community and residential. Again, just to advise you that Villa Maria certainly is a strong supporter of the co-contribution concept. We recognise that is going to be requirement to enable the future. We support means testing for the care services and we also support the stop loss limit concept that's been put forward. Following on that, in regard to the establishment of the different frameworks to enable this, we support the Australian Pensioner Bond scheme and also the Australian government backed equity release scheme, both of which we believe will be valuable for this exercise.

In regard to residential care for those of limited means, obviously at Villa Maria, with our background, we see this as a very critical issue and we're very concerned about this. We recommend, if in fact this is to proceed, that there's a trading of obligations, that this is trialed, that some quotas are retained and sustained to enable and ensure caring for those who might be financially disadvantaged or of special need groups. Importantly here we also make the point that when we are referencing, the subsidy for approved basic standard of residential care accommodation for support of residence should increase to reflect the average cost of providing such accommodation, I think it is again important that we have the same level of service that we provide to anybody, so we've got equity of service delivery. There is a need to ensure that we increase funding to enable that to happen.

In regard to the establishment of an independent regulatory commission to review indexation and lifetime stop loss limits and the standard basic levels for residential care accommodation, again Villa Maria is strongly in support of this approach. I think the indexation has been one of the biggest challenges for this sector across the last decade. We would be very pleased to see that independent review process effectively established. Are there any queries on any of that in regard to financing, before I move to care and support?

MR FITZGERALD: Yes, a couple. If I can just raise the issue of the bond. If supporting the ability of a consumer to choose a periodic payment or a bond, in the report we've indicated that the bond should more accurately reflect the cost of the accommodation, including, obviously, a return on capital, a return on investment. The only thing in our proposal that in any way changes the dynamics of the bond, apart from that particular issue, is the Australian Pensioner Bond scheme; in other words, you can sell your house and put all of the proceeds into the bond scheme, or you can pay a bond and put the balance into that bond scheme. In a sense I just want to understand, what do you think in our proposals shifts the balance against bonds, if anything, other than those two issues; (1) consumer choice; and (2) the establishment of the Australian Aged Pensioner Bond scheme?

MS LYONS (VM): I think the issue for clients, potentially - obviously there is a need to have the choice - but obviously at the moment one of the drivers in that

choice criteria that exist - for instance, low care or aging in place models - is the implications around their own financial arrangements and management. I think it's important that we don't lose the incentives, if you like, to enable the accommodation bond to be a real option for individuals to make. I've heard in different environments the reflections that perhaps this current system is weighted more towards the provider than it is to the individual. But we've got to bear in mind that it's really important that we ensure a sustainable financial sector so that organisations, whether they're not-for-profit or whether they're commercial, can survive into the future and get effective returns, because, if in fact that doesn't occur, then we have a situation where we have reduced access to individuals that we want to support.

MR FITZGERALD: Would it matter for you that, in the proposals we put, a reasonable percentage of consumers would continue to pay a more modest bond; the bond closer to the accommodation charges? Nobody can tell what the percentage would be, but do you have any view as to what that likely model - sorry, the model we've proposed is likely to look like in terms of consumers that will actually pay a bond and consumers that wouldn't?

MS LYONS (VM): Well, I guess we don't really know, do we, until we test the market. That's like everything, until such time as that happens you don't have a conclusive position on it. But I think there is - the way it's currently positioned I think there is - I perceive that there is a real risk that there will be a shift towards the accommodation charge as opposed to the accommodation. So I think that's certainly something to bear in mind and to look more closely at the implications of that in terms of long-term financial modelling, not just from individual providers' perspectives but also from a macro perspective in terms of the potential inflow that will come into the sector.

At the moment we've got - as you well know, we've got some $13 billion sitting in accommodation bonds in terms of value into the sector. There's obviously some key issues around that, should that reduce, in terms of managing that, from a macro and an individual organisation perspective. But more importantly - well, perhaps not more importantly, equally importantly, is the issue in terms of just exactly how do we access appropriate levels of capital into the future.

MS MACRI: Just around the implications of the retention, you mentioned that - I mean if you - - -

MS LYONS (VM): I guess that raises in my mind the issue of whether or not we're going to have effective financial returns. At the moment the retentions are included in one of our key benchmarks, which is earnings before interest, tax and depreciation, EBITDA. It's a critical component. Now, obviously if the conversion rates in terms of the alternate allows for that adequately, well, that may well be the

case. But I'm concerned that we're pulling out a core component of the finance income stream at the moment, even though it has limitations because it's time limited, which may have some risk issues around the financial long-term modelling for organisations. So I think that that is again something that needs closer scrutiny in terms of financial modelling.

So to move on then into care and support. Again, Villa Maria supports the establishment of the gateway agency and the concept of an entitlement system. We do have concerns in regard to regional access, the issue of access for those that might be in regional areas through this process. We do have concerns for those with specialist needs, and obviously with our particular focus on those with disabilities that's a primary issue of concern, but I'm sure that that can be catered for.

In regard to care continuity and consumer choice and end of life care, Villa Maria supports consumer choice of provider and a single system, if integrated. We certainly support the need for greater funds for end of life, because that is, of course, a key issue within senior services. Something that we'd perhaps like to talk briefly about is the day therapy centre and the capacity of these centres, perhaps, to provide a greater focus into the future with preventative, wellbeing and health prevention and educational aspects to be more considered than perhaps they might be in the current proposed model. So that's something that we would put to you for consideration.

Moving through to catering for diversity. Again, obviously, Villa Maria again, given the nature of our organisation, being a very diverse organisation but also with a principal focus on those with disability and those with some financial needs, we certainly support the recommendations that are going in there. We do question whether there has been enough focus around the issues of special need groups such as the younger carers and the homelessness and the disabled and those with mental health - and we talk to that more in our submission.

Moving on, the housing of older Australians. Again, in principle, we support all of the reforms that have been proposed in the summary document, and we would draw particular attention to the building design standards and request that they do get a particular focus. We actually believe that this is - if in fact this is effectively integrated into housing design in the community as well as in residential facilities then this has - in part will be part of the solution to the housing needs shortage that we currently have for senior Australians.

In regard to the regulation of retirement specific living options. Whilst in principle we support the exclusion of retirement living, Villa Maria believes that there is a risk with the revised prudential arrangements in regard to residential care that may impact things in respect to retirement for the future. So whilst today we are

talking about a $13 billion sector that we're looking to protect with new prudential arrangements coming into play, there is a risk that another decade on that there may be a need to reconsider the implications of retirement living in a similar vein.

We certainly support the establishment of nationally consistent retirement legislation across Australia. Moving to the workforce issues, again, keeping it fairly high level, we certainly principally support all of the proposed reforms, in principle, and certainly have significant experience in that regard. Villa Maria is very aware of the need to find our own solutions. I guess that's reflected in our awards for the last two years. We have been awarded fair and flexible employer for two years running, with also equal opportunity employer for women, one of 98 organisations this year. So it's really great achievements which reflects our commitment and dedication to the workforce. Having said that, I think that at a much higher level I do believe that the government has a principal responsibility in regard to workforce as well, and this is something that differs to the position that has been put by the PC.

I would make the argument on behalf of Villa Maria that there needs to be greater consideration to increased immigration into Australia. I think there's a real need for increased workforce. The aged care sector is not going to be able to deal with this issue alone. We all know the demographics and the ageing of our society. So that is something that I would strongly recommend for consideration or greater consideration.

In terms of the regulatory institutions, Villa Maria supports the separation of regulation activities from the policy function body of DoHA, as is outlined, so the separation of responsibilities is well supported.

In regard to the issue of complaints, we propose that there be independence from the AACRC in regard to that aspect, but do appreciate that the arm's-length appeals process as put forward through AAT will be positive. So they're really the key issues that we wanted to put on the table for discussion very succinctly.

MR FITZGERALD: That's fine. That's a very thorough going through of our recommendations. Thank you. Sue? Whilst Sue is looking - - -

MS MACRI: Yes, sorry, I did have something.

MR FITZGERALD: If you could just go back on day therapy.

MS MACRI: Yes.

MS LYONS (VM): I might ask Beryl to talk a bit about the day therapy.

MR FITZGERALD: What are you precisely saying we should do? I mean one of the issues is that we didn't - we acknowledge that we haven't done enough in this area in the draft. The question is what do we say, is it an entitlement to a service and that's all we say about it? What do you think we should be saying about day therapy?

MS RAUFER (VM): From our perspective I think what needs to happen is for the government to make a bigger commitment to the day therapy centres to provide that equity in access, because it's a preventative and rehabilitation service that currently is available to people who on a user-pay system can't afford some of that sort of treatment. But it's quite limited, because it's not of great - they're not funded to a large extent, so the number of people who can access them is actually quite small. Our argument is that day therapy centres are a fantastic way of keeping people still active, still well in the community. It's a cheap way of providing that sort of equity of access through the gateway. So we'd like to see them linked but to be beefed up, really.

MR FITZGERALD: Are you saying that - as you know with the gateway, the person ends up walking out with an entitlement to services and there's a price attached to each of those services. Is that the way you think you should deal with day therapy or does day therapy for some reason have a characteristic that would require it to be funded through direct allocation or block funding?

MS RAUFER (VM): Well, it's currently funded through some type of block funding and we think that to provide the greatest access that's the way to go, but it needs to be greater than it is, because they have been on hold for a number of years. It started off as a fantastic innovation and has helped a lot of people but they've not actually been grown and developed, which could happen, and that's where we believe a greater amount of block funding would help.

MS LYONS (VM): So it's a combination of both.

MS MACRI: Just interested around the issues you raised around catering for diversity and just to say that in terms of the homeless, we'd be interested in your thoughts around both community care and residential aged care. First of all, the funding, the appropriateness of funding, is ACFI reflecting the needs of that particular cohort and again in the community, just some thoughts around homeless - - -

MS LYONS (VM): It's quite a challenging area, and again I'll get Beryl to supplement this, but it's quite a challenging area, the homeless, particularly in the community sector, and we do support a number in those environments. The restrictions that we have there in terms of financial are significant because their

needs are greater. They typically don't have the accommodation issue obviously addressed to the extent that it needs to be and in some instances they don't actually want to have it addressed and so you need to be able to still support those people in the broader community. We have some very specific examples of that, don't we, Beryl, so you might like to add to that, Beryl.

MS RAUFER (VM): One of the things I think that the report does not really explore a lot of is the issue of case management and its importance in ongoing care. In a community setting, the homeless and people with complex needs who want to stay in the community, the case management is really an essential part of that process. With the homeless, that makes up quite a large part of the care that they need, but it's actually one of the more expensive parts of the care that they need. So it comes down to that issue of equity again, equity of access. The homeless really find it very hard to access services and the case management is crucial to that. So I would argue that it's not going to be one - a unit price process is not necessarily going to fit the needs of those who have those sorts of very complex needs.

MS MACRI: Are you going to flesh that out in your submission?

MS RAUFER (VM): Yes.

MR FITZGERALD: One of the approaches is to say that you have specialist providers of aged care for homeless people, but on the other hand, we've also got clusters of and individuals who are homeless entering mainstream services. So what we're trying to look at is how do you deal with the issues of additional need for homeless people or people with high levels of mental health conditions that are often associated? Is it through specialist service provision and you block fund that, or is it through the ACFI or is it through some other approach? So any comments you have - and I'm sure there's no one answer - but at the moment we are seeking, particularly from providers like yourself, some sort of guidance about how to deal with issues around people with homelessness or experiencing homelessness.

MS LYONS (VM): We'll certainly give some further thought to the process going forward. But there's no doubt about it, whether it's directed to a specific provider or whether it comes to a generalist provider, if you like, I think we actually need a mix of both, I would suggest.

MR FITZGERALD: Sure.

MS LYONS (VM): That's the solution. Both provide very good services and both are able to target different segments of the market, but still always reaching a greater number of people. But the underlying issue is: is there adequate funding? So whether it's through the ACFI or whether it's through block funding, so long as

sufficient funds come through.

MS RAUFER (VM): I'd actually add I think that mix, I would also support that, a mix of specialist providers and individuals because you have concentrations of the homeless in large urban settings but in rural settings and remote, we still have homeless people, and a specialist provider is not necessarily going to be able to access and support those people.

MR FITZGERALD: Yes. I think you're absolutely right. What we're trying to work out is, without being prescriptive about this, what is the right mix of approaches that you will need and what is the mix of financing instruments that you would need based on those models? Any guidance you could give us on that would be terrific. Sue, have you got any other comments?

MS MACRI: No, I don't think so.

MR FITZGERALD: Look, thank you very much for that. That's terrific.

MS LYONS (VM): Our pleasure. We did want to compliment you on a comprehensive report because for all that we think there are some challenges associated with it, I think the issues that you've picked up on have been very complementary. Thank you.

MR FITZGERALD: Thank you very much. That's terrific.

MR FITZGERALD: I think you know the drill by now. If you could just give your name and any organisation you represent or if you're appearing in your own capacity.

MS YOUNG: My name is Cheryl Young. I'm a director of nursing at an aged care facility in the south-eastern suburbs. I actually am representing myself.

MR FITZGERALD: All right. Just your opening comments and thoughts and then we'll have a discussion.

MS YOUNG: Right. I mainly want to address the workforce that we have in aged care at this present moment. I'm extremely concerned about the fact that the PC did not address ratios in any way, other than to say that they could be looked at by the accreditation process. That process hasn't worked up until now, so I don't see why it will in the future, so I do have issues there. I have issues with the training of our workforce that we have at the present moment in aged care.

I've been working in aged care for 22 years and I don't think we have progressed very far in lots of areas as far as the workforce is concerned. I think we have gone a long way in setting standards under accreditation and improving patient care or resident care but I don't think that we've actually addressed the whole workforce issue as well as we could.

I specifically don't think the accreditation process is the way to actually look at workforce issues. I feel that they still rely very heavily on what residents say, what staff say, and a cursory look at paperwork when they come in. As far as rosters and things are concerned, it's possible for aged care facilities to put on extra staff for the period of accreditation, prior to or whatever. It doesn't necessarily mean it's there all the time, and that I think can be observed quite easily by the things that they should be measuring, like weight loss, pressure areas. The incidence of those kinds of things will show you whether there's enough staff or not and whether they are trained well enough. So I guess that's probably one of my really big points that I really want to make.

I think there's a complete separation of accreditation, ACFI funding and what really is required on each facility for the kind of acuity of the residents that they have in that facility. I don't think there's a lot of marrying up between the two. The ACFI I know is under review at the present moment and I think that may address some of the issues as far as funding is concerned. I'm hopeful, but I'm not overly hopeful.

Accreditation seems to be a process of looking at paperwork only and not looking at the resident and the actual resident outcome as far as actual physical outcomes for that particular resident. The ACFI - you can have a high-care resident

who you would presume would need lots and lots of care and when you actually look at that resident, they don't need as much care as somebody else who is actually low care, but may have behaviour problems. Behaviour problems are not weighted very heavily at all under ACFI and so therefore you're not getting very much money at all, up to $12 a day for a really high-care behaviour problem and I think that is letting the whole system down because you actually spend all of your time with those residents and the others who are actually bringing in the money are the ones that you're actually not caring for as well. That's just an observational thing which I've seen both in our own facility and in other facilities as well that I have worked in.

The ACFI was originally designed to actually fund residents as well as they could by assessed needs but then when you have the assessment done on, say, behaviours, and the weighting is so low, then it's just making a mockery of the whole thing because behaviour is what's going to compound everything you do for that person in a whole day, it's going to impact how they're showered, how they're toileted, how they're fed and it's just not there. The funding isn't there for those kinds of problems. So that was one point that I just wanted to make.

Then I want to actually go onto the skill mix that we had in our facilities. At the facility I am at we don't actually have any problems with retention of RN div 1s at the moment but there are other aged care facilities who are really struggling to get RNs and yet we desperately need them still within aged care and there seems to be this downgrading of our whole care system which just means we can rely on PCAs and division 2 or enrolled nurses. There seems to be a lack of understanding of the acuity of the residents that we now have in aged care. They really do require quite highly-skilled nursing or at least the supervision of a highly skilled nurse and at the moment that is really quite impossible when you have things like ratios of one registered nurse to, say, 60 residents during a day shift. It is just impossible to look after 60 people and to see how they all are and you're relying on your enrolled nurses and your PCAs to actually give you feedback and I don't think they are really qualified to be able to do that.

I have seen many instances where enrolled nurses and PCAs have totally ignored quite serious symptoms in somebody because they simply do not know what those symptoms relate to and when the RN finally gets to see them, it's either too late or it's a well-established infection or a pressure sore or something is already well established. It's not the fault of the enrolled nurse or the PCA, it is the fault of the system which is not giving us any kind of guidance as to how many registered nurses should be in any one facility at any time.

There is no career path for registered nurses in aged care. It seems to be very - you know, you're there and it's what the older nurses are supposed to do is aged care. There is no encouragement for younger RNs to actually do their graduation year and

come out and to become aged care nurses who have a skill which is considered by the community as an important skill and I think that leads to just another point that within the media, within all of the community aged care nurses are still seen as bottom of the rung. We're not supposed to be seen to be skilled, it's just where you go when you're older and you can't cope with the acute system any more. I think that is really sad. For the residents that we're caring for I think we should have skilled nurses who are able to say, "This is what I want to do with my life. I want to look after the elderly. I want to be rewarded for looking after the elderly at the same rate as those who are in hospitals and acute care."

At the moment we have a 20 per cent wage difference for registered nurses who are in acute care and yet we actually have more responsibility for more residents in aged care than they do in the acute system. They may be looking after four, we're looking after up to 60, maybe more. You may not be doing all of the hands-on care but you actually still have the accountability for the care for those residents and I think that is what is scaring many, many registered nurses from actually going into aged care. It is that responsibility that you have, that you are supervising so many people who are doing the personal care. I have a son who is a registered nurse and he would love to go into aged care but he says, "I am not going to go where I have the responsibility of so many people. As a fairly new registered nurse," he said, "It is just ridiculous that you're expected to watch all of the personal carers, you're supposed to be responsible for managing medication, you're supposed to know what is going on with all of those residents that you're looking after and those residents you know are suffering because you simply cannot get to them on time."

If you're trying to do analgesia, PRN analgesia especially if they are in pain, you can't get to them because there may be half a dozen others who are also waiting. To actually get to them all at once is extremely difficult - well, it's impossible - and so somebody has to wait and so somebody is waiting in pain. I just object to that. I think the care that we give our elderly is the reflection of the kind of society we are and we should be actually giving them the best care rather than the worst care or less care than what they get in acute.

I also think there should be a ratio. The PC has looked at this and said, "Yes, there should be ratio," but actually hasn't said what kind of ratio or what it would be based on and they are basically leaving it once again to the accreditation process. I don't think the accreditation process is able to do that. I think it still has to be laid down somewhere along the line the kind of ratio for the kinds of residents you do have in the facility. At the moment it seems to be that it's a way of getting more value for money, I suppose, in getting hours worked if you have more PCAs who cost less than if you have enrolled nurses or registered nurses. So you do get more hours but those hours that you are getting are actually of a lesser quality and that is not by any means putting down personal care workers. I have the greatest admiration

for them because they work very, very hard in very difficult circumstances for very little money.

I also think that the whole recruitment process of personal carers is flawed. When you know that Centrelink will tell people that there are two choices if you want jobs and it's hairdressing or aged care. Hairdressing takes 12 months to learn and do a course and aged you can be out in five weeks nursing frail, vulnerable, elderly residents and you actually have done three weeks in theory and two weeks in a work placement scenario, it could be any facility, it doesn't necessarily mean it's a good facility. You may have been supernumerary, you may have been shown a lot of bad habits in that two weeks and then that is then perpetrated right through the whole of the industry. I think that is of great concern that anyone can be trained in five weeks to look after the frail and elderly and it's not just, "Yes, you wash them and get them up." It is actually being able to know the signs and symptoms of various ailments and illnesses and problems that could be occurring. So I think we are doing both the PCAs and the residents a real disservice.

I have seen PCAs that I have worked with and I have seen one who was well trained by an organisation supposedly - you know, she did an eight-week course. I then actually had her on as a supernumerary for quite a few weeks because I wanted to make sure she was up to speed and up to scratch. Then I walked past one evening as she was feeding a resident and she was feeding him and she kept shovelling food into his mouth as he went blue and he was about to die as I walked past. She had no knowledge that what she was doing was wrong. She was feeding, just keep on pushing it in as this poor gentleman went bluer and bluer. I think that is probably fairly - probably not too common hopefully but it was a reflection on the kind of training that she had had and I then had a choice, do I terminate her, do I actually put effort in this person to make sure I educate properly and that is what I did. I chose to keep on educating her and to get her much more trained than she was rather than send her out on the street because if I had sent her out she would have gone to the next aged care facility down the street and go a job just like that and still would not be any better than she already was and that would mean that other residents were then put at risk.

This is the choice you have at the time because there is no regulation of the personal care workers. As well as not being trained particularly well, there is no regulation, there is no scope of practice, there is no level of education which they have to come up to so, therefore, anything really goes and its extremely sad. Many of them don't speak English well. There should be an English component to their training so that they can speak to the residents. I mean, I'm in an ethnic-specific facility, so as well as English they have another language as well to deal with. They need to be able to write and document what they do. It is a legal requirement that what they have done they should be documenting, therefore, they should be able to

do it in reasonable English which is understandable to other people and at the moment, some of them, it is extremely difficult to know what they're even talking about.

I have a pile of resumes of people who are new immigrants who are non-English speaking in my office and all of those resumes actually are identical. They've obviously been written by other people for them. They have minders who bring them in, even for their interviewer - try to tell me I have to put them on and their English is obviously not even - they're not even able to write a resume, because they're getting other people to do it for them. They are the people that we are trying to say should be looking after our elderly and I think that is just - it's just not fair to everybody. I, as an ageing person, would not like to think that in the future I will be totally dependent for everything - if I should happen to end up in an aged care facility - on somebody of that ilk. I want to know that the people who are looking after me or for my mother have good qualifications. So yes, I feel very strongly about that.

MR FITZGERALD: Okay. We might need to ask some questions - - -

MS YOUNG: Yes, certainly.

MR FITZGERALD: Sue?

MS MACRI: I just want to make a comment first around - I mean you've put a lot in there - - -

MS YOUNG: Yes, sorry.

MS MACRI: - - - and it has come from the heart and I understand that. I guess just to clarify when you say that the PC has not gone into specifying ratios, I would suggest it would be very remiss of us to be specifying particular ratios because that's not within our area of expertise, nor would we start to dictate around skills and skill mix and the number of staff. I mean the approach of the commission is around talking about quality care, adequate workforce with the proper skills, education and qualifications. It is then for the nursing fraternity and profession to start to have a look at what are minimal staffing hours, what ratios should exist, what skills.

Now, certainly the ANF in its presentation this morning is coming back to the Productivity Commission with some thoughts around those sorts of issues. Obviously from the Productivity Commission's point of view that's where we look to, is to the experts and the profession in terms of what they think should be occurring in relation to making sure that people receive adequate care by the right number of staff with the right skills and expertise. So we hear you, we hear that, and we'll certainly

take those sorts of issues into consideration. So I think it's important around that and yes, those issues are being raised.

The other one I want to just talk about because it's aligned with that, and we have had - and it's around the preparedness of your Cert IIIs, your Cert IV aged care workers and the education. I think it's in the report, if I remember correctly. We talk around people that have been through TAFE courses, who have done their Cert IIIs, Cert IVs, come out incredibly well prepared and are an asset to the workforce. There have been criticisms of some RTOs and some of these courses that are manufacturing people through with inadequate skills and inadequate expertise. Again, that will be picked up in the report, so that those two particular issues are issues that we're really aware of. I guess it comes back to starting to have a look at what are - and we'd love some further feedback on what is the appropriate length of time in terms of education in relation to a Certificate III, a certificate aged or care worker, and then what sort of orientation, mentoring and how you bring through the system. So I think all of the issues that you have raised around that are incredibly important and certainly were reflected in that workforce chapter.

MS YOUNG: I actually am aware of a scheme which they had in Germany and had for many, many years where they actually have a two-year trained nurse who is just an aged care nurse, the Altenpfleger, and that is what she is. She doesn't ever work anywhere else, so they therefore have this career path within their own thing. They know that that's what they will become, that's what they will work in for the rest of their time. So there's no sort of dragging off to then an acute sector because of better wages or anything like that. That is a career path that they choose when they leave school, that's what they want to become. I think that is - and there's probably other - some of the other European countries, I think, do much the same. I think that is probably worthy of looking at, so that it's not even an enrolled nurse or a PC or a - it's an actual aged care nurse who is skilled in looking after the elderly.

MR FITZGERALD: Just in relation to the first point, the ratios and the accreditation scheme, your issue is firstly, that you don't think the accreditation system works well enough to be able to actually assess the outcomes for clients, and yet on the other hand it's almost impossible to come up with an accreditation model where they actual assess individuals. I mean all accreditation is paper based or process based. So do you actually believe the accreditation system can be improved in and of itself? The second issue is about the ratios, but putting that aside do you actually think that the accreditation system itself can be sufficiently improved?

MS YOUNG: Yes, I do. I do believe that it could be improved, but it has to get its focus off the paper-based systems and the risk management to the Nth degree on so many small issues and start actually looking at the residents, their care, their needs and whether they're happy. You can tell when you walk into a facility whether the

residents are happy, and that's what they should be looking at, not whether I've got thumbtacks on my pin boards, which was what I got picked up on last time. You know, I hadn't risk managed my thumbtacks.

MR FITZGERALD: Sure.

MS YOUNG: Now, that is just absolutely ridiculous, when I can then show that I have got below 5 per cent pressure sores at any stage of any year any time, and I know that that is good. But that's not what they were interested in. They were interested in thumbtacks, because a resident might swallow them. However, in all the time I've known - not one resident has ever swallowed a thumbtack. So I think that is my issue, is that they look so much at the small stuff and do not see the bigger picture.

MS MACRI: So how do we change that? I mean we've had outcome standards.

MS YOUNG: Yes.

MS MACRI: We've got accreditation. Accreditation is under review at the moment as, you know, the standards and the process.

MS YOUNG: I think their process has to be different. I think they have to be coming in as a support mechanism rather than one that's out to get you all the time. It seems to be that no matter how many times it's said that that's what they're there for, is to support you, when they finally come it's not like that. They can be as friendly as they like, they're still looking at your paper-based systems and if this bit of paper doesn't match that bit of paper, you're in trouble, and really in trouble.

MS MACRI: Yes.

MS YOUNG: The most important thing is the resident and whether they are being looked after well or not.

MR FITZGERALD: All right. Thank you very much for those comments. They're very helpful, thank you. That was terrific.

MS YOUNG: Thank you.

MR FITZGERALD: If we could have the next participant, which is Connect Care.

MR OSTROWSKI (CC): Thank you very much.

MR FITZGERALD: If you could give your name and the organisation and the position you hold within that organisation?

MR OSTROWSKI (CC): Certainly, it's Care Connect. My name is Paul Ostrowski. I am the chief executive officer. Just by way of background on the organisation, Care Connect has been operating for about 17 years now. We support nearly 5000 clients broken across aged care and disability spaces, and some peripheral areas as well, through 15 offices and about 350 employees, Victoria, New South Wales and Queensland. As an organisation we operate on what's known as a brokerage model, leveraging case management and care coordination techniques to basically understand what a client's needs are, the challenges their facing, to build a services support plan to allow them to remain independent in the community and then to broker out those supports to organisations that meet with that particular client.

In terms of our response to the draft report, I am going to keep the comments to the community care base and what we're going to do is talk by exception, so we really only have five or six points; everything else, take it that we support. Just by way of me personally too, I've been with the organisation for just under 12 months and my background is in home care. It's mostly outside of Australia and a very specific area which was respiratory home care. So the last 12 months have been a bit of a window for me too on how aged care operates in Australia.

MR FITZGERALD: Could I ask one question: is Connect Care a not-for-profit or a private organisation?

MR OSTROWSKI (CC): We are a not-for-profit organisation.

MR FITZGERALD: Thanks.

MR OSTROWSKI (CC): So the first point is that Care Connect supports strongly the market model which is envisaged in the draft report. We believe that the notion of client choice and client-centred funding is going to maximise the efficiency in the aged care system.

The second point relates specifically to the proposed aged care gateways. We do support also the recommended individually set funding, funding to the individual set, based on their needs. I believe that the manner in which that will succeed will depend very, very heavily on how rapid and how successful the assessment component of the gateway system actually operates. Looking at today's system, as we know, care packages are allocated on demographic data rather than pure market demand and so the proposal will address that. We also know that the gap in funding between what is known as a CACPs package and EACH or EACHD is wide, so the

proposal can certainly address that.

Finally, the packages today, as we all know, all cater to organisations rather than to individuals and we are impressed by the number of public submissions from members of the general community that expressed their dismay at the fact that community care organisations seem to retain an unacceptable portion of their individuals' care package in what might be considered profit or surplus funds or pooled funds. Effectively what we're seeing is one person's support package being used to subsidised another individual. I cannot comment how widespread or consistent that is within the system - certainly I can talk about our own organisation.

What I might say is that cross-subsidisation certainly does occur. It actually creates a unique safety net in the system that many people are unaware of until they actually avail themselves of it. It will happen without the individual necessarily knowing that it's actually happening. I would commission the proposed system. Each individual is going to be assessed; their funding will be allocated based on their needs. So that funding is going to be attached to the individual and not the organisation any longer, so that means the individual will get the funds, not the service provider, and the individual will only have exactly the funds associated with their needs, not a cent more and not a cent less.

Now, I agree that that is indeed the ideal situation but it presumes the gateways will operate ideally as well. Gateways, as I understand it from the report, are essentially planned structures, so it's vital that they're going to have the resources to assess seniors at short notice. Old age is not a static process. It's punctuated by acute episodes. It means the person's health will deteriorate, improve, deteriorate, improve, and the care supports need to be adjusted quite rapidly to ensure that person maintains the best possible state of health.

So what we'd like to do is just illustrate a situation we see today using a case study and how we think it may sort of unroll based on the gateway system. The characters in the case study are fictitious but they represent a classical character that an individual at our organisation might deal with. This is a case study of George and Molly. George is a senior who lives at home in Melbourne's eastern suburbs with his partner Molly. Although they live in an upper middle-class area, they are of nonetheless modest means and they purchased their home back in the 60s. George and Molly have two wonderful children, both of whom have grown up and they are setting their own lives. Their daughter has a high-demand career in finance and is ostensibly of wealthy means, but she also has a mortgage to match and she's living in another state. Their son is building a life for himself in a trade with his family but given issues of affordability of housing in Melbourne, he's living in the outer west. So George and Molly's children love their parents dearly but because of mortgage and family pressures, combined with the distance from their parents, they very rarely

see each other.

So let's look at how things might go for George under the current aged care system. George has needs as a senior. He's assessed. He is awarded the equivalent of a CACPs package. Under the current system, the package is going to be placed in a provider's hands rather than in George's hands. That will get him about four hours of direct care support a week. Under the new system, George might be assessed, he will be assessed and have an identical result and he might get the equivalent funding, but through support of the gateway, he may obtain perhaps four or five hours' support per week.

Now, unfortunately one day George suffers a fall at home as many people in their senior years do. He is admitted to hospital and he spends about 10 days recovering. The hospital, like all hospitals, is under pressure and they seek to move George back home. He seems to be doing well. They put him back home as quickly as they possibly can. Unfortunately George is not quite back to normal when he's returned home, so he spends much of his time in his lounge room, just sitting. He is unable to complete even the most basic household tasks. Becoming sedentary now, George actually deteriorates over the coming weeks. Molly, his wife, becomes quite concerned and says, "Something needs to be done."

Now, under the current system, the way in which this scenario is unfolding is the case manager with George's current provider who has come through the CACPs package agrees entirely with Molly's assessment and recommends a significant increase in George's services to support his rehabilitation back to the way George used to be. The specialist services comprise an additional five hours per week. However, there is no funding left in the current package, he's reached the limit of his CACPs. So they organise for George to be reassessed for an EACH package.

The current wait time with George's ACAS is 10 weeks. With negotiation - the case manager has a strong relationship with the ACAS team - he's able to reduce George's wait time to about eight weeks. It's clear to the case manager, however, that George should not be allowed to deteriorate, even for eight weeks. So she organises a case conference back in her office. Her team manager quickly recognises George amongst all the clients that that team is dealing with as a clear priority. So they organise immediately an additional three hours of rehab support from what the provider currently has as pooled funds, so there is a degree of cross-subsidisation here addressing George's immediate needs. But George is actually getting much more support than what was envisaged in his CACPs package and the action has been virtually immediate. Eventually George is reassessed and he qualifies for his EACH, but the problem is there are no EACHs available at that time, so he has to go for another three months before he gets additional funding. Fortunately, the provider has enough pooled funds to get George through those additional weeks and the three

months.

Let's take a look at how the scenario might have unfolded if we go to the proposed gateway system. I return to the time when George has come home from his first hospital, say, and Molly is seeing George's decline and knows something has to be done, so she contacts her gateway. Unfortunately the gateway's resources are also centrally planned. They don't actually respond to the peaks and troughs in demand. George still is on a 10-week wait for his reassessment. But because funds are now individually attached, the providers have no longer any pooled funds to respond to George's needs immediately, so Molly begs her provider for support. There's nothing the case manager can do, even though the case manager recognises George needs support immediately. George remains immobile for a further five weeks and unfortunately, being immobile, he suffers a minor stroke. He's admitted to hospital where he remains for a further three weeks but of course then is able to get immediate assessment and he's discharged back home and he gets the additional funding.

Now, having had a stroke, George's health is absolutely not the same as it was before. A few weeks later, he deteriorates further and Molly calls the gateway for another reassessment. Now, things have improved. The gateway assessment wait time is now only five weeks. So Molly asks the providers for more help in the interim, but without full funds, there's nothing the provider can do.

So at the end of the case study, just highlighting, today the ACASs are also centrally planned assessment functions and we have a very high level of respect for the work the ACASs do, and I will tell you there are certainly some of them who will provide an assessment for an emergency case absolutely instantaneously. There are others that we know are up to 10 and 12 weeks. It's critical therefore that an assessment service under the proposed gateway model is going to need to be over-resourced so that seniors are never left to deteriorate while they are waiting for a much-needed assessment. The importance of the point is going to be amplified by the fact that under the new system, providers no longer have access to pooled funds to plug any gaps in wait times.

The third point we wanted to raise is despite my aforementioned comments, we actually support strongly the idea of an aged care gateway for information and assessment components, provided it's resourced appropriately. We have concerns, however, with care coordination being within the gateway and believe that should remain independent which will preserve the market principles which are inherent in the draft report. There's no doubt that the current aged care system is complex and so a single point of information for seniors to go to is absolutely the right way to go.

Further, it's highlighted in the draft report that assessments need to be

consistent for social equity reasons, so again provided those assessments are appropriately resourced, it's logical for them to remain within a gateway-style structure. The report also envisages that the gateway will be providing initial care coordination services and I think our concern is that we should not underestimate what the actual demand is going to be for care coordination in the aged care system. Although there is very strong support for self-directed funding, it's actually difficult to estimate how many seniors, if they were truly given the choice, would choose to hold all their own funds, and find and manage all of their own services.

I make the point that during the initial phase of submissions to the commission there were a number of compelling submissions from seniors, their families or carers who were again quite dissatisfied with providers holding funds and specifically requested they be able to hold and direct their own packages. I suppose the question that we have is, of those submissions that have come to the commission, do they represent the majority or did they represent some very active individuals. The responses support that we don't know the answer to the question. The problem is that people who want to self-direct and engage with the system are likely to be the kind of people who are motivated to make a submission to the commission. However, those that might be seeking a less complex retirement might prefer to have someone coordinate the services on their behalf. Logically, those same individuals are less likely to advocate strongly to the commission, the system remain as it does today rather than change.

Unfortunately a provider who advocates to hold funds on behalf of an individual is almost certainly going to be seen as self-serving rather than acting in an individual's interests. So we believe that the only way to resolve the question, of course, is to give people a choice as to whether they have care coordination provided by a gateway and hold the funds themselves, or they go outside to have a third party hold funds on their behalf. I will say that there is now a growing body of evidence, and research that has come about during the time the commission has been doing its work, on the very matter of self-directed services. The recent tri-state conference on aged care in Albury, a presentation was made by a group. I was surprised by the presentation. This group is very strongly advocating - and has very strongly advocated in the past - self-direction. They work in the disability sector and also in the aged care sector.

Their conclusions in either sector are actually quite different. They have engaged in large-scale research on specific subjects in Australia. They didn't clearly state the point towards the end because their research is ongoing but the audience was left in absolutely no doubt whatsoever that from their point of view, the majority of seniors in the research actually preferred to give the package of support back and say, "Could you please manage this on my behalf," rather than, "I'm managing myself."

We therefore believe the commission should not underestimate the demand of the care coordination services that are currently being proposed for the gateways. The gateways also provide a vital care coordination function. This implies the resources for that are going to be government resources or centrally planned resources. Since the funding - to do so we've embodied in the gateway. That care coordination service could be seen to actually represent a government monopoly if they have the funding to do care coordination. The clients' only alternative - if they want care coordination provided by an alternative organisation, irrespective of the quality they're getting from the government - would be to pay for that service privately, presuming they're even allowed to do under the future system. The resultant potential loss of competition may well lead to substandard coordination services within the gateways.

The last point in terms of coordination is that we believe it's important to note that coordination often establishes the initial provider relationship for many clients, and whether they like it or not care coordinators are seen as principal recommenders for service provider. Care coordination is a government function, and the government actually risks the perception that it may be favouring one provider over another. So we look at those points in summary related to care coordination. We feel that if they're centrally planned it's less likely to be able to flex up and down in line with what the market really needs; that it's going to be a competition with market based care coordination services, but of course with government funding it has a monopoly funding.

It will be contrary to the concept of consumer choice which is embodied within the draft report and it risks criticism that the government-managed gateway could in fact be seen as being biased towards some providers rather than others. As an alternative we propose that care coordination functions be provided by the market outside of the gateway. In that case part of the client's funding would simply go to care coordination should they choose to do that.

The next point that we wanted to raise was in relation to the seniors' gateway being able to cater for diversity, like providing interpreter services or diagnostic tools that are culturally appropriate. We, as an organisation - in my 11 months with Care Connect - have been quite impressed with the manner in which it engages with special needs groups; Aboriginal groups; lesbian, gay, bisexual, transgender, intersex groups; culturally and linguistically diverse groups.

What we know as an organisation is that diversity, particularly in relation to matters of health, is actually an extremely complex subject. For example, amongst our Aboriginal clients in urban settings I've been lucky enough to go out with a number of the case managers and they have worked at building bridges into the

Aboriginal community for many years, realising that it is a trust phase that needs to be built up. Without that trust phase in place, the community will not even declare to you what the needs are within their area.

So it seems we have concerns that the provision of a gateway with interpreter capabilities will in itself engage these groups. What we've found is a more successful model is an outreach style program where people go actively into those groups and are active in that trust-building phase. Once people are convinced you're actually there to do the right thing, they're much more likely to declare needs that before seemed invisible.

MR FITZGERALD: We're going to need to have some time for questions, so if you could just bring it to a conclusion in the next minute, then we can have some questions.

MR OSTROWSKI (CC): Certainly. Key point 5 is that we strongly support the independent determination of co-contributions. It's a vexed subject for us. People who are in the caring industry do not like to go in and talk about how much an individual can contribute. We would very much support it being put with a third party, provided the third party is resourced. The final point is that we believe that the paper could emphasise more strongly the cultural change that would be required in Australia for people to accept funding their own accommodation and partially or fully their own care. That's going to be a political chestnut to digest and it's no small chestnut.

MR FITZGERALD: Thanks, Paul. I didn't want to cut you short but I'm conscious of time and I do want to raise some questions; I'm sure Sue does too. Let's go back to the gateway in your example. Of course what you say could be true but it is unlikely to be true. One of the dangers in your scenario is that you've made a number of assumptions which are not necessarily correct. One of the things we would welcome is your view about the nature of the entitlements. Clearly we acknowledge that an entitlement taken to a service provider, because part of a pool within that service provider - the question is how prescriptive is the entitlement, and we've raised that in the draft. So we're waiting for people to come back and say, "This is how you would express that entitlement."

So the position that you take exactly $13 to the service provider and you only get $13 worth of care, and there's no risk pooling is not correct. In fact that's not how it works in any place. It's very different from if you give the person $13 which they can cash out, and we're not cashing out our proposals. So there is a risk sharing that takes place. But more importantly what we have to do from your scenario is what does that entitlement look like; how flexible should it be. The second thing that is very important is that we are still trying to work out how you come back into the

gateway. So taking your example where George goes into hospital and comes out with assessed need; if George has a care coordinator in fact that could happen extremely quickly. By going back through the care coordinator that sits in the gateway there could be a very quick assessment of his needs, not the current system.

So the fact that your assumptions were they could be true, are unlikely to be true given the safeguards we've put into the gateway system; in fact what we would think is a much responsive system than what currently operates. I just want to raise the query: we want the system to be as responsive as possible; we don't see it through rose-coloured glasses, so there's going to be variations. But I would be very, very surprised if the scenario you've painted was in fact accurate if you can get reasonably quick reassessment of the needs of the client. Now, that's the critical issue. So you don't have to wait your eight weeks or 10 weeks of that arrangement. I'm just raising that with you. Do you think it's possible to create an environment where the assessing agency - in our case the gateway - can in fact be more responsive as clients' needs change?

MR OSTROWSKI (CC): I think the point is a good one. I suppose it's the point in parallel we wanted to make. The gateway system in terms of information and assessment provides appropriate resource, and can respond quickly is absolutely the right way to go. I think one could say that if the ACAS's were appropriately resourced and were able to respond immediately, and we had more than three levels of funding in the packages, then we wouldn't need the safety net that has been created by providers, putting money aside so they can compensate one client against the other.

Our fear is that the commission's report will be interpreted in a government implementation, whereby the resources will not be necessarily as the commission envisaged. So the point that the system is to be appropriately resourced is a critical one.

MS MACRI: Can I just make a comment there too. I'm not quite sure if your services go across states or territories or if they're just Victorian.

MR OSTROWSKI (CC): No, they go across three states.

MS MACRI: They go across three states. Because, obviously, ACAS and ACATs, as they're known in all of the other states, are actually funded and accountable quite differently from state to state and territory to territory. Our vision with the gateway is that the Commonwealth will set the policy, it'll set the funding, so that there'll be greater coherence between gateways, that it will be on a regional basis as opposed to now being linked like, if again I come back to New South Wales where they're under the auspices of an area health service; you go to South Australia, they could be

amalgamated with an aged care provider; you'd come to Victoria - there's a variety of models.

For a start, I think we see the gateway as being more Commonwealth funded and with a greater policy on a regional basis in a variety of settings. I think that is important and the resourcing is - you're absolutely correct, that's the critical component of the whole thing. I was really interested, because I hadn't really thought about it. It comes to the diversity, the ATSI, and I'd even put the homeless in there in light of some of the other discussions in terms of an outreach-style program, as opposed to trying to get somebody centrally through the gateway. I thought that was interesting, and we'd welcome some thoughts around looking at that contextually as to how it would fit within our gateway model but being an outreach program that works for those particular communities.

MR FITZGERALD: The point about it is also true, how do they get to you anyway? One of the fictions in this is that somehow they magically find the provider. Firstly we know that most providers are referred by somebody else. Either they're referred by a GP or another source, or a government agencies; they're referred, they just don't find them in the phonebook. The second thing is we'd envisage a set of support services that are still around people from Aboriginal backgrounds or non-English speaking backgrounds. So there are support services that in all likelihood are actually going to aid and assist people to get through the gateway. Perhaps that's underdone at the moment, but certainly we would see that.

We know, absolutely, that people find services now because of a support group, a community group, a recommendation from somebody. We would imagine that being improved under the current system. So I think your point is valid, but my point would be that our system actually recognises that and perhaps needs to be beefed up, but it is actually the case today. It's also true that, at the end of the day, people go to services because someone has told them. A care coordinator or a case manager is probably in a better position to make that decision than what's currently happening, where it's really just pot luck. If you get a GP that's good, he might send you to a good service or not; if you get a poor one, you might go to a very ordinary service. In a sense, again, whilst I accept that there is the danger of preferential treatment for service providers, on the other hand it's probably a bit better than what we've got at the moment, which is completely random.

MR OSTROWSKI (CC): I think the underlying comment would be, what we see is significantly better than what we have at the moment; the principles all make sense to us. To go back to your comment earlier, Sue, on the government funding, we support it going to Commonwealth management, but going to Commonwealth management there is always a risk that what the commission puts forward will be misinterpreted, it'll still be centrally planned resources. Will those resources be able

to flex up and down with demand? It simply remains to be seen. All we feel is that the point should be made.

MR FITZGERALD: In terms of entitlement, that's the critical issue. The government has to make a fundamental decision; does it move to an entitlement-based system, entitlement based on need, or does it maintain a rationed system. That's the fundamental question in public policy, absolutely. Our view is very clear and it won't change; that is, that it's an entitlement based on need system rather than a rationed system.

MR OSTROWSKI (CC): In terms of the comments on special needs groups, and I actually bring in, as you mentioned, Sue, homelessness. I was listening very carefully to the questions you directed to Villa Maria and I would support their response in terms of case management. It's new to me over the last 12 months. One of the marvels for me is to see how case managers go outreach into the community; they discover a need. Things like homelessness are actually a result of many other issues; it could be a mental health issue, a family violence issue, a drug and alcohol issue, an aged care issue. It's the ability of a case manager who understands the system to say, "Okay, this individual has multiple coincident needs here and we're going to have to draw support from our aged care system, we're going to have to draw support from our mental health system." We should not underestimate the importance of that particular component of what we have today and going forwards.

MS MACRI: Yes. I think that's a really important issue.

MR FITZGERALD: If I can, just under the type of care coordinator, what we've described for care coordination within the gateway is a default function; that is, if you haven't got a person that can assist you with the care, or you choose to have a care coordinator. So again it's not a mandatory position; not everybody needs one, not everybody gets one. It's also possible for the gateway to contract that out. What we've not said is that the gateway has to have a thousand employees; it can in fact contract that out, including to not-for-profits or anybody else. But it's function, the gateway, what we have said is the case management is different. The case management is an entitlement, it's provided by a non-gateway provider. Your concern with the care coordination seems to be much stronger than that. You have a view that care coordination shouldn't actually be in the gateway at all?

MR OSTROWSKI (CC): I suppose it comes down to the demand and supply construct: if we believe the gateway will absolutely be resourced and deliver a high quality, then it's not an issue; if however an individual says, "I understand what the gateway concept was, but I'm waiting three or four weeks to get access to my care coordinator, the one I know and trust. I'd much rather go to an organisation outside. Will I have the ability to do that without losing part of my funding by going

outside for those kind of services?"

MR FITZGERALD: Putting it the other way, you're saying to us that we should look at the ability for the care coordination function to be an entitlement provided with the provider.

MR OSTROWSKI (CC): Absolutely.

MR FITZGERALD: We made the distinction with case management, as distinct from care coordination, but we're happy to look at that. Any other questions?

MS MACRI: No, not really.

MR FITZGERALD: Thanks for that. Thank you for doing the illustration, it's been very insightful.

MR OSTROWSKI (CC): Thank you very much.

MR FITZGERALD: Can I just make one suggestion. I'm not sure if you've put in a written submission yet or you haven't done so. One of the things I would be very interested in is, what do you think the entitlement should look like. Just assume the gateway is there, it does the assessment in the way that we've described, and it's going to give to Sue a bundle of entitlements. In order for there to be sufficient flexibility but also sufficient accountability, one of the things we're struggling with is, what does the entitlement look like; is it 4.5 hours or is it something else? So we are asking providers, given you are the recipient of these entitlements, what should it look like? Because if it's a straight jacket, then it has not achieved what we want. If it's endlessly flexible, it doesn't achieve what we need. So we are keen on that and, given your breadth of services, that would be really helpful.

MR OSTROWSKI (CC): Thank you very much.

MR FITZGERALD: Thanks, Paul.

MR FITZGERALD: Okay, if we could have Ross Johnston from Regis.

MS MACRI: That was good timing.

MR FITZGERALD: It was, we're running spot on time.

MR JOHNSTON (RG): Can I just show you some material?

MR FITZGERALD: Yes, sure.

MR JOHNSTON (RG): I haven't got one for everyone in the room, obviously.

MR FITZGERALD: That's a bit unusual. No, that's fine. If you could give your name and the organisation that you're from and your position for the record.

MR JOHNSTON (RG): My name's Ross Johnston, I'm the chief executive of Regis Aged Care Group.

MR FITZGERALD: If you can give us some opening comments and then leave enough time for questions, that would be terrific.

MR JOHNSTON (RG): Sure. Firstly, thanks very much for the opportunity to present today. This presentation is a synopsis of our submission, which you've received this afternoon. Quite quickly, Regis is a residential aged care provider. We have about four thousand residents, about four thousand full-time equivalents. We've constructed somewhere between 550 and 700 new beds in facilities around Australia over the last couple of years, and we've employed 600 staff in mobilising those facilities. So we believe we've got reasonable perspective of what's required in terms of the future of the industry and the growth and delivery of those facilities. We do all forms of residential aged care, effectively.

Firstly I'd like to say the commission's report is very good. I think it deals with a number of the issues. What we've tried to achieve in our submission is to put the meat on the bone, if you like, and give you some more practical examples of our experience in relation to those issues. So to that end, I'll just touch on three. So consumer-directed care opening up supply. From our perspective to bring a greenfields facility on and for a first resident takes up to seven years and a brownfield facility, which is an existing field expanded, takes up to two years. So not withstanding the commission's time line for implementation, it should consider that it takes five to seven years to bring new beds into the market.

MS MACRI: Can I just ask you, in that seven years I would assume you're putting into that in relation to applications through the ACAR?

MR JOHNSTON (RG): In land, purchase of land - - -

MS MACRI: Yes, land purchase.

MR JOHNSTON (RG): - - - consolidation of sites, the whole - - -

MS MACRI: Yes.

MR JOHNSTON (RG): So the sites that we have delivered in the last two and a half years started five to seven years ago.

MS MACRI: So that's around an application for ACAR as well?

MR JOHNSTON (RG): Yes.

MS MACRI: And licences?

MR JOHNSTON (RG): Yes. Our implementation priorities: we see the primary objective around this issue as to implement the commission's proposed changes prior to the introduction of bringing competition into the market. So we support competition as an organisation but to do that, the funding, the application for places, extra service that all needs to be, if you like, the regulatory environment needs to be streamlined prior to competition being brought to the market. So we see the key issues in that is removing the cap on extra service places or at least increasing it so there is certainly for providers. We actually have a facility in Queensland that we fully constructed. We have applied for extra service places in the last two ACAR rounds, we have none. So we now have a $30 million investment and we're not quite sure how we're going to get our capital back. But that's okay, there will be some very well looked after residents.

Low accommodation bonds to be taken for any care levels which is consistent with the commission's report. The parameters around the basic standard of accommodation, I think it's important to look at use, so it's put into the report as a generic standard accommodation. We see that it's fine for concessional, high-care residents but any other resident you won't basically attract into that room configuration. The pathway to competition needs to be progressive to allow the existing players, whether they be residential care or home care, to adjust their business models. Assessments need to give choice between permanent and respite. In the current system respite is not tried before you buy, it's actually a process, as I'm sure you're aware, that's undertaken to allow people from carers - for the carers to have a break. Reconsider putting regional places for supported residents to competitive tender. I'm not quite sure how you deal with the transition of residents

from one facility to another if you lost that tender so resident continuity is important.

I'll skip through this. Funding aged care: we see the issues (indistinct) acuity leads to a range of issues that we've tried to demonstrate in our report. That version of staffing, obviously a combination, equipment, consumables, medical equipment, it just goes on. Care needs have become far more complex. Our portfolio now we're 88 per cent high care. Three or four years ago we were about 70 per cent high care. So the shift is happening quite quickly. We have an increased number of residents with dementia and obviously the onset of dementia is accelerating across our aged care residents. High turnover means greater frequency of providing end-of-life care, again a real issue for staff and families.

Funding indexation has not kept pace with costs obviously. Staff expenses: we're advocating that staff expenses in aged care are higher than the acute sector because we have tried - we have matched them in a number of facilities across the country, can't attract people, can't retain people. So there is obviously working conditions and part of that remuneration. The cost of compliance, we have outlined in our report, is quite significant under the current structure. So we would applaud any modification of that.

The next page tries to deal with the level of accommodation bonds. So we have gone to some length in our submission to work out area schedules and give, if you like, the commission a very detailed of what goes into a facility. So, if you like, those numbers there give you a sense of the different types of accommodation, what an accommodation bond should look like. I'll skip through the rest. In terms of implementation priorities around funding, we believe the critical issues are revealing the scope of ACFI and expanding to cover complex care issues. That is particularly in relation to dementia, psychogeriatric, that would impact the ADL, behavioural and, to a lesser extent, the complex health care domain.

Implementation of a new indexation takes into account the real cost of increases in the provision of residential aged care. Obviously the CACP was discontinued three years ago. Our costs are running at sort of 2 to 4 or 5 per cent depending on which category you pick on a per annum basis. So care delivery by the informal and formal workforce: there has been quite a shift in ethnicity in the workforce in residential aged care and we have some tables in here. There are greater gaps between the required competency levels and the competency levels of new employees. They require significant on the job training which isn't recognised in the current system. The challenge of attracting staff to aged care versus acute is growing. There is quite a gap in terms of not only employment terms but conditions.

Meeting the requirements of accreditation: actually we find it is very detrimental to retention. It is a significant issue. It scares a lot of people. The

provision of a career path for carers is a challenge. That chart on page 8 you can see the change in ethnicity in our workforce over the last four or five years, so we have tried to bring that forward with key issues. I'll just do the last bit. Reform of the regulatory framework: we support reforms to the framework, including the simplification and the rationalisation of the government agencies involved. The cost of the current framework is very high. Not only the direct cost to management and staff time but also the indirect cost to staff in turnover of our carers and clinicians and the inability of us to attract staff from other sectors.

In our submission we have detailed some of the demands on our business. We provided over 20,000 pages to the various agencies over the last eight months to support announced/unannounced visits of the CIS et cetera. In addition to that, we not only have the aged care accreditation standard through our facilities, we have food safety audits in varying degrees in various states, drugs and poisons, WorkSafe, a complaints investigation scheme and when we have gastro we have the local councils through as well. So you can see our staff have to deal with many, many represetations in doing their daily jobs. The last point we make is in all that it is a very complex environment. It actually doesn't add much at all to resident care.

So in summary we believe the supply of places, the concurrent constraints around licences and extra service places is constraining supply. Based on the time frame of up to seven years for the development of new facilities, the time line outline in the commission's plan potentially delays this further. So be cognisant of the time taken to bring new beds on. Funding in aged care: we believe the scope of ACFI review needs to ensure it meets the cost of care, considering particularly increased acuity, complex care needs and behaviours like dementia. Retaining the value of accommodation bonds established by the market is critical to funding and accommodation and the introduction of competition, which we support.

Workforce issues need to be resolved, we believe in a whole of government and industry approach. It's too big an issue for the industry to resolve on its own. This consider the impact of increased ethnicity in the workforce, increased training requirements and competition for staff within the acute sector. So the acute sector is about the same employee base as the aged care sector which is interesting. Lastly, the cost of compliance is significant, both direct and indirect, and moves to streamline this are welcomed.

MR FITZGERALD: Thanks. Could I just raise a couple of questions - maybe Sue can go first.

MS MACRI: Can I just ask one very quickly. It's great on page 5 looking at the funding and having a look at a 120-bed single with ensuite, 120-bed with two bed and en suite. I'm just wondering what the figures would be if it was around the 1.5.

MR JOHNSTON (RG): 150 beds?

MS MACRI: The 120 beds with 1.5 rooms, so a facility that's got single - - -

MR JOHNSTON (RG): The middle column is two, it wouldn't be a lot different to - - -

MS MACRI: So what we are talking about is a the facility that has probably a higher proportion of single rooms and en suite but has - - -

MR JOHNSTON (RG): We've actually built five of those in the last while, so it would be closer to the 100 single en suite cost. In our submission we've broken out every part of an aged care facility into area schedules so you can actually go and maths out.

MS MACRI: Okay.

MR JOHNSTON (RG): We haven't seen that in the industry and we thought it was important for the commission - anybody that is analysing this can actually go and cost out our area schedules, so you would be able to work it out yourselves.

MS MACRI: Okay.

MR FITZGERALD: I want to clarify a couple of things. In relation to residential aged area we've indicated obviously, as you have supported the removal of high and low care and extra service status and you agree with that. On the other hand you're suggesting that there be a - what are you suggesting in the interim? You've indicated - I don't quite understand this. You've said that our proposals may in fact delay future investment. Explain to me exactly what you're suggesting, What's the time frame and what happens in that time frame?

MR JOHNSTON (RG): At the moment I believe the commission's timetable is within about year two, start to reduce the delineation between high, low and extra service.

MR FITZGERALD: Yes.

MR JOHNSTON (RG): For us that will stop us probably moving forward for over two years, because at the moment you can't - extra services is almost unavailable. So for us to build a high-care facility the only way to recover your capital under the current structure is to charge accommodation bond. 88 per cent of our business is now high care. Low care is very, very difficult in the market at present. So I

suppose what we're advocating is as a first step increase or remove the cap on extra service to free up, if you like, supply, and the industry will respond to that, I believe. We certainly will. Does that answer your question? So I think what we're saying is - - -

MR FITZGERALD: But do you require a wholesale removal of the cap on the number of extra services - - -

MR JOHNSTON (RG): No.

MR FITZGERALD: - - - or do you only need a marginal increase?

MR JOHNSTON (RG): Well, because none of those statistics are published and as a provider we have no idea where a region is - - -

MR FITZGERALD: So basically what we could be looking at there is an increase in the number of licensed beds under extra services category for a period of time, for that transitional period?

MR JOHNSTON (RG): Yes, it could be 10 per cent, I don't know. Melbourne south-east might be at 22 per cent today, I don't know. But we're advocating a percentage increase on the current status.

MR FITZGERALD: Based on regional variations?

MR JOHNSTON (RG): Yes. There is a blending at the moment in terms of ES. It's a black box for us. We submit into a round.

MR FITZGERALD: Yes, sure.

MR JOHNSTON (RG): We don't know where - there's some words in the ACAR which says, "We think this is highly bedded, this area," but it doesn't go to extra service.

MR FITZGERALD: Okay.

MR JOHNSTON (RG): Yes.

MR FITZGERALD: The second thing, I just want to understand your position on accommodation. In our report we've indicated that consumers should have the choice of whether they pay a periodic charge or an accommodation bond. What's your view about that, that the choice remains with the consumer as to whether they pay you periodically?

MR JOHNSTON (RG): We don't mind, provided it's representative of us getting return on the investment we've made. Again, in our submission we've amplified that, so we've actually looked at returns and - - -

MR FITZGERALD: Sure.

MR JOHNSTON (RG): Yes.

MR FITZGERALD: But then you say here you do not support the capping of accommodation bonds. That is, where we've said that the accommodation bonds should reflect the true cost, including a return on capital. So whilst you support the view that a consumer can choose whether they pay a periodic payment or an accommodation bond, consistent with our recommendations, you're also saying that the accommodation should be able to be at any level?

MR JOHNSTON (RG): Yes, basically. If we're going to make it a competitive marketplace, providers - - -

MR FITZGERALD: But what's the justification, apart from it being a cheaper way of financing? In other words, it avoids debt financing, which we understand. What's the rationale for having - - -

MR JOHNSTON (RG): Sorry, accommodation bonds - - -

MR FITZGERALD: Accommodation bonds is a cheaper form of finance capital than it is to go with debt financing?

MR JOHNSTON (RG): I think it's about the same, actually.

MR FITZGERALD: Well then if it's the same - I don't understand this. What's the justification for charging bonds, even if consumers are willing to pay, well above the actual cost of that accommodation?

MR JOHNSTON (RG): We've outlined what we believe the cost of accommodation - - -

MR FITZGERALD: Yes, so this goes back to my point. What do you mean when you say, "We do not support the capping of accommodation bonds"?

MR JOHNSTON (RG): In the commission's report, some of the words in there are a bit grey, so it looks to us like - the way we put our submission forward we assume that the commission's reference to accommodation bonds, periodic payments, is it a

supported resident level and above that it's a competitive environment?

MS MACRI: No.

MR FITZGERALD: No.

MR JOHNSTON (RG): Well, we've misinterpreted it then.

MR FITZGERALD: What we tried to say, maybe not clearly enough, is that if you charge an accommodation bond you also have to issue - which you've supported - a periodic payment, and it's the equivalent.

MS MACRI: It's equivalent.

MR JOHNSTON (RG): Provided that's calculated on a reasonable basis.

MS MACRI: Yes.

MR FITZGERALD: Yes, we agree. There would be argument about what that reasonable basis is, but you support that. So I just want to be absolutely clear. You support the notion that a consumer can choose between a periodic payment or an accommodation bond. The accommodation bond should roughly reflect the cost, the true cost, of that accommodation.

MS MACRI: Yes.

MR JOHNSTON (RG): Yes.

MR FITZGERALD: And that's right.

MR JOHNSTON (RG): Including getting it there.

MS MACRI: Yes.

MR JOHNSTON (RG): Yes.

MR FITZGERALD: Okay, I need - fine.

MS MACRI: So that goes down from your extra service model to your non-extra service model?

MR JOHNSTON (RG): That's right, yes.

MS MACRI: Yes.

MR JOHNSTON (RG): We've included in our report some return hurdles, again, which - the accommodation charge would have to increase dramatically.

MS MACRI: Yes.

MR FITZGERALD: Some people have said to us that what will actually happen - and given that we're not absolutely certain is that more people will prefer to pay a periodic charge than they will an accommodation bond. We have no doubt at all that some people will prefer to pay an accommodation bond. Given that this is uncertain, when you say you're quite happy with that choice between a periodic payment and/or an accommodation bond, have you made any assumptions in that conclusion that you've come to? Have you assumed that you will still retain roughly the same number of bonds or have you assumed that there will be a dramatic change in the - - -

MR JOHNSTON (RG): I think if you compare - two issues here. We don't find much of a demand at all for periodic payments, and we have pressed it, and people seem happy - the aged care - the current system with bonds compared to a retirement village, for example, it's quite good from a resident's perspective. The charge out of the bonds is moderate - because you understand, retirement model, it's quite heavy, you might lose 40, 50 per cent of your capital over time. So we find people would rather pay the bond than the accommodation charge, even today. I understand the pension assets test and all the rest of it. So we think that will continue. People are happy to pay - we've got from five-star facilities to two-star facilities, if you like to put stars on it. The people in the five-star facility they're happy to pay for the quality of the accommodation and the service. The problem at the moment is we can't provide those services because of constraints on the service offering.

MR FITZGERALD: Okay. Well, that's very insightful. Good.

MR JOHNSTON (RG): Again, we put about 500 bonded beds into the market over the last two and a half years. We have pressed periodic payments and there's not a big demand for it, because it's quite draining of people's cash flow, at the end of the day. I know you will say to me, "So is a bond," but - - -

MR FITZGERALD: So when we - if the government were to adopt our recommendation of this Australian government aged pensioners bond scheme and a person chooses to sell their home, your anticipation is that you still think most people would use part of that sale for an accommodation bond and part of it into that government pensioner bond scheme?

MR JOHNSTON (RG): Yes. We have bonds from $20,000 up to many hundreds of thousands of dollars, and that usually runs in terms of the quality of accommodation and to some extent the service offering. We've been packaging our services now over the last 12 months into three different levels; so if you like, supported resident, lower end of extra service and higher end of extra service, and people are happy to pay, actually. It's how they pay is the issue. So there's quite some demand. The industry doesn't do that well - because of the schedule care and services it's quite - there's a lot of black ink, if you like.

MR FITZGERALD: In relation to non-supported residents we're obviously not capping the price that can be charged provided that it is aligned to the true cost of the accommodation.

MR JOHNSTON (RG): Yes.

MR FITZGERALD: In relation to supported residents we've made recommendations, as you would see, that quotas set regionally would apply to all accommodation services other than those grandfathered. But we've had this novel recommendation that they perhaps could be tradeable within these defined regions. I was wondering whether you have a view about that?

MR JOHNSTON (RG): Well, the current system sets, if you like, standards for supported residents, so I think it's interesting. I'm not quite sure how it would work. We probably haven't got a view. I think it's a good thing if you want - if someone wants to stand in the market and offer a facility for supported residents, that's probably quite lucrative for them, but we tend to put a blended mix of residents in our facilities, being both supported and non-supported, if you like. That seems to be a good model.

MR FITZGERALD: The other point that Sue raised - I just need to go back to it, in relation to this 1.5. At the present time the specification that the government has required is that it's 1.5. You would think therefore that providers would be developing facilities which have a mix of one bed, two bed and a shared en suite and variations of that. Yet constantly we hear the providers can only deliver one model, that is, one bed and an en suite, to meet so-called demand, the demand of families, not necessarily the older person but - that issue. But going forward, if we were to retain that the government funds supported residents on the 1.5 - in the report we said 2 - what does that mean in terms of a provider, because that's the current arrangement, if the government funded it accurately?

MR JOHNSTON (RG): I think that's the point of residents. We're advocating in here that a two-bed shared en suite - it's about use, so if we put a two-bed shared en suite in the market for low-care residents, bonded, we'll never see anybody. If we

do it for high-care supported, I think it'll work. If you do it for high-care bonded, you haven't got a chance basically, so it's about the product. So I think if it's aligned correctly to its intended resident, it's fine. So the one and a half I think is fine at the end of the day. We have a number of shared rooms in even our bonded facilities; they're just more difficult to sell.

MS MACRI: You obviously vary the bond.

MR JOHNSTON (RG): Yes, absolutely, we do.

MR FITZGERALD: So going forward, when we have only a residential aged care facility, not high and low, extra service, it's all one. The whole of the facility is both periodic payment and/or accommodation bonds and supported residents.

MR JOHNSTON (RG): Yes.

MR FITZGERALD: The government contributions you're suggesting could remain at 1.5, provided it reflected the true cost.

MR JOHNSTON (RG): That's correct, yes, and new facilities, we've generally provided about 20 per cent supported residents. The other 80 per cent are generally high and low care, and the high care are usually extra serviced so we can get a return.

MR FITZGERALD: Just in relation to the workforce issues, we continue to hear, and as you've rightfully said, there's a substantial pay differential or remuneration differential between nurses working in aged care and nurses in acute care and what have you. In a normal market in order to be an employer of choice, we would have seen providers offering more commensurate wages in order to attract the staff. Some might even offer better ratios in terms of staff to clients. I'm sure that's happening but it doesn't seem to be happening very much. So the constraint is what? Is the constraint that ACFI is insufficient? Where is the constraint, because this is not operating like a normal market at all. By now, even though collectively there is a workforce shortage issue and there are disparity issues in wages, we don't seem to be seeing much market response to this, or are we?

MR JOHNSTON (RG): Personally I think the funding is so constrained, particularly over the last three years - I'm doing my budget at the moment, so I'm budgeting on a sub 2 per cent COPO increase. Our real wages cost is escalating at about 3 and a half to 4 per cent and our other costs are escalating at probably close to - occupants' expenses rates, 15, depending on which state you choose and which state you're in. So I suppose if you look back over the last seven or eight years in the residential aged care space, there's been a massive increase in productivity. I think we're at the end of that and we were probably at the end of it two and a half years

ago. So the system has absorbed as much as it can. We're out there negotiating pretty competitive EBAs because we can't afford to pay, but you have to offer 3 to 4 or 5 per cent in this space, and to receive a 2 per cent funding increase or sub three years in a row erodes your capacity to pay, as well as everything else in your P and Ls.

I think the ACFI - some areas are good and we've again provided some further detail, but from a behavioural perspective, I think the ACFI is underdone. Complex health care is okay and I think the ADL domain is probably a bit wide too, depending on again what service you're providing.

MS MACRI: Yes, we're getting a loud and clear message around behavioural problems.

MR JOHNSTON (RG): Yes. We've detailed that at some level, including the facility impacts as well in our report.

MR FITZGERALD: We've heard also, just in relation to workforce issues, today about the variable quality of staff coming through with certificate III levels.

MR JOHNSTON (RG): Yes.

MR FITZGERALD: I was wondering whether you have an industry insight into that. Why is that occurring?

MR JOHNSTON (RG): Well, cert III, you can achieve it in a classroom setting in four, five weeks, six weeks. It's partially funded. They arrive at the front door with no work experience whatsoever, so we then go through - a buddy system is what we use and we run that for up to three months. The space is quite a tough space, so our staff turnover - we've brought it down. We've outlined it in our report, I won't talk to it here, but it's quite significant. You find you're continually turning over new employees. Some don't like the space. A lot of people entering the industry use it as a stepping stone into acute or somewhere else, some other career. If you benchmark the wages of a carer compared to many other industries, we're very low, given that 85, 90 per cent of our workforce is carers.

MR FITZGERALD: So what's the public policy response to that? What do you think we should be saying about cert III training?

MR JOHNSTON (RG): I think it's fine but there needs to be an on-the-job component as well as a formal component, so when they arrive, they know what the standards are. We have to deliver to 44 standards every day in this industry, 44. There's a lot of standards. They need to understand what they are. They need to

have experience with clinicians. They need to have experience with the managers. They need to understand the environment in an aged care home. They need to understand the expected level of customer service, dress. Language is an issue. So all of these things, I think if you want good quality care, it has to be dealt with before they arrive, or if it is as they arrive, we need to be, if you like, remunerated to provide that training.

MS MACRI: Can I ask, at the other end, and there are a number of the larger organisations that are now doing new grad programs for registered nurses, are you - - -

MR JOHNSTON (RG): Yes, we've just started that ourselves. We've just put in an online learning system which we believe is the only real way to get - the carers, to give you - we've done a pretty extensive survey about carers. They earn a very small wage. As soon as their shift is up, they go home. We can't even hold them back for half an hour to do some classroom training. So we've actually gone to online learning because they have commitments. Usually in those families, both parents are working or both partners, if you like, are working, so they haven't got time. So we have tried to ease the impact, if you like, and we've got 3700 carers, just to put it in perspective, and then you add a turnover number to that. As I've said, we have employed six or seven hundred new people into the space in the last two years, plus turnover. So we're probably fairly well qualified in terms of having built an infrastructure to deal with it, but we'd support more on-the-job training, and that could be done quite easily.

MS MACRI: What about registered nurses and new graduate programs, have you looked at that at all?

MR JOHNSTON (RG): Yes, we have looked at it. We have a small new graduate program, but again, our experience is that most of the nurses want to go into acute. Residential aged care is a generalist environment from a nurse's perspective. The care is nutrition, hydration, it's wounds. It's pretty straightforward. It isn't sexy. So we're advocating a higher wage for clinicians over acute because it's a very general environment and it's the same thing every day, not that it isn't important.

MR FITZGERALD: Can I just raise an issue which you haven't raised but it's been raised throughout the day and it is a significant issue, this issue of whether or not there needs to be mandatory ratios of staff to patients, care hours per day.

MR JOHNSTON (RG): Yes, sure.

MR FITZGERALD: There are pros and cons and obviously we're looking at it. We've had submissions, and you may have heard Cheryl Young mention it and the

ANF have mentioned it. I'm just wondering from a provider's point of view how you think that issue needs to be dealt with, if you have a view.

MR JOHNSTON (RG): At the moment it's a highly regulated performance environment, so we measure on outcomes. So if you're measuring us on outcomes as well as inputs, it could be very difficult if we weren't able to meet those staff ratios. So if you've got supply controlled, funding controlled and staff ratios controlled, there's nowhere else to go, and you're measuring us on a performance basis, on 44 standards. It becomes a very complex environment. I hear the unions. It could work, but yes, it doesn't account for performance at the end of the day because everybody will have the same ratios. If you have high staff productivity and you can operate below a ratio - you can't, so I think it will constrain productivity, if you like, if that's the right word. It's a mechanism of control again. I don't think it will go to better care actually, personally. Isn't that the thing we're all after, better quality care? Staff ratios won't improve that in my view. It doesn't automatically deliver it.

MR FITZGERALD: Again, I don't want to put you on the spot because it's not in the notes you've given to us, but the union this morning have indicated there's been quite some success in three of the states, Queensland, Victoria and WA in relation to the public health system in re-engaging nurses into the public health system. They attribute that largely to compulsory ratios being put in place. The argument may well be that if you had compulsory ratios in aged care you'd actually be able to retain or re-engage workers. So that whilst there's an issue about the direct correlation between ratios and quality of care, there's another issue as to whether or not it would work to retain staff or not.

MR JOHNSTON (RG): Our view is it's about remuneration, working conditions and the work. As I said, the work is hard, it's very - you do the same thing every day. Ratios won't fix that. Remuneration on its own won't fix it. There needs to be some career structures in this industry, and perhaps even a different model.

MR FITZGERALD: Very last comment, a question of - I've got the ACFI at the moment. You've indicated that the scope of ACFI needs review to ensure it meets the costs of care. You've mentioned here, "considering increased security, complex care needs, behaviours like dementia and so on". This issue of behaviours, to what extent do you think the ACFI instrument is actually effective in relation to the behaviours issue?

MR JOHNSTON (RG): Is it effective or ineffective, sorry?

MR FITZGERALD: Your view is, is it effective or ineffective and to what extent is it ineffective?

MR JOHNSTON (RG): For dealing with dementia - just as an example, which is the biggest incidents in the behaviour domain.

MR FITZGERALD: Sure.

MR JOHNSTON (RG): I think we've said in our report our resident to staff incident have moved materially in the last three or four years, and that statistic is in there. It's about additional labour. You can't manage a resident with dementia with the same labour ratio as a resident with complex health care needs. You just can't do it. It's entirely different. So what we're seeing is the incidents of dementia at all levels is increasing, because the body is outlasting the mind, and that's thanks to medical science. We're all in the same boat here. So the ADLs, for a dementia resident, the food - it's entirely different to your average - it doesn't - it's not recognised in the ACFI structure. The real estate needs to be different. It's not recognised in the funding. Again, we've brought all those things out in some detail for you.

MR FITZGERALD: That's excellent. Good, thanks very much, Rob, that's excellent.

MS MACRI: Thank you.

MR FITZGERALD: Sorry for rushing you through it. I didn't realise you had to deal with it that quickly, but it has been very helpful.

MR JOHNSTON (RG): I'm sorry for the audience. I spoke very quickly.

MR FITZGERALD: Thanks very much.

MR FITZGERALD: Lorraine Andrew? Lorraine, if you could give your name and whether you're representing just yourself or an organisation.

MS ANDREW: Yes, my name is Lorraine Andrew and I'm an RN. I'm representing myself.

MR FITZGERALD: Good. Please give us your comments.

MS ANDREW: So I think I'll probably start with - just bear with me, I'm not a public speaker, but I'm very passionate about this and I have extensive experience in nursing. I've actually been nursing for well over 30 years. Primarily that has been in aged care. Certainly it has been in aged care, including the community district nursing, case management, and a large period of time in an aged care facility. So I certainly do have some experience in talking about this and it is definitely just getting worse and worse. It is getting quite tragic. I will touch on some of the things that have been previously spoken about but perhaps with a few more examples.

I am really, really concerned about the staffing and the skill mix. I did hear the previous speaker but from a person who is on ground level we should be looking at resident care. It's so much documentation. It's very much rush, rush. Everything is rushed. I do say that - despite what the previous speaker did say, every day is not the same. That is, every day is not the same as a nurse. You have different illnesses, you have different infections, you have different things happening. People are falling left, right and centre. You've got lots of allied health, lots of people visiting. So every day is definitely not the same.

But going back to resident care, the concerns are certainly we have a lot of non-English or very poor English speaking carers. Whilst the carers have hearts of gold - they are wonderful, the majority of the carers that I have worked with over the years - they just don't have that training. They don't have that background, and that's absolutely tragic, because it's the resident in the bed who is suffering for that. So I'll go through a few of those things.

So with the untrained staff, the things that are basically lacking, markedly, are - when we talk about PRN medication, for those who don't know, we talk about - the PRN medications are those that are not given on a regular basis, they're when needed. So that would be for pain, anxiety, any behaviours, restlessness, nausea et cetera et cetera. Now, carers cannot dispense those medications. So if you don't have an RN on site residents are not going to get a lot of medications because they are not allowed to dispenses these PRN ones. If anything can be purchased over the counter, a carer can dispense that, as an example, Panadol.

But if someone needs anything for agitation, for pain, for any behaviours, that

cannot be administered by the carer, so therefore the resident misses out. Carers cannot administer oxygen. So therefore you're going to have someone who might need some O2. What's going to happen to that person? Just basically looking at it and being very realistic, that person is going to become breathless, undoubtedly - there's no oxygen happening here, they can't have it. They're going to become breathless, they're going to be more agitated, become more anxious. Then the end result is if there's not an RN on site, no oxygen, off to hospital. So a lot of these hospitalisations can be markedly decreased if there is an RN on site.

So we have people in pain, we have people who are restless, anxious, agitated, we might have someone who is vomiting and nauseated. You have a great amount of these things happening and if you don't have an RN on site they are not addressed. We do have RNs, sometimes, who are on call, and I could talk about that later on, just very quickly about the joke, it's actually quite a joke, for what we do get paid for being on call. But going back to the resident - so all of these things are not happening if there is not an RN on site. There might be three or four GPs might visit, a specialist might visit the home, any changes of medications, anything that he assesses the need to arise, that does not happen until an RN is on duty. Now, that could be the next shift, it might not be - if this is an afternoon it not be the night shift and it might well be not till the next day.

MS MACRI: Can I just - is that a low-care facility?

MS ANDREW: Yes, sorry, I should say that I do - - -

MS MACRI: It's just in your high care there's a requirement, legislatively, for - - -

MS ANDREW: Sorry, Sue, I should have actually said - - -

MS MACRI: Yes, okay.

MS ANDREW: So I do - at the moment I work in a low-level care facility - - -

MS MACRI: Okay. I just needed - - -

MS ANDREW: - - - with ageing in place.

MS MACRI: Okay.

MS ANDREW: So moving on from that, talking about the levels of staffing, which is - and I'm talking from a low-level ageing in place. We have, naturally, the residents being admitted - people now being admitted have higher complex needs. So they are coming in to us with much more higher needs and complex care. Care

staff - they don't know, they don't have the training, they've got no idea. I had someone admitted a couple of months ago and he was on continuous oxygen. The care staff, their eyes just boggled. They were like, "What do we do here, Lorraine?" So they had to have training. But they were really scared. The resident picked up on that. He became increasingly scared. The family picked up on that as well. So it snowballs and it's really quite tragic.

But going down to the nuts and bolts. Morning shift, we might have one care staff member for 15 to 18 residents. So just backtracking, low-level care, someone might be admitted with high complex needs but they still come under the low-level care assessment because it's like a script, they might have had that for 11 and a half months. Their care needs have markedly changed and increased in that time but they can still be admitted under a low-level care assessment. Unfortunately it does come down to money. We live in a very sad world where I think it's money and documentation and so therefore it's bottoms in beds. So we have had a lot of people admitted. Incidentally, the man on the oxygen, I think he lasted a week and he was sent into high-level care and he passed away about a week later.

MS MACRI: So your position, because you're a registered nurse, so are you the hostel supervisor, or where do you fit in?

MS ANDREW: No, I work normal shifts, morning and evening shifts.

MS MACRI: In the hostel.

MS ANDREW: No, it's a low-level care facility, so we're actually called a home or an aged care facility, we don't call ourselves a hostel as such. Day shift, I will have a manager with me, unless she's off doing some educational something somewhere else, but otherwise I might be the only RN. So I might otherwise be the only RN. We don't always have an RN on-site, and, for 60 residents, 40 of our current residents are high-level care. They are being claimed for high-level care in-house funding, so there is more money actually coming in for those residents, but we can't see where the staffing has been increased to compensate for those higher needs. Just reiterating and going back, for morning shift I have one care staff member for 15 to 18 residents. That could incorporate 10 to 12 showers, depending on resident choice, depending on incontinence, and a lot of residents might have been admitted five or six years ago to this facility, and they're used to having a daily shower and we can't change that. It's very much these days about resident choice. We have to try to accommodate that to the best of our ability. One care staff member for 15 to 18 residents. That will also incorporate a couple of medication rounds, so for that period of time the care staff member is withdrawn off the floor, so to speak, and is doing meds.

My role as an RN is totally supervisory, very much problem solving, ensuring that resident care is followed up. The residents come to me or to the RN on the following shift, if there's another RN. They come to me with any concerns. It's my role to make sure that they're reviewed, they're assessed, things are followed through properly. Very much of my role is problem solving. The care staff, as I said, are brilliant, but they're not trained, they have got no idea with medications and, sadly, a lot of the meds are dispensed in different names, so the care staff who is looking down here, they've got no idea what they're doing. They're coming to us consistently with queries. Also of course what we have to do is sort out any medication errors, and that substantiates quite a bit as well.

Afternoon shift, for 60 residents there will be two full-shift carers and a short-shift carer. As I said, at the moment we have got 40 high care in our low-level care facility. There are a lot of people to be settled at night and there are more medication rounds to be followed as well. On top of all that of course there's documentation, which is absolutely huge.

MR FITZGERALD: Sorry, I don't want to cut you short about your experiences, but I do want to get to the point of your recommendation. What do you think we should be saying in relation to this?

MS ANDREW: Undoubtedly, we need more trained staff. It's difficult as an RN; I also work in another facility casually and that's 120 beds, so I'm the only RN. One of my previous colleagues said that you cannot follow up, you cannot address issues/illnesses if you have that amount of residents to look after, so you have to prioritise.

MR FITZGERALD: Given your vast experience and my lack of it, what do you think the right ratio is? Let me put this in a broader context, we're going to get rid of low and high care, but within any facility there'll be a range of care needs from less to very complex. If you were guiding government in this area, what do you think the ratio - and we're not trying to be prescriptive here. Roughly, what do you think is necessary?

MS ANDREW: In an ideal world, one to six would be fabulous.

MR FITZGERALD: One what to six?

MS ANDREW: One care staff member, I'm sorry, to six residents would be wonderful. That would equal good care. At the moment it is not good care. We do the best that we can, but it is not good care.

MR FITZGERALD: What about in relation to enrolled nurses and registered

nurses, what do you think is the appropriate ratio for that?

MS ANDREW: Definitely you need a registered nurse on all shifts. You need that person there in body.

MR FITZGERALD: All shifts?

MS ANDREW: All shifts, absolutely all shifts. Being on call is not the same. I've certainly been on call a lot and I've had the three different care staff members phone me at different times; the left hand doesn't know what the right hand is doing. I'm sitting at home, being on call, being paid $12.50 for the whole night, regardless of whether I get called or not, and I've got these girls saying, "Lorraine, what will I do now? This has happened Lorraine, what do you want me to do?"

MR FITZGERALD: Does it matter about size? If you have a small facility - and there are small facilities around, you know, 25 or 30 - does that make a difference as to whether you need a registered nurse on every shift or not?

MS ANDREW: No, I don't think it matters whether it's 30 beds or if it's 200 beds; you must have a registered nurse on, feet on the floor, not on call. It's not good care otherwise, and it's tragic. It's our residents who are suffering. As far as the staffing, whether it's an RN, an EN, or a care staff, we're all getting very stress. There are a lot of people who are going off on stress leave and it's the residents who are ultimately suffering, which is the tragedy. Just quickly going on, night shift for my 60 bed facility, low-level care with aging in place, we have two staff members and that is all. That's night shift. That might not be an RN at the moment. That's the concerns there.

What really concerns me with the care that's being provided is palliative care, end of life, and that's just a tragedy. If you don't have an RN on-site, end-of-life care can be tragic, and I can give you some examples of that happening. The care staff, hearts of gold, they just don't have that training. Often a person who is dying - and I'll just be explicit here - will have a huge vomit. This is, what we call in nursing, a coffee-ground vomit. It's basically all the stomach contents coming up and it's the end of life. Somebody might have one, somebody might have six before they've actually passed on. If you don't have a trained staff member there dealing with that, these girls and boys, care staff, they just don't know what to do. They don't know how to address pain, nausea.

We're not only looking at the resident in the bed, we're also looking at the family and the loved ones around. What occurs is really bad. It would be nice to die thinking that you're pain-free and you have your loved ones around you in a nice quiet environment, but, sadly, that doesn't happen. That's due to lack of trained staff

and also, obviously, ultimately, lack of staffing.

Other things that I have seen without an RN, I have witnessed thing and I have been aware that things are happening. Indirect care, this is going off the resident in the bed a little bit, but things do happen. I've seen staff returning to assist. I've been working late and my morning staff have come back, and I've said, "What are you doing here?" "I've come back to help in the dining room because there's not enough staff." They just don't seem to get it. I've said, "You can't be here, because you're not here. If anything happens to you, you're not actually here; you can't be here." "But I've come back to help my friends." Care staff don't understand the boundaries of professionalism, because they just don't know; they just haven't had the training.

When I say to them, "You can't be here, because - - -" "Okay." But they still don't really get it. With care staff we have to continuously remind them to - resident dignity is badly compromised. Sometimes they just don't think, they're not aware. We've got en suites where I work. I've walked into rooms, the doors have been open, the bathroom door is open, there's a resident there pretty-well totally naked and the carer might be making the bed or doing something else. They just don't understand the dignity involved, and that happens very frequently. Care staff need to be reminded or prompted to turn the breaks on, put the breaks on when they're showering residents, they need to be reminded to put the breaks on the beds when they've finished making the beds, they need to be reminded to put the beds down low, the high-low beds, because that's a safety risk, of course, if you're leaving a bed up high with a resident in it. They just need to be reminded about so many things that to a trained person just comes naturally.

MR FITZGERALD: Good. Sue, questions?

MS MACRI: I don't really have any comments. It's about hearing people's experiences. Asking you how things can be done better: it's around education, it's around training.

MS ANDREW: Absolutely.

MS MACRI: I guess it's about hearing and understanding how things can be improved in terms of these people.

MS ANDREW: Absolutely. One very important thing - I can't believe I've missed it out - I have found, when I first started working in this particular facility - I've been there for two and a half years - I discovered that residents were being showered on the toilets. Now, this is something that a trained person would never even think about. I should have clicked. Why are all these toilet seats wet? Hello. But when I discovered that, I then questioned the girls as to why they were doing that.

"Lorraine, it's easier, because if people are incontinent, you just flush it down the toilet." I said, "Excuse me, I'm a district nurse." I come from a different background, in that there are ways of doing it, but certainly not undignified like that. I certainly wouldn't like my family member being showered on the toilet. I have to say that was stopped. That was stopped.

MS MACRI: I have to say I guess the other thing, hearing many negatives and problems and issues, we also have lots of submissions and people talking about some of the really good care that's going on as well.

MS ANDREW: Absolutely.

MS MACRI: What are your thoughts? What's making the difference between - of course there are lots of people in the industry providing very good care and so what's the difference between the organisations that are telling us - - -

MS ANDREW: The good care.

MS MACRI: - - - that they've got stable staff establishment, they've got good education, they're doing better practice with the agency and doing all sorts of innovative things? So what's the difference between where you're at and where some of these other people are at?

MS ANDREW: Okay. I have to say that this facility is a very good facility. We do have some wonderful care staff and our residents are very appreciative et cetera. But I think the difference lies in the staffing, as in the people like me in their 50s, the RNs who stay. We are staying one to two hours' overtime every shift and we're not getting paid for that. The budget just will not allow it, so it's just a no-no. But we don't leave until we make sure that everything is followed up, written, reviewed, written in the diary, so the residents have very good quality of care. I would say in places like where I work, that's why the care is so good, because we have the staff who will stay and follow things through. But how long can that continue, really? I'm basically working a full shift a week and not being paid for it.

MS MACRI: So you're saying good care is happening on the goodwill - - -

MS ANDREW: Absolutely. I think a lot of nurses would back that up.

MR FITZGERALD: Thank you very much, Lorraine. That's terrific.

MS ANDREW: Thank you. Could I just very quickly add, with the ACFI, as a tool it's actually been quite good but it is flawed. It is flawed. I have, as a nurse, been asked to remove histories when we have had an unannounced visit "because that

wouldn't look so good, Lorraine". So I do think there are some flaws definitely in the ACFI.

MR FITZGERALD: Okay, good. Thank you very much for that.

MS MACRI: Thank you very much. Thanks, Lorraine.

MS ANDREW: Thank you very much.

MR FITZGERALD: Saskia, if you can give your name and if you represent an organisation.

MS VAN DEVENTER: I'm Saskia Van Deventer and I'm here on my own accord.

MR FITZGERALD: Good.

MS VAN DEVENTER: I've worked in aged care probably for the last 10 years, of which I've worked probably about eight on the floor as an RN division 1 and I'm currently working in a management position. I don't quite know where to start.

MR FITZGERALD: Firstly, you've given us a submission which we've just got, so all you have to do is highlight just a few of the very key points because it's very clear. So if you can just highlight the main issues from your point of view, that would be great.

MS VAN DEVENTER: I think one of my first comments is that I strongly feel that the ACFI does not really reflect the amount of care that we give to our residents. One example of this is in accreditation, they encourage us to promote independence of our residents and yet we get funded the most for our residents that are more dependent and I feel that this does take away a lot of incentive for facilities to actually encourage that independence of the resident. Oftentimes encouraging the independence of a resident does actually require more staff or more staff time and this is not available.

I know that you mentioned earlier that it should be the providers who make the decision about how many staff there should be or the nursing staff should work out what the ratio should be. My comment to that is that often we are bound by the provider or what the management sort of says regarding how many staff we have on the floor. I think there's a lot of problems with having too few staff members. Probably one of my most upsetting sort of interactions was with a resident whose room I went into and he was absolutely devastated because he had been incontinent. He's a man who's got a lot of pride and he is totally continent but because, when he rang his buzzer, there wasn't enough staff to come and help him, he ended up being in "a big bloody mess" as he put it, and he was absolutely mortified, embarrassed, humiliated and ashamed. I just sort of thought if there had been just an extra person around to be able to answer that buzzer, that would never have happened.

Again, as I said earlier, there's a problem with not being able to encourage independence with the residents because it's much quicker to put somebody in a wheelchair and push them to the dining room than it actually is to walk them to the dining room. I strongly feel that we need more trained staff.

Lorraine just talked about division 1 nurses. I've been in the position where I've been on call and that's not really been satisfactory, especially where you have an incident where I got a phone call about a resident who was a diabetic who needed Actrapid insulin because her blood sugar was high. However, the person on the other end of the phone actually gave me the wrong blood sugar level which was the difference between giving four units or six units of insulin. At the end of the day, the resident was given the lesser of the two amounts, which was probably the safer of the two, but the fact remains if I'd been there, I would have been able to check it myself and give the appropriate instruction, rather than being dependent on someone on the end of the phone who happened to give me - I think it was 15.6 and she said it was 16.5 or whatever. She just gave me the wrong reading and I only discovered that the next day. So I think it's potentially dangerous not having a division 1 on duty.

I work in a mixed care facility so there are low-care and high-care residents and I strongly feel that there should be a division 1 on duty at all times. I also think that we should give more trained staff on the floor. Ideally if we had a ratio of one carer to six residents, and included in that, we should have at least a division 2 nurse just to be able to help with things. For example, a personal carer may not realise that a resident is actually potentially going to have a skin problem. They may not be able to recognise that skin is being compromised and then it breaks down and you have a pressure sore. They are not trained to look for things like that.

I think two incidents I've had with PCAs, I've had somebody fall and a PCA has just come and told me that the person has had a fall but there's no injuries, and when I have gone to check, that person clearly had a fractured arm. Again, they are not trained to look for things like that, so they don't know. We've also had incidents with PCAs giving out medication which they also give out to high-care residents. These medications are packed in sachets. If the doctor makes a change to the order, they don't know what the tablets look like, they don't know what they do and they will give whatever is packed. So again if the pharmacist has made an error in the packing, that just gets missed as well.

I think the worst episode I had was with a resident who went into a diabetic coma and the PCA came to me and said, "I can't wake up Mrs X to take her to the shower. She just won't wake up." It's on the handover sheets that these people are diabetics. She had no idea. She just thought she was sleeping, in a deep sleep. One other incident was with an agency nurse who was actually trying to feed a deceased resident their breakfast because they didn't realise that the person had actually deceased.

The other thing is that we do need standardised training across for the PCAs. We have PCAs come to us asking for placement. The one I had last week has done

eight days of training. He is trained for a month every Saturday and Sunday, so that equates to eight days. There is no standardisation of training for the PCAs and I think this is downright dangerous. They need to be taught basic anatomy, physiology, ethics, occupational health and safety and infection control; in theory, that's just to mention a little bit of the theory. Then in practice they need to be taught observation skills so that they can recognise if somebody is well or unwell, you know, together with your basic hygiene skills and nutrition skills.

Then I think my last comment, I sometimes think that we are a little bit over-regulated in the industry. I appreciate that we do need standards, and I'm really happy with that, but I just think that sometimes the documentation required to maintain - to have proof that you are maintaining these standards which involves auditing left, right and centre, I think you're sometimes spending so much time doing audits that you're not actually spending time giving the care that you are auditing to say that you are given.

MS MACRI: Yes.

MS VAN DEVENTER: I got that out right?

MR FITZGERALD: You got that right. We understand what you mean.

MS VAN DEVENTER: So yes - - -

MR FITZGERALD: Thanks for that. Thanks for the submission, the point form submission. Sue?

MS MACRI: Yes. Look, I think we've - you know, this afternoon had three presentations that are probably telling us fairly similar stories. I guess it's for us at the moment to hear that and to ask you how it can be improved. I think we've probably pretty well heard that too. I mean ACFI - not even just - you know, everybody is talking about ACFI not reflecting - especially behavioural. It's a pity around the - promoting dependence rather than independence, and those sorts of issues. So I just thank you again for the work you've put into your presentation. We're hearing you loud and clear.

MS VAN DEVENTER: Thank you.

MS MACRI: If you've got any great solutions for us, we like to get those as well.

MS VAN DEVENTER: I'll work on that.

MR FITZGERALD: The issue about the personal care workers and the standard

of training. This is a recurring theme we've heard, not just today but throughout this. You've made, I think, a fairly substantial recommendation here that it should be six months training. You've listed what it needs to cover. You've also indicated that English competency should be there at the commencement of training.

MS VAN DEVENTER: Very much so.

MR FITZGERALD: We are in a dilemma here. How do we move from the current system where we've got very variable courses, we've got workforce shortages and we've got issues around English skills or language skills generally. So I suppose that in one sense if we were to implement your recommendations that would exacerbate the workforce shortages. Yet on the other hand we recognise absolutely that there is an issue around training an competencies of PCWs. We do recognise that there are issues around English skills in that area. So it's hard to work out how you transition from where we are to where we need to be without exacerbating the workforce shortage issues.

MS VAN DEVENTER: I think perhaps one possible way would be to have aged care facilities perhaps act as a training centre but then having the colleges provide a mentor or a tutor to actually be with that person. What is happening now is - well, in our facilities we're giving students who have done their Cert III and who want to come and do placement, but it means that normally myself or - they're buddied with somebody who we know is really competent to sort of oversee them. But ideally - I mean the extra time that I put in with tutoring these people I don't get paid for. I sort of do it with my general manager not near my office because he sort of says, "Hey, I don't pay you to do that. I pay you to do something else." So I feel that there should be some sort of agreement made with the large training colleges that they do come and train people on site, get them in the real world, but that they give you - tutors present to train them properly.

There needs to be some sort of standardisation. I'm not quite sure - I don't know, I just feel that a lot of people have jumped on the bandwagon. I mean there are your big institutions who still have really good training but then you - any local newspaper you can pick up and it says, "Become a PCA in three weeks." How do these people get a licence to train? Is there not some - shouldn't there be some sort of training system that says you have to - why aren't they credited? Why don't we have a standard that says to become a training centre for PCAs Certificate III you need to have X amount of training? I've come from overseas and before I was allowed to register in Australia I know that all my training documents were sent over and had to be assessed to see whether I meet the standards here. Why aren't we doing the same with our PCAs?

MR FITZGERALD: Well, we are asking those questions.

MS MACRI: We're asking that very question. This is what I said before, people tell us that in fact they know now the RTOs that provide a good end product and the RTOs where they just - if a person arrives with a certificate from certain RTOs they don't even consider employing the person. Now, the sad thing about that is, is that a person has possibly done that with goodwill and paid, in a lot of instances, thinking that they've now got their piece of paper and they're going to walk into employment. So there's a whole lot of issues around this. I mean I would think the ANF - Paul, are you guys concentrating on this?

MR GILBERT (ANFV): (indistinct)

MS MACRI: Yes. I'm sorry, yes, but - - -

MR FITZGERALD: No.

MS MACRI: No, he's not. No, I'm sorry.

MR FITZGERALD: You can come up and say something.

MS MACRI: Yes, come up - - -

MR GILBERT (ANFV): No, I won't say anything in this forum.

MS MACRI: Yes, sorry, I shouldn't have asked.

MR FITZGERALD: It's only that it has got to go on the record, sorry about that.

MS MACRI: Yes, sorry, Paul. I just - - -

MR GILBERT (ANFV): (indistinct) tomorrow.

MS MACRI: Yes. Well, I'll ask you tomorrow. It is such a frustration, this whole Cert III, Cert IV aged care worker. It's a huge dilemma. We'd love some - yes.

MR FITZGERALD: It's an issue not only in this inquiry but in a number of other inquiries, so we'll be able to look at that. Well, thanks very much for that.

MS VAN DEVENTER: Thank you.

MR FITZGERALD: I appreciate that. One of our participants has not turned up, so we're going to conclude at this point. Tomorrow morning we start at 8.30 for another very full day and then again on Wednesday here at Melbourne. So if you're a

glutton for punishment, keep coming back. Thank you very much. Thanks for your cooperation during the day. We will adjourn till tomorrow.

AT 5.27 PM THE INQUIRY WAS ADJOURNED UNTIL
TUESDAY, 22 MARCH 2011