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# TRANSCRIPT OF PROCEEDINGS

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**PRODUCTIVITY COMMISSION**

# DRAFT REPORT ON CARING FOR OLDER AUSTRALIANS

**MR M.C. WOODS, Presiding Commissioner**
**MR R. FITZGERALD, Commissioner**
**MS S. MACRI, Associate Commissioner**

**TRANSCRIPT OF PROCEEDINGS**

**AT MELBOURNE ON TUESDAY, 22 MARCH 2011, AT 8.29 AM**

**Continued from 21/3/11**

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**MR FITZGERALD:** Good morning everybody. Welcome to the second day of public hearings in Melbourne. I just remind people that today we'll try to keep the proceedings as informal as possible and invite participants to make opening statements and then allow time for questions. If you could just state your name, the organisation and the position you represent for the record.

**MR GRATTAN (ASU):** Thank you. I'm Igor Grattan. I am the assistant branch secretary for the Australian Services Union. We're the union that looks after the HACC industry in local government.

**MR FITZGERALD:** If you can just make your opening comments and then we'll have some time for questions.

**MR GRATTAN (ASU):** We presented a submission and we would rely on that to a large extent, but I will just draw your attention to a couple of points. We strongly believe that the Victorian HACC system and the way it's administered through local government is, for want of a better term, a benchmark. It is, we believe, one of the best services - or the best service - in Australia. That is due in no small measure to the part that local government plays and the economy of scale that that brings to the process. Local government, as I'm sure you're all aware, provides a very large range of services and the HACC services in Victoria sits very well under that: Meals on Wheels, the HACC services, the library services, the home maintenance services; all those services fit.

Of course the extra funding that that brings in shouldn't be discounted either. Most local governments kick in above their weight, so there is a large amount of money that goes in. This provides a local, high-quality, well-regulated service, not only to the clients but also to the carers themselves when you bring in things such as occ health and safety processes, the ability to support a one-stop shop, if you like, and I believe that that is the keystone. Any change to that would have quite a devastating effect on the services in Victoria.

We do have some areas where it is contracted out and we do see a breaking down of communications when that happens. Situations I can talk about are services being run from Bendigo, and up north in central Victoria a woman was left in a house for four days and no-one knew that the carer had not been going there because there was no other service going to that house, whereas if it was done by local government, you've got the local people around there, you've got the local community, people know each other, all that comes into play, and when that's run from a centralised area it all breaks down.

The other side of the coin - and I am trying to keep this brief because I appreciate we've only got a limited time - is that I've recently had personal experience. My family is in New South Wales , my father was hospitalised and I tried to work out care after the hospital in New South Wales, and I can tell you I would not like to be an elderly person trying to work myself through that maze, because even with my experience at negotiating with people - which is quite large - I was struggling; whereas in Victoria, while the system I wouldn't say is perfect, it is much more advanced: you go to one place and you work it through. Having experience in Victoria with my wife's mother and having experience in New South Wales, I can personally tell you the experience in Victoria was much less stressful.

I think the other component that needs to be taken into account is the economic effect of changing the system in Victoria. This is talking about the industrial effects for a moment. The cost of redundancies to councils would be astronomical. A lot of the councils are pretty close to the board; they're struggling to keep their heads above water as far as maintaining the infrastructure as it is. To hit them with a large number of redundancies - even the smallest council you'd be looking at 30, 40 redundancies - would be an astronomical cost to the councils themselves.

I really struggle to see any case that could be put - other than self-interest - to say that any change to the Victorian system is in the interests of the Victorian people, whether it be counsellors, whether it be workers, whether it be the people who are benefiting from the service. Why would we want to diminish what we've got? Any transfer of funds, any realignment - just the upset of going from council to contractor across the state would cause a disconnect. People falling through the cracks, of itself - if we took out all the more important factors or the more dominant factors, even that factor alone should be enough to give us pause.

We feel very strongly - not just because these are our members, but we feel very strongly because we've fought for many years to get these people's terms and conditions to something near what we should be paying people for the attendancy skills of looking after people at home. Even if it was back as it was where it was basic house cleaning, the attendancy skills there - they are the people going and talking to people, they are the people that tell when things have gone wrong, they form relationships with these people, they are sometimes the only contact these people have in the outside world; very important stuff. Why would we be putting them in a position where the support, the backup and the service that they need to do their jobs is diminished?

Home carers are some of the lowest-paid workers in the industry as it is. Why would we take away the benefits that they do get from being employed by local government, such as the leave arrangements, penalty rates - we do pay higher travel, which is very hard for these people, trying to keep a vehicle on the road. Once again, if we have a race to the bottom of the industrial side - which contracting it out will do - we just won't find people. You can't find people to do school crossings at the moment because the pay and conditions are so low. We need, as a society, to look after our elders and we need to pay people reasonably to do that, and I think the Victorian system, while not perfect, has got it right, has got the best balance, and is in the best position to deliver that service. I suppose that's really all I've got to say. Of course, being a union official I could talk for hours, but I don't think that's in anybody's interest.

**MR FITZGERALD:** Thanks for that. You just raised some questions. The first point is that we recognise that the HACC system in Victoria works relatively well, relative to any other states. That's true and that's universally acknowledged. Nevertheless, the proposal that we're putting forward doesn't mean that, in fact, local government ceases to be a provider. It simply means that there's a gateway through which a client or a consumer has an entitlement that they take to a provider.

Why is there such a concern that local government would be not a preferred supplier of the community? Our expectation would be that local government would continue to be a very significant provider if the municipal councils decide to stay in the business, but there seems to be a view here that, for some reason which I don't understand, in a more open market local government providers would miss out.

**MR GRATTAN (ASU):** I think that comes to individual councils. I think there are a number of councils who provide a service at the moment that, if they had to go through any more whistles and bells, they just wouldn't. There's a lot of rural councils that provide a service. Once again, if they had to compete they probably just wouldn't bother, because they haven't got the resources to put in to do it. So it's about adding other levels on; it's about discouraging them from getting out of the business.

There are some councils out there and while they support - I agree, there are some large employers out there - and even talking to CEOs in some of the smaller rural councils they say, "Look, we really want to do this, but if we're going to have to put more resources in it's just easier for us to pull us out," plus we've got councillors who question whether this is core business and what we'd be doing is giving them an argument to bolster their case. I think that's dangerous. We do live in a very political world and I can tell you there are councillors up in the rural area who would rather see the money the council is putting into the HACC area go into infrastructure and roads. To hand them a better excuse to run that argument I think is dangerous. Councils are councils by nature.

**MS MACRI:** I just wonder if, as Robert says, this is really not changing from the client's point of view other than they go through the Gateway, get their entitlement and then go to the HACC provider of choice, and that HACC provider in rural communities will be one HACC provider. In metropolitan areas they might have a choice, as they do now, of a variety of HACC providers. I wonder about councils that are providing these services that is not their core business and they're not perhaps a willing participant per se, as to whether they really run an efficient service or an effective service if really their heart isn't in it in terms of being their core business.

**MR GRATTAN (ASU):** I think I may have misrepresented. It's not the councils; it is some of the councillors. The people who run the service are extremely dedicated. What is at risk here is the component the councils put in, which in some cases is higher than what the state or federal government put in being at risk. That's the real crux of it. When councils pull out they will not be putting that money in, plus there is pressure on from some of the councillors who don't see it as a high priority when it comes to infrastructure and roads. So while the CEOs would be and are on side - and we've seen that from the MAV surveys and local government surveys. The majority of CEOs in local government wish it to stay the way it is. It would create a political environment where other factors could come into play.

In real terms it would lead to all the problems I've talked about, such as we've seen before when services have gone to providers in other areas. You know, the terms and conditions of employment of those people drop. That's a real concern. The people don't stay in the industry, it turns over, or they are forced to stay in the industry and suffer real hardship because the terms and conditions are diminishing to such a stage where they're really fighting to stay employed but there's no other option for them. At least coming through local government there is some regulation of terms and conditions and the broader avenues of council to provide the support and the backup they need.

So local government by effect, being such a broad provider, would shelter these people in a lot of ways and have access - look, the HACC area is a phenomenal area for personal injury. You've got an aged workforce, predominantly female, who have been working all their lives, you know, and don't just work at work, they work at home, and they carry injuries, but in local government when someone is injured we can work with council to find them alternative duties, help them back and what have you. In private enterprise that is not there.

**MR FITZGERALD:** I understand where you're coming from in relation to the conditions of workers in local government and it's often superior to those in the community service sector, that's true. That's an issue about the community service workforce generally. But one of the problems we've got is that the local government is not the main provider of aged care services throughout Australia generally and even in Victoria it's only a partial provider of aged care services. The HACC, yes, but there's a huge amount of community based aged care that is not delivered through HACC services. In fact it's delivered through the very providers that you're worried about.

So in a sense what we're trying to do is to remove the dysfunctionality in the system, the discontinuity in the system to try to create a more seamless aged care service for consumers.  What we have is not that.  We don't have it in Victoria, we don't have it anywhere else.  We're trying to deal with this problem from a different angle.  That is, what is in the best interest of the consumer throughout their life as they need a different range of aged services?

We are going to have a difference of opinion, because one is to say we keep this part in Victoria exclusively almost for local government but the rest of it is provided by all these providers for whom you have some concerns, and there is throughout the rest of Australia - with the exception of perhaps WA - in fact it's going to be all in the hands of community service providers.

From our point of view we've entered it from the consumer's point of view or the client's point of view and we're trying to create a more continuous system for them in which local government could be a significant provider.  There's nothing in our proposals which say that local government shouldn't be a significant provider.

**MR GRATTAN (ASU):**   I appreciate what you say.  That's why in our submission we actually said that the services run by local government should be expanded to take in care and EACH and those sort of things, and maybe even some of the disability.  We think local government should be able to do that, so we're saying the walls should come down and some of the dissuaders be removed.

As far as one system across the state, this very much reminds me of the debate around Medicare when it was first brought in and Queensland had free hospital and medical.  Poor Queenslanders don't have that any more since Medicare came in and that was a loss to the state and, of course, there was a whole range of concern and upset.  We don't want to be throwing the baby out with the bathwater.  I appreciate that you would prefer to have an across-Australia system but I see no reason why - and discussions we've had with advisers, politicians, a range of people doesn't show me anything to say that we can't find a way to keep the Victorian system as it is and improve it without diminishing what we're doing.

**MS MACRI:**   There are enormous opportunities for local government and I just come back to your comment about CACPs and EACH, which in the brave new world won't be in that context because it's a building block of going through, but it's also about opening up the ACAR round so that local government as an approved provider of that service then has the opportunity, instead of trying to apply for CACPs or EACH in ACAR rounds and not being successful - so in a local rural community they can only provide a small package, ie HACC, and then if somebody needs additional care they need to move on to a different provider. This is giving local government an opportunity to be able to provide that care, going right through the building block system, so that from our mind there are some excellent opportunities for greater continuity of care and services to the community by local government than currently exists.

**MR GRATTAN (ASU):** If local government was going to partake.

**MS MACRI:** Yes.

**MR GRATTAN (ASU):** Once again, I think what you're putting at risk with this sort of thinking is local government will put out and the amount of money local government currently puts in will disappear. That will hurt the HACC system in Victoria and it will outweigh any benefits that you're trying to get across the state. Don't for one second believe that what you are going to put in is going to match what local government will lose in Victoria.

**MR FITZGERALD:** Igor, nobody has told us yet what local government puts in. In other words, we have a scheme where we believe it should be fully funded by the Commonwealth government - fully funded. Now, one of the things that's happened here in Victoria is people keep saying local government puts in additional amounts. What we need to see is what the evidence of that is. I'm not disputing it. I'm just sort of saying there's no evidence.

Secondly, we're actually saying that local government shouldn't have to put in. We're saying that in relation to aged care services, not other community social inclusion services, which is the province of local government. At the end of the day this scheme - the Commonwealth government has said it will fully fund it, and it should, and that's the commitment. Now, whether it's provided by a local government agency, a nonprofit organisation, a for-profit operation or a state government, we say the Commonwealth funds that for the full ticket. That's what the arrangement being proposed is.

Even if local government were putting in additional amounts, that money could be redirected into a whole range of social inclusion and support programs as part of the healthy ageing agenda, rather than necessarily into the actual provision, so that money isn't necessarily lost if the local government involved wants to stay in the provision of care for older Australians. But of course, as Sue says, if the local government doesn't value that and doesn't believe that it should be a provider of any services to its residents that are older, then I'm not sure that we should be saying that they have to; but I would think that most would want to. So that money wouldn't be lost.

**MR GRATTAN (ASU):** Can I say that is not what we've been told. We have not been told that that would cover dollar for dollar. As a matter of fact, the only thing we've been told is that the state and Commonwealth amounts would be covered dollar for dollar. I can tell you, councils put in different amounts. I've got councils that put in over a third, I've got councils that put in around about a third, and there are councils that would kick in just a bit less than a third; so it's all over the place. So I'm not sure how you do that.

I'm concerned that, if you try and unscramble the egg, services will be lost, and remember, the amount that councils are putting in also compensates in some ways for the terms and conditions that these people have, and how it ends up is that funding goes or it gets redirected, unless there's a commitment that that component goes to wages. Of course it's going to be put into more services and more aged housing, so that's all wonderful, but at the cost of the people who are delivering the service; at the genuine cost of people trying to live in rural communities; the genuine cost of people trying to make a reasonable living - not a flash living by any means; a reasonable living.

Long gone are the days when people did this work as an adjunct, to get holidays, because they didn't need to. This is real "keeping a roof over our heads" stuff we're dealing with nowadays, and to tamper with that and to bring that down in Victoria will have an amazing effect. Will the federal government pick up the cost of redundancies?

**MR FITZGERALD:** Well, you're assuming that local government can't compete.

**MS MACRI:** Yes.

**MR FITZGERALD:** We have greater faith than you do in the ability of local government to provide services, and remembering that the competition is not the normal competition; it's consumers, citizens, choosing where they get their services provided by. I would have thought in Victoria the reputation of the local governments as a service delivery body is very strong. It is not so in some of the other states, that's absolutely the case, but I fail to understand why local government in Victoria has such little faith in its own ability to attract its own citizens when it has a reputation for delivering good services.

**MR GRATTAN (ASU):** The faith is not lacking in that. The faith is lacking in the political agendas that come along with what's being put. Let's be very clear. There is no lack of faith, and the CEOs have showed that before. So I want to be very clear that there is no lack of - in competing, you're not comparing apples with apples. The client hours that some of these other people will put up are less. To tinker with something that is working like this, without showing that there can be clear guarantees and clear benefits, that none of the recipients will have to jump more hurdles, will be worse off, will be harder for them - you know, I know people up in my area, up in central Victoria, who should be applying for stuff but don't understand it. To make that even worse is, to me, of concern. If we've got a good system, if we've got an Australian-best system, why risk diminishing it? Why risk making it worse?

**MS MACRI:** Can I just put one thing to you. The other issue that we have had very loud and clear from consumers of services, and certainly even HACC providers, is that quite often people are on HACC and then their care needs have increased but they're reluctant to go across to a CACP or an EACH because it means changing service provider. So there's a disconnect between the care that a person needs and requires and the capacity of a service to deliver it. In this, your local government can step the person through, as their care needs increase, under the same provider. That continuity of care has to be a preferable system to somebody having to leave the service provider of HACC services and go across to a new service provider.

**MR GRATTAN (ASU):** Well, I'm sure there are ways we can work out where that can happen under the Victorian system.

**MS MACRI:** Yes.

**MR GRATTAN (ASU):** I don't think that's an insurmountable problem.

**MS MACRI:** No.

**MR GRATTAN (ASU):** But I think we can do that without putting the main body of the work at risk. We say you can improve access to that. I know for a simple fact that some of this stuff at the moment, you're bidding on it and local government won't bid in on it because, to match the other providers, they've got to pay people a different pay structure and that brings in problems for them and it just makes it too hard. If we can address some of those issues, if we can walk through those issues, if we can sort that out, if we can make it more attractive or less problematic for local government in Victoria to deal with these issues, I'm sure we could have the same seamless system.

There's not one way to skin a cat - I probably shouldn't say those sorts of things. There are definitely other ways of addressing it without dismantling or putting at risk what we've got. And it's a very clear fear: as I say, it's not just shared by ourselves; it's shared by the local government associations; it's shared by the CEOs, and especially the CEOs that I've spoken to who asked us to step up to the plate and guarantee their support for us in stepping up to the plate.

**MR FITZGERALD:** We have no doubt at all that local government in Victoria will seek to absolutely protect the current system, for the reasons that you've outlined. Nevertheless, I think we do enter it from a different space and that is, we are very much focused on trying to come from a consumer's point of view over a fairly substantial period of care, and what is the best system going forward for that. So we absolutely understand why local government would be mounting a very strong case to retain - - -

**MR GRATTAN (ASU):** Can I also say - - -

**MR FITZGERALD:** And we've acknowledged that the system here, relative to many of the other states, has been quite good. That's not in dispute. It's whether or not it's the best system, on which I think we probably are going to disagree, going forward, when we look at the enormous demand that is about to flow through for these sorts of services.

**MR GRATTAN (ASU):** I want to make very clear that our concerns and the concerns of the CEOs and the concerns of our members who actually administer this stuff in local government are based on the person who needs the service. This is not us just protecting our turf. I want to be very clear on that. This is about a service provided to people in Victoria - provided to my wife's mother, you know. It touches everybody here, and I will go back to saying that I believe my wife's mother, 96 years old, has had a better service in Victoria and a more seamless service in Victoria than she would have had in New South Wales or anywhere else. The fact of the matter is, if the issues are removing barriers and moving people across services, we will work with you hand in glove. If the risk of doing that is that our people in Victoria, the elderly and frail in Victoria, risk losing an Australia-wide best practice service, then of course we're going to oppose.

**MS MACRI:** Sure.

**MR GRATTAN (ASU):** And we will oppose as strongly as we can. The reality is, there are community interests here, there are social interactions here, there are interests right across not just the aged community but across the communities in Victoria in general that are at risk of being turned upside down.

**MS MACRI:** There are great opportunities too for - you know.

**MR GRATTAN (ASU):** And we can work with those. We're not opposed to change. We're just opposed to change that can be detrimental.

**MS MACRI:** And that's understandable.

**MR GRATTAN (ASU):** So understand where we're coming from.

**MR FITZGERALD:** We do. We fully appreciate it.

**MS MACRI:** Yes.

**MR FITZGERALD:** We'll probably differ about the outcome of those considerations.

**MR GRATTAN (ASU):** Vive la difference.

**MR FITZGERALD:** Well, we try to look at a national approach.

**MR GRATTAN (ASU):** And I appreciate that.

**MR FITZGERALD:** And every state has its variations and every state has its strengths and weaknesses. But I might say, the other thing too is that the HACC system is not a perfect system: the silos, the way in which we fund it. Despite the fact that it works relatively well, it is by no means a perfect system. It's a rations system. It in fact has major distortions and perverse outcomes for clients in it as it is, whoever delivers it or whether it's local government. That the system needs to change is not in dispute; how it needs to change is. So the way in which local government operates, even in Victoria, would need to change substantially, even if it were to remain a major provider, because the current system needs improvement. So I'm pleased you say that you're not averse to change - - -

**MR GRATTAN (ASU):** No.

**MR FITZGERALD:** - - - because the system does need change. Having said that, can I just make the other point. In relation to the wage differentials between local government and the community sector, I presume that there is a dialogue between your union and other unions about that? This is a significant issue, where, in the report that we did on the not-for-profit sector, we showed the enormous differentials between people employed in community services, people employed in local government, people employed in state governments. That issue which you've raised is a significant issue that needs to be addressed. It's not going to be addressed through the lens of aged care, but it is a significant issue.

**MR GRATTAN (ASU):** Can I tell you that that issue - since it comes to the argument of federal and state funding - it's not conversations with other unions we need. We need politicians to buy in. We've just seen yesterday that the Victorian government has moved away from its commitment to support that.

Can I just make one point on our push for Australian standards. I understand that, but can I say we've seen a push for a standardisation in the award system which has led to workers losing terms and conditions. We've seen a push for standardisation and the harmonisation of occ health and safety which has seen some states lose the best system; like, I believe that New South Wales or Queensland had better occ health and safety regulations than we did. In Victoria we kept what we had and they lost some of their state stuff.

What I'm saying is that every time we go to a federal system - whether it be Medicare - that's going back a few years - but whether it be occupational health and safety harmonisation, whether it be award modernisation, all these wonderful terms - somebody loses. What we're saying is that the aged population in Victoria should not be losers out of this, and with what's been put on the table at the moment we see that they will be.

Happy to discuss how we'll work it through, happy to discuss how we implement the changes you're talking about, but we are bound and determined that the recipients in Victoria don't lose any of the services they have now and that the system is not a lessened system simply so that it marries up or that other systems come up - yes, by all means bring up the Western Australian system, bring up the Northern Territory system, bring up the Queensland system, bring up the New South Wales system - please, for my parents' sake alone - but don't diminish ours. That's the plea I put to you again.

**MR FITZGERALD:** That's fine. Thanks very much for that. That's helpful. Thanks, Igor.

**MR FITZGERALD:** Do we have the Australian Psychological Society with us yet?

**MS ..........:** No.

**MR FITZGERALD:** Are there any other participants that are presenting here just yet? Is anyone else here formally presenting?

**MS MICHAEL (FC):** I am.

**MR FITZGERALD:** What's your name?

**MS MICHAEL (FC):** Penni Michael. I'm on at 1 o'clock.

**MR FITZGERALD:** Do you want to do that now or would you prefer to wait? It's up to you. You don't have to do it now if you don't want to. You can wait if you like. That's fine.

**MS MICHAEL (FC):** It's just that we were wanting to be heard with DutchCare, but they're before lunch and they're at 11 o'clock, so it's not too far away.

**MR FITZGERALD:** All right, that's fine. Please if you can give your names and the organisation you represent, that would be terrific.

**MS MICHAEL (FC):** My name is Penni Michael and I'm the CEO of Fronditha Care, and this is Anne Davey and she's a regional manager for the Southern and New South Wales region.

**MR FITZGERALD:** Right.

**MS MICHAEL (FC):** Firstly, thank you for the opportunity to present. I have written a presentation which I wish to read, but also speak, and you also have another extensive written submission which is quite separate to this.

Fronditha Care is a not-for-profit organisation. It was developed 34 years ago by a group of three fairly young people who at the time were considered rogue in the Greek community because they, like you have said, entered into a brave new world. So they established an organisation to provide residential aged care at a time when the Greek community thought it was blasphemous.

What we want to argue today is that the CALD responsive services must be planned, funded, delivered and assessed which address CALD issues. What I also want to say is that the statistics indicate that our current CALD population is primarily those who migrated after the Second World War. They were instrumental in building the Australian society as we now know it, and we all know about the Snowy River scheme.

I believe there is a policy, economic and moral obligation on the current aged care system - and I'm not talking about local government or individual providers, but the aged care system as a whole - to provide for and ensure appropriate aged care services to these neglected migrant nation-builders. It needs to become core business, and I am pleased to hear this morning that you have a very strong focus on what the consumer wishes, that you talk about a seamless service provision and you talk about blocks which need to eliminated.

We often talk about statistics and we've argued this to the nth degree, but I'm going to start off by talking about a particular story. In 2002 a Greek elderly gentleman came to one of our facilities and, after extensive diagnosis and discussions with one of our mainstream health providers, he was deemed to be so severe that he entered into our dementia-specific unit. We questioned our ability to care for him because of the severity of his issues, but the healthcare provider assured that they would support the facility so we took him in.

We have a policy of minimal medication - which is not uncommon in aged care - so the first thing we did was review his medication. Because we were able to do the assessments in his language and because we were able to understand the nuances of his behaviour, his medication was halved within the first week. Within the first month what were deemed to be difficult behaviours were now considered to be not so bad. He was no longer angry, frustrated. He was able to eat normally, function normally. He was cooperative, he was sleeping, he was communicating easily with residents and staff. So where this story become implausible is that in three months' time he was discharged home without any diagnosis of dementia; so he had been severely misdiagnosed because of his inability to speak.

CALD definition is important. It establishes a framework in which we understand how we respond to these people. It's currently listed in the report. It's the cornerstone of our personal identity, social belonging, and it is the glue which connects us to each other. Gerard Mansour, the CEO of ACCV, in a keynote address to a particular conference, stated that:

> Culture is not a mere add-on, but rather informs the whole experience of CALD clients. It is not just about language. It is about life and who we are.

In a service system it is critical, because without it we cannot ensure that the fundamental rights which are listed in the Aged Care Accreditation Standards are met: that is, that they need to be able to exercise their fundamental right to be informed and to choose; they need to have their needs assessed; they need to jointly develop intervention strategies; they need to be able to have their day-to-day responses and care plans actioned by staff who understand the nuances; they need to be able to obtain and give feedback about the service they received. It's particularly important in residential care because there is no respite; it is their home, there is no other place to go.

We often visit aged care facilities. Again, that's something that aged care providers do. We were walking through a mainstream facility because we were interested in the building structure. We came across a woman who was seemingly screaming at the top of her voice, but if you're familiar with Greek elderly people they often speak in loud voices. So to the rest of the world she is screaming at the top of her lungs. And what do you think she was saying? "Is there anyone here I can talk to?" I want to deviate from this for a moment.

I often present at conferences because I want to get across what it means to be isolated. So I start off by asking people, "Do you come from another country? Have your parents come from another country? Do you understand what it's like to live in a host community where simple things that you take for granted can't be understood?" So I ask people to show me their hands and a few people put their hands up. Then I say, "Well, how many of you have travelled overseas? When travelling overseas, have you gone to a country where you don't speak the language? How have you been able to communicate your requirements?" So there's sign language; you learn a few phrases and that gets you so far.

In a short space of time and when you're travelling, it's exciting. You're becoming accustomed to a new culture and you're learning and growing. But end of life, this is not what it's about and it's not about communicating the minimal requirements. It's about communicating all the things you need and all the things you wish to express. And then there are some of us who speak a second language and we talk about what it's like to actually visit our relatives in another country, and we find that our language skills here in Australia, second language skills, are considered reasonable, but over there we're speaking like primary school children. We're not able to conceptualise all the things we think and feel. So we feel trapped, and that's what these people do.

I am interested in the brave new world you talk about. I'm not interested in service providers having ownership of their turf. I am interested in mainstream providers, whoever they may be, as well as CALD agencies with specific skills, to work together and provide for these people. We talk about the statistics again, and within the Greek population we can say that there will be something like 10,000 people by 2021 who require aged care services. There are insufficient Greek-specific beds. There won't ever be sufficient Greek-specific beds. That's not what we're talking about. What we are talking about is that the response to these people, the appropriate and quality service, needs to be given to this group of people as it is to all older Australians. The need is now and we need to be responding immediately.

Catering for diversity: there's a section in there which talks about it, and what I wish to say is that the answer is not only in interpretive services; it helps, but it's not the answer. When we talk about assessment through the Gateway Agency, which is critical, we need to talk about the cultural identity experienced by the person. I'll go on to explain what that means. We need to talk about the cost involved in CALD responsive services; we need to talk about the accreditation standards in residential, and quality reporting in community services.

In assessments, we need to specifically look at the person's proficiency in English because that has a role. We need to look at their level of integration into the host community. We need to look at their preferred language of communication. The year of arrival is also helpful, because those who have arrived most recently are the most disadvantaged. We need to look at their history and social economic participation or non-participation in Australian life. We need to look at their work history, their social networks, their capacity to negotiate the service system. We need to look at how they identify with the original culture and also their cognitive impairment.

There are costs involved, there's no denying that. Those people who are currently providing CALD responsive services are picking up the additional costs. Very quickly, they relate to food, preparation and also special dietary requirements; the costs of interpreters and the translations of key documents. At the moment, there doesn't seem to be a pool. There's a duplication of time and effort. When an interpreter is used, it takes double the amount of time to actually get through an assessment. There are costs of tools, such as cue cards. There is also a cost involved in pursuing community partnerships which engage the CALD community volunteers, which are required and are a necessity, to try and eliminate the isolation. There's the purchase of special activities and music programs, and there's installation of various satellites for specific viewing programs.

When we talk about the service system and the approach which means that we come from the consumer, then we have to give the consumer real choice. This is not about rationalising the market so that consumers are only left with one choice and that's a mainstream provider. We need to create opportunities for small CALD communities to provide services, because at the moment they are strapped for finances, resources and expertise. In a deregulated market where competition prevails, large providers will not be interested in partnering with these groups, so there are small numbers of communities which will be disadvantaged.

The removal of high and low care extra service is something we commend. The removal of allocations of caps in each is something we recommend as well. What we are asking is that you give serious consideration to bringing together all PCCAC programs across Australia, to deliver a national approach to information and support to all agencies in terms of specific cultural identity. There's voluminous information about responding to a person from a cultural identity, but we need specific information about what that means.

In terms of the Gateway Agency, it has enormous responsibilities, as stipulated in the commission. If this is able to work effectively, then we would commend the move. One of the concerns we have, in terms of planning at a regional level, is that there will be small numbers of CALD people that will miss out because of where they live or because of the region's inability to respond. So how will these people be cared for? We are interested in an integrated and flexible system, but more so than what is stipulated in the commission's report, and that is to look at alternative models; not just one-on-one care but group settings which seem to be favoured by CALD communities. Regarding the prevalence of dementia, it's well documented that this needs to be taken into consideration when delivering alternative models of care, both in the residential and community settings.

Fronditha Care supports the commission's proposal that the system for care and support for older Australians should be assessed against the criteria of equity, efficiency, effectiveness and sustainability. We're saying that all key agencies should collect and collate statistics and industry measures regarding this. Lastly, we're saying that a CALD response needs to be core business. Thank you.

**MR FITZGERALD:** Thank you very much. Sue?

**MS MACRI:** Yes. Gosh, there's a lot in there. Having married into a Calabrian Italian family - - -

**MS MICHAEL (FC):** I'm pleased to hear that.

**MR FITZGERALD:** I'm sure you're declaring this as an interest.

**MS MACRI:** Yes, one of my many, sadly. There are a number of things there that I would like to ask you. The first one is around the accreditation standards. Where are they lacking and what needs to be done to make them more appropriate for a start? There are quite a number of issues then leading off from that that I would like to get your feedback on. But just starting at the beginning when you talk about the accreditation standards, what needs to be done there?

**MS DAVEY (FC):** From experience, what is missing is an understanding and an acceptance that things will be done in a different way. For example, using the Greek culture, one of the things that our residents like to do is cluster together. They don't like - you know, we might have small lounges but you will find that they're never used, or very seldom, because people like to congregate together. That can raise issues with the standards. Say, for example, privacy might be seen in a different way, so there needs to be some understanding around what people actually want and why there are differences.

**MS MACRI:** Do you think there needs to be something written into the standards specifically around this, called, you know, "Care for People From NESB Backgrounds"?

**MS DAVEY (FC):** Yes, but I think it's more than that.

**MS MACRI:** Or it's the process.

**MS DAVEY (FC):** Yes, it's the process, but it also comes back to understanding and knowledge as well. That's an experience, so for it to be written, I think it also - you know, people need to have a level of understanding, so it could be with assessors that have demonstrated that they have cultural awareness and understanding of that.

**MS MACRI:** Can I just make another comment? We have had a number of comments in the special needs chapter around CALD, in terms of perhaps just our focus on language and food. There have been some comments around that that it's far greater than that. I was interested when you spoke about the isolation of language but also partnerships, activities, music, appropriate programs, all those sorts of things. We have struggled a little bit with that cultural area in terms of how we flesh that out a little bit in the report and what does that mean for different people from different CALD backgrounds, and we would really welcome something from you in terms of trying to flesh that out a little bit more and make it a little bit more appropriate.

**MS MICHAEL (FC):** I'm assuming you don't have this yet. Is that right?

**MS MACRI:** No.

**MS MICHAEL (FC):** Because this is our lengthy submission. So Fronditha Care actually has done a consultancy regarding what it would look like in terms of accreditation standards, so they're listed in this report in detail. We've also had them published in an industry magazine. In addition to that we've looked at what it means in terms of CALD assessments and what are the benchmarks, and there's another table which actually clearly indicates what this means. So it's very specific. It almost becomes a tick box and what we're saying is that the emphasis on CALD needs to be embedded in every recommendation, so it's not just one.

So it's not enough, as you said, to have language or food, but to be able to choose the type of services you provide; to be able to take your own risks; to be able to exercise affection and care in an environment where it's considered elder abuse if a staff member kisses an elderly gentleman who is a family friend and because another staff member says this is elder abuse it must be reported. Now, where's his dignity? So it is around process but it also can be embedded into standards. It's in there.

**MR FITZGERALD:** Can I just go back to a couple of recommendations you've got, and obviously your detailed submission will be helpful. You mention a national framework or a coming together of peak bodies or peak groups in the CALD area.

**MS MICHAEL (FC):** It's PCCAC.

**MR FITZGERALD:** Please explain that to me, what you're proposing.

**MS MICHAEL (FC):** The reason I'm suggesting this is that we need to become more savvy with technology that's currently available, so when people talk to us about - occasionally we get phone calls from mainstream organisations, "How do you actually work with the Greek elderly?" That information can be captured through a web site which is also interactive but it can sustain fairly lengthy information specific to that cultural group, including the migration experience, the work patterns, whether it was likely that the woman worked in or out of home, whether she was likely able to speak English. There is such a web site developed which was funded by the Commonwealth. We evaluated the model. It's www.greekcare.

**MR FITZGERALD:** Yes.

**MS MICHAEL (FC):** We evaluated the model. The expectation was that it would be funded across the major ethnic communities that are currently ageing and peaking within Australia, and it hasn't happened.

**MR FITZGERALD:** Just explain, what is PCCAC?

**MS MICHAEL (FC):** They're agencies which are funded by the Commonwealth.

**MR FITZGERALD:** Right, they're the agencies and then this is a technology tool?

**MS MICHAEL (FC):** That's right.

**MR FITZGERALD:** And what's that called?

**MS MICHAEL (FC):** We developed it. It's www.greekcare.

**MR FITZGERALD:** Greek care, right, okay.

**MS MICHAEL (FC):** And we did evaluate the model for the Commonwealth and established a booklet or a framework or a tool that says, "This is how you establish it for other communities."

**MS MACRI:** Right. One of the things I know - and I'd be interested in your thoughts around this, taking it outside of just the Greek community, but - - -

**MS MICHAEL (FC):** Yes, please.

**MS MACRI:** A facility that I visited in New South Wales in the middle of Sydney, around Leichhardt, had 60 residents and I think out of those 60, 15 of them were from 15 different CALD backgrounds and they were really struggling in terms of how to meet the needs of 15 different CALD backgrounds amongst those residents.

**MS MICHAEL (FC):** Exactly. The idea of multicultural service provision in aged care does not work. It's not the model we're talking about. People need to be grouped, people need to belong to a community, and the best way to do that is to argue for a service system rather than service providers. It should be the obligation of a regional approach or a grouping approach which says, "The Italian community will be placed in this facility. This becomes the specialist Italian wing and this one becomes the specialist Arabic wing," and there's communication rather than a guarding of occupancy rates. It can work. We've seen it work. We run those facilities. Our Newcastle facility has that model.

**MR FITZGERALD:** But going forward, consumers will be able to choose a provider.

**MS MICHAEL (FC):** That's right, yes.

**MR FITZGERALD:** The expectation, at least in the metropolitan areas - and we accept that the regional and rural areas are slightly different - is that ethnic-specific organisations will in fact have particular market niches. They will be able to establish themselves as having specialist services in relation to the Greek or Arabic or Vietnamese, whatever it might be, over time. So by freeing up the system in the way we've described, one of the outcomes of that is likely to be a greater diversity of providers for particular groups, rather than the government centrally planning it and saying, "There will be a Greek facility. There will be a Spanish-speaking facility."

Is that your view?  Because if you don't believe the multicultural sort of approach to service delivery, the alternative is either, as you say, specific ethnic wings or specific ethnic services.

**MS MICHAEL (FC):**   Yes.

**MR FITZGERALD:**   If the government is not going to plan that, and we're suggesting the government doesn't plan it, rather it lets it evolve - - -

**MS MICHAEL (FC):**   For large communities it will work.  For wealthy large communities it will work.  Where it won't work is for emerging communities who don't have the wealth to establish these facilities.

**MR FITZGERALD:**   So what's the right response for that?

**MS MICHAEL (FC):**   Then if you're looking at the zero real interest loans, you need to include those small communities.  Plus we're currently working with the Serbian community in the west.  They're post-war migrants as well.  One would argue they ought to have established themselves in a way - not to the extent we have but somewhere - and they haven't been able to do that.  Now, we're partnering with them.  Their elderly are just at the moment entering into that area of need.  They don't have the resources.  There's one worker in that community agency.

**MR FITZGERALD:**   Just take the Serbian community as an example.  There are two or three levels to this.  One is that the Serbian person will need to be able to access the Gateway, so there may be a need for specific services to support people, as there are now through the various community services that operate.  The second thing is that within the Gateway there needs to be a capacity to be able to deal with that particular individual; to deal with them and their needs in a way you've identified.  But the third thing is then the service provision.  They get the entitlement.  How do you see that person's need being met?  So let's assume they get support, let's assume they get properly assessed.  How would you envisage that particular community of individuals being serviced?

**MR WOODS:**   And can I ask it in respect of both:  if they need community based services, ie in their own home, so there's no capital infrastructure required, or then if they need residential care.

**MS MICHAEL (FC):**   Okay.  If they need services in their own homes, in the ideal world what you would be looking for is a Serbian worker, a worker who is able to speak the language and understand the culture.  That missing, then what we would argue is that you need to differentiate between the home care and the personal care tasks, so there's further segregation to the service delivery within the home.  I understand about streamlining services, and it's something we're experimenting with. You then look at older people from that particular cultural group who are trained to assist but not undertake the labour, but they're able to converse and create the conversation and be understood.

So there are responses which are appropriate but at the end of the day, and this is what I come back to, they cost money. So at the moment our organisation has some funds which enable us to run those services parallel to what we do. We self-fund them. In a small community they don't have those resources.

**MS MACRI:** And quite often not even the number of people to support.

**MS MICHAEL (FC):** When we talk about residential, if you are talking about a competitive market, there is no answer. They'll be lost. Some provision needs to be given to these particular groups, or incentives to people who are larger, who are able to establish even a small grouping of three, four or five places. The Serbian community will then partner with that agency and will assist during the Gateway assessment and enable them to move there if that's what they want to do, because in some instances they also want to be anonymous. So we're not saying one model fits all.

**MS MACRI:** I think one of the things we need to think about - and you're right in this and this has just twigged with me - is in the current ACAR rounds people often get preferential consideration if their submission or their tender document has an aspect of CALD within the tender document. When we go out to the competitive market and open up the ACAR there still needs to be some incentive around CALD or CALD communities and I think that's a really good point - in a competitive market.

**MR FITZGERALD:** Just in relation to that, if the community service organisations that specialise in providing social and other support for various CALD communities are appropriately funded, are they the right vehicle by which this social support, these additional supports, are provided? You've indicated there's a difference between the actual delivery of the labour, the actual service, and in a sense what we might call social support. I know that's a broad term and it has many meanings but are the associations like your own and others the best organisations through which those social supports, those advocacy supports, those personal services - if I can use that term - are provided, because obviously you can't embed all that in every aged care provider?

**MS MICHAEL (FC):** That's right.

**MR FITZGERALD:** It's not possible.

**MS MICHAEL (FC):** It's not.

**MR FITZGERALD:** Nor are you suggesting that, so you need organisations that sit outside of the formal aged care providers providing these sorts of services. Now, we've had that for a very long time but I'm sure you'll say to me very inadequately so. Are they the right organisations through whom these social support systems, especially to the smaller communities, are provided or is there a better model than that?

**MS MICHAEL (FC):** The best model is where people feel connected. If that means that they attend an agency which is well known to the community and there is already embedded trust - because again we're talking about migrant groups who have experienced trauma and there is a mistrust to political or government agencies. If the relationship exists with that organisation you're more likely to get participation.

**MR FITZGERALD:** Sure.

**MS MICHAEL (FC):** So that's the short answer to that.

**MR FITZGERALD:** But I need to be a bit more specific if I can.

**MS MICHAEL (FC):** All right.

**MR FITZGERALD:** I understand it's the principle in terms of a public policy response. You're saying to us that there needs to be additional resourcing in order to meet the needs of the CALD communities. What is the best means by which the government can provide those resources?

**MS MICHAEL (FC):** In terms of community care and residential?

**MR FITZGERALD:** No, in terms of the social support in terms of enabling people to be helped to access the Gateway in terms of - - -

**MS MICHAEL (FC):** You're familiar with the supported access program?

**MR FITZGERALD:** Yes.

**MS MICHAEL (FC):** Are you asking me does that work? Yes. The short answer is yes, but do you know where it falls down? We could go out and educate and speak with communities. We can talk to them about the service system and we can fund it in a way that is familiar to them. We help them along and we get them to the agency. The agency tries their level best to be inclusive and to be responsive. Sometimes they enter into the service but it's highly likely they would drop out if the actual service delivery is not CALD responsive.  What does CALD responsive mean?  The person delivering the service within their own home needs to come from their own cultural background.  That's it.

Why are CALD populations not well represented in HACC but they are in CACP?  It's because they have an ethno-specific model.  Why are planned activity groups so well supported?  Because migrants of a Greek background - probably Italian and Polish and German - are social beings.  They are accustomed to meeting and working and providing for each other in group settings.

**MR FITZGERALD:**   Okay.

**MS MICHAEL (FC):**   I don't know if I've answered the question.

**MR FITZGERALD:**   No, I think you have.  That's fine.  It sounds good.  I think we're out of time.  Thank you very much, and you're coming back with the Dutch group or not?

**MS MICHAEL (FC):**   Yes, I'm staying here, waiting for them.

**MR FITZGERALD:**   All right.  Okay, thanks very much.

**MS MACRI:**   Thanks for being so flexible.

**MR WOODS:** For the record, could you please state your name and any organisation you may be representing.

**MS HOWE:** My name is Anna Howe and I'm not representing anyone; just here as an independent consultant, observer, interested party in the aged care system.

**MR WOODS:** Thank you, Anna, and thank you for your contributions to date to this inquiry. We're very grateful for the effort you've gone to and for allowing us to modify your little triangle or pyramid and all the rest of it. We have appreciated your ongoing input. Do you have an opening statement you wish to make?

**MS HOWE:** Just very briefly. First of all, about the triangle, I think I'll go home and try and draw it as it should appear in 2020.

**MR WOODS:** Okay, that would be good.

**MS HOWE:** It would be interesting to see what's the shape of the system that we're trying to get to. Just I guess by way of commenting on the report, the draft certainly has a lot of material in it, plus the appendices was a good read. I have to say I did find it somewhat uneven. Keeping retirement villages separate from residential aged care: I think everyone heaved a sigh of relief on that. That was very good. At the other extreme, I guess, are some of the international comparisons. I'm not quite sure what we can learn from the South African system in terms of health insurance. I think there are virtually no parallels between South Africa's healthcare system and Australia's, and I think that is not a very useful comparison; especially when in my efforts to track down what the South African healthy ageing savings accounts were, I couldn't even find the web site that was cited in an earlier Access Economics report.

And even comparisons to Singapore. Singapore has barely the population of Victoria, it's a highly cohesive society; very, very different retirement income system, health insurance and everything else. So to make comparisons to bits of very different systems I don't think is particularly useful.

**MR WOODS:** Is there anything you do like? Is there anything you do like in our report?

**MS HOWE:** Yes. In between these two extremes, yes. But I think it would be quite useful to have the final report a lot shorter because it is a huge read to get through. The summary report, I thought, was very useful. In today's brief presentation - and I will be putting in a further written submission - - -

**MR WOODS:** Thank you.

**MS HOWE:** - - - I really just wanted to focus on some areas. I don't want to talk about the new agency or the housing areas and so on, but I did want to look at the aspects of paying for aged care, some issues of care and support, aids and equipment, monitoring and data, and then the timetable. The quickest one, I guess, is the aids and equipment. I'd like to see a lot more on that. It seemed only to come up fairly incidentally in relation to housing, and yet aids and equipment are very, very widely used, there's a huge demand for them, and they can make a big difference. There is an American author with the delightful name of Emily Agree, who writes what I think is very agreeable research, very large-scale studies on the value of aids and equipment, and I think we could learn a lot from that. So that was just a brief comment there.

On the care and support, this is where we can learn something perhaps from overseas. I would hate to see us going down the UK model of years ago of separating out the social bath versus the medical bath, or the ordinary meal which was an everyday living expense versus the diabetic meal which was a health expense. I think trying to split what is HACC everyday living into something else is probably not very helpful. The cost of recovery of very small amounts: I note that the City of Moreland where I used to live in Melbourne one year collected something like $4 million in fees which sounded terrific, but it cost them $2 million to do it, and the bank - every dollar it counted - probably took 10 cents. So the inefficiencies, I think, in some of that area do need to be looked at.

But what I did want to talk about a little bit more is that, without diminishing the value of carers at all, I think we do need a little bit more in the report about the carer allowance. Expenditure on carer allowances 2008-09 was $1.8 billion, which was in fact $10,000 more than was spent on HACC in that year, so that's a large block of expenditure that just doesn't ever seem to show up in aged care or community care but it is substantial. When we look at the take-up amongst primary carers: about 60 per cent, if we just take the primary carers from the SDAC's data and the number of recipients. The criteria though for carer allowance are more strict, so take-up amongst the eligible population is probably up around 75, 80 per cent. So there is quite a high take-up of that benefit.

Whether the eligibility criteria are too strict or too lenient may be another matter, but that is a large amount of cash that is injected into the system with discretionary expenditure. There are no controls whatsoever on what you do with it. It does seem, from anecdotal - if there's such a thing as anecdotal evidence, which I doubt - a lot of people do seem to use it to top up services. They buy a bit more respite, a bit more something from the service provider they are already using, not someone else. So that's, I think, something that does need more attention.

When we look at the use of HACC - which again I think is a bit underdone in the report, compared to some other areas - in the target population, 30 per cent of the target population have no carer and use HACC. This is juggling with several different sets of figures: 15 per cent have a carer and use HACC; 25 per cent have a carer but don't use HACC but they may use Respite for Carers Program, DBA or a package; and 30 per cent interestingly do not have a primary carer and do not use HACC. Most of them are probably people with the lower end of impairment, but it's quite a dispersal there. I think the 30 per cent who have no carers and use HACC are probably the most disadvantaged. They don't have the backup of a carer and all the other benefits that that provides, and they don't get the extra $40 or $50 a week from the carer allowance, and I think there's a need to make the system less reliant on carers and more carer neutral. The focus should be on the disabled person or the person needing care. Whether or not they have a carer or a primary carer or anything else, to my mind shouldn't really come into it.

The carer allowance expenditure actually is more concentrated than HACC, which we know about. It's not so much a thin spread of HACC as a very variable spread. There are more people on HACC getting package-level services than are on packages, so it's sorting that out. I'll come back to that, though. The other point I guess I'd like to make: while there does seem to be some difficulty in accessing services, 800,000 people do manage to get to use HACC, so they can't all be wrong. They got in there somehow, for better, for worse, and I don't think most of them are getting the wrong services. So the Gateway things and so on, most of these people get in at a very local level and not Access 1800 in the sky, and I do think some of the Gateway in the virtual world is - well, it's a bit virtual for many people to grasp, when I can imagine you go to your local council, they say, "No, you've got to ring Access 1800." You do that. They say, "Go back to your council to get the service." So I think there are going to be a lot of unnecessary complications, especially for the low end.

**MR WOODS:** That's certainly not our intention. In fact, it would be using councils, GPs, everyone, to disseminate the access to it.

**MS HOWE:** I think there's some of that in the appendix, but I would like to see more of that in the final report - how it's actually going to work - so that that looks a bit more on the ground. On some of the modelling and reporting of things in the report and elsewhere, I guess, in monitoring what happens, I think we do need to decide: are we talking about in aged care the population of 70 and over, all of them, or those with some level of impairment as per the disability surveys, or 65 and over? And it just drives you crazy when you look at different tables with different denominators and it's very hard to work out all of these things.

**MR WOODS:** We agree.

**MS HOWE:** Yes.

**MR WOODS:** The failings of the data more than the failings of our intention.

**MS HOWE:** Yes. I would congratulate DOHA on producing an annual report for the HACC program 25 years after the program started. Well done. On the other hand, the community care census, most of it duplicated what was already reported by the AIHW and at vast expense and difficulty for everyone. It did have a little bit more data on carers but not much, and I think that really does need to be sorted out. AIHW can do it much better than DOHA and, if there is to be another census or more data on carers, perhaps every two years is enough; it doesn't change that quickly, and just a bit more regular presentation and access of data for other people to look at.

In terms of the DOHA submission on modelling of efficiencies, they talked about, I think, 10 per cent who seemed to be pretty inefficient, but they didn't tell us who they were, and it seems to me that there's a great difference here if this 10 per cent of homes are small or regional, rural, remote homes that account for maybe 3 per cent of beds. If, however, it's a major for-profit or not-for-profit provider or a group of providers, the 10 per cent of the largest homes that account for say 25 per cent of the beds, we're really in trouble. So please tell us which beds they are or which homes they are and what proportion of beds they account for.

The Stewart Brown submission did go a little bit further in that, but I think we need to talk about the proportion of beds as well as the number of homes, and are these little stand-alone homes or are they parts of a big conglomerate, because if you've got a bit, inefficient conglomerate, in terms of benchmarking that would very much skew the level you wanted to set, whereas if you've got some big, efficient, high-quality providers, that benchmark is going to be the one you aspire to, I would think. So some of the data analysis was, I thought, a bit peculiar.

In terms of the time frame, just recapping a long history here, we seem to have a major review in aged care about every 15 years. The House of Reps inquiry in the early 80s, its recommendations lasted from - I think the first things came through with HACC in the 1984-85 budget and that ran till the mid-60s, then we had the Aged Care Act and that has run until about now. I think with the 40-year time span to 2050, we do want to have a vision of what we want to get to, but I think we need a bit more up-front action.

The forces of inertia I think are already gathering: some of the commentaries around, saying, "Oh, we can't go too quickly here," or, "We can't go too quickly there." My view is you actually need to go a bit quicker and have a few big bangs to get the momentum going, because if we're waiting for momentum to build up, it might never do that, whereas if we have a big jump, it will trickle down - a big jump and it might take off.

So, looking at the momentum of reform, certainly HACC got things going, because expenditure increased by 20 per cent per annum for three years. If you inject funds like that, that's terrific. And I think we do have a window here. Looking at the number of new residential care beds, the expensive part of the system, the number coming online in the last few years: as at the last - 08-09, just on 4000, a lot lower than in the preceding three years, and that's the lead and lag of approvals, and then there was the GFC and so on and so forth. But if that low level of resicare approvals continues for the next little while - and I think people have been sitting on their hands waiting for your report, and various other reasons. Uncertainty is a great inhibitor for development.

I would like to see a new level of packages just announced, like the other ones were. There was never any evidence based research or anything. There was just a decision to have CACPs so DOHA didn't have to give the unspent money back to Finance, and that's not a bad thing - better to go into the system than back to Finance.

**MR WOODS:** Back to the taxpayers.

**MS HOWE:** Well, no, the taxpayers do appreciate having services. The taxpayers are also the recipients of services and so on. There's not "taxpayers and the rest of us". Most of us are both. I remember, while we're on it, for many years the tax I paid exactly paid my father's veteran's pension, so I thought that was a very neat return.

We have a window here of low increasing beds, so expenditure will be down, so I think we'd like to see that money just strike an intermediate level of package between CACPs and EACHs, about 24, 25 thousand, including nursing, and the only people who can get them are those who are really strained on a package or HACC-equivalent people; people who are on a CACP, say, getting top-up nursing, which actually probably puts their cost up to this level anyway. Doing that would relieve pressure on the lower levels, which is where I think there is the pressure; so shifting these high-cost people over.

I couldn't see why the minister just couldn't announce he was going to have 50,000 of these or 50,000 over five years, 10,000 a year over the next few years, or some number along those lines - probably less than that to start with. It's how it's happened in the past. Everyone says we need more packages, but if we're just going to have some huge research exercise to work out, you know, "If you can tie your shoelaces, you're not in and if you can't, you're in," we'll never get there. We can always start it and then have them grow faster or slower, depending how it works out, which is how it's happened in the past.  So I'd certainly like to see that.

The last area, on which I won't say much but I will put in my submission:  on the funding, in the modelling and the appendix that has the expenditure data, I'd like to see a little bit more modelling on how much extra income is going to come from bonds for high care, how much we expect.  I do find it bizarre that we expect maybe - I think the AIHW reported bonds were collected from 15,000 newly admitted residents last year, and if we had bonds for high care that would go up somewhat, but I do think it's bizarre to have the capital funding of an aged care system dependent on maybe 20, 25 thousand out of 200,000 residents.  It seems to be a bit skewy to me, and having some more paid bonds is still going to leave a big burden on the taxpayer to pay the accommodation charges for everybody else, and I do think we do need some other kind of funding arrangement.

I think we can afford it.  One of the other submissions talks about the huge tax breaks on superannuation - $26 billion a year.  I think we can afford to trim that back a bit and redirect the money into capital for aged care.  Some might say, "Oh, super helps people pay for their future."  Most of the people who are getting the major part of those tax breaks are highly unlikely to ever go into aged care, because they're very well-paid men.

In terms of the implementation timetable, too, I think we're looking at two generations of older people, especially the women, who are most likely to need care. Those who are ageing in the near future, if they worked they sure didn't have super and they didn't even get equal pay, so I think a bit of restitution there might be in order.  I'd love compensation for that.  So we do need to look at just who we're talking about here.

The difficulties of bond-paying for people who are then going to go in and qualify for the highest benefit on the basis of dementia, when three weeks earlier they've managed to auction their house:  I find that a bit contradictory.  The prospects for pressure on older people to rearrange their assets and so on:  it may not be extensive, but it can happen.

One other report does mention what was known as "the nursing home debacle". I don't know that you considered whether this would recur or not and whether that's going to be dampened down or whether community groups are going to get up again. I'm sure there are plenty of old newsreels of debate in the parliament of the present government members tackling what was the government on that issue.  But my greater concern is that, even with more bonds, it doesn't mean the money is going to flow to where it is going to be needed.

The biggest winners, in a way, of bonds for high care will tend to be smaller private-sector providers, who may never be going to reinvest or expand. The group who haven't been getting bonds so far - it's not the big not-for-profits, who have a lot of low care; they age people in place, so they've had the flow-in there. Some of the large privates, they've had extra services, so they've had bond income from that. But there's a long tail of providers who have one or two facilities, high care, who would collect relatively small bonds maybe, relatively small amounts of money.

That's probably not going to add up to enough to be reinvested and I certainly don't think it's going to be reinvested in the right place - the mid-north coast of New South Wales or South East Queensland or the western suburbs of Melbourne and so on. There's a big redistribution effect that has to happen there, and I'm not quite sure that these are going to be the providers who are going to do that.

I'd like to see a bit of modelling there, not treating all providers as if they were the same, because someone who's a part of Bupa or one of the big not-for-profits doesn't behave the same as an owner-operator who has one or two small facilities. Their investment decisions and so on are going to be very, very different - their capacity to borrow and so on.

**MR WOODS:** Getting the data is of course a little tricky in these areas.

**MS HOWE:** A bit of abstract modelling can help. I think you can have a go at it.

**MR WOODS:** Thank you.

**MS HOWE:** All of the economists there, they're pretty good. Get David Cullen onto it. I'm sure he could churn out something. Even if we look back in the last few years, we know who has invested because they've got approvals, and it's a very, very uneven pattern. It changes from year to year a bit. A few privates have a go at it. We had a lot of restructuring around 2001. That seems to have settled down. So who's getting it now?

Looking at the rural and remote areas, it's not a high proportion of beds, but there's virtually no private provision; there's very little not-for-profit. It's nearly all community and, say, local government or state government; multipurpose services in Western Australia. I know Victoria is odd. But that investment coming through bonds for high care is certainly going to be very unevenly spread across the country, so I do think we need to look at that and see where it might go.

I think there's a much broader band of funding to be drawn on than that very narrow band of high-care bond payers, and looking at the projections there, some who perhaps have the capacity to pay have more choice to offer for other things like retirement villages, getting services in there and therefore maybe less likely to say, "There's so many going into high care. What proportion do we expect to pay bonds? What's the maximum percentage, the minimum percentage, and is it really going to solve the problem into the future?" and it may not.

The use of resicare has been going down by 20 per cent over the last decade. That's very consistent. So just who the paying customers or consumers are going to be: the prospect, in fact, that those going into subsidised residential care will be more and more financially disadvantaged - a bit of cause and effect there, one would have to say.

I do also think there are a lot of questions to be asked about building a residential care facility. One way is building a box into which the Commonwealth - taxpayers - pour money. For care benefits, most of the user payments are transfer payments through the pension and for accommodation charges, and I do think we need quite a bit of control over where they're built, how they're built, who they're for and so on. I'm less sanguine about the market prevailing and doing the right thing - where they're needed and so on.

I don't think in fact providers are going to rush out and build where they think they ought to because they think the market is going to work. I think there's going to be a lot of sitting on their hands. If they're not certain that they can fill the bed with a paying customer, either paid for by the government or paying themselves, I don't think they're going to build them. I think we're going to see - - -

**MR WOODS:** But that happens now: they don't take up their allocations or they don't apply for ACAR rounds. Nobody forces the provider to build now, even though we've got an ACAR system.

**MS HOWE:** No, that's right. So the money that's going into bonds, we've got no guarantee that it's being reinvested; absolutely the case. It could go anywhere or down the gurgler in the GFC. I think it's a very risky way of funding into the future.

**MR WOODS:** Yes. I'll let you finish, but there are a couple of things I want to go back to.

**MS HOWE:** Yes. I'll be, I guess, developing more on that, but I'd just like to see a little bit more of where we think the - how much, if there is likely to be, and which provider it's going to come through, and where it's then going to be invested, and a bit of analysis, say, of the ACARs and the outcomes over the last five or six years, because it's a two to three-year time lag and the ACAR approvals have gone up and down a bit, they've been a bit steadier for the last few years. And then the failure to realise: is it because there were fewer approvals or does something happen in the pipeline in terms of what comes out and so on there? So there are a number of factors interacting there and, indeed, which will continue to interact with considerable uncertainty.

**MR WOODS:** You've traversed a large amount of ground, and we do look forward to your final submission - which will be coming in very soon?

**MS HOWE:** Yes.

**MR WOODS:** Thank you.

**MS HOWE:** I'm aware of the time line. I'm not DOHA.

**MR WOODS:** Now, now.

**MS HOWE:** Can't I have an extension for three weeks, please?

**MS MACRI:** No.

**MR WOODS:** We have their second submission. Their second submission has come, Anna.

**MS HOWE:** It seems to be a lot shorter.

**MR WOODS:** It is. We'll pick a lot of that up when you put in your final submission. Just a couple of points: we don't see bonds as being the sort of panacea to the capital funding. We, in fact, anticipate that a number of people will choose to pay a periodic payment, whether it's a daily charge or weekly rental, whatever it chooses to be, and that providers are going to have to take that as a bankable proposition to their financial institutions and say, "I think I can service debt of this on the basis of occupancy of whatever." So I think we've got to keep bonds in perspective. It's not going to be the capital force that it was and up to date. I think that's a very good turnaround. The level of bonds, we're 11 billion and rising, its - - -

**MS HOWE:** And turning people who are quite wealthy into pensioners who then didn't pay any means-tested fees. So I think we've certainly corrected that.

**MR WOODS:** Yes, and all of those sorts of distortions. We have tried to neutralise the age pension effects and so far nobody has identified any significant holes in that arrangement. So we do see the importance of periodic charges, that the provider for non-supported residents can set whatever they think is the appropriate charge that the market will bear - but that's what happens in a community for accommodation now. People go out and choose a level of accommodation that (a) they can afford and (b) want to - - -

**MS HOWE:** Some choose, and some are forced into pretty grotty boarding houses because that's all they can afford on a pension.

**MR WOODS:** Yes, but where they get accommodation assistance, we're proposing that they would continue to be assisted and that they would be supported residents. But, importantly, for the providers, the accommodation payment for supported residents would give a return on investment - unlike the 28.72 at the moment - for new construction. Arguably it's not bad if you've got a very old facility and it's just a cash flow, but not for new construction, which partly explains the current capital strike. So I think when you are finishing your submission, if you could just reflect on how important bonds will or won't be in the future, that would be useful.

One other thing that I wanted to pick up - and there is a whole range of stuff, but given the time - your reference to making use of HACC more carer neutral, and you made some comments earlier about the amount going into carer allowance and how that was untied funding - which it is - and how some of that got reinvested in services, but if you could elaborate a little. What's your vision happening there about making - it would be basic support but a HACC type service. I mean, we won't have HACC and CACP and things, but we'll - - -

**MS HOWE:** First of all, I have a lot of trouble with the term "basic support", because a lot of the people who are getting what appears to be a low level of support are actually highly dependent and with a carer. They may only use, say, day care twice a week - which looks like basic, low level of support, but actually the carer is doing an awful lot.

**MR WOODS:** True, yes.

**MS HOWE:** I do think that is a real problem, to say that low level of support equals low dependency; not much need.

**MR WOODS:** No, low drawing on government-supported services, not low dependency.

**MS HOWE:** Yes. There's very little evidence that people with low dependency use anything anyway, so we don't have to worry about moral hazard or anything like that.

**MR WOODS:** No.

**MS HOWE:** There's just no evidence of - the odd politicians aunt in Tasmania perhaps; but you hear those silly stories. But I think that my preference would be for an allowance that is paid to the person with the disability, that's equivalent to the carer allowance, but the carers only exist because of the person with a disability. It's a sort of a relationship. I guess we have to ask: do we want to recognise their role and, if so, how do we do it? It can lock in a person with disability and their carer in a way that neither of them might actually choose to do, if we're on about choice.

Person-centred care: I think the person with the disability should be the recipient of care, should be at the centre of that, and I would gradually phase out the carer allowance and replace it with another kind - I think I'd call it something like a community living allowance for the cost of disability, which are more than the everyday living costs - if you need community transport or taxis instead of being able to take the tram and so on - and the other incidental costs, minor aids and equipment, the kinds of things all the chemists have these days.

So I would be inclined to transfer that over, both at the younger age group - I don't know what's going to happen to the carer allowance under your disability report; where that sits in there. The carer allowance, very anomalously, is not means-tested. If it were, it would hardly remove anyone, because most carers have a low income.

**MR WOODS:** Yes.

**MS HOWE:** You wouldn't be doing it to save the government money. But I think for consistency with everything else, it seems very strange that we're going to means-test Meals on Wheels and things like this - which are kind of tested anyway now but not very stringently - but then give out a carer allowance, albeit ía small amount of money, without a means test. So there's a bit of a disjuncture around all of that.

I think that the carer allowance is a recognition of carers. We certainly want that. But I was very surprised at the meeting that Sue Macri attended, the Australian Association of Gerontology, where the spokeswoman for the carers association actually said they preferred services to cash. I nearly fell off my chair, because it seems to wax and wane from time to time. A few years ago everybody wanted the cash; now it's gone back to wanting more services. I would think that, if we gave my community living allowance to the person, they could decide whether they wanted to give it to their carer or use it for services and, for the people without carers, who I think are the most disadvantaged, it would even things up for them.

**MR WOODS:** Okay, thank you. We have run out of time, but we will read with interest your further submission in the near future.

**MS HOWE:** Thank you.

**MR WOODS:** If we have any questions or issues on it, we know how to find you. Thank you very much for presenting.

**MR WOODS:** Can I bring forward the Australian Psychological Society, please. Thank you, gentlemen, for waiting. Thank you, gentlemen, for your patience. Could you please, for the record, each of you state your name and the position that you hold in the organisation you're representing.

**MR STOKES (APS):** My name is David Stokes. I'm the senior manager of professional practice for the Australian Psychological Society.

**MR LI (APS):** And Bo Li, senior quality adviser for professional practice, the Australian Psychological Society.

**MR WOODS:** Thank you, and thank you for your contributions to this inquiry. It's been very helpful. Do you have an opening statement you wish to make?

**MR STOKES (APS):** If we might. In fact we might just divide it and be as brief as we can.

**MR WOODS:** That's all right.

**MR STOKES (APS):** I want to start off at a fairly broad high level and just comment on what we see as something of a paradigmatic conflict, in the sense that although we very much value the opportunity to read your draft report and to take on board your comments, we still feel that the balance between the sort of grappling with psychosocial issues and the economic structural issues still remains. We think it's a challenge that this report needs to take on board or it will have some significant gaps.

I guess you're not surprised that the Psychological Society has some convictions in this area but we clearly do have issues that we don't feel are perhaps well dealt with, and they're issues that I think are generally referred to as the human factors issues. I'm not saying that there aren't references to these factors in the report. We just don't feel they're sufficient to create a balanced view of this. I suppose, for instance, from our point of view there needs to be greater attention to the interplay of economic and human factors, particularly things like the social and psychological needs of the aged, the social impact and the psychological impact of structural reforms and changes, and the whole issue of quality of life which needs to be viewed as part of it.

We feel if some of these issues could be grappled with in a bit more depth then the balance would appear in this report because they are fundamentally important issues, and perhaps that's enough for me to kick off the discussion.

**MR LI (APS):** Just to add to what David has said, we put six dot points to the commission prior to today's hearing. We might just go through them very briefly and go through that at the commissioner's choosing. The first issue, having said about the psychosocial aspect, is back to the economy. The argument once again is that there needs to be a greater focus on the allocative efficiencies, as well as the structural efficiencies, to understand the proposed gateway and the regulation commission which structurally would make the system more efficient. However, there is demonstrable evidence out there, particularly in the psychosocial domain again, to demonstrate that behavioural interventions in conjunction with or as a substitution for medication can produce fairly significant cost savings, not to mention qualify of life efficiency for the residents concerned. So that's point number 1.

Point number 2 really regards the concept of ageing in place. We see ageing in place as a much more universal concept, not purely about helping residents to stay in low-level care even though they need high-level care. We see that as only one aspect. The broader concept is more about improving public access to transport, buildings, access to services and general connectedness, if you like, with the community so that the older person can stay active and be a member and active participant of the community. That, in our view, is active ageing and ageing in place.

The third aspect is really about the lack of recognition of behavioural issues within the aged care system. We note that several submissions have pointed out the lack of remuneration in the behavioural supplement in the Aged Care Funding Instrument and that's something we certainly concur with, in that people with behavioural issues - it's sometimes perhaps easier to deal with by medication rather than extensive behavioural interventions, and I think that's a lack of human understanding in the current system.

The workforce area has been dealt with well in the draft report, we felt. However, there has got to be a greater interplay between the aged care workforce and the general health workforce, even though funding-wise they are separate, but people move in and out of those two systems fairly seamlessly and the workforce has got to be flexible enough to deal with those patients' journeys as they travel between aged care and the healthcare system. Again, philosophically, we see the issue of health care as a right and entitlement, and reflecting on an earlier speaker, we think the distinction between personal care and health care is somewhat artificial and does not reflect the real world. For example, if someone needs assistance with their showering and grooming, that is defined as personal care but without that personal care that can lead to skin breakdowns and admission to hospital. So it is a fairly slippery slope if we start dividing the personal aspect and the health aspect of care.

Finally, reflecting back to an earlier speaker again, I think with all the structural reforms we've got to recognise that there are predominantly female members of the older Australian communities who don't have a lot of assets under their names and don't have a lot of savings, and that even reforms, particularly in relation to funding, must need to have a no-disadvantage clause of some sort to ensure that the spouse can still remain active in their chosen place of residence.  We might just leave it there and ask the commission whether they have any specific questions.

**MR WOODS:**   A couple of things that I'd like to pursue, one fairly briefly:  your first point where you're talking about the use of polypharmacy versus other interventions.  Are there actually any impediments?  You talk about the cost-effectiveness of other forms of behavioural management, et cetera.  Where are the barriers?  Where should we direct our attention to ensure that it is the best and most appropriate care that is being delivered, rather than care that is driven by some sort of schedule or other regulation?

**MR STOKES (APS):**   There are two things that immediately come to mind and the first is the medical paradigm which dominates health care, as it does aged care too - that the focus on resources and management is very much medically based.  What we're saying is that there needs to be an acknowledgment of other avenues of resourcing and support, and of course that brings up the second aspect, the availability and access to those resources, because we know that funding generally goes much more strongly with the medical processes than the non-medical processes.

**MR WOODS:**   We understand the importance of support in its broader diversity than just a medical model, and in fact we've been at great pains to not have aged care a downward extension of the medical model but an upward growth of the community support and care model.  I just don't know what specific recommendations or changes you would propose that would achieve some of what you're aiming for in this.  I can't operationalise it at the moment.

**MR STOKES (APS):**   I was going to say one of the things that we have been promoting is the notion of a training model that incorporates some of this into the system; so a training model, for instance, where psychological interventions might be a placement opportunity within a residential aged care facility.  That would both provide experience and exposure and adaptation of the aged care facility to understand those sorts of approaches.  So that would be one recommendation as part of your training.

**MR WOODS:**   Okay, and on that one we have recommended that there be more training in - - -

**MR LI (APS):**   Which we support.

**MR WOODS:**   - - - particular residential care facilities.

**MR STOKES (APS):** Absolutely.

**MR WOODS:** So that would be a way.

**MR LI (APS):** That's certainly one aspect. The other aspect which the commission might be aware of is the lack of access to qualified practitioners within an aged care facility. For example, if an elderly resident in the facility is displaying emotional behavioural disturbances, it's much easier to get a GP, assess them and put them onto medication, rather than get perhaps a psychologist or even a social worker to come in and assess the emotional state and put in therapies. Even that may produce long-term cost savings. The subsidy for the PBS outweighs the psychosocial input.

**MR FITZGERALD:** One of the things we've indicated in the report is the notion of these integrated and multidisciplinary aged care health teams.

**MR LI (APS):** Yes.

**MR FITZGERALD:** We're waiting for, obviously, feedback on that particular proposal. But at first glance, this seems to be a very good way forward: team based medicine; team based health, more importantly; within those teams, the role of psychologists generally and social workers. I mean, people are talking about geriatricians and nurse practitioners and others but if you were actually developing these teams which can do visitation into residential services and/or into the community, what is the best way to structure those teams? What do you think the skill mix would be in a properly integrated health team, dedicated to older Australians?

**MR STOKES (APS):** Before I specifically answer that question, that's another aspect of the paradigm problem, too: that the physical issues are always seen as much more easy to work with and deal with.

**MR FITZGERALD:** Sure.

**MR STOKES (APS):** So there are dieticians and physios and so forth in abundance perhaps - in quotes.

**MR WOODS:** Relative.

**MR STOKES (APS):** Relatively. But, nonetheless, the psychological issues pervade much of the residential aged care facility population. We know the high incidence of depression.

**MR WOODS:** Yes.

**MR STOKES (APS):** Way above that of the normal population. So the teams have to reflect the needs and that's why we felt the grappling with some of those social needs and emotional needs was an important part of the report, to bounce it into making recommendations about the structure and formation of those teams.

**MR FITZGERALD:** One of the dangers we have is in the term, the use of the "social" and "psychological". Whenever we talk about "social", people talk about "social supports" and we have a lot of social support systems in place, run by community service organisations.

**MR STOKES (APS):** Understood, yes.

**MR FITZGERALD:** Rarely, if ever, would anyone contemplate that there is actually a psychological professional attached to those words. So is it wise to talk about "psychological needs" in isolation from "social", simply because of the misunderstanding that takes place when you do that?

**MR STOKES (APS):** You're probably quite right, and yet we would hesitate to just talk about "psychological" because they're so closely wound together.

**MR LI (APS):** Exactly.

**MR STOKES (APS):** But if it would help the communication, we would be more than comfortable to work in those terms.

**MR LI (APS):** We know that with regular social contact there have been psychological benefits.

**MR FITZGERALD:** Absolutely.

**MR LI (APS):** So the distinction again is not always artificial.

**MR FITZGERALD:** No, and I'm certainly not trying to indicate that there is a difference between the two.

**MR STOKES (APS):** No.

**MR FITZGERALD:** But it seems to me, when we use the word "social" in this context, it's very much about what people are now saying "social inclusion type arrangements; social connectiveness".

**MR LI (APS):** It is clearly defined, yes.

**MR FITZGERALD:** All of which have a wellbeing effect, mentally and otherwise. But just relating to that, you've indicated that you think our report doesn't deal enough with the social and the psychological issues.

**MR LI (APS):** Yes.

**MR FITZGERALD:** As Mike was indicating, one of the challenges in our report is that we have to operationalise it. In a sense, we're not actually creating the panacea for caring for older Australians. We're trying to create a system.

**MR STOKES (APS):** No, we understand that.

**MR FITZGERALD:** Again, in relation to the community aspects, the community care, people living in the home in the community, are there specific things that you think we need to address that we have failed to?

**MR WOODS:** Could I just as a preface to your answer - because your second point, which I think Robert in part is alluding to, this ageing in place as a universal concept - the draft report, and maybe it hasn't articulated it quite as clearly as it should, aims to put the increasing emphasis on assisting people in their community environment, to stay at home; either the current home they're in or more appropriate housing of their choice, but to remain within their community, to remain with their social contacts, to age in that environment. We know that "ageing in place" as a specific term has related to residential aged care facilities, but the whole thrust of our report - which I was hoping would come through but maybe hasn't as clearly - is that ageing in place and coping with frailty, et cetera, should occur within the environment in which they live, to the extent possible.

**MR STOKES (APS):** We see that, and I guess it was that term and the use of that term that worried us, and that's why we commented on it specifically. But to go back to your operationalisation issue - and I do think that's a very important thing; it's easy for us to talk about psychosocial needs of the community but how is it operationalised? - one of the ways I thought that might help was that in the measurement of success of a system there needed to be some very clear psychological measures. I mean, quality of life is now a commonly used and assessed concept. To what extent is that going to be a measure of the success of a program? Things like patient benefit or client benefit or community member benefit, however they're characterised: how have we benefited this person in the psychological and social sense?

**MR LI (APS):** And also going slightly beyond the terms of reference of this inquiry, any finding for support services - a loose term - social support, disability support, carer support, as well as all the other type of welfare support, if you like - how can it benefit the community? Older Australians are part of the community, so by benefiting the community or benefiting older Australians, it's benefiting the system as a whole. So the argument that we need to put more money into aged care for the sake of aged care is slightly distorted, because providing easier access to care, full stop, for the older community, will benefit all sections of the community, including the elderly that live in the community, because many people live very happily in the community.

**MR FITZGERALD:** Could I just go back to your issue about the quality of care, and it's related to what you said about happiness there. Yesterday we had the Australian Unity present to us their wellbeing index, and I'm not sure whether you're familiar with it; I'm sure you are. There are a number of wellbeing indexes throughout the world being developed both in terms of society wellbeing and individual wellbeing.

**MR STOKES (APS):** Yes.

**MR FITZGERALD:** You indicated that "quality of life" is an often used term, but it also now has some meaning or some way of measurement.

**MR STOKES (APS):** Yes.

**MR FITZGERALD:** From your society's point of view, for older Australians, ageing Australians, is there now a robust set of measures that you would promote in terms of being able to identify whether a particular system and/or provider was in fact delivering what you might regard as an increase or an improvement in the quality of life?

**MR STOKES (APS):** Our basic principle on the quality of life measures - and there are, as you know, many of them - is that they have to be suited to the situation in which the person finds themselves. So you select the instrument that is most robust for the particular circumstances with which you're dealing. I mean, there is no sort of a quality of life instrument that you would say, "This is the answer to all God's questions." It's really more a question of saying, "Here's a setting. Which is the best instrument to evaluate this setting?" and then you look for the most robust in that context. "Robust" means it's been well investigated, validated and there's some good data to support it.

**MR FITZGERALD:** But do you know of a preferred instrument that you might use or recommend? Yesterday I think there was criticism of the accreditation process. For example, that is very much about ticking the boxes, looking at processes, looking at paperwork.

**MR STOKES (APS):** Yes.

**MR FITZGERALD:** Somebody suggested we should try the accreditation process. We should look at the happiness of the residents or the clients. I'm not sure that accreditation can ever do that, but even if it wished to, do we actually have the instruments available to do that?

**MR STOKES (APS):** Well, I believe we do. We would be happy to make some suggestions along those lines. But, as I say, the principle in the end is about finding the appropriate instrument for the setting, and there is no one instrument that meets that expectation.

**MR WOODS:** But if you could elaborate on that in a supplementary submission - - -

**MR STOKES (APS):** We would be happy, to, yes.

**MR FITZGERALD:** The other thing in relation to specifically psychological services - and it may well be in your points or discussion - what are you actually recommending in terms of that specific area? Apart from more of them, do you have a particular set of recommendations about what needs to happen in terms of the provision of psychological services for older Australians?

**MR LI (APS):** Certainly. There's got to be a greater focus on, I guess, healthy aspects of ageing in the workforce training, and by "healthy ageing" it means the biological, psychosocial and health aspects of ageing. So there's got to be a reshift or refocus of aged care as healthy ageing from a workforce training perspective. Moving on from that, at a postgraduate level we can look at things like greater cooperation between the aged care workforce and the health workforce in general, because people do move in and out between those two somewhat artificial systems.

The other issue we mentioned is the use of qualified clinicians in assessing residents' needs. One of the criticisms we had of the Aged Care Funding Instrument is that it's a quick and dirty job, if you like, and if the clinician is not trained well to pick up some of those behaviour indicators or psychological indicators, those issues are often overlooked and therefore they are not recognised and therefore they are not funded and so on and so on and so on. So it's got to be a workforce initiative as well as an ongoing training initiative.

But in terms of going back to the funding, the lack of recognition in the behaviour supplement of the Aged Care Funding Instrument is a real shortfall, and that needs to be rectified as soon as possible.

**MR WOODS:** That was your third point that you elaborated on.

**MR LI (APS):** Yes, it is, and I think that point has been well made by other people.

**MS MACRI:** Yes. It's very consistent with people across a broad area.

**MR LI (APS):** But that's only reflective of once you've picked up the signs and symptoms. We've got to pick up the signs and symptoms in the first place and that requires extensive workforce investment.

**MR WOODS:** Can I go back to the one in the middle, this ageing in place issue. Is there something in our report that is not communicating that concept that in fact we want the focus to be on people remaining in their community context and their family and social relationships and to get increasing services, or is there something else lurking behind your second point there?

**MR LI (APS):** There is probably a greater recognition that, as the population ages, there's got to be a proportionate increase in the funding for aged care and related services, but what we're arguing for: there's got to be a greater investment in the area, greater than the rate of ageing of the population, so that the community as a whole benefits, including those living in the community who happen to be elderly. So the funding is not pegged to the ageing of the population per se but it's got to be growing at a greater pace than the ageing of the population.

**MS MACRI:** I think one of the things that's happened there, Mike, too, is that "ageing in place" has been a term used by the industry in relation to low care and ageing through the facility - whereas your submission is much broader, and appropriately so.

**MR LI (APS):** And again reflecting the earlier speakers, they mentioned things like aids and equipment. That to us is an element of ageing in place, because by providing the right support, people can remain in the community.

The other point which I mention is the issue of carer support. I understand the commission put together a diagram, figure 3 I think - it was on the overview - that says there is a building block approach: that we've got to have carer support, we've got to have training, we've got to have this, and low care, high care, so on and so on. We'd like to differ with the commission on that. We see carer support as integral to every aspect of care.

Again, going back to the notion of ageing in place, you've got to support the carer.  For example, it's no good just giving somebody a wheelchair.  You've got to train the carer in how to maintain the wheelchair so that if the wheelchair breaks down they can call for help.  Going to the other extreme, dementia care and palliative care:  of course they need carer support.  So carer support is not a building block.  It needs to be integral in every aspect of care of the elderly.

**MR WOODS:**   Basically, turn it from being a layer to - - -

**MR LI (APS):**   Turn it from horizontal to vertical.

**MR WOODS:**   I understand.

**MR LI (APS):**   We will describe it better when we tender a supplementary submission.

**MR FITZGERALD:**   I must say, I agree.  The concept is not in doubt.  I'm not quite sure that it works that way.  In a sense, at the end of the day carers will say to us they want specific support services.  So, whilst we recognise the importance of the carer in all aspects, at the end of the day it translates into an entitlement or set of services.  I don't think we're in disagreement, but one of the problems we do have is, you can say that carers are important.  At the end of the day you've actually got to say, "What does that actually mean?"

**MS MACRI:**   Yes.

**MR LI (APS):**   Of course.

**MR FITZGERALD:**   "What are you actually going to deliver in terms of carer support, and who, and how is that going to be funded?"

**MR LI (APS):**   Yes.

**MR FITZGERALD:**   That's what that diagram, figure 3, is really about.

**MR LI (APS):**   Point taken, yes.

**MR WOODS:**   Are there other matters that you wish to raise today?

**MR STOKES (APS):**   No.  We actually haven't yet submitted our final report, so we've got a chance to remedy those things that you asked us to do, and we'll do that.

**MR WOODS:**   That would be much appreciated.  If it could come in in a timely manner, that would be very helpful.

**MR STOKES (APS):** We've been given until Friday or Monday or something.

**MR FITZGERALD:** That's fine.

**MR WOODS:** Thank you very much. We'll take a very short break and be back by quarter to.

**MR WOODS:** Thank you. We will resume the hearings and welcome the next participants. Could you please separately identify yourselves, the organisation you come from and the position that you hold.

**MR YATES (COTA):** Thank you. Ian Yates, chief executive of COTA Australia.

**MS ROOT (COTA):** Josephine Root, national policy manager, COTA Australia.

**MR WOODS:** Thank you, Josephine. Thank you very much for your contribution to date to this inquiry. We have been very grateful not only for your written contributions but for your arranging and contributing to other forums and dialogues. It has been very valuable. Do you have an opening comment you wish to make?

**MR YATES (COTA):** Yes, I make a few in relation to our second submission, the submission on the draft report.

**MR WOODS:** Thank you.

**MR YATES (COTA):** Firstly, we really would like to put on the record publicly our congratulations to the commission for the draft report. This area is extremely complex, with multiple stakeholders, and the draft report has, in our view, in general, done an excellent job of a comprehensive approach, presenting a coherent system that will be a major shift, but is nonetheless consistent with the learnings and the aspirations that have been emerging from consumer organisations and many providers - as I'm sure you've heard already - professionals and indeed, I might say, many within the federal government within DOHA - with whom we've worked over the years - who have shared those aspirations.

The second point to say is that our second submission to you on the draft report, like our first one, has been through a process of consultation throughout the COTAs. They have held a mixture of public events, invited comment through all our media publications. We ourselves have published our positions in our magazine, in our policy newsletters, and consulted through our policy counsellors. So I make that point, because although time has been limited this time, in the preparation of the initial submission - many of our proposals of which are reflected in your draft - there were extensive consultations. So it's not a development of a policy or propositions dreamt up by Josephine or I or, indeed, by other COTA personnel, but indeed tested widely and, I might say, reflects the positions that have been put to us by consumers for many years.

The third thing is that I just think we would like to emphasise what we see as really the key pillars. One of the dilemmas you face - and indeed we faced - is that really, in our view, the inquiry is about what kind of system goes forward, and then within that system there is lots of stuff about practice that is live and contestable now and will continue to be live and contestable issues as we go forward.  The question is:  does the system make their resolution more likely?  Is it more amenable to them? So you have had put - and we have had put to us - much detail that is not reflected in either of our submissions.

So what we see as the key pillars:  firstly is entitlement; the notion that a person properly assessed as in need of support and care should have an entitlement to be resourced to obtain that.  We think that's fundamental to what you're putting forward.  For us it is fundamental.  We emphasised it as a rights issue in our original submission.  Some people - in our interactions about your draft report - get it, and other people still don't seem to get it.  So if anything, we wanted to say that one of the things that we would like you to reinforce in the draft report is that.

The second key pillar is freeing up services so that you don't have packages and bed licences and all that but you actually have a range of things that people can choose amongst.  The third - clearly and obviously, but worth reinforcing - is the Gateway - and we'd be happy if you want to explore detail about the Gateway, but we think the notion of the Gateway is fundamental to the reform process.

Fourthly is independent pricing.  If you don't get the price right, you won't get the quality right.  That's important to us.  Also it's quite clear to us, in our fairly extensive negotiations with providers around the draft report, that one of their great fears is that they'll end up with a structurally better system but still underfunded and, if you're opening them up to certain risks in a transition, they're worried about trying to make do without enough money.

Then the fifth pillar, I think, is your framework on user charges, which is, as we've said, well based in principle, comprehensive and consistent, and that's not what happens now.  We should say that there is a degree of nervousness out there in the consumer sector about it because of the difficulty of pointing to specifics - "Case by case, what will it mean for me?"  Very difficult to do that when you're actually saying, "All these fundamentals will change."  So our caveat is that there is a degree of nervousness about what that will be.  Clearly, you have to end up with a set of user contributions not only that is fair - which you've said - but is, in the end, affordable for people.

**MR WOODS:**   For both.

**MR YATES (COTA):**   For both, exactly.  In terms of the submission that we sent you last week, we would draw attention - without going into the detail, but we're happy to be drawn out on - to the sections.  We've given increased emphasis, and suggest you should, on a broad approach to dementia, not as one more special needs group but as fundamental to the nature of the sector, and we have liaised closely with Alzheimer's Australia in the development of their submission, which I think has now reached you.

Secondly - and relatedly - respite, where we think that that needs greater emphasis, and where we suggest fairly strongly that that's an area in which cashing out might be seen as an early option, although we agree with you about caution, about cashing out more broadly.  Thirdly, the supported resident issues:  we have noted comment in the public space that the commission has moved away from the two-bed position.

**MR FITZGERALD:** This commission has.

**MR YATES (COTA):** This commission.

**MS MACRI:** Yes.

**MR YATES (COTA):** We have put a forceful argument about the two-bed issue in the document - and I won't rehearse that now, you've got it, so we can explore that.

**MR WOODS:** Yes.

**MR YATES (COTA):** Next are the workforce issues where - as we have said in the document, we think you acknowledged the issues in the draft report - we think there is merit in the broad claim put by the unions that action is needed earlier.  We agree with you that that has to be through a concerted set of activity, and we are engaged in those conversations through NACA at the moment, and would like the option to come back and submit about that.

Just to emphasise the section we put in the submission on the need for consumer support during transition:  we get a lot of stuff about the industry being supported during the transition, but this is a culture change for everyone; happy to engage in that.  Finally, in terms of implementation, we went into more detail in our first submission so we've just reminded you of that, but we've made a few points in there in terms of implementation - which I think is becoming fairly consistent; of the need to move quite quickly in the community care space and make community care much more available.

**MR WOODS:** Yes.

**MR YATES (COTA):** There is, we acknowledge, some nervousness in some parts of the provider sector.  Although others are agreeing with us that an early move to entitlement for community care would be good, there is some nervousness about vacancy rates in low care, and that's a transitional issue. So I probably would stop there. We're happy to open up in conversation with you anything in either of our submissions - or, indeed, anything that's not in them, because, as I said, we didn't put in everything, but we probably have a view about anything else as well.

**MR WOODS:** Perhaps we can start on Gateway. We did acknowledge in our draft report that we used your terminology as being - we thought it quite succinctly embodied the concept that both yourselves and ourselves were trying to embrace. Our model is slightly different but not to any great extent, and we do see the benefit of the Gateway being controlled by an agency so that you get national consistency but delivered at the local level - including assessments, information dissemination et cetera - through whatever are the most appropriate mechanisms, whether it's local Medicare officers or Centrelink or doctors' surgeries or local council or wherever.

Are there any features of our particular slight variation to your model that cause you any difficulty? I think it's conceptually the same, but a lot of this then comes down to appropriate design, and I'd be interested if there were any issues in particular that you wanted to pursue further.

**MS ROOT (COTA):** One of the things that has come up in our consultations quite often is a concern that the Gateway Agency - and also your regulatory commission - would lead to a significant increase in the bureaucracy for aged care. That's come up in a number of settings. I guess there's a strong view coming through, certainly from the COTAs, that the Gateway Agency may best be run by an NGO rather than government, or separate from government in some way that might be - but certainly there's a concern about the additional bureaucracy involved, which I guess our network approach was seen as not putting an extra layer in. Happy to - - -

**MR WOODS:** Yes. In fact we were trying to reduce bureaucracy by collapsing a whole range of things that currently exist.

**MS ROOT (COTA):** Yes.

**MR WOODS:** We have individual ACAT regimes - or ACASs here in Victoria; we have HACC providers doing their own assessments; we have the ACAT assessment process then being turned into an ACFI process by aged care providers. So there is a multiplicity of things that happen at the moment, particularly around the assessment side, that we tried to consolidate and reduce the bureaucracy and reduce the overlap, and that message hasn't yet filtered through to everybody. Some have understood it, but not enough, so I think we need to be very clear in selling that message that that's in fact what this architecture is trying to achieve. Whether NGOs or others should deliver at the local level, you would still want a national consistent regime but with regional expression, and how that is then expressed and through what agencies and vehicles will be partly circumstantial.

**MR FITZGERALD:** One of the things that is critical in the final report is setting some principles for what is a region, either a region for the Gateway and a region for the setting of supported resident quotas, but we are committed to a regionalised aged care system and, as Michael has indicated and you've indicated, the regional gateways could well be operated by state governments, local governments or NGOs, depending on what the Commonwealth government decides. Nevertheless, there's this issue, but the issue of the region is a very significant issue.

One of the things you may want to contemplate, or already have: what would be the principles we should be providing to the government in establishing those regions? And as I say, one is in relation to the Gateway, one is in relation to the separate issue of supported residents' quotas. We don't intend to say what the regions are but I think we are obliged to say, if it is going to be the region, what might that be? Some people have encouraged us to use the local - you know, these new - what are they called? Medicare locals. Others believe the different regions, so you may or may not have a view about that, but it is important.

**MR YATES (COTA):** I think we might take that on notice and come back. We probably do have some views but we might want to test that, and in fact there's a federal government workshop on the relationship between aged care and the National Health and Hospitals reforms tomorrow in Canberra, so I want to come back on that. Can I just say, I think the way that you talked about the Gateway was read by many people as sounding like a Commonwealth bureaucracy, to use those terms.

Our reflection on that was that we understood it was necessary to be clear that this was a pretty solid operation because all the other - this is the sharp end of fiscal risk, basically, and we have absolutely - we certainly understand that. Not all of our constituency perhaps places as high a priority on that as you, but it is part of your brief, but we also understand the necessity for government to be confident of that in terms of the reform process. So, yes, our emphasis was rather more that there might be a variety of ways, while cleaning up the various programs that are out there at the moment. Why not, because sometimes messy ways of doing things are good, but because at the moment the outcomes are appalling.

Frankly, let us not pretend that we are getting good assessment. By and large we are not getting good assessment; we are not getting good access to information. So one of the other things that we draw attention to, almost in passing but it's important, is that you specify what the Gateway ought to be achieving - you know, the kind of KPIs for a gateway, however it's done - and we dwelt on some of those in our original submission. We suggest that one of the ways of getting up early is to network quite a bit of what's out there but that would have to be under a really strict discipline against those principles, because it is fundamental to the whole reform if you get this wrong, and it will require more resources too.

**MR FITZGERALD:** In the interim stages the Gateway, which is a Commonwealth bureaucracy - let's be very clear about that.

**MR YATES (COTA):** Yes.

**MR FITZGERALD:** It is. It can contract any nature of organisations. For example, one of the things we've said is that it is possible in the transitional phase that it subcontracts existing ACAT teams to do the complex assessments but it is the Gateway's function. It is the Gateway establishing the rules and it's the Gateway determining the outcome. We're open to the notion that the Gateway can use whatever means it wishes to achieve its functions and we're not being prescriptive about that, but eventually what we are saying is that the Gateway controls that function and is responsible and accountable for that function.

**MR YATES (COTA):** Absolutely.

**MR FITZGERALD:** Whether it uses employees, subcontracts or any other arrangements.

**MR YATES (COTA):** I think we agree with that. I would want to say that the minimum performance criteria for the gateways would need to exceed considerably the current performance criteria of ACATs - most ACATs. We've had conversations around how there are some exceptional ACATs around who have begged, borrowed and stolen to get the resources they need to do the job well. This is of interest but this is not a model on which you build a system.

**MS MACRI:** There are just a couple of things. I mean one of things that's come through around the Gateway, especially over the last two days and just at a couple of meetings we've been to, I guess is again around timeliness. I just make two comments, Ian. One is around moving quickly in the community care space and putting more out there is going to put greater strain on what's currently there, so I guess there needs to be a balance around that timeliness and the resources and the capacity for that to happen.

The other comment I wanted to just make was around that - moving quickly on that community care and some nervousness for low care. If, at the same time as that increase in the community care space and the delineation between low care and high care being removed and it being a residential aged care facility - I mean that, you would have to think, to a large degree would negate some of those concerns around the low-care end.  I'd just be interested in your comments around that.

**MR YATES (COTA):** Okay.  Can I just backtrack one?

**MS MACRI:** Yes.

**MR YATES (COTA):** The other thing that I think we would want to emphasise about the Gateway that we've said in here is it must have some capacity for face to face.  It may well be that's a minority of the traffic but we've had that really strongly emphasised to us.

**MR WOODS:** And we agree.

**MS MACRI:** Yes.

**MR YATES (COTA):** That's not necessarily current thinking in the consultation going on about the front end, for example.

**MR FITZGERALD:** Yes.  Clearly there's something wrong in our messaging because the assessment process can go from, you know, telephone or Internet access right through to full-scale complex assessments in the home.  But the message seems to be that it's all going to be by telephone or something, which is not correct.

**MR YATES (COTA):** I think we're making a slightly different point.  Obviously we actually think really strongly that comprehensive assessments need to be done in a person's normal context.  In fact, I've been known to say frequently that it should actually be illegal to do a long-term assessment of someone in an acute care context.  I think it's a breach of human rights to do that because it frequently ends up in people being locked up, based on short-term assessments.

**MR WOODS:** You're heading into a broader issue.

**MR YATES (COTA):** But the other issue was, even if someone at the very early contact level wants to have a face to face, they should be able to do that if that's how they're comfortable.

**MR FITZGERALD:** Sticking with the Gateway, one of the issues that has come up, a bit surprisingly, is the care coordination.  It came up yesterday and it's come up a couple of times in private discussions with people.  There's a fear by providers that by having care coordination within the Gateway, that in a sense that coordinator will in fact prefer different suppliers over other suppliers; in other words, it becomes a way by which clients are directed to different services.  Now, to some extent that is true in a sense that what we know is it's pointless giving somebody a list of

100 providers and saying, "Go fetch." On the other hand, we don't want a situation where a particular provider is favoured over other providers.

But this issue about care coordination generally, do you have a particular view? We think it's an important function within the Gateway but it has raised concerns, particularly by providers.

**MR WOODS:** Perhaps if you deal with that and then go back to answering Sue's second part of her question.

**MR YATES (COTA):** It's an important point. I've done quite a lot of discussions with providers, both peaks and the national structures of some of the major providers, and it has always been raised in those discussions. I think we would approach that from the principle of consumer choice and preference, so actually it could happen in either place but the consumer has to have the right to have the key coordination from the Gateway. Provider capture can happen anywhere and one of the principles of the Gateway ought to be that there isn't provider preference. It has to be that they're facilitating consumer preference and, as we recognise in here, in the early stages of a culture change that's not easy.

Similarly, if people are clearly really happy with a set of services and supports they're receiving, then there's plenty of room for the provider to play more and more of a role there, provided always that the consumer has the right to both advocacy and to go back to the Gateway. That's quite critical for us, and we've made that comment in terms of people wanting to exempt certain things from the Gateway. There's no reason why you can't access block-funded services through a gateway, or any service through a gateway. I'll stop there. Going to Sue's point about community care - there were two points. One was about affordability, but your first point was?

**MS MACRI:** Well, the first one was about timeliness, because I agree that we need to increase it, but we already have a timeliness problem. I mean, people are telling us it's eight to 10 weeks, more often than not, to currently even access ACATs.

**MR YATES (COTA):** Yes. What I guess we're saying is that, assuming the government says, "Go", then day one we ought to be working out how you can start to free up the services that are currently in different baskets; not start to necessarily impose access issues that aren't there now but to speed up people's access; but get that gateway organised as fast as possible. But right now we've known for a long time that those rigidities are a problem. There are good, sound people out there working really hard to provide services now, who are juggling all those complexities. Some of them manage to twist the system and get a good package to people; others don't. But we need to get rid of those rigidities. The really glaring one is the gap between a CACP and the whole EACH system. Frankly, it does not take a lot of imagination to come up with a bridging solution between where we are now and model 4, if you like, in the appendix B.  You could add some steps quite quickly, if there was a will to do it.

**MS ROOT (COTA):**   Also, Sue, the issue about ACATs, I think eight to 10 weeks would be good, because I know ACATs, that you wait 26 weeks in the - - -

**MS MACRI:**   Yes.  Well, I'm being generous.

**MS ROOT (COTA):**   But I think the issue is that ACATs tend to give a lower priority to assessments in the community because they are put under enormous pressure by the state health systems to ACAT people out of hospital.  So I think one of the first steps, if you were going to free-up community would have to be to divide the ACAT function in some way so that more of it went to communities; that it either separated out or built up a part of it so additional funding for assessment may go to ACATs initially but it would be specifically for community assessment.  Then you might get over that bottleneck.  I think that's one of the structural problems that needs to be dealt with.

I personally think that the comprehensive assessment part of the gateways process, or whatever, should be done by an agency that is not owned by the state health departments, because I think as long as you leave it with the state health departments you're always going to have pressure to get rid of the dreadful "bed-blockers".  So I think there's a problem there.

**MR YATES (COTA):**   One might observe, in terms of Robert's earlier question, that commonsense would indicate that you probably wouldn't subcontract a gateway to, for example, a state government agency where the state government also had a major provider presence.

**MR WOODS:**   Or to NGOs who are major providers - - -

**MR YATES (COTA):**   Absolutely the same.

**MR WOODS:**   - - - who then do an assessment and say, "Oh, by the way, coincidentally, I happen to have these services."

**MR YATES (COTA):**   As you may recall in one of your roundtables early on, a prominent provider - because we were in-confidence, we won't say where - recognised that that happens continually now, even when they have principles against it.

**MR WOODS:**   That program is one we're proposing be abolished for exactly that reason. Robert, where do you want to head?

**MR FITZGERALD:** Moving beyond the Gateway, can I just come to one issue that you haven't touched on. A number of groups have raised with us the issue of supports for people even before they get to the Gateway; in other words, both advocacy supports and general social supports, both for the CALD community and other groups as well. We've indicated in our report that those services should be provided and we've got to do more work on it in the final. We've also indicated that individual advocacy should be increased. Do you have a view as to the best way to achieve that?

If I can just preface that: yesterday afternoon we had the Elder Rights Centre here in Victoria. They went to a part of that National Aged Care Advocacy Program. So if we are going to increase, firstly, advocacy, do you have a view as to the best way that should be achieved? Do we simply increase funding to the existing agencies? Secondly, in relation to what we might call "social supports" supporting individuals, even before they get to the Gateway, do you have a view about the best way to provide that support?

**MS ROOT (COTA):** We thought the Gateway should actually start a bit earlier than you're envisaging it. I guess we saw the Gateway - part of our model was that it would be the place that people would go to to get information; more like a seniors' information line, if you like, would be part of its function. So it just gives out information and can direct people to support that's not normally seen as part of the aged care or an aged care system. So I guess we saw the Gateway as having that earlier function.

So if you weren't going to put it in the Gateway, then I guess you'd need to think about where you might put it, but we would advocate that it would be part of the information set that the Gateway had, and I guess that's another reason for us saying - and I'm going to say it again because at a consultation I was at last week in the front end it was put to us categorically by the Department of Health and Ageing that they didn't see the front end as having a face-to-face component, and we reject that. We think that you actually need to have shopfronts in a Centrelink office, a Medicare office - wherever you want to put it; on the street corner. Older people like sometimes to go and talk to somebody about what their issue is. So I'll just stress that. But that could be like - I don't know - a Citizens Advice Bureau or something like that. That was the first part of the Gateway.

**MR FITZGERALD:** That's not inconsistent with what we've put. But what about the support services to which it refers, and what about the advocacy services? You may not have a view, but given that we're talking about increasing funding for those services and for advocacy, is there a particular or preferred way that should be achieved?

**MR YATES (COTA):** I think in terms of general support services - and we might reflect on that and come back to you when we come back about other things - there are a whole range of people in our community for whom basic support services are important and in this case, in terms of what Jo outlined, what the Gateway would do would be to point older people to those services which are not necessarily part of the aged care system. I think one of our fundamentals is, let's not bracket everything into being about older people when they're citizens - and we could talk about lots of things there. So I don't think you have to have everything classified as aged care. There's an argument for a community development infrastructure in our community that I think is more recognised now than it was for a couple of decades and used to be before that - - -

**MR WOODS:** We won't try and solve that through this window.

**MR YATES (COTA):** - - - when people like you and I were much younger, Robert. In terms of advocacy services, we recognise that you said there should be more funding for them, and we've argued as to why there will be a greater need at this point in time. For transparency, let us declare firstly that COTA in South Australia auspices the advocacy service and has done since its inception, and I personally have some significant involvement in that. That said, it would seem to me that prima facie that network of services can do with additional resources. It's essentially not grown in keeping with the growth of the sector for a long time.

But it has also sat almost in a kind of sidewater - almost a backwater - and I think we would want to have a little bit of a look about what the scope and potential of expanding individual and system advocacy might offer. That program hasn't been significantly reviewed for a long time. There has been talk about tendering it out and it backed off; there were periods of time where it was extended year by year. I think the potential in that area is much more than anybody has thought about, and we ought to be looking at that as a matter of some urgency. But they provide a platform that certainly could be expanded initially while that went on. There's room for growth in that area. Again, with everything, you would want to be careful how fast you did that.

**MR FITZGERALD:** Sure.

**MR YATES (COTA):** But that's a very important program and does remarkably good work. I think the other thing we said in our first submission is that, in reviewing the role of those kind of programs, you might look at how they link to organisations like ourselves and other consumer organisations out there in the community; not that we would in any way own it - that's a historical issue in one state - but looking at the linkage between the bodies that are out there anyway and the formal advocacy services.

**MS MACRI:** Do you at the moment have a high degree of CALD services coming through COTA or do they tend to sit out there a little bit isolated or separate from COTA? This has continued to come up over the last couple of days, again, in terms of advocacy and information around specific CALD communities.

**MR YATES (COTA):** It's a bit of both. I'd say that, of course, individual jurisdictional COTAs are quite different to each other. Some are very large and have a wide range of programs and others are quite small. The COTAs nationally, for example, have a program with beyondblue called Beyond Maturity Blues, which is a peer education program aimed at the community. We have exceptionally successful CALD programs flowing through that, rolled out nationally, that beyondblue has said quite publicly has exceeded their expectations. That's an example.

In the advocacy work that we were just talking about, some of which is connected to some COTAs and some not, there's good outreach to CALD communities. Many of the COTAs have significant numbers of CALD organisations in their membership, others not so many; it varies. But certainly it is something, in terms of our national protocols, that we are pressing COTAs to be constantly reaching out.

**MS MACRI:** Yes. How do we do that better? Have you got any thoughts?

**MR YATES (COTA):** I think there's a tension out there in the community anyway between how much some CALD groups want to do it themselves versus work as part of others. That's inevitable probably. I think that if we had some more resources in some of these areas, some of them could have those as outcome indicators: that we're putting more resources in, so you reach more out into CALD communities, and particularly CALD communities that are not necessarily as well served as others.

**MS MACRI:** Yes. So partnerships and - - -

**MR YATES (COTA):** Yes. I think partnerships is a good model, yes.

**MR WOODS:** We'll have other participants who will no doubt have a view on that as well.

**MR YATES (COTA):** Which I also think is a significant - partnerships is often a good option - not the only one - in terms of Aboriginal and Torres Strait Islander programs as well; pairing those organisations. The same advocacy service in South Australia has good Aboriginal programs twinned with the Aboriginal Elders Council.

**MS MACRI:** Yes.

**MR FITZGERALD:** Can I just ask about respite. It's come up a lot and I just want to get a view from you about it. We have planned and we have emergency. At the moment our thinking is that planned respite is an entitlement and emergency respite would sit within dedicated care or support centres and would be part of a block-funded service. I'm just wondering whether you have a view about that.

The second thing is just taking up the point that you raised of the possibility of having more flexible respite and how that might work. Obviously you're aware of the discussions with the Alzheimer's Association and others about a desire to increase accessibility to what we might call informal respite providers.

**MR WOODS:** A broader definition of what constitutes - - -

**MR YATES (COTA):** Yes.

**MR FITZGERALD:** Yes. So can you just talk to me about your general approach to respite. What do you think we should be saying about both planned and emergency respite?

**MR WOODS:** You use the phrase "cashing out", but I'm just not quite sure what that - because that in itself can be defined in a range of ways.

**MS ROOT (COTA):** I think we're starting from the position which I know many other organisations have - and it came up again last week in Queensland - that carers identify respite as what they need most, but they don't use it, and this comes up time and time again. That's because what's on offer doesn't work for them. It doesn't work for them as individuals and it doesn't work for the person that they're caring for. So we clearly think there's a problem here. Carers won't use respite that doesn't meet the needs of the person that they're caring for, often, so it has to meet both sets of needs.

We're saying that if we gave people the money for - let's take planned respite. If we gave people an entitlement in money terms, they could then use their informal networks to find respite that met both of their needs, both the carer's needs and the care recipient's needs. One of the examples is - and people piece these together for themselves already - using the local bowls club where the person who perhaps has dementia had always gone to play bowls. They can still go, but with a support worker or with some kind of assistance to help fund it. There is also using neighbours, and we've cited the example we could look at usefully, which would be the child care idea, where you can be a registered provider - obviously with some checks - and that would allow people to use their networks.

We think that might work better in rural and remote areas where there may not be a respite service. It certainly is a model that the CALD community has said that they would like to try, because that way - the lesbian, gay, bisexual, transgender and intersex population have also indicated that they would then be able to find respite with people that they trust and who they know understands their needs.

So we just think there might be a bigger pool if you could cash it out, give them the money entitlement and say, "You can spend it on this and that." That can still be with lots of checks and balances. We probably wouldn't just pay a deposit in their bank account and trust them to use it on that. That might not work, although it could.

Emergency respite: I guess if people had a cashed-out entitlement that they could dip into, held with a budget-holder, they could still use and we think there's scope to use informal networks for emergency, maybe even more so than planned, because an emergency is an emergency. It doesn't happen between the hours of 8.00 and 4.00 or 9.00 and 3.00 that respite services work. It happens at 4 o'clock in the afternoon on a Sunday, you know, and so maybe you can ring up your neighbour and ask them to do it if they've pre-registered. We've had this conversation with you, Mike, already.

**MR WOODS:** Yes.

**MS ROOT (COTA):** We've got to get people using respite more. We've got to make respite work for them if the network of informal carers who perform an invaluable role in aged care - and we really couldn't afford it without them - are going to keep performing, are going to be able to continue to care.

**MR FITZGERALD:** Can I just ask this question, and I don't want to go into too much detail, but when you talk about a registered, say, informal respite provider or person, are you envisaging that that registration would take place through the Gateway or through the carer support centres or through another provider? Again, I don't want to try and over-plan the system, but this is an important issue.

Some people say, "We should be able to use any one." Others say, "We've got to have some safeguards around that." You've mentioned the word "registry". So one of the models is that one of the providers or the carer support centres or the Gateway, in your language, registers a person who can be used by a carer. You may not have a view about that, but if we do start to talk about putting safeguards on, the next question is: by whom?

**MS ROOT (COTA):** I think we would say the Gateway. We're not convinced about your carer support centres, so the Gateway would probably be our preference. That's where the entitlement is developed and allocated, so that would keep - the Gateway would be the registering body.

**MR FITZGERALD:** Okay. Thank you for that.

**MR YATES (COTA):** I would emphasise the need for some kind of registration process that identifies the person and involves a certain set of checks. Again, through the advocacy services we see plenty of examples of elder abuse. We are not rose-coloured in terms of our understandings of what can go wrong.

**MR WOODS:** Yes. So it's trying to get a balance between a broader range of people that can be called upon whilst still maintaining appropriate - - -

**MR YATES (COTA):** Yes. I mean, Alzheimer's actually talk about those categories of people becoming approved providers. It depends how strict your approved provider status is, but that might be a bit of overkill if there's a simpler process.

**MS ROOT (COTA):** You've got to keep it simple, but with checks.

**MR FITZGERALD:** Yes, I know. That's the difficulty. The simplicity: once you say "checks" it's - but thank you for that. That's very helpful.

**MR WOODS:** Can you elaborate a little on your concerns or thoughts on the carer support centres.

**MS ROOT (COTA):** I'm not sure that we've really thought it all through. I'm not clear what function they would really perform. It wasn't clear from what you wrote, and there is some ambivalence about what the current respite for carers and things actually does to enhance the system. If the carer support centre is going to be a service provider of training and support for carers, then I would think that that could actually be just part of an approved provider function. I'm not sure it needs to be set aside into yet another silo and another set of program guidelines, and I can just envisage the Commonwealth setting up another branch to support them. So we're not entirely convinced that we understand what you would put into a carer support centre.

**MR WOODS:** Would you be willing to elaborate on that in your follow-up submission?

**MR YATES (COTA):** Sure.

**MR WOODS:** That would be helpful, because the drafting of the report reflects some of that general uncertainty anyway, as to what role it might play and what it might look like.

**MS ROOT (COTA):** Yes, okay.

**MR WOODS:** One thing that I'd like to raise that hasn't come up yet is the care co-contributions. Specifically, we have in the draft report a system proposed that says if somebody is receiving a range of services - so they've had their entitlement and it's beyond a minimum threshold, so it's not just a basic support, and they've also been assessed for their financial capacity- so say they're assessed as requiring to pay 10 per cent and their service package costs say 15,000 a year; they'd be paying 10 per cent of that.

If their acuity rises - in fact our whole system is aimed to not just assume some linear progression but, in fact, to try and restore independence et cetera. But take the situation where somebody's frailty increases, their acuity of service need increases, and they go from a service that costs 15,000 to a range of services that now cost 25,000 and, in fact, their care co-contribution has gone up from 1500 to two and a half thousand, so they're paying more as their acuity increases. But in terms of the special needs groups, you make a statement:

> We are also keen to ensure that people with special needs do not pay a higher care contribution simply because their needs cost more to deliver.

In the case of acuity there seems to be general acceptance that if your care costs rise your care contribution rises. Why is this one different?

**MS ROOT (COTA):** The example that led us to make that statement was around the need to use interpreters. If you are somebody from a non-English-speaking background - and your needs might be the same as somebody from an English-speaking background, but to get the care you need you need to have an interpreter - that's actually going to cost more, and we didn't think that people should have to pay for that part because otherwise you're almost negating them having a special need. So it was really those kind of special needs.

It might be that you need somebody who's particularly trained, somebody using sign language; you might need a service provider that has to put a lot more training into having some cultural awareness of diversity; however it manifests itself. So we were just concerned that people wouldn't be penalised. You'll see a similar concern in the Alzheimer's submission as well, that we just wanted to make sure of that.

**MR WOODS:** Okay, as long as we can be clear how you would propose to differentiate between matters of delivering the care as distinct from the acuity of the care.

**MS ROOT (COTA):** Yes.

**MR YATES (COTA):** There is a certain tension, I think, in some of what your report says - and also certainly in our work - between if you really had a system that worked against those set of bedrock principles that I talked about earlier on, that actually implicit in that is that the way people's needs are responded to is individualised, and therefore you're actually going to have a certain higher cost to do that for everybody, that many people from a mainstream Anglo-Australian background have special needs if they are regarded as individuals whose care ought to be designed around those needs.

**MR WOODS:** There would be a price for the delivery of care and their care would be drawn from a range of services that meet their situation at the moment - again with the emphasis being to try and restore wherever possible or rehabilitate, but obviously in the majority of cases that won't always be possible. Sue, have you got other - - -

**MS MACRI:** No, I think I'm - yes.

**MR FITZGERALD:** Just one final question on the co-contributions and that's my final question. The range that we've put in - 5 to 25 per cent - is an indicative range. I must say we've had very little comment on that. I presume that means people think that's a reasonable range, but maybe I'm misunderstanding the silence. People, as you say, are interested in how does it apply to their own particular circumstances - and we're looking at cameos at the moment. But does the general membership of COTA think that's a reasonable proposition?

**MR YATES (COTA):** The answer to that would be, firstly, that a number of us have looked fairly closely several times at that section of the report and tried to put ourselves in your heads thinking through, "What do people pay now?" and, yes, it's all over the place. So we kind of understand how you got there, I think. We also, as I said, recognise that it's really hard to be precise about that without seeing it in place.

**MR FITZGERALD:** Sure.

**MR YATES (COTA):** But intuitively it didn't feel wrong and we haven't had any strong kickback that says it is. With the caveats that you've got - firstly, you've got the stop loss, which our people certainly do understand - not necessarily straightaway, but in talking it through and thinking through - is really important. Secondly, where it is really clear that, through whatever mix, the person is in a circumstance where it's unaffordable, you've got to be able to deal with that, so - - -

**MR WOODS:** Sure. Including the residential care where they're already paying 84 per cent of their pension so that there's no - - -

**MR YATES (COTA):** Exactly, which you've instanced - - -

**MR WOODS:** Yes.

**MR YATES (COTA):** Although not everybody has noticed that. Can I just use that to make a point that I did want to make, which we've twice in the latest submission said we assume is the case, which is the protection of a partner, spouse, cohabitant. If the person is actually paying for their care out of equity and they die, for example, and then the partner is still alive and in the house, those arrangements are - - -

**MR WOODS:** It's only their share of their equity that is affected.

**MR YATES (COTA):** Yes, their share of it, yes. But what we're saying is you wouldn't then say, "Sorry, we've got to sell up the house now"?

**MR WOODS:** No. No, you don't sell up. No, you don't.

**MR FITZGERALD:** No.,

**MR YATES (COTA):** That's what we read you were saying.

**MR WOODS:** Yes, sorry. Yes, we can be - - -

**MR FITZGERALD:** We do need to be clearer - but it has come up in a number of the forums we've done. It's absolutely clear that if a spouse or a partner still resides in the home, then the debt to the government doesn't become repayable until that person either sells or, on death, transfers that property. That's correct, and we'll make that explicit.

**MR YATES (COTA):** Thank you. I was aware that that was your position, but it would help us if you could make that point specifically.

**MR WOODS:** Yes, we will.

**MR FITZGERALD:** Yes.

**MS ROOT (COTA):** On the contribution, the only thing that's come up in the consultations we've done with members and with other organisations has been around really whether people who live on a single pension with no other source of income and might be in the private rental market can even afford 5 per cent. That has come up in quite a few discussions that we've been in, and we're just, I guess, concerned. We get stories of people who don't buy their medications, even on the PBS, because they can't afford it.

**MR WOODS:** Sure.

**MS ROOT (COTA):** So we're concerned that people might not get care. So we think the people living just on the pension - and particularly single pensioners - - -

**MR YATES (COTA):** Private rental, in particular.

**MS ROOT (COTA):** - - - and in private rental would really struggle to pay even 5 per cent.

**MR WOODS:** We do have a hardship sort of clause that - - -

**MS ROOT (COTA):** Yes.

**MR WOODS:** We haven't tried to prescribe it though.

**MS ROOT (COTA):** But hardship - - -

**MR WOODS:** Some of these things, because of the diversity of individual situations, can - you know the more you try and codify it the less likely you are to succeed.

**MR FITZGERALD:** Can I just ask this question: at the moment that person would be expected to pay some co-contribution to HACC-funded services?

**MS ROOT (COTA):** Some of them; not all of them.

**MR FITZGERALD:** No, not all. We understand that's all over the place. But the principle at the moment is that, even a person in that circumstance, at first instance would be asked to make some co-contribution. Then, of course, the second thing is that if they're not able to because of certain hardship then that's waived. That's the current position. Yes?

**MS ROOT (COTA):** Yes. I guess we would - our concern with hardship provisions is that (a) it makes people an object of charity in their minds - you know, hardship, special case - and that's not necessarily where we want a new system to go. Secondly, they are applied fairly variably.  I guess it's just come up as an issue.

**MR FITZGERALD:** No, I agree.

**MS ROOT (COTA):** And the other one has been the use of the family home in that thing because you're talking about using the assets test as though people are taking the family home into account in the assets testing for this process, whereas currently in the aged pension it's not included.  That has come up as an issue in all the forums I've been at, not necessarily people being very averse to it but actually it's just been raised as a query.

**MR WOODS:** It is registering with people but, again, we're not getting a lot of angst:  interest, and you could sort of move into concern, but not high-level angst.

**MR YATES (COTA):** Yes, I think that's true and we've made comment on some aspects of that in this report.  I think we recognise, and it has been recognised in our consultations, that an outcome of a system as you've recommended or moving to recommending will incur significant additional public expenditure - taxpayer expenditure - and therefore it is important that we have a fair and reasonable user contribution framework as well in terms of getting this thing up, and we recognise that.  It would be nice to live in a world that some people have commented on where everything got paid for by the government, but that's not the way we - - -

**MR WOODS:** By taxpayers.

**MR YATES (COTA):** By taxpayers.  And then there become, as we've pointed out in here, issues about which taxpayers are subsidising which in that process, and frequently it works in a regressive rather than a progressive fashion.

**MS ROOT (COTA):** And on that, it's come across that people have said, "Well, if I'm going to make more of a contribution, I want better quality and more guarantees of service."

**MR WOODS:** That's a very good point.

**MS ROOT (COTA):** And I think that's a key point and it's come out in all our consultations and discussions that - - -

**MR WOODS:** We would encourage that.

**MS ROOT (COTA):** - - - people will pay but, once they're paying, they're going to want more and better.

**MR FITZGERALD:** We think that's a very good outcome.

**MS MACRI:** Could I just say that already occurs, to a large degree, with extra service and people don't separate out the accommodation from care. As far as they're concerned, they're purely and simply going into a facility that's charging and the expectations go across both care and service.

**MS ROOT (COTA):** Even though extra services are not supposed to be - - -

**MS MACRI:** Yes, exactly, but that's the consumer expectation.

**MR YATES (COTA):** Absolutely, yes.

**MR WOODS:** Thank you for your supplementary submission as well as your first one. Thank you for your ongoing engagement and thank you in anticipation of the homework we have set you.

**MS ROOT (COTA):** Yes, I was going to say thank you for the homework.

**MR YATES (COTA):** Thank you, and perhaps in closing I can just draw attention to the point we made about, as things evolve, the Commonwealth stake in planning and housing standards and all that I think is something that we've become more conscious of as we've thought that issue through.

**MR WOODS:** We noted your comment to that effect in your supplementary submission.

**MR YATES (COTA):** Okay, thanks.

**MR WOODS:** Could you please, for the record, each of you state your name, organisation and position that you hold.

**MS NEELEMAN (DCL):** I'm Petra Neeleman and the organisation is DutchCare Ltd and I'm the chief enthusiasm officer.

**MS MACRI:** I like that.

**MS NEELEMAN (DCL):** In most organisations it's executive officer.

**MS HUGHES (DCL):** I am Alexis Hughes. I work for DutchCare. I am their social inclusion officer.

**MR WOODS:** Very good, thank you. Thank you for the several submissions we have had to date. Thank you for coming to our workshops, thank you for organising events for us and for your general contribution to this inquiry. We've been well informed on issues and of course not only in relation to DutchCare but to cultural and linguistic diversity issues more generally, which you have also advised us on, so we're very grateful for that.

Your supplementary submission, the response to our draft report, if I could sort of make a bit of a general observation before I ask you to make your opening comments, but you don't seem to have sort of grasped some of the opportunities that I was hoping the draft report would offer to you in terms of where your service could grow and flourish, but maybe that's a tone thing. I'd like to explore that in this session a bit, but can I invite you to make an opening comment first.

**MS NEELEMAN (DCL):** I will and I'd actually like to start by telling you some stories.

**MR WOODS:** Thank you.

**MS NEELEMAN (DCL):** It would have been my mother's 91st birthday today and I'd like to share with you the last few weeks of her life. She came to Australia as a 35-year-old Dutch woman with five children and I guess she had enough English to get by and to have conversational English but, as she got dementia, that was lost to her. In the last three months of her life, Labour Day weekend on the Friday night, she welcomed back another resident into our aged care facility - a lifelong friend - and she was bowled over by the two transport guys that were bringing back the other resident and broke her hip.

They tried to stand her up, even though our staff were saying, "Don't do this, don't do this," and somewhere in the back of my mind I think hang on, we have an expectation that people coming into our facilities who are providing services would have (a) some cross-cultural awareness but also would know what to do in basic health care for our clients, and in the case of older people we certainly know that, you know, if somebody falls you check out their hips before you even start to lift them up.

That be as it may, mum was transferred to the local hospital and my sister accompanied her and she said to the doctor straight off, "Look, mum can no longer understand English.  She will answer yes and no to questions she does not understand," and they asked her whether she was in any pain.  It was obvious that she was grimacing and she answered, "No."  During the whole intake process we were not given a lot of assurance that she was going to be cared for in the right way; that any indication of her language loss was being taken into account.

Mum was admitted.  She wasn't going to be operated on for three days because it was the long weekend and so we organised amongst the family for us to be there 18 hours a day.  One or other of us Dutch-speaking would be there to support her. My niece went in the next morning at 8 o'clock in the morning and mum was in bed. Her breakfast was on the tray, hadn't been touched.  She hadn't been looked at overnight and she was screaming with pain and had received no meds that we could see on the medication chart, and in fact my niece called me in tears and said, "What can we do?" and I went in.  20 minutes later I got there.  The situation was still the same.  Nobody had been to care for her.  She was screaming and nobody was trying to talk to her in any shape or form, let alone in Dutch, other than my niece.

I went to see the head nurse who knew me because of my role in aged care, and she responded and gave treatment.  But when I went back to the bed, above my mum's bed was her name and the comment "Nil by mouth".  She wasn't having surgery for three days and her breakfast tray was sitting on the bedside table.  When I looked at the med chart - and thank God I work in aged care and I can read those things - her medication was PRN.  How is my demented mother going to ask for medication in a language that anyone could understand?  Whatever we do within our systems, we need to make sure that across our systems these people actually get care.

If I could say that the situation improved over the 10 days she was in hospital, it would be wonderful, but it didn't.  Unless we were there providing care to my mum and feeding her, nothing was happening, and I can tell you that the person in the bed next to her, who was an older English woman, wasn't getting fed either.  Now, if this happened in an aged care facility, we would be sanctioned.  We would probably be closed down, and yet we tolerate that for older people generally but specifically for people of a CALD background.

There was another story that I want to share with you, and that's the story of

Fica. Fica came to our aged care facility from another facility. We were late in opening the facility and there was some real discussion about whether we should move Fica at the later stages of her life. She came to us doubly incontinent, she was on a lot of medication to stop her aggressive behaviour, and when she came to us the first night I really wondered what we had done because Fica spent the night in the corner of the room, cowering, frightened; not letting anyone near her. We didn't have a Dutch speaker on in that household that night and I couldn't go home, seeing this woman in that state. So I sat at the door of her room, singing every Dutch children's song I could remember, because I had seen other residents respond to that stimulation.

It took us a long time, but I want to share with you the letter I got from her husband 12 months on:

> I need to express my heartfelt gratitude and thanks for the splendid work that is being done in this facility, where Fica lives and the team of carers whose unremitting care and courtesy is much appreciated. My wife is still aggressive when she feels she's not being treated with the respect due to her. She doesn't like being showered or toileted, but she is now drug-free and talkative, and sometimes says a whole sentence. I also received a report that she has an intelligible conversation with one of the elders, which raises some hopes for the future. Physically, she's gained nine kilos and is now heavier than at any time in her adult life, including two pregnancies. She is steadier on her feet and sleeps better. Of course, she will never recover but all-around improvement in her has been remarkable.
>
> My wife has also been an animal lover and it's good to see her all interested when the dog and the cat come near her. The Eden principles are much more than the birds and the animals and fish and plants. It's the respect shown to the elders by the staff. It's the freedom to dawdle over lunch. It's the right to choose when to go to bed and when to get up. In short, it's being treated like a human being. For me, the greatest gain that has happened is that when I visit I'm greeted with a smile and a kiss from my wife instead of an uncomprehending stare of a drugged zombie. It makes it a pleasure to visit instead of a painful chore. Thank you again for giving me some part of my wife back.

Finally, I want to tell you about John who was in our facility last week. He came in with a diagnosis of dementia and on the first evening with us, I was working upstairs and one of the staff members came up and said, "Can you give us a hand? We've got a resident who's trying to bash other residents with his walking stick and he's trying to break all the windows." They called the police and an ambulance and when I went down John was not having a bar of anyone and was trying to get out. So I opened the doors and said to him as I let him out into the secure garden area, "I can open the doors but I can't open the gates. I don't have a key to the gates." So he wandered through the gardens, up and down, with me talking to him in Dutch about, you know, what was it - I understood he wanted to go home. I understood that he was frustrated. "Could we go inside and have a cup of coffee and talk about the options."

After about 20 minutes I had him to the stage that he was going to come inside and have a coffee with me, and the police arrived. They immediately tried to remove his walking stick from him and manhandled him, even though by then he was quite calm. It set us right back to the beginning. They had no training whatsoever with dementia. In aged care we don't have a choice when somebody gets that aggressive. We have to call the ambulance. The local psychogeriatric unit won't take them because they have a dementia diagnosis. Our only option is to have them transferred to a psych unit.

As the night progressed - I finally got the police to back off and John and I sat down and had our coffee, and I was able to talk him into taking his medication. We had a coffee and a biscuit because he had done the right thing and he went off to bed and settled that night. The next morning, however, he was back to being aggressive John and eventually, after smashing two windows, we had to have him transferred to the hospital.

My problem is: what happens to John now? I have limited staff on because that's all the funding will let me have. Three staff were involved with John that evening. He's going to go to the psychogeriatric unit. Nobody speaks Dutch there and so he will just be diagnosed for his aggressive behaviour without having time to understand what it is that's actually going on in his mind and getting him settled. He will stay on that concoction of medication for the rest of his life and he's likely to come back to us at some stage as a zombie. We will try and remove that, but if he goes to another aged care facility, there is no guarantee at all that they will try and meet his language needs. And language is the base of everything we do.

Having a translator come in, or an interpreter, is only a short period of time. It may help us with the assessment, but it only provides life to the person; it doesn't provide living. Living is about being able to express my needs. It's about being able to communicate with the people around me and to have some social conversation. Without that language, we can't do it, and I know there are a whole range of providers out there who have been funded to provide CALD care and there are no benchmarks, and I know that the Fronditha submission talks about the benchmarks. We've been talking about it in the ACCV CALD task force. There is no guarantee that they are getting what they deserve to get, and I can tell you that anecdotally I know it doesn't happen.

I know that one of the lead providers in Victoria who gets funding from the department to provide CALD services has recognised that they don't get anywhere near what is required, and they're doing something about addressing it. But my fear is that unless we have some sort of benchmarks built in, unless there is some sort of way in which whatever form the accreditation agency takes, or the people going in, is actually looking at what's happening - we can tell you in the last 12 months there have been six facilities that failed standard 3.8, which is the one about culture - well, lifestyle and culture. It really doesn't include what gets down to what we call "culture", and there has to be a way.

These people came to our country to help build our country up. They are our neglected migrant builders, nation builders. We really need to be doing something. They form now in Victoria 38 per cent of our population. We can't just sweep it under the carpet. They're not a minority. We have to find a way.

**MR WOODS:** Thank you for that. Building on those three life stories, do you want to extend that then into responding to the draft report?

**MS NEELEMAN (DCL):** We certainly will do, and develop our services, and we've been talking with Fronditha and the other CALD providers about how we tackle that, but it's unsure what it will mean for us as CALD providers in the future. What safeguards will we have? I mean, DutchCare started because the local community wanted to build it up, but it was helped along significantly when the Victorian office of DOHA decided to do some pilot projects and we were given funding to develop five-year plans, and then packages and things to go with it.

That allows us to be where we're at today. Unless you've got that sort of support, most communities won't be able to do that. To talk about partnership, my observation of partnerships is that it's the CALD community needing to provide their resources to support others, and we're not always wealthy. We don't always have those resources available to us.

**MR WOODS:** But doesn't the proposal in the draft report allow you to not have to worry about whether you do or don't get packages in an ACAR round, et cetera; that you can offer yourselves as a provider, knowing that the fees that you are being paid are reflective of the costs, and to expand to where your populations are, and so that if you do have populations in other centres who you think would want to access your services, and that you can find staff to employ who have the requisite skills, you'd be able to expand there and offer your services, and so all of the barriers that sort of constrain you at the moment would be removed under this proposal? But I just didn't get any sense from your draft report as to how you would use that new environment to grow and expand and to service the population that would benefit from your services.

**MS NEELEMAN (DCL):** I don't see it as being an exclusive market, however, and so you would still see other providers going out and providing services. The Dutch community is an ageing community, and so you say, "Well, we only have X number of workers available who speak the language. Are we going to dilute that across the whole of the state as more and more providers pick up those Dutch services?" I guess the thing is, yes, the clients will go where the services are best. Do they really? Do they really have that ability to make that decision? A lot of the information is just not out there in the community languages. You can't tell what's expected, because it's not translated by the department. So how do you get access to that information?

**MR FITZGERALD:** Sure. One of the things with the Gateway, however it is actually designed, is that if somebody presents as being Dutch-speaking and they've lost or significantly lost their English language, one of the things you'd expect the Gateway to do is to be able to say, "Within your rough region, these are the providers that provide an appropriate Dutch-speaking service," of which there will be very few. So in a sense, the Gateway allows for the first time ever a portal which actually has readily available information based on the service providers, based on their areas of expertise and specialisation within regions, so in fact the Gateway facilitates that. The question is whether the person then wants to go to your service or not.

Now, whilst I understand that certainty is important, in a sense we would be surprised if you didn't feel confident that most Dutch-speaking older Australians in Melbourne would not want to use your service, but if they choose not to, should the government say, "Well, sorry, we're only going to fund one." The answer is no.

**MS NEELEMAN (DCL):** No, and I'm not saying that. We don't see it as an issue for us. What I do see as an issue is emerging communities - - -

**MR FITZGERALD:** Yes.

**MS NEELEMAN (DCL):** - - - and how you actually pick those up. I mean, the Greeks and the Italians and - - -

**MR FITZGERALD:** Sure, the Dutch.

**MS NEELEMAN (DCL):** - - - we've almost got it, although we only service 50 per cent of the Dutch within regional Melbourne. The issue for us is getting that information. It's very difficult. We have no way of telling really how many people are actually getting services and what quality are those services.

**MR FITZGERALD:** I think the Gateway, as we've indicated, will become a much more centralised source of information both about providers and clients, in a way we've never had, so I think over time we get better. But can I ask this question. I don't understand right at the moment: do you receive additional funding as a Dutch-speaking service or are you operating on exactly the same funding arrangements as everybody else?

**MS NEELEMAN (DCL):** We operate under exactly the same funding arrangements.

**MR FITZGERALD:** Right.

**MS NEELEMAN (DCL):** But in addition to that, we're expected to play a role within the community in translation services, in advocating for the Dutch community; all those sorts of things that other providers would not do in the same way.

**MR FITZGERALD:** Sure. But can I be very specific about this? I understand that there may be additional needs that require additional funding, but is a service that provides a non-English speaking service, whatever that is, to the majority of its clients - are there additional costs that the government needs to recognise through ACFI or through any other instrument? Is that an issue in a residential setting or not?

**MS NEELEMAN (DCL):** It's an issue both in residential and in the community, because, just simply, food. We supply Dutch meals. The components of those meals are often more expensive than what you would do, because we've got to import them, and so the cost of that goes up. The cost of teaching staff how to speak Dutch is a training cost as well as a resource cost, because most of my generation didn't learn how to speak Dutch. We were the model migrants. You know, we assimilated until our parents got old, and all of a sudden we found we couldn't communicate with them. We're not the only group that faces that, but it is an additional expense. Having the numbers means that there's a reason for us doing that, but it is an additional cost. The cost of videos, the cost of getting books from overseas or DVDs - all of those things are additional because there's a higher cost component to it than buying just mainstream DVDs and videos.

**MR FITZGERALD:** My last question on this, but I just need to understand it: we obviously have a situation where some services have a predominance of a particular ethnic group. Then we have smaller clusters within non-CALD-specific services, and then we have the occasional person who can't speak English. I might say that's the same with homeless people. I might say it's the same with mental health things. You get specialist services, you get clusters, and you get individuals. So I'm not comparing the characteristics. It's just that particular phenomenon. What do you think is the best way in terms of public policy for us to recognise those three different circumstances? Is it a change to ACFI? Is it in additional funding? Is it funding through the CALD support services which we've heard about this morning and elsewhere?

So in a practical sense, I'm not understanding what the public policy response is. We understand absolutely the issues you've raised. I in particular have been around non-English-speaking issues for a very long time in many, many aspects of my life, but what is the actual practical policy that you think we're missing in our report that would address that?

**MS HUGHES (DCL):** Can I just throw my bit in there? I suspect there will need to be some additional funding somewhere along the line. Can I just clarify a bit about your individuals, the odd individual?

**MR FITZGERALD:** Yes.

**MS HUGHES (DCL):** In a number of Victorian residential care facilities here, it's not just the one or two. It might be 15 or 20 all from different backgrounds, and that is scary - just to do something half decent to acknowledge their linguistic and cultural background.

**MR FITZGERALD:** Sure.

**MS HUGHES (DCL):** Buried in the back of my mind here is the notion about planning, and also tying CALD considerations if you like into the other structures being set up in connection with the National Health and Hospitals review, and I'm thinking of the Medicare locals, for example, who should have a finger on the pulse of primary health care and all this kind of thing, bearing in mind also that people from a non-English-speaking background also get a lot of their information from doctors, so they should be in the know as to who is presenting, basically.

But getting back to the notion of planning, I was sort of taken a bit by the notion of having quotas for supported residents, and I wonder whether that could be a way to go too, and have sort of trading of CALD people between facilities so that you could get groups of similar people - a cluster by another name, if you like - so that at least they could have access to language in a social context, et cetera, and be able to speak to people.

**MR WOODS:** Wouldn't they start to choose that themselves? If there are providers who are offering and one provider says, "Look, we've got a whole wing that's" - you know, "It's a small cluster of this group who you may feel comfortable with that you can share language and share culture, et cetera," why wouldn't we then let the older person or their carer or advocate then make that decision as to, "Well, yes, I like the overall package that's offered, including this feature of it," or, "No, I want to go to that provider because although they don't have that support cluster of other residents, there are other features about that provider that I prefer."

So rather than sort of trade them from top down, why wouldn't we let the individuals or their carers or other support help them find - and picking up your point about information, I totally understand that. You've got to have the information out there; it's got to be in the right languages; it's got to be in a form that makes sense and that accurately depicts the situation.

**MS HUGHES (DCL):** There's an immediate need now. I think what you're talking about will come in time. I think it will take at least five years. Actually it does depend on the information being there. I'd like to digress and just say that the Gateway arrangement is a huge task, basically. It is enormous. Getting the information in one repository, if you like, is going to be huge. It's not just collecting existing information. Information has got to be developed, and for your CALD communities there's a long way to go.

**MR WOODS:** But it's a gap at the moment. It needs to be dealt with.

**MS HUGHES (DCL):** Yes. Getting back to your question though, what's an answer? With ACFI there is absolutely - well, it's based on an ill-health model actually, so there is no sort of recognition of social considerations, whether they're ethnic or not, quite frankly, and they are a cost. So you might get care for an hour a day. What the hell do you do for the remaining 23? I think we've said that in a previous submission - two submissions in respect of ACFI anyway. But I think, getting right back to TORs, unless there are cultural and linguistic considerations or sensitivities embedded in the policy-makers down into action, there's just going to be more of the same.

**MR FITZGERALD:** But can I just check that? I'm deliberately being pushy here and it's not because I want to be offensive in any way but I just actually need to understand. Already, as I understand it - and correct me if I'm wrong - in the standards there is recognition of CALD backgrounds and you've indicated - - -

**MS HUGHES (DCL):** It's encapsulated in standard 3.8.

**MR FITZGERALD:** Yes. So in a sense the standards are there, so is the question that the standards are inadequate or is it the way in which the standards are assessed by the assessors with the accreditation agency? In other words, I'm trying to understand it because, as I look at it, where is the system - from your point of view -

falling down?  Is it the standard?  Is it the way in which the assessment of that standard in practice is being applied?  So that's just one illustration.

So again, I'm trying to elicit from you the concrete steps that you think need to change in the system.  We understand about the training of staff and trying to absolutely increase cultural competencies in mainstream and other organisations.  Hard to do; understand it.  But again, coming back to the more systemic issues, what are the things that you really think, "If we tweak these, there would be an improvement"?

**MS NEELEMAN (DCL):**   I don't believe that standard 3.8 actually addresses the cultural needs of the elder.  It talks about lifestyle, it talks about airy-fairy stuff, and there is nothing in ACFI that funds that cultural side, the requirement of language: do people understand what it is that you're saying to them?  Are people isolated in the facility?  There often is an expectation that because we all arrived on a boat - and far be it for me to call us boat people, because we're not - but, you know, I often present with Peter Gogorosis from Fronditha, and just because we both came out in a boat doesn't mean we're culturally similar.

**MR FITZGERALD:**   Sure.

**MS NEELEMAN (DCL):**   Greeks like to smash plates, and I can prove to you that my residents see it as being an absolute waste, because we tried it when we closed our overdue kitchen when we were changing our model of care.  So there's no similarity and yet we tend to get lumped in the same basket.  So the expectation is that if you've got 20 CALD people in your facility, as long as you have a lasagne and curly kale and something once a week, it's fine - and it's not.  And that's what the assessors are looking at.  I've had this discussion with the agency and Mark Brandon, and he says, "I'm not required to do that.  I don't have the jurisdiction to look at those things," and so it's not there.

**MS HUGHES (DCL):**   Can I just add to that?  I think the standards as they're stated might just pass muster.  I think the considerations, what is looked at in the audit handbook that the accreditation assessors go by, is wanting, to say the least.  If I were assessing CALD care I would be going into an organisation and I would ask to look at the articles of association or whatever and their vision and whatever, and if it didn't include anything about inclusion or whatever, they get a black mark.  I would look at their recruitment practices.  I would look to see if they've even looked at the history.  You know, who is in their catchment area?  Just go to the census stuff.  You can do it easily.

I'd look at recruitment practices to see if there is an attempt to at least get some staff members who speak the language of the dominant CALD communities in the area.  I'd be looking at the continuous improvement thing to see if they are reflecting on what they're doing for the communities there.  Can they do better?  Can they add to that?

When it comes to clinical care, for example, I would be looking at the admission notes to see what kind of history they'd get:  date of arrival in Australia, preferred language spoken, trauma in background, for example.  Were they carted off in a cattle train in Poland or whatever?  Because that will come back to visit them.  You know, family life, type of employment.  How good is their English?  Do their children speak the language they do, et cetera - a decent kind of history and a lifestyle.  I would look at the incident reports to see, if there is a person who doesn't speak decent English, did they get an interpreter or a telephone interpreter to find out whether that arm really is broken?

Looking at the lifestyle stuff, I would look at diet, I would look at whether there's a consideration about their spiritual needs, whether there is a consideration of whether male staff are okay with women - you know, decent sorts of culturally appropriate activities, and even with the environment.  Is their decor, et cetera, reminiscent of home but not necessarily home?  That's a start.

**MR FITZGERALD:**   Okay, that's a good list.

**MS MACRI:**   I haven't got a lot more.  I'm pretty aware of Petra and the organisation and what they do.  I think accreditation is one of the issues, but it's interesting, because it becomes an issue generally as well in terms of the appropriateness of it for a whole range of different cohorts of people, and the same with ACFI.  We have heard consistently about ACFI's inadequacy around behaviour, those sorts of issues, and then they're exacerbated by - - -

**MS NEELEMAN (DCL):**   The Cornell scale is not appropriate to use.

**MS MACRI:**   It's grossly inappropriate.

**MS NEELEMAN (DCL):**   And so there's a whole range of issues around how care is delivered.  I think the removal of the ACAR round is just wonderful and it removes that whole issue.  Going to the market removes that whole issue of people putting their hand up and applying for CALD beds or packages and then not delivering the services.  There is within me some hesitation about family members making the right decision for their parents.  I know that there are a lot in my generation who don't speak Dutch who are placing their parents and their consideration is about, "What's close for me?  What's good for me?  How does the room look?" rather than what the care is.

How do we then pick that up? What is the responsibility on the service provider then to make sure that they're delivering good care and how they do it? I don't see a translating service working very well over the telephone when you've got someone - you know, you really need them face to face. There are three Dutch interpreters in Victoria and I can tell you you need to book them seven days in advance. When you've got an emergency, how do you deal with that if you don't have the language around?

We go out of our way to employ Dutch-speaking people. The 457 migration visa stuff is a nightmare and is making life more difficult for us. It's all those ancillary bits that make life tough when you're doing a specialist service.

**MS MACRI:** Thank you.

**MR WOODS:** Thank you for your ongoing contributions to this inquiry. We've been very grateful for the information and support that you've been providing to advise us in these areas, so thank you very much. We will adjourn until 1.30.

(Luncheon adjournment)

**MR WOODS:** Thank you very much. The next participants, Alzheimer's Australia Victoria. Could you please, for the record, each of you, state your names and the organisation that you're representing and any position you hold.

**MS McCABE (AAV):** Maree McCabe, Alzheimer's Australia Vic, and I'm the CEO.

**MR SACH (AAV):** Jack Sach, Alzheimer's Australia Vic, and I'm the general manager for strategic initiatives.

**MR WOODS:** Excellent, thank you. We have a note from you on a couple of points you want to raise, but I notice that you've just presented us with a PowerPoint presentation. Do you wish to take us through that?

**MS McCABE (AAV):** That would be great, thank you.

**MR WOODS:** Thank you very much.

**MS McCABE (AAV):** Firstly, thank you very much for the opportunity to present at the public hearing. Just a bit of background about Alzheimer's Australia Vic. We're the peak body for dementia in Victoria, and our role is to empower and enable those people living with dementia and their families and carers and advocate on their behalf. We're an independent not-for-profit organisation supported by government and community donations and a member of Alzheimer's Australia.

I thought it was important to just state or to distinguish and describe dementia, which describes the symptoms of a large group of illness which attack the brain resulting in impaired memory, language, functioning, behaviour, and ultimately death. It's one of the most disabling of chronic health conditions and to date there's no cure. Alzheimer's disease is the most common form of dementia. In 2009 in Australia there were over 245,000 people with dementia, and by 2050 there will be a million with dementia, and the Caring Places report that was issued in January this year has identified a shortfall of over 279,000 beds and packages by the year 2050.

We were really delighted with the Productivity Commission report, and there are certainly a number of areas that work in the report, and it's great to see that a new vision for aged care provides greater choice and flexibility in service delivery and personal responsibility. I know that it's certainly a good response to what consumers have demanded in terms of reform - that's certainly been the feedback that our consumers have given us - and Alzheimer's Australia has long advocated for proposed reforms, including separation of accommodation and care, increased priority for community care, improved access to coordinated assessment and information, and greater flexibility in service delivery.

I guess some of the concerns in the report are that it was disappointing that of the 42 recommendations none related specifically to dementia, and we were concerned that there was little understanding of or recognition that dementia is, and must be, the core business of aged care services, and the shortage of residential aged care beds into the future will be driven largely by those consumers with dementia. Currently, about 60 per cent of residents in aged care have dementia and that figure is likely to increase with the prevalence.

In terms of the social impact, dementia complicates the management of all other conditions. So it's much more difficult to maintain someone at home for an extended period of time, and it's difficult for these residents to self-medicate or to communicate their care needs, and they often have comorbid illnesses which make the management of their needs quite complex. Dementia is the third highest cause of death after heart disease and stroke and by 2030 will be the highest cause of death here in Australia.

The social impact for carers is quite concerning. Caring for a person with a dementia is particularly challenging. It's a progressive degeneration of the person's cognitive capacity that will eventually occur, and carers often experience negative social and health effects, and loss of work and social activities can lead to them developing depression and anxiety. The social cost on families: over a million Australians currently provide care with people with dementia, and in many cases family carers are the only source of care. The cost to replace family carers with paid carers in 2008 was estimated at $5.5 billion per annum.

In addition to the personal impact, the economic consequences of dementia, as one of the most disabling chronic conditions, are daunting; the cost in 2008 estimated at 5.4 billion per annum, and the lost productivity by individuals, business and governments was estimated at $881 million. It will become the third greatest source of health and residential aged care spending within two decades, at approximately 1 per cent of GDP, and in 2060 is projected to be 11 per cent of the entire health and residential aged care sector spending.

In terms of workforce - and I think it's important to remind ourselves that this is in the context of an ageing workforce - there will be an estimated increase needed of more than 150,000 carers for people with dementia in the year 2029. That's a 76 per cent increase on the 2008 workforce figures, and the shortage is made up of 58,000 paid dementia care staff and 94,000 family members. The issues of most concern are really to build on the Australian Government Dementia Initiative, making dementia a national health priority, and the interface between aged care and mental health, a specific new funding model, networking a proposed gateway to information and counselling and respite care and care for individuals from special groups.

The draft report makes no reference to the Australian Government Dementia Initiative and the role it has played in promoting awareness of dementia and improving the quality of care or of increasing access to community care or enhancing dementia care research.  From a consumer perspective the Dementia Initiative has been effective, and an independent evaluation commissioned by the Commonwealth government reached a similar view and recommended it should be continued and in some areas strengthened and the gaps addressed.

So one of the things that we're requesting is that the following initiatives be built in:  to promote timely diagnosis of dementia - so really important that there's early referral and treatment for people and planning for them in terms of their future and future care; that we improve hospital care - hospitals are dangerous places for people living with dementia and what ultimately occurs is an increased length of stay and poorer health outcomes for those people with dementia.  We're recommending a look at adjusting the funding for counselling and support services in line with the growing numbers of people living with dementia, and to promote greater awareness for potential risk reduction by changed lifestyle initiatives.

The second area is the interface between aged care and mental health. Individuals with severe behavioural needs often face problems with continuity of care because of barriers between the state-funded mental health and the challenge of being referred between the systems - so there's this toing and froing that goes on between aged care and mental health.  For those clients with younger onset dementia -  that is, a diagnosis under 65 years-of-age - they fall through the gaps.  They don't fit into the criteria for aged persons mental health teams and they don't fit the criteria for the crisis assessment teams.  So that's an area that needs to be looked at.

The aged care system is probably best positioned to care for this group, hence the Commonwealth government should take on this responsibility.  To quote the expert psychogeriatric group in the draft report, "There will be much higher numbers of older people with mental illness in years to come that will require management in generic settings."  Individuals with psychogeriatric disorders require a higher level of care provided by highly trained staff and, as a result, their care is much more costly.

The ACFI Funding Instrument provides a behavioural supplement, but the supplement doesn't cover the true cost of providing care for those with severe behavioural concerns.  The commission acknowledges these concerns and suggests they'll be addressed by the new benchmarking of the cost of care services.  The new funding system must include a supplement which covers not only the additional cost of care for individuals with moderate behavioural concerns but also those with severe behaviours including aggression.

A specific funding model that recognises the additional costs of dementia is recommended, and the commission examines a number of models.  Alzheimer's Australia supports a layered model that covers specialist areas including dementia, mental health and palliative care.  Looking at the Gateway, the Productivity Commission has certainly responded to consumer concerns re streamlining access and information and assessment, and would deliver services in a regional structure. However, it's unclear how the Gateway would interact with the NGOs like Alzheimer's Australia that provide information, counselling, support services and education, and it's proposed that rather than a single gateway, the new Seniors Gateway be networked with existing services of NGOs like Alzheimer's Australia.

In terms of respite care, the need for respite is critical, and enables many people living with dementia to remain at home for as long as possible, and really accessibility to respite that meets needs is quite limited, so the system currently is not flexible in terms of what's available, and we're recommending that respite be elevated as a priority within the first two years of reform, and that flexibility be really built in, so similar to what occurs in the disability model, where respite allows for and caters for family and friends to provide that respite, and that that's actually paid.

In terms of special needs groups, the recommendations in relation to the needs of people from culturally and linguistically diverse backgrounds and Indigenous communities needs to be strengthened, and we're requesting a consideration be given to a partnership approach and cash entitlement, and certainly consideration needs to be given to ensure that individuals have access to services appropriate to their needs and are not burdened with excessive charges.  For those groups who are financially and socially disadvantaged - for example, the homeless - the report doesn't address how these groups will be supported.  Consumer-directed care for individuals from special needs groups should be expanded to trial a cash entitlement for care and respite.

So our conclusions and recommendations are really to build on the dementia initiative, making dementia a national health priority; to manage the interface between aged care and mental health; adopt a specific funding model; replace the single gateway with a networked approach; elevate respite care into early stage of reform; and strengthen the actions for special needs groups, including the financially and socially disadvantaged.

**MR WOODS:**   Thank you.  That's a very succinct summary of your key issues, and we're grateful for you to have prepared it in that manner, and to take us through it. Perhaps one comment that's worth making at the start is that you're not the first to remind us that none of the recommendations actually have the word "dementia" specifically in it, that you're aware of, but that doesn't mean that we weren't fully cognisant of the issue of dementia. In fact, a lot of our recommendations we considered would go a long way to meeting many of the needs of people living with dementia and their carers, so the fact that the word "dementia" didn't appear wasn't that we didn't recognise the needs. They were seen and continue to be seen by us as a core part of caring for older Australians, and we had felt that many of those recommendations would address those needs. So we will take on board the importance attached to the appearance of the word "dementia" but it won't necessarily sort of change our understanding of the importance of dementia, that hopefully is displayed through the report.

There are a couple of issues that I wouldn't mind pursuing first, and then if my colleagues want to chime in or go in different directions, but one is the question of respite. We do understand how critical it is. We do understand that it's not always being taken up to the extent that you would expect, given how important it is, and therefore there are barriers or constraints in its design and in its application that prevent it being taken up more often, and particularly in emergency. So we're interested in your views - you did make some cross-reference to disability - on how to be able to have a sufficiently broad group of people who can provide respite, who are known to and are people that feel comfortable with both the person needing the care and the carer themselves. So how would you envisage a broader based model of access to respite?

**MS McCABE (AAV):** I think it's important that one of the things to acknowledge first, to provide a context for this, is that in a crisis situation it is difficult to access respite. It's also difficult to access respite if the person living with dementia has significant behavioural concerns, and moving them to somewhere other than their familiar environment is not conducive to a good outcome; so I think the idea of a cash entitlement where the family can best work out with the people, under a case management approach perhaps, how the respite is best delivered. It may be that the respite is best delivered in the home, by a friend of the family who's willing to do that, and who's known to the client, or it may be that it's a carer from a community centre that's providing the respite in the home. But I think the critical thing is that the person is not moved from a home, from their familiar environment, where it's going to cause poorer health outcomes, and potentially exacerbate already challenging behaviours.

**MR WOODS:** Would there need to be some protections around who are the providers of that care? Particularly with cashing out, one shouldn't assume that there would be the occasional abuse of the system and the like, so it's a balance between flexible and appropriate care - - -

**MS McCABE (AAV):** Absolutely.

**MR WOODS:** - - - especially in emergency situations, and proper protection. So where do you strike that balance in your thinking?

**MR SACH (AAV):** I think that there needs to be sort of a range of approaches and models in this regard. I think one of the issues is when you try and become too prescriptive and offer just one or two choices, that's when we run into difficulties. The respite service option that's offered is often not suitable for the person, or the timing is not suitable, or the separation from their carer creates stress. Now, we wouldn't suggest for a moment that consumer-directed care is the panacea and should be available to all, and for some people it will be appropriate.

There are a couple of consumer-directed care trials under way, and I think that the questions that you raise about how do you set those parameters, and how you manage it, need to be further explored. But I think that the issue is that we're really trying to get quality of care for people living with dementia, where they do have some real choice, and I think that's the principle that we'd rely on, and exactly how that rolls out needs to be further developed.

**MR WOODS:** Again, we will soon approach our level of competence if we try and go too far into detail. I think it's much better for others to do that. Also, the danger as you say of being too prescriptive means that if you try and tie it down too tightly, you in fact create inflexibilities and boundaries and transitions and all the rest, so you've got to get the principles right, but then there has to be some element of flexibility and to adapt to the particular situations. Again, if we're talking in rural and remote areas, the flexibilities there are different in part to in major metro areas and the like. So we're conscious of that.

**MR FITZGERALD:** COTA in a previous submission earlier, just before lunch, indicated that some sort of registration of informal respite carers could work. They weren't prescriptive about what that would be, but the dilemma that everyone is facing in this is flexibility is fine and we agree.

The problem is that the minute something goes wrong, then that system comes under great scrutiny, so there's an injury to the person that's a carer, there are issues around whether they're a contractor or an employee; there are issues around elder abuse and, in your case, people with dementia, all of which will happen. Accidents will happen; abuse will occur. So in its public policy sense, trying to marry flexibility and responsiveness to the needs is clear, with a system that at the other end of the day has enough structure for people to be confident; it is our challenge at the moment. At the moment I don't think anyone has come back with a very good model. There are models from overseas, particularly in the disability area, and we will look at those. But it's actually quite difficult because all of the problems will happen, but they will only happen very rarely.

**MS McCABE (AAV):** Yes.

**MR FITZGERALD:** As soon as one happens, the whole system comes under scrutiny. So it is a complex issue and I'm not yet sure that we have a way forward. And it's exactly the same with the disability inquiry that's being undertaken at the moment in this space.

**MR WOODS:** So further thoughts from you, either today or in a follow-up piece of paper, would be very helpful.

**MR SACH (AAV):** I take those points on board. I think it's very valid: how do you actually manage that balance correctly? But the alternative of having a too prescriptive and narrow system where people don't use them just puts stress back on the person at home as well, and we have to find a way that meets all of those needs.

**MS McCABE (AAV):** And certainly, to keep people at home in the community where it's better for the person and less of a financial impact economically, the area of respite is absolutely critical.

**MR FITZGERALD:** Sure. That's true.

**MR WOODS:** Anything on respite, Sue?

**MS MACRI:** I absolutely take your point on that, but sometimes it's also been pointed out to us that when a carer becomes exhausted because the person has become increasingly more challenging to care for, quite often when they go into respite into a residential aged care facility where there's skill assessment done by staff, they start to have a look at nutrition, hydration, medication management - all those sorts of things - that sometimes it's about re-educating the carer in terms of what they're doing with the person and getting them back into the community but, again, changing that relationship a little bit. Whilst I take your point about it being good for them to be in their home, we get the converse quite often from people we meet with about the importance of that reassessment within a - - -

**MS McCABE (AAV):** Absolutely.

**MS MACRI:** And your thoughts around that?

**MS McCABE (AAV):** I'm certainly not saying that it should all be in the home. There are absolutely valid reasons for people to go into residential aged care, and I think that has a very positive spin-off in terms of reassessment and a fresh set of eyes looking at the client as well - so, you know, the medical review which doesn't occur in respite necessarily, but I think there are very valid reasons for people to go. It really is about what's best suited to the individual and not a blanket rule.

**MS MACRI:** And the carer at that time.

**MS McCABE (AAV):** Absolutely.

**MR WOODS:** And looking at even extended respite at times but not assuming that it's entry into resicare but a period of reassessment, stabilisation, re-education and adjustment, and then back in the community.

**MS McCABE (AAV):** And sometimes it's the opportunity to use both models, to have residential aged care respite and then respite in the home for perhaps a shorter period of time. So that might be something that suits - - -

**MR SACH (AAV):** I think the issue is to try and create a simple system that responds to all, in the sense that we should progress with build-ups and choices so that we have weekend respite, places overnight, at home; some consumer-directed care. So people at different stages under different conditions can have some quality choices to make, and I think that just happens over a long period and we would be saying, I think, that there's a valid reason to start to accelerate the priority given to that issue.

**MR WOODS:** Can I pick up the Gateway issue. You talk about replacing a single gateway with a networked approach. From our perspective, it is essential that the Gateway that will be in effect the entry point and deliverer of entitlements is a nationally governed body that is responsible to the government, because it sort of controls that whole front end. But that doesn't mean that it need be the deliverer of all services and in fact we wouldn't anticipate that it would deliver many services itself. It would have a range of models. There would be some staff that it would have itself. It would contract out. It would network with others. So I think your concerns about the possible diminution of your particular services might be a bit unfounded in the way we have set up the Gateway, because we would envisage that the Gateway draw on a whole range of community services and use those where they best deliver.

**MR FITZGERALD:** If I can just explain a little bit about that. In relation to the issues you've raised - which are not about assessment or care coordination but rather counselling and that - there are a couple of comments I'd make. The first is it's a bit like Centrelink. Centrelink provides the repository of information but that information is delivered through multiple agencies - welfare, rights centres, community groups, neighbourhoods - many of which are funded for that purpose. So in a sense we see it the same way:  that the actual information will be available through Gateway, but will be available through multiple sources; very much the same as - if I can use the word - welfare.

The second thing is - and we haven't made this clear enough in the report - we would imagine that a number of organisations like Alzheimer's associations in the states would continue to be directly funded to provide a range of supports for their particular client groups.  That really sits outside of the Gateway.  It's almost exactly what you do now.  So we need to make it clearer that there's a legitimate role for various bodies, including the advocacy bodies, that sit on the side as they do now, but it's absolutely right, as Mike says:  the Gateway itself could use any number of means to deliver its particular services.  So I think we haven't made that clear enough in the report.  The network model - if that were to mean networking the whole thing, that would create some significant problems for us.  So we'll make that clear in the final, just how that would work.

**Ms McCABE (AAV):** Commissioner, the feedback from consumers was their concern that they would have to go to a gateway; that that would put some of them off seeking the counselling and support that they needed.  I think that's their concern.

**MR FITZGERALD:** The counselling and support they could directly access from a service.  But the one thing I think that's pretty clear is that they will need to get to a gateway in order to access a range of aged care services.

**MS McCABE (AAV):** Of other services, yes.

**MR FITZGERALD:** But that may well be with your support.  It may well be with the support of advocates which we've recommended be increased, and we've been talking to participants about how that might work.  But at some point, yes, they will need to go through the Gateway and, in your case, perhaps with some supports to do that in order to access the entitlements to a broad range of services.

**MR WOODS:** That might be by going through their GP or through their local council or all sorts of - - -

**MS McCABE (AAV):** That was actually going to be my question:  how do people get to the Gateway?

**MR WOODS:** Yes, exactly.  It would have multiple outlets back through those processes.

**MS McCABE (AAV):** Right.

**MR WOODS:** But if the local GP, in talking to them, or the nurse practitioner, identifies that there are some needs arising and emerging, then they would help them fill out forms or seek an assessment, depending on the severity and acuity of the particular needs, so that they would help them through that process. But ultimately there has to be a decision point that says, "Yes, you are entitled to a publicly funded or publicly subsidised set of services and here is your entitlement. Here are the prices of those services. You can go to any provider who delivers those and choose which one you want for the delivery of that, and here is the co-contribution that your circumstances require you to pay."

**MR SACH (AAV):** Just briefly in conclusion, I think that once we get to the formal service provision requirement, that argument holds up well. For us, a lot of people ringing our helpline, for example, are coming because they don't know what the issue is. They're concerned, they're worried; they need to talk; they need counselling and they need support.

**MR WOODS:** Absolutely.

**MR SACH (AAV):** We're just concerned that that relatively softer end of the support really needs to continue and needs to be strong.

**MS MACRI:** Absolutely. In fact we'd see it being enhanced as you go down. We've talked about advocacy groups and the importance of strengthening those in the future.

**MR FITZGERALD:** But we'll make that clear in the final report. Can I go to - Michael?

**MR WOODS:** You may.

**MR FITZGERALD:** One of the most important issues you've got is on page 16 - sorry, slide 16, which is in relation to younger onset dementia. Sue and I were at a forum for Alzheimer's Australia New South Wales the other day and one of the most important issues that we need some clarity about and advice from your association and your Australian association is, how do we deal with younger onset dementia? Because the commission is doing the inquiry into disability and the inquiry into aged care, this is an exceptionally opportune but very important time. So can I just clarify your point there. Do you believe that younger onset dementia clients from the moment of diagnosis should fall within the aged care system - that is the assessment processes and the support systems? I'm not talking about residential aged care. I'm talking about generally. Is that the preferred area?

Or, alternatively, do they sit in the disability system? Now, you haven't referred to the disability system, and if I can just preface that by a question. I'm now not sure how the dementia community sees itself. Some would say to us that they do not see themselves as a group of people with a disability, and yet the other day at the forum a couple of people thought that that was only a view held by older people and that younger people with dementia might have a different view.

So it's a very important issue. It's a critically important issue for both inquiries and I just would like your view, if you have one, about which system best caters for the needs of younger onset dementia.

**MS McCABE (AAV):** This is Jack's area, so I'm going to defer to Jack. I have a view but I'll wait until you - - -

**MR SACH (AAV):** I think you put your finger on a very important issue. One of the issues about dementia is it's been perceived to be an aged care issue up to date. It is a health issue. It is a chronic health issue and we have to - just the same as a heart condition is, a stroke is. Dementias are related to an organic disease affecting the brain. We have to learn to and incorporate our response to dementia within the health system as a whole.

There is an aspect that some people with the condition are older and some are younger. The majority are older. Probably from this inquiry's perspective it would make a lot of sense to relate younger people to that aged care system without - but I'd like to take that on notice, in a sense. The difficulty with linking it across to the disability sector is that I think that the frame of reference in which that works is quite different and unfamiliar to people generally with dementia, but I think the primary point is that dementia is not just an aged care issue, and that's what we need to build into our thinking.

**MR FITZGERALD:** We acknowledge that but we do need to know - and I know this sounds awful but we do actually need to know which system has primary responsibility once the diagnosis has been made.

**MR SACH (AAV):** Yes.

**MR FITZGERALD:** And that is a challenge, and as hard as it is for people to actually say - because they generally say, "Well, it should be everything should be responsible" - we actually need to know which is responsible.

**MS McCABE (AAV):** I actually don't know that there's a specific answer to this and I know that that's not the answer you wanted, but it is the answer I'm going to give. There are some people with younger onset dementia that are managed very well in residential aged care settings and in community care settings. There are others where behaviours are a significant issue, where they are actually better managed in the mental health centre, and for that particular cohort of people they're actually a risk to people in residential aged care, so they're a risk to residents, to staff and potentially to themselves.

**MR FITZGERALD:** Sure.

**MS McCABE (AAV):** But when they're not, when behaviours are not a concern, they're managed very well in aged care.

**MR FITZGERALD:** And your slide indicates that, notwithstanding there is a group of people that from time to time require specific mental health treatment, in general you would think that the aged care system is the system that should largely be responsible?

**MS McCABE (AAV):** I do.

**MR SACH (AAV):** Providing there's sufficient flexibility within aged care to respond in an appropriate way to that group so that we don't treat people as though they are older, even though the aged care system is managing them.

**MS McCABE (AAV):** And I think it fits into the younger people in nursing homes issue that has been a - - -

**MR SACH (AAV):** Problem.

**MS McCABE (AAV):** Yes, that has been a big - - -

**MR SACH (AAV):** For example, so we can get special units which are appropriate to them that mightn't link through to an aged care facility but still respect the fact that they're not old people.

**MR FITZGERALD:** That's very helpful. Thank you for that.

**MR SACH (AAV):** Thank you.

**MS MACRI:** I guess it goes on from this a little bit where you talk about the interface between aged care and mental health. I guess that comes on from that younger onset but it also comes around people with particularly challenging behaviours that are not dementia associated, and I just wonder how you see that interface in those relationships. We hear from residential aged care, and we heard this morning about the difficulty of a person, an older person with a mental health problem, being admitted to a nursing home with not proper discharge information, the nursing home being unable to cope with the person - back to the hospital.

**MS McCABE (AAV):** Yes.

**MS MACRI:** Their concern was, well, they have absolutely no doubt that it had gone back through the mental health system but back out to another nursing home.

**MS McCABE (AAV):** Yes.

**MS MACRI:** This is a real issue and it's come up a number of times.

**MS McCABE (AAV):** It is a real issue, Sue, and one of the issues I think is that there's inadequate funding for people with significant behavioural challenges in residential aged care, and I know that a lot of those challenges could be met by the sector if they were appropriately funded because for some people what it is, it's a matter - I mean it may be that somebody needs continuous observation and somebody to be around to prevent certain behaviours of concern, but the sector is not funded to do that, so it makes it very difficult and I think that some of the challenges could be accommodated if there were funding specifically for behaviours.

I know that under ACFI it's acknowledged but it's not appropriately funded, and it would certainly stop some of the toing and froing that goes on and which doesn't usually produce a good health outcome for the resident concerned.

**MS MACRI:** We've heard fairly loud and clear that ACFI doesn't reflect behaviours and challenging behaviours. I mean, sometimes these behaviours are episodic rather than continual, for whatever reason. Would you see some form of a trigger that may allow for additional funding for an episodic period of challenging behaviour?

**MS McCABE (AAV):** I think it actually goes back a little - the step before that as part of the assessment, and ACEBAC have done a really great study on person-centred care that's been implemented and trialled with very good outcomes in areas with dementia-specific units and with people with challenging behaviours. The context that their study is looking at is, behaviours are actually displaying an unmet need. So if you can identify the kind of needs that people have and meet those needs before behaviour occurs, then you eliminate the need to be looking at triggers. So looking at that kind of model I think would be really useful in managing this issue.

**MR SACH (AAV):** I think that the cost and complexity of managing the issue has been around for a long time and it's one that we struggle with, but I think that the creation of the Dementia Behaviour Management Advisory Services, the DBMAS services, at least is a start in the right direction, where we try and build up advice that's available to people working in the industry and people working at home, so I think that building up that expertise is part of the solution - not entirely but, yes, it is a difficult issue.

**MR FITZGERALD:** Can I just clarify: when you talk about a specific funding model, just from my understanding, following on from your question and discussion just then, are we in the residential aged care facility talking about an adjustment to ACFI plus this episodic-type funding that Sue has referred to? And then in the community care it's ensuring that in our building blocks - you know, the building block approach - - -

**MS McCABE (AAV):** Yes.

**MR FITZGERALD:** - - - that the aspects that are related to dementia are taken into account? When I looked at your slide about a specific funding model - certainly our building block approach specifically talks about dementia.

**MS McCABE (AAV):** Yes.

**MR FITZGERALD:** And in residential, I would imagine the ACFI is the core issue, or are you talking about something more radical than that?

**MS McCABE (AAV):** We're not talking about anything more radical, but I think certainly enhancing that is what's needed, that it's insufficient currently to manage people in residential care and in the community, and they could be if the funding were more suited to that particular cohort of people.

**MR WOODS:** But is that insufficient in dollar terms or insufficient, in the way it is structured, to be able to recognise these issues?

**MR SACH (AAV):** I think it is ultimately reflected in dollar - - -

**MS McCABE (AAV):** In dollar terms, yes.

**MR SACH (AAV):** But I'm not sure, commissioner, in terms of the episodic. It's a question of how you define that episodic. I just think there has to be a supplement somewhere within the system where people can establish that a person has a behavioural issue that needs additional support, but exactly how you define that is very difficult.

**MR WOODS:** It's also been put to us, which we're considering with our, as you describe it, layered or building block approach - and we do have an additional component there of specialised services for behaviour management, but the other way of representing that - and it's more diagrammatic than relevant on the ground - is to have the challenging behaviour issues right across basic support, through personal care.  Obviously if you have a behaviour dimension to your funding, then that would occur as a matter of course, so the issue is a little bit more about how you would actually describe it pictorially, but the intent is to recognise behavioural components right the way through the system.

**MS McCABE (AAV):**   Yes.

**MR SACH (AAV):**   But I think we've got to recognise, too, that if there was funding available, that it isn't perversely managed; people manage to identify, "There's additional funding here," and so we've got a behaviour.  We do need to target the resources to where the real need is.

**MR WOODS:**   Absolutely.  Completely agree, and any thoughts that you have on how to enhance that assurity would be well received.

**MR FITZGERALD:**   Can I just ask about your special needs groups on your slide 21.  I just want to be clear.  These are general groups with additional needs?  Or when you're talking about special needs there, are you talking about, for example, the homeless that also have dementia, so that that slide is about people with dementia who have additional needs, or was this a more generic population group?

**MS McCABE (AAV):**   Well, it's really with additional needs, yes - people with dementia.

**MR SACH (AAV):**   I think as an organisation we would really dearly like to move away from the idea of special needs groups as such.  I mean, we're just trying to reflect diversity and to ensure that whether a person is GLBTI, whether they're homeless, Aboriginal or CALD, regional and so forth, the system incorporates and absorbs their needs as part of everyday practice.

**MR WOODS:**   These are dimensions of their needs, not special needs.

**MS McCABE (AAV):**   Correct.

**MR SACH (AAV):**   Absolutely.

**MR WOODS:**   Well, if we could find some nomenclature that would solve that - - -

**MS McCABE (AAV):**   That would be a help.

**MR FITZGERALD:** I think after yesterday we've moved closer to "additional needs", but there may be yet a better term than that.

**MR SACH (AAV):** Maybe "reflecting diversity" or something like that.

**MR FITZGERALD:** Well, you see, this is very dear to my heart, that sort of approach. I know we're running out of time, but I do just want to raise this question: dementia-specific services within residential care. Michael is right: we were a bit surprised that Alzheimer's - we're concerned about a lack of mention of dementia because we actually thought it was a core business. So we actually realise that the vast majority of people in residential care will in fact have either mild dementia or increasingly significant dementia.

**MS McCABE (AAV):** Yes.

**MR FITZGERALD:** But in relation to the actual care and the models of care being provided within residential services, do you have any particular concerns that we should be aware of? I'm sure you have some, but I don't get a sense, in talking to the Alzheimer's groups, that that area is evidencing itself in terms of public policy responses, and your slides don't refer to that either. So I was just wondering, not whether you're happy with what's happening but whether or not from our point of view there are specific issues around dementia-specific care within residential services that we should take on board.

**MS McCABE (AAV):** You've raised a topic that's actually very dear to my heart. It is inconsistent, so dementia care and residential aged care is inconsistently applied. So you may go somewhere and people living with dementia get excellent care, but that's not necessarily across the board. So things like pain management are often poorly managed and that then can lead to exacerbating people's behaviours. So that's a real concern.

In terms of general management, I think the education of staff is the place to start, and I certainly have concerns that the carer workforce is not registered, I guess, as a body. When we look at issues around elder abuse and mandatory reporting, unless there is some sort of charge laid, then a carer can toddle off down to the next residential aged care home or the next community setting and get a job and it's not reflected on their police check, and often reference checks aren't made.

I'm not even sure how to articulate this, but there needs to be some registration body that they're part of where those things are managed in a professional way that protects people, particularly living with dementia, who are unable to express the sorts of things that may actually be happening to them. So it's a big deal and certainly, as I said before, it's inconsistently applied. It depends on the home that you're in as to the level of care and the quality of care that's provided and there needs to be some way of ensuring consistent care and quality care across the board.

**MR FITZGERALD:** Just related, and my very last question: do you feel that your associations are voices effectively heard in the accreditation processes and regulatory processes? With the new regulator we're putting together, one of the things we have to give consideration to is how do we formally ensure that the voices of the consumers and carers are taken into account in that structure, which we haven't yet done, and I'm just wondering whether or not you feel that the voice of people with dementia is adequately heard when it comes to things like standards and regulation.

**MS McCABE (AAV):** My personal view is no, it's not, and organisationally - I'm going to have to get you to speak. What do you think, Jack? I'm asking Jack, I'm sorry. My appointment has been fairly recent. I've been there for a few months. I have a view about what I've seen to date, but I just want to check in that my view is accurate.

**MR SACH (AAV):** I think we've got a long way to go in terms of the consumer voice. We are really elevating that issue now. We do need to have consumers speaking for themselves. We're at the point now where carers express their views. We actually aren't talking enough and getting people living with dementia themselves to express a view in that regard and I think that we do need more formal mechanisms. We've developed a consumer dementia research network, for example, where consumers are now having a say on research priorities. That sort of model needs to move into consumers having a say on things like regulations. So I think that you're absolutely right; we need to formalise that further.

**MR FITZGERALD:** Thank you.

**MS McCABE (AAV):** And in residential aged care, the accreditation agency looks at it under behaviours, so it's viewed under behaviours and then they look at other things under specialised care. So it's very fragmented.

**MR SACH (AAV):** May I just say quickly in conclusion, please, that I think the issue of people with dementia in residential aged care is - we really need to move to a position where we're working with a range of individuals with different needs, that we're not just thinking about dementia as a common set of characteristics. The themes that we really need to address are things like pain management, palliative care and behaviour management, and I think that that can be done through greater workforce capacity and education, as well as developing our models around this more personally centred approach. So I think we've got to move to a whole area of capacity building of the service rather than trying to segment out dementia as a category of people or with a common set of needs.

**MS McCABE (AAV):** I think social interaction in that is equally as important.

**MR WOODS:** Thank you very much.

**MR SACH (AAV):** Thank you for the opportunity.

**MR WOODS:** If you could bring forward the next participants, ANF Victoria, please. Just yourself?

**MR GILBERT (ANFV):** Just myself, yes.

**MR WOODS:** Yes, okay.

**MR GILBERT (ANFV):** Thanks.

**MR WOODS:** Thank you. For the record, could you please give your name, the organisation you're representing, and your position in it.

**MR GILBERT (ANFV):** My name is Paul Gilbert. I'm the assistant state secretary of the Australian Nursing Federation Victorian branch.

**MR WOODS:** Excellent. Thank you very much. Thank you for contributions to date to this inquiry. Do you have an opening statement that you wish to make?

**MR GILBERT (ANFV):** I do, and I went to some trouble to keep it brief, so brief that I left it on the printer. However, I have emailed it to myself, and it's not as brief as I'd like it to be because in some ways it's responding to some of the questions I know the commissioners have asked other people who have been presenting since we've made our two submissions.

Firstly, I picked up this morning a copy of the Recruitment and Retention of Nurses in Residential Aged Care Commonwealth Report in 2002. In there you'll find many of the recommendations that I'm sure the commission is being encouraged to potentially repeat. I'm fearful that that might be an approach the commission ends up inadvertently adopting: that many of the things that people are asking for, they have asked for and commissions have found these things should occur yet they never have occurred, and simply making a broad recommendation as to a type of thing that might happen or could happen is potentially going to leave us in the same place as we've been in every previous report.

If that happens, one of the consequences for our membership - which nationally we've got 30,000 members working in aged care, we've got the biggest aged care membership of any trade union in the country, we've got 9000 members in Victoria alone working in residential aged care across the spectrum of care ; first, second and third level nurse, if you like; registered nurse, enrolled nurse, and assistant nursing personal careworker.

The concern that I see overriding everything else - and I know the commission has had to spend, understandably, a lot of time looking at the financial structures that might underpin a new aged care system. It runs the risk, however, at this point - and I accept that it's a draft report and that's what these discussions are about - that there are no strong recommendations that go to the improvement of care as compared to the generation of income. I'm not aware of any - - -

**MR WOODS:** We'll have that discussion.

**MR GILBERT (ANFV):** Yes, I'm happy to have that discussion. I'm happy to be wrong. We certainly welcome the recommendation about competitive wages. Wages is never, alone, the chief source of improved recruitment and retention of direct care staff. It never has been; it never will be, I don't believe. I think that perhaps the best evidence of that is in Victoria, where the issue of wages - as a comparison between nurses in Victoria, Queensland and other states - Victorian nurses are at the lower end of that comparison, and yet we have by far the greatest level of participation by nurses, and I've got some graphs that I'm happy to provide to you that reflect that.

**MR WOODS:** Thank you.

**MR GILBERT (ANFV):** On a national average, 8.6 per cent of the registered nurse workforce is not working and does not wish to. In Victoria that's 5.4 per cent That's a big difference across 90,000-odd people. In any meaningful-sized state, we have the lowest number of people who aren't actively nursing. Our belief as to why that is so can only be based on the experiences that we've seen in Victoria; that we were the only state that had nurse-patient ratios. Nurse-patient ratios gave people the confidence that when they went to work there would be six people on. Not five, not four, not three and a half; there would be at least six. Six might not be enough, but, hell, it's better than five. And it gave people the confidence to return to the workforce. People say it's a blunt instrument, it's inflexible.

As was said at the time - and I believe it's still the case today, and to paraphrase Winston Churchill I expect - it's a bit like a democracy that's not very good, but it's the best one that they've come up with so far. It is a sort of blunt instrument, but the importance behind that is that people understand it. The staff understand that this means that 30 beds divided by 6 equals 5. People understand: that's clear, clarity, understood, they know what the expectations are.

New South Wales had no staffing control mechanisms. New South Wales has the highest number of people who are not actively nursing but remain registered, yet their wages are some 18 per cent higher than ours in some areas. So it's not money. Money is something. Money adds a level of - obviously we all need money, but on top of that, when I started working - I'm an aged care nurse originally and I've been working for ANF now for some 18 years, and during that time - and I'd like to think that there's no link between me and what I'm about to say - the wages have gone from equal wages for nurses working in Monash Medical Centre or Prince Henry's or whatever and a private nursing home in Carrum Downs - a registered nurse in charge of those two facilities was getting the same rate of pay; an enrolled nurse in either of those facilities was getting the same rate of pay.  That was true from 1938 to 1995.

It's not about the work.  It's about the capacity of those people to be rewarded in the same way that their colleagues in other sectors are rewarded; colleagues working as school nurses, colleagues working in private hospitals, colleagues working in public hospitals, colleagues working in public aged care.  That's a very recent phenomenon.  They have not been getting classified and paid at the same rate. That is about recognition, that is about how people are seen and judged by people and how they see themselves being judged; it is that level of reward that goes with the job.  At the moment that reward obviously isn't there - and I accept that the commission has recognised that.  So you've got staffing levels, you've got the reward.

Skill mix is another incredibly significant factor.  I know from personal experience of people who have gone for registered nurse positions in aged care and they've rejected them on the basis of the skill mix that they've been left with.  A registered nurse is responsible for activities that they delegate.  That's not to say there isn't some shared responsibility with the person to whom it's delegated, but you have a responsibility as a registered nurse not to delegate something to a person who isn't competent to do it - which requires you to have some amazing innate and untrained ability to competently assess someone you've never met before who might be on their first shift and you're incredibly busy.  It's just impossible to achieve that.

The added difficulty or problem in that area - and I was interested to hear the previous people speaking about the regulation registration argument about the third-level worker, and I read, obviously, your report as it went to that issue, and I read some of the information that it appeared to rely on, which was the submission of the Royal College of Nursing and another submission of the - - -

**MR WOODS:**   LHMU.

**MR GILBERT (ANFV):**   LHMU.  I've obviously come here with a particular view, but I found neither of those compelling reasons not to proceed down the registration path.  In fact, the college's submission appeared to wholeheartedly support the rationale that we also have provided to the commission for that.  They then deviated at the end, without really being clear as to what system they wanted to put in place that would achieve those outcomes.

People speak of a negative licensing system.  That would, to some degree, deal with some of the issues that were presented before you just before.  Somebody who has been charged with an offence - no, that's going to show up in a criminal check. Someone who is just not a fit and proper person for whatever reason: firstly, that puts the resident at risk while you sort out which people are fit and proper people and which ones aren't. That's not a particularly attractive proposition.

Secondly, it just doesn't deal with the education issue. Of all the submissions that I read in Victoria - and I presume the same can be extrapolated nationally - two people with the same certificate do not show the same level of skill and knowledge, and people can't be confident that a person with a certificate III in aged care has the same skill set as somebody else with a certificate III in aged care.

There are two reasons I believe that's the case. One is that there's no-one properly accrediting the people who deliver those courses, the registered training organisations, and there's also no-one who has sat back from a nursing perspective anyway, and said, "This is a course that is suited to someone performing third-level nursing work in aged care. This is the course that we accredit. This is the course that we say people should do."

Then you have somebody saying - and this is what happens with enrolled nurse training through RTOs now, is that you then also have to meet as an RTO very stringent minimum quality requirements that ensure in the vast majority of cases that every enrolled nurse who comes out the other end of that RTO training course is the best that can be delivered. You don't get that quality in the certificate III, and it's unfair on the people who pay for it, whether they be the individuals or the employers; it's unfair on the industry; and of course it's unfair on the people who rely on care, as the majority of people providing care in private aged care clearly either have the certificate III or potentially nothing at all.

There is another important issue about staffing levels. We made mention in our supplementary submission about a case that was heard before Fair Work Australia recently involving an unqualified personal careworker, so a personal careworker with no underpinning education for the task, who was left in charge of 45 residents on her own, and was terminated for being unable to fulfil the employer's expectations of that person. In fairness, of some benefit to her was that after a long fight she got her job back. But that expectation is real. It is out there: one person, no qualifications, looking after 45 residents. There's evidence that that is the case.

There's evidence - and we've provided evidence to the commission by way of University of Melbourne research - that shows there is a registered nurse to resident ratio ranging between one to five and one to 53. Now, there's no logic to that. I do not understand how the accreditation system can be said to be capable of dealing with that. The facility that had one unqualified personal careworker looking after 45 residents on her own passed 44 of 44 standards before and after that event. The accreditors - they may not have been aware of this, of course - - -

**MS MACRI:** Is that a low care or - - -

**MR GILBERT (ANFV):** It's a mixed - high and low.

**MS MACRI:** It's a mixed, so there's no regulation around the requirement for registered nurses in a high-care facility?

**MR GILBERT (ANFV):** No.

**MS MACRI:** In this state?

**MR WOODS:** New South Wales does.

**MR GILBERT (ANFV):** The only requirement for a registered nurse is to have a registered nurse manage the care of a high-care resident, and manage the administration of scheduled medications to a high-care resident, so there's nothing that applies to low care, and the regulations as they apply to high care are all - and I emphasise the word "manage" because "manage" means "delegate" and "delegate" means you have to have someone competent to delegate to, which goes back to what I said at the start, and nurses don't want to work in that environment, where their own practice is being put at risk, and they're not doing the best that they can do in that area.

So there's nothing in Victorian law, and in Australian law, as you know, we have an accreditation principle that talks of "an appropriate number and an appropriate skill mix of staff", which means what? I don't envy aged care accreditors trying to determine what is an appropriate skill mix or an appropriate staffing level. I had a very nonchalant sort of a conversation with a director of nursing of a large facility, and just asked that person how things were travelling, and they said, they'd been within budget, blah blah blah, but February the budget was 115,000 "because we had accreditation that month". I sat back, and this person is a friend, so I didn't want to play work conversations with them, but I had to just stop for a minute, and say, "Why the extra 15,000 over budget this month?" "No, well, we always budget an extra 15 per cent on accreditation month," and, you know, that just means as I'm sure you know, the good staff don't get annual leave. They have to be there. The ones they want presented to the accreditors are the ones who are on site during the accreditation visit. Staffing is better during an accreditation visit. Yes, you can have spot checks, but spot checks are, by their very nature, time-limited and quite superficial.

There needs to be, I would have thought, for the benefit of everyone in the industry, some bottom line as to what was an unacceptable skill mix, and an unacceptable staffing level, otherwise we leave it in the hands of those who in the majority try to do the right thing, but in my view regulation is there to bring the minority up to what the majority is doing, and we don't have that regulation currently to achieve that outcome.

We wholeheartedly support the registration of the third-level worker. We believe that's the only way to get the educational skill up to a reasonable level, and that will take transition. I accept that. It's been achieved before. Enrolled nurses were not registered by their state boards. For a very long time they were nursing aides, then registered nursing aides, then enrolled nurses and so it went. It was achieved; there were transitions; and it was achieved successfully.

What always happens, of course, is if you brought in a regulated and registered third-level nurse, you would run the risk of having a fourth-level nurse, and I think that's the dichotomy that we find ourselves in whenever we have this discussion, and I put my mind to thinking about how that might be addressed. If the recommendation of the commission was accepted that the care component and the accommodation component are split again, like they were some years ago, then it's quite conceivable that you could say the care component could only be spent on people who are registered and regulated by AHPRA, so that's it. That takes away the profit motive behind pulling any funding out from the care component.

The care component itself is a great first step in achieving that, but within that there has to be mechanisms to stop, and we've seen evidence in New South Wales, you know, of people who paid for their son's university training, who was supposedly an employee of the nursing home, but really was never there. They all find ways to rort, but at the moment it's open slather. We go back to the CAM component type funding model, where we saw, from memory, around 70 per cent of the subsidy spent on care. Within, I would say, two years of that, I'd experienced that drop to as low as 51 per cent in a two-year period, from 70 per cent to 51 per cent of subsidy spent on care.

These weren't criminals. These were people providing not-for-profit aged care, who saw that that money was better spent in this other part of the business over here, where they were looking after, genuinely, people who needed looking after, but that wasn't what the residential aged care subsidy was for. So they were sliding that off into other areas of interest to them.

The other thing I wanted to concentrate on - we've attached these reports to our initial submission, and just to highlight a couple of things from those - in facilities where each nurse had to care for fewer residents, there were significantly better outcomes in relation to employee turnover intentions, fewer medication errors, residents' safety, family satisfaction, and better overall resident care.  That's evidence that improved staffing levels improves resident care.  At the moment, people would argue that there's no evidence that it doesn't, or something in that double negative. Well, there is evidence.  This is Australia's pre-eminent university, according to the newspaper a couple of days ago, where we have evidence that it does do certain things.  It does improve safety.  It does improve resident outcomes.  It does improve medication errors.

I heard just before about treating Alzheimer's as a health condition.  Of course, it is a health condition, and I accept and endorse and agree with that, but you talk to the average aged care provider and they don't believe that to be true.  They believe that people who have Alzheimer's and other forms of dementia need to be in a safe environment, and need someone to take them to the toilet.

They don't seem to understand that people with dementia may also have pain and, with severe dementia, how do you express to a carer that you have pain?  A nurse is trained to be able to pick up and assess a resident like that and determine that there are indicators of pain, even if the resident is not themselves able to in any way show that, except their behaviours might be particularly extreme.  The less skill you have, the less capacity you have to do those kind of things, and we now have facilities simply that do not have the skill mix or staffing levels to enable that to occur.  That's, to me, a very sad indictment.  I want to provide the commission with copies of that case about the one carer to 45 residents - - -

**MR WOODS:**   Thank you.

**MR GILBERT (ANFV):**   - - - because I think that's real evidence that this stuff exists, and this is just one of the rare ones that goes through to a final determination by Fair Work Australia.  Most of them are settled by some poor soul getting three weeks' pay and going on and working somewhere else.  So I did want to highlight that.  I have the two graphs here, and I'll obviously hand those over to you.  But that shows what happened with the introduction of nurse-patient ratios in Victoria.  That's the number of nurse registrants.  That was the year before nurse-patient ratios and that's now.  That shows a remarkable increase in the recruitment and retention of nurses and that graph shows what I was speaking about earlier - the 14.3 per cent of nurses in New South Wales who won't nurse, as compared to Victoria's 5.4 per cent who won't work.

Other than that, commissioners, I'm just obviously pleased to have had the opportunity to speak to you and also I would be pleased to take any questions you might have.

**MR WOODS:**   Thank you.  It's been a broad-ranging front end to this session.

Perhaps one area where we can find some heated agreement to start off the conversation:  the inadequate and patchy performance of RTOs in delivering cert IIIs and, to some extent, cert IVs.  This has come up in a whole range of other inquiries that the commission has also been dealing with.  Your view, to one extent is, well, let's ensure that the course is accredited or authorised or set out by a higher body. There are industry skills councils that design these courses, and then there are RTOs of all shapes, flavours and colours who deliver them.  But where is the current system falling down?  I mean, the content is something that is debated and there is consultation, there are outcomes, there are reviews.  Where is it falling down at the moment?

**MR GILBERT (ANFV):**   Firstly, to some degree the course has been developed backwards.  It's been developed from a home and community care course that was sort of originally designed for council workers; it's just slowly become a different course.  It's been developed back to front.  It should be a course that's developed within the context of aged care, recognising that the work it does is work that has been delegated to them by nurses.  So the course needs to develop competencies that reflect the competencies that a nurse would expect those people to have.  Where it's falling down in the main is the lack of oversight in the registered training organisation sector from someone who knows what this course is about.

That's why I used the enrolled nurse example, where an RTO that wants to deliver enrolled nurse training has to meet what were, in Victoria, Nurses Board standards.  They had to be accredited by the Nurses Board to deliver the course that the Nurses Board accredited.  So there were two separate accreditations that had to occur, and they are quite fierce accreditation processes:  about the number of educators; the number of clinical time; how you access clinical time; the size of your lab; access to computers - everything you can imagine.  Now under the national system that's split up between ANMAC the Nursing and Midwifery Accreditation Council who accredit the course, and I think the NMBA who accredit the deliverer of the course.  That's my current understanding, but it's in transition at the moment.  So that will continue.

In the personal care worker assistant in nursing - however titled - sector, I don't believe there's any kind of oversight that reflects that.  You hear of courses delivered in six school days.

**MR FITZGERALD:**   Yes, right.  We do.

**MR GILBERT (ANFV):**   Can that be right?  You hear about it all the time.  I guess where there's smoke there's fire.  I don't know.  What I do know is that there's nothing that says you can't do that.  So I think there is a very inclusive process around the development of training packages, and I don't at all speak poorly of that process.  I do think it would have been nice at some point to refocus on what the course is; what people who are undertaking that course are now doing.

**MR WOODS:**   Need to actually deliver.

**MR GILBERT (ANFV):**   Yes, to reflect their actual jobs, as compared to something that's been just picked up in dribs and drabs over many years.  The primary problem, though, is that there is nobody out there with oversight of the course and the delivery of the course, and that can be remedied, as I say, by following the same line as enrolled nurses have over the last 50 years, I guess.

**MS MACRI:**   Just following on from that, which I think is sort of related when we talk about registration, somebody registered at that level, that's not going to work unless the RTO and the education side is fixed up first.

**MR GILBERT (ANFV):**   There would need to be an accreditation process for those facilities who chose to continue to operate, yes.

**MS MACRI:**   Yes.  It would be really good from the ANF for us - and I've spoken about this before.  There are people that are saying, "It's not so much about registration, but it's around skills and competencies and being fit for the job," in terms of the educational training component.  The registration is another matter around, I guess, accountability for your performance and practice.  So it would be really good for us, in terms of trying to get something to link those two together in a proper framework.

**MR GILBERT (ANFV):**   Well, you can only be accountable for what you're supposed to know.

**MS MACRI:**   That's exactly right.  That's why I'm saying, registration - - -

**MR GILBERT (ANFV):**   From a nursing point of view, I find it surprising that the two things aren't just hand in glove, and I guess we're not always talking to nurses. But our professional registration body will judge me according to what it is that I know or should know, or what a reasonable nurse in my position would know or should know, along with any additional education that I've done, and within that is my scope of practice, if you like.

**MS MACRI:**   Yes.

**MR GILBERT (ANFV):**   For a personal careworker, there is no scope of practice. It's what my employer tells me to do and what I think looks like a good idea because this person is hurting or something.

**MS MACRI:** Yes. But that's the dilemma.

**MR GILBERT (ANFV):** In my belief, you can't be assessed against some blancmange over here. Whoever is assessing you as being a skilled practitioner or potentially not a skilled practitioner has to be the person who has an expectation of what a skilled practitioner is, because at common law or anything else that's what you get judged on: what would the ordinary skilled practitioner do in the same set of circumstances? To me, if the third-level nurse is registered, you can do away with mandatory police checks in aged care. There's a reluctant conversation I recall about, "Well, if we're going to introduce regulation of the third-level worker, we've got to do away with some other form of regulation because that's government policy." I won't say where I heard it, but that's a genuine conversation that I had some years ago, and I did offer to trade hairdressers because they're still registered, as you probably know, but you just call yourself something else.

**MR FITZGERALD:** Only in some states.

**MR GILBERT (ANFV):** Only in some states. So we still register hairdressers, but not people who are involved in intimate direct care, alone, unsupervised. Police checks: as a nurse registered with AHPRA, if I commit some sort of felonious - not even commit. If I am charged with a serious offence, the board is notified and I'm called before the board and I could be suspended immediately; within 48 hours I could be suspended pending a hearing in VCAT or whatever.

That's the way it works. We're seeing that happen now every day under the new national system. These systems - why would you reinvent the wheel? The work that personal care staff are doing is nursing work. It's what nurses have done forever. Yes, nurses have branched out and become more and more and more skilled, but it's still a component of nursing work. I did want to make a quick comment in case you don't think to ask me, about the industrial consequences of low and high care being treated as one.

**MS MACRI:** Yes.

**MR GILBERT (ANFV):** I did have a little weak-kneed moment, actually, when I saw that, because our agreements have traditionally picked up - where a facility was a nursing home prior to 1996, generally speaking in Victoria they will have an industrial instrument with us that treats them as high care, and places that weren't were, of course, hostels, and we know that is now the most blurred of blurred boundaries that you can imagine, but for us it was a case of what was industrially achievable.

We felt that if we didn't do that, we'd lose nurses out of that sector, so we locked in some minimum staffing requirements in what we've called in those agreements the high-care sector. The reality is, that could be a ward. You know, there might be a facility like Andrew Kerr in Mornington. They always had a discrete nursing home and a discrete hostel, and only the nursing home was covered by the staffing requirements and not the hostel, and they got different wages in the nursing home.

All of that stuff is just a mix of stupid history. However, if in treating high care as the same, we simply take away the industrial nursing requirements in high-care facilities, what you'll see is another massive loss of nurses in that area.

**MS MACRI:** Would you not see the reverse: that in fact the instrument would be requiring the low-care facilities to meet the - - -

**MR GILBERT (ANFV):** It would be very much dependent on the strength of your advocate in Fair Work Australia, the terminology in the statements made by the Productivity Commission in making that recommendation, and government in its second reading speech of what the bill is intended to achieve, and having a good commissioner as well hearing your case obviously is important. But all of those things put us on the back foot. The immediate assumption in the industry would be, "No rules. Rules don't apply now," and we would be on the back foot fighting against that.

**MR WOODS:** Is that your genuine view of how providers are discussing these changes with you, that they're saying, "No rules. Doesn't apply"?

**MR GILBERT (ANFV):** I'm seeing 30 per cent of the pie, right. I have very little interaction with really good employers and I'm not suggesting - - -

**MR WOODS:** Well, spend more time with them.

**MR GILBERT (ANFV):** I don't get the chance to. I accept from the outset that I'm seeing this 30 per cent of the pie and 70 per cent might be brilliant, but if I'm one of the people who's unfortunate enough to either be employed or be a resident in that 30 per cent, this is where I think government has a role to play.

**MR WOODS:** As long as you're careful in your language, that you're not applying this as a - - -

**MR GILBERT (ANFV):** No.

**MR FITZGERALD:** Can I ask a question. Yesterday your federal body indicated that there was a national framework agreement in the process of being discussed between the union and the providers.  I'm not quite sure how that's happening and with whom that discussion is.  Is that agreement, or those negotiations or discussions, going to look at those sorts of issues?  In fact, are they going to look at all the issues you've raised today, or is it a much narrower set of discussions, or is it too early to tell what they will look at?

**MR GILBERT (ANFV):**   I've seen the framework agreement and I'm aware of its content, and I think it's amended and it's attached to their - - -

**MR WOODS:**   Appended to that, yes.

**MR GILBERT (ANFV):**   I think that's a goodwill document.  We have six to seven hundred aged care facilities in Victoria covered by enterprise agreements.  Under the law we can't do another one while that agreement is in place.  That document is aimed at getting a commitment from employers that additional funding aimed at competitive wages is transferred to employees and, as a statement of intent, that's a beautiful thing.  It's industrially virtually - it has no place under the law, might be the best way of saying it.

**MR WOODS:**   This is on the record, as you would be aware.

**MR GILBERT (ANFV):**   It's a statement of intent.  I've lived through two separate unambiguous budget commitments to provide nurses with wage parity - funded budget commitments.  I've lived through them.  Neither of them added one cent or put me 0.01 per cent closer to parity.  Not one person offered one more cent as a consequence of that.  50 million, then 204 million - not a cent.  So you can understand my cautiousness.  I like these things locked in pretty clear because I've seen the consequences of not locking things in.

**MS MACRI:**   In New South Wales, for instance, there is legislation both at a state level through the Public Health Act in the requirement of aged care, as there is industrially written within the award.  It's a bit like a dog with a bone, but coming back to the registration and the RTO, my only other comment is, if registration went ahead, or licensing of that level of worker, and you managed to fix up the whole RTO cert III training/education component, what are your thoughts about what you would do with your existing workforce in relation to that framework?

**MR GILBERT (ANFV):**   We've got 17 varieties of enrolled nurse in Victoria at the moment, depending on when they did their course.  About 14 of those varieties have happened in the last five to six years.  We've now completed a process of working out the knowledge differences between those groups and we are now able to generate bridging courses to get them all up to the same level.  That work can be done.  I don't know whether there are 17 or 70 different courses that people might have done. But you develop a time frame, you commit to moving towards an outcome, and sometimes that time frame needs to be flexible if, despite the best efforts of all involved, you're not quite there yet.

The government are not afraid to offer money for training. It's about some of the lowest-paid people being able to afford to take time out of work to do that training. If there is a financial commitment from government, we can get everybody through that training process. You look at enrolled nurses. There's no obligation on enrolled nurses to do medication administration education, but we've tripped over each other to do it. You give people an opportunity for education in our industry and they will jump at it.

An outcome out of this that is probably as significant as any from a workforce point of view is that if you have a Nurses Board accredited course or an ANMAC accredited course for a third-level worker - and there's no fourth-level worker - they can enter aged care at that level, progress to an enrolled nurse in aged care at that level, progress to a registered nurse in aged care at that level, progress to a nurse practitioner in aged care at that level. It's a career from go to whoa. And aged care is some of the most beautiful nursing you can do. The difficulty with it is it's underpaid and it's damned hard physically and emotionally it can be very draining, but what I think hurts the most is, it appears to be the one that has the least resources put into it and I think that's what makes it so unattractive as a career option for people.

But if you bring someone in - and this is something we've been doing in country Victoria: bringing people in who have done the cert III, giving them assistance to go through to do the diploma or cert IV in enrolled nursing and, of those, 50 per cent of them have jumped straight in to do registered nursing and they've not left the town they lived in. They have not gone to Melbourne and said, "Oh, I like this kind of coffee. I'm not going back to Cobram." They have actually been able to keep that in place so that those people have remained in the community, and it's become like an infectious thing.

They say, "I want to go and work there, because if I work there I can not only do my cert III but they will help me do my diploma and they will help me do my degree," and people stay there under those circumstances. It's a potential for a very real and relatively seamless career for someone who's potentially not had the greatest luck at school, who can find their way through, the same way as someone who was academically good and did the degree and came in that way.

So you get everybody being able to take part in that workforce and, to me, that's leaps and bounds over any suggestion that we should loosen up the boundaries for 457 visas, for example, and take Third World nurses and bring them here. If the work is so unrewarding that you can't keep people in it, then bringing people in whose expectations are lower is a pretty sad way of dealing with it.

**MR FITZGERALD:** We're almost out of time.

**MR WOODS:** I understand that.

**MR FITZGERALD:** Could I just ask this question: why do you think since 1995 the lack of competitive wages emerged? I probably can guess the answer but you've drawn this thing that since 1995 the disparity between the acute system and aged care has gone - - -

**MR GILBERT (ANFV):** Compared to New South Wales, we lost our state industrial relations system, so that took away the vehicle that New South Wales have used to maintain some level of parity. We didn't have that. We were a deregulated industrial relations environment in Victoria. We sought enterprise bargaining from 1995 and in particular 1997 through to 2000; could not get - I think we got one agreement in the whole state and that was paying public sector wages and they still do, I have to say, which is interesting. We ended up having to run a very long, convoluted arbitrated wage outcome and, because of our rules, we could only deal with nursing homes, which is why you've got different rates for nurses in hostels versus nursing homes, and the Victorian health minister can go, "Nothing to do with us." There's no public pressure on the Victorian government to do anything about it, because it's Commonwealth funded, and the Commonwealth government might easily say, "Well, New South Wales aren't complaining. They get the same rates. Victoria mustn't be good enough or something."

It's a very complex environment, enormously unregulated; the workforce are, by far and away, predominantly part-time, predominantly women, predominantly people from non-English-speaking backgrounds. All of those things play into a workforce that stays and then goes. They put up with it and then, when a better option comes, they leave. So rather than nursing in an acute hospital in Melbourne where you really do feel part of a collective group and you will fight for decent staffing levels and those kinds of things, it's so much harder for people with all of those demographics behind them to achieve the same outcome in an environment where it's not the government that's the employer; it's the government who's the funder, and the employers range from very beautiful, fantastic, law-abiding citizens, through to what are effectively milk bar operations, although they are sliding out the bottom end of the market, as I'm sure you've noticed. But that's been the history.

**MR WOODS:** Thanks. Sue.

**MS MACRI:** No, that's it.

**MR WOODS:** Your federal colleagues flick-passed a question to you that I had about the importance of management and the training of staff at all levels to accept more and more management responsibility, given that that's what is actually happening, and the role that good management can play in having a stable, focused, dedicated, career-progressing staff in the various facilities or in community care organisations. We don't have time at the moment, but if you were to contemplate that issue and if you had any further thoughts on it, it would be very helpful to us to understand your thinking on how - we've made some suggestions in our report, but if there's anything further that you think you could add to that particular issue for us by way of an email or a piece of paper or some contribution, we would be very grateful.

**MR GILBERT (ANFV):** Yes, I'd be very pleased to do that. I also note that it took up about four or five of the recommendations in the 2002 report as well.

**MR WOODS:** Yes. You can just see the difference as you go into different facilities or different community care providers.

**MR GILBERT (ANFV):** Not surprisingly when you do that, the nurse in charge is generally being paid 30 to 40 per cent above other ones.

**MR WOODS:** Yes. I'm not sure that's the only - - -

**MR GILBERT (ANFV):** The recognition that a well-educated, skilled manager can bring - mind you, a lot of that is in the generation of income under the funding system. But there are some organisations who will devote a large amount of their resources to attracting the right people into those roles and there are others that see it as a role that has to be filled, rather than one that they're prepared to make an investment in. But, anyway, I'm happy to do that.

**MR WOODS:** That would be very helpful.

**MR FITZGERALD:** Thank you.

**MR WOODS:** We've got your other submission, with variations on our recommendations. If you leave all that, we'll put it - - -

**MR FITZGERALD:** We'll take that from you. Thanks.

**MR WOODS:** Thank you. We'll take a short break and then we'll have Wintringham.

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**MR WOODS:** For the record, could you please each of you give your name, the organisation you're representing and the position you hold.

**MR LIPMANN (W):** Bryan Lipmann, CEO of Wintringham.

**MS SMALL (W):** Helen Small, general manager of operations at Wintringham.

**MR WOODS:** Can I say thank you very much for the contributions that you have made so far to this inquiry, not only giving of your time as we came and quizzed you on all sorts of things, but also the submissions. We do note the tone of a little disappointment lurking through your subsequent submission, but we'll explore that and just find out where the issues lie, because you can be assured that we do have some appreciation, partly due to your own good efforts, of these issues and have every intention to try and come up with the best balance of recommendations that will address them. But, in that context, do you have an opening statement that you wish to make?

**MR LIPMANN (W):** Only to repeat what I've said to you privately and also in the report: that we greatly appreciate that all three of you - in fact Paul as well - have been to Wintringham and spent a long time talking to us and have clearly listened to our concerns. That's something we're very grateful for.

**MR WOODS:** But in your subsequent submission you've raised - - -

**MR LIPMANN (W):** We've raised a number of issues, but that's something different from acknowledging that you're listening.

**MR WOODS:** Okay, yes. So do you want to take us through the issues?

**MR LIPMANN (W):** Yes. Something that came up just in conversation while we were waiting which I haven't reported on, which perhaps may be of interest - because you can obviously read what we've already written there and can quiz me on it - is the issue of ageing in place. It's clear from the few comments we have heard and also just from discussions that we have a very different concept of ageing in place. Some people are obviously narrowing ageing in place right down to make the definition almost farcical. We would be the other way around, so we would actually say ageing in place starts at housing.

So we start at 50 years of age, premature ageing, and our outreach workers would find a prematurely aged male or female, look to provide supports, which may well include housing, in either one of our housing - and we're housing all through Victoria now - either on our own or on behalf of the government, and then slowly start to bring in supports. In fact Wintringham's motto, which my wife invented, is, "It's a home until stumps," and behind that nice expression there's a lot of truth.

As we have mentioned to politicians over many years, we have virtually no recidivism at all. Now, that's an amazing statement. That's really saying that we have a solution to elderly homelessness, which is quite a staggering statement. We have about 1200 clients a night, and virtually none of them ever return to the homeless world. No other aged cohort would be able to say that. Whether it is transferable or not is an issue that FaHCSIA is obviously looking at, but in terms of aged care it is quite an amazing concept.

That support will ramp up from relatively small supports of just checking and collecting rent, right through until the final hours in palliative care in a nursing home. So "a home until stumps" or ageing in place is considerably wider than what the industry would - - -

**MR WOODS:** Can I just explore that for a minute. Is your central focus to support the homeless and to give them life skills and to address issues of safety, health, nutrition, hydration, personal care and all of those so that they can then find their way in the community better than they had, or is it to provide a lifelong environment within which they can grow and develop and socialise and become more integrated but within sort of a community that starts from Wintringham out? I'm just not quite sure - - -

**MR LIPMANN (W):** No, that's a good question, which we've been asked before. I think the fundamental difference - and I had a very vigorous discussion many years ago with a government policy adviser who told me that he didn't think there was any difference, in a policy sense, in providing homeless services to the youth or to the elderly, and in fact there is a fundamental difference. It goes to the heart of what your question is.

Many years ago I was a youth worker. If you come across a 15-year-old homeless child, part of your responsibility is to ensure that you set up a system that somehow enables that child to re-form into society, to have a chance at a job, housing, maybe even being reconnected with the family - well, that's probably not often the case, but certainly some way that you can set the child up so that he or she becomes a member of society.

Elderly homeless people are dying. That's the bottom line. We're not really into rehabilitation. What we're trying to do is give them some peace, some security, some sense of community, before they die. The chances of them leaving our services and either getting a job or moving into independent housing is relatively minor. It's not unheard of, but it's rare.

However, we have so many ranges of housing that we'll have some people who move into aged care services and, because of their relative youth, they will actually get stronger, get onto a good medication, get some decent tucker into them and then they can move out into independent housing and then perhaps get some community supports from us to enable that to happen.

**MR WOODS:** I understand that. That's helpful. Do you want to start going through some of these particular issues; for instance, the ACFI and the behavioural domain issue, et cetera, which not only comes up as an issue in your situation but in dementia and the like, but they have different characteristics?

The proposal that we have that the regulatory body would properly, transparently and openly price care delivery so that when somebody gets an entitlement to services there is a price attached which reflects the situation, the level of support required, the complexity of skills that need to be input to deliver that care: does that go some way to addressing your concerns? I notice that you have this proposal that Richard Rosewarne be engaged to pursue some of the unintended impacts of ACFI, but does our model in itself also help overcome some of the constraints of the current system?

**MS SMALL (W):** Yes and no. Yes, in that we gave you an example in the report of quite a horrible and violent event that occurred that technically isn't funded under ACFI that could be funded under a scheme that you're proposing, but how do we keep funding the recurrent care that we've put in place to ensure that event doesn't recur?

**MR WOODS:** Yes. I understand that. So it's not just responding to the incident; it's putting a care environment around that person to avoid it. So the success is the non-occurrence.

**MS SMALL (W):** Yes. No occurrence at all would be our optimum.

**MR LIPMANN (W):** And the RCS - we're unable to provide that and be viable under that system, and we clearly can't be at this stage.

**MR WOODS:** You do have - I wouldn't call it a special relationship with the department - or departments; you deal with FaHCSIA and DOHA, but thinking in terms of DOHA - it's on the record, but nonetheless do you have ways in which you can work around some of the constraints of the system?

**MR LIPMANN (W):** No. Helen can answer this because it's more her area, but I think it needs to be said, just from my level, that we are granted no favours whatsoever in terms of the auditing of any of our claims. In fact, we maintain that we're audited more often. Where we get special attention is the respect they show us and they listen to us. Their doors are open. We engage them regularly about our discussion. I've got nothing but the highest praise over the last 20 years for the senior people in Canberra, for our supports, but we don't get any special deals. Nor necessarily should we; but we don't.

**MR WOODS:** But if the system is not adequately meeting the needs of the homeless that are in this situation, then has it not been able to respond in one way or another to addressing them, other than your own good efforts?

**MS SMALL (W):** We haven't been able to find a solution that can be confined, so several of the solutions that we have discussed would actually impact and be available to most other aged care providers and that's I think been a large part of our problem, trying to find a solution that is relevant to only the group of clients that we provide care for.

**MR FITZGERALD:** Can I go to the broader issue, the bigger issue, and you've referred to it here in point 3, block funding. One of the issues for us is we've got three sets of circumstances for people that require additional needs and, in this case, people that are experiencing homelessness.

One is where the service is predominantly for that client group, and in this case homeless people, older homeless people in your case. The second is where it's, for want of a better term, a mainstream service but there is a cluster, so you have six, 10, 12, doesn't matter, a cohort of residents on a regular basis. The third is where you've got the single man or woman who may be homeless and needs to access a small service in regional rural areas more predominantly. So for cohorts of people that have these additional needs, we've got those three scenarios.

Take the first one, where in fact your whole service is geared to this particular client group. The real question for us is whether or not the system that we've been talking about, with ACFI and the entitlements and that, works at all, and whether or not that aged care service should be separately and differently funded, where you are a predominant provider; or the alternative is to try to make the mainstream service work for that client group. Then we've got the second group, the cluster, and then we've got the third one where you've got the individual who must by nature fit within the mainstream service.

So I just want to get a sense. We've been talking to a number of providers, and I notice a couple of providers from the Brotherhood of St Laurence and St Vincent Care are presenting, and we'll raise the same question: where you are the predominant provider of services for homeless people, should we have a different funding model for that group or not?

**MR LIPMANN (W):** Yes. Well, certainly in terms of the other people you've been speaking to, as I mentioned to you it's very important to recognise that that's all we do, so there are no opportunities for cross-funding, and we're a considerably larger organisation, under one management scheme, of large numbers of people who are homeless. Your question goes right to the heart of when we set the company up. We said that under Peter Staples' day the people were aged and homeless, not homeless and aged. That's a fundamental concept for us, and when it was accepted, that really meant that aged homeless people have a right to aged care services, and that's been our mantra for 20 years.

So obviously to embrace a movement out of that is difficult to accept, because I've really fought hard to keep the right that homeless people should be able to access mainstream services, but on the other hand we're also trying to keep the company viable, so there's an element of pragmatism about how you respond to that. I think - and it was discussed particularly with the previous aged care minister and their chief of staff - I'm certainly inclined towards that view now, because everything that we are told by senior government people at DOHA is that a little bit of tweaking of ACFI may well be successful, but as Helen says, if it's tweaked too much then the floodgates will open for the mainstream industry, who will seize upon an opportunity to gain additional funding.

So it would appear that contracting out to an organisation like Wintringham and actually setting that 90 per cent or something like that will be homeless, or any definition that we can mutually agree on - there are other issues though, commissioner, not least of all how additional services would be procured. We wouldn't be part of the ACAR funding round, so that would have to be looked at.

**MR FITZGERALD:** There will not be ACAR funding rounds.

**MR LIPMANN (W):** Well, that's right. Yes, you're quite right. Well, yes, I suppose it's all possible. I was in Canberra two weeks ago and at one stage I said, "Perhaps we're just going to look at block funding," and it was interesting. For the first time people were saying, "Yes, maybe you're right," whereas previously they'd always been saying, "No, no, we don't want to do that. Let's look elsewhere." But that's part of the reason why we came to you with the suggestion about Prof Rosewarne, because if the best brains in DOHA and Wintringham, who does nothing but this, if none of us over the last seven years or six years has been able to come to a conclusion, maybe there isn't a conclusion.

**MS MACRI:** Richard's report which was done on behalf DOHA, specifically for Wintringham, which we've had a look at - is that a block-funded - - -

**MS SMALL (W):** I don't think he offered any solution.

**MS MACRI:** It didn't offer any solutions, yes.

**MS SMALL (W):** He mentioned that if we interpreted ACFI in a certain way, he believed we could improve our funding.

**MS MACRI:** Right.

**MS SMALL (W):** We then participated in a 100 per cent audit across all our sites, probably about 18 months after that report, with representatives of the Department of Health and Ageing to try and actually apply that solution. I think we got two residents to a higher category. It was spectacularly unsuccessful and I think it just brought home the fact that ACFI is such a prescriptive tool, it's very hard to manipulate things into it, in a nice sense.

**MS MACRI:** Yes.

**MR LIPMANN (W):** Can I also say that one of the preconditions we had with the secretary at the time, or the first assistant secretary, was that whatever is agreed, it has to be transparent. It's no good having a relationship between me as the CEO of Wintringham and a senior person in the government that's a nod and a wink that this will be interpreted in this way - - -

**MR FITZGERALD:** No.

**MR LIPMANN (W):** - - - because what would happen is the auditors will come down, they won't know anything about it, and there will be a mess, so it has to be something totally transparent, and we just can't find one.

**MR FITZGERALD:** Let me make a couple of comments. The commission is not averse to looking at direct allocation of block funding where appropriate. Indeed, in the report we've acknowledged that multidisciplinary integrated services for Indigenous communities is likely to be better funded in a block-funded arrangement. So the point that I think we're looking at is to say, if at the end of the day it is better to have a separate direct allocation for this particular cohort, then is that the right way to go, and if it is the right way to go, then that's what we should recommend.

The next groups, where you've got a block of clients but within a mainstream service, or an individual, is another issue, but we are trying to get some sense of - not consensus, but some sort of theme coming through from the providers to say, "Is this time to actually say, 'Let's do it differently,' or not?" You're now saying that after all your experience, and having tried to make the mainstream work - am I reading you correctly that you're saying you think now a separate funding stream for this client cohort might be best?

**MS SMALL (W):** I think what we're trying to say is that we're reaching crisis point. We've been working with ACFI now for three years. We've been working with reduced funding for that period of time. For that period of time we've put hours of work into working with the Department of Health and Ageing and their representatives, trying to find a solution. As Bryan says, our senior management team has been in on this, a Department of Health and Ageing senior team has been in on this, and we just don't frustratingly seem to be getting an answer. Block funding, when you hold that out to us, is just a wonderful answer. It's very simple.

**MR FITZGERALD:** Can I just ask the question, to break it down: is the answer for community based care, the care that you bring into somebody's home within the community, different from the answer where you've got a residential aged care facility? In other words, can some parts of the funding work as mainstream funding - that is, the community care side - or is the nature of the client and the services that you have to provide such that really all of the services to this particular cohort of men and women lends itself to a different funding model?

**MS SMALL (W):** It is less noticeable in the community, but it does exist in the funding streams there too.

**MR WOODS:** What does exist, Helen?

**MS SMALL (W):** The different type of care that you're providing to clients - - -

**MR WOODS:** Yes, okay. Sure.

**MS SMALL (W):** - - - to people with a past history of homelessness in the community, as compared to, say, my mother when she was receiving community care. There was more middle class, you know - - -

**MS MACRI:** Are you using CACP or EACH funding in your community care?

**MS SMALL (W):** We have CACP, EACH and EACH-D funding.

**MS MACRI:** And EACH-D funding into your - - -

**MR LIPMANN (W):** We're a very large provider now. We have 480 packages, so we are very familiar with the - - -

**MR WOODS:** And on that side, is it adequate or sufficient or at least passable for the delivery of the care that you're trying to - given that there are all the other constraints associated with delivery of community care to homeless people?

**MR LIPMANN (W):** The problems are less than in residential care, is probably the easiest way to answer you. There are problems still with our - - -

**MS SMALL (W):** For example, in your report you quantify CACPs as saying that's generally five to six hours of support a week. Now, reading that, I am going to assume that for most people, they can put money gained from fees, income gained from fees, into care delivery. We can't do that, so the most hours we can offer is four hours of support and yet we know anecdotally that we have one of the lowest administration fees attached to our CACPs, and so we're struggling to provide comparative levels of support to our client group because of their inability to be a co-contributor to the cost of their care.

**MR WOODS:** What does four hours of care deliver in a meaningful sense to your client group in a community setting?

**MS SMALL (W):** It gives them a case manager, which is one of the biggest bonuses.

**MR WOODS:** Just somebody to relate to, who keeps half an eye on them, who can then take them to hospital if they need - - -

**MS SMALL (W):** That's right.

**MR LIPMANN (W):** There's I guess an expression, they become the family member. All of us - certainly Helen and myself - in recent years have had to care for our elderly parents, and our clients don't have a Helen or a Bryan, so they take Helen or Bryan from Wintringham. It sort of flies in the face of social policy theory but it really works. It's being the nagging, annoying daughter often, because the daughters always take more care than the sons, it seems, always reminding, "Dad, have you done this? You need to go to the hospital. You've had those strides on for a week now" - all of these types of issues which no-one else is doing, and if we don't do that then they degenerate and get very frail and get very sick.

There's a report - I haven't included it in here. I'll forward it on to you if you like. It was done in America. It's called Million-Dollar Murray. I don't know if you've heard of it. It was just an analysis of an organisation who have tracked a homeless man who consumed $1 million in services, all of which could have been prevented if he had received a Wintringham-type care model.

**MR FITZGERALD:** If I can use a more bureaucratic-type notion, it's intensive case management in a sense. Others would call it that. You call it something much more friendly but that's what this is about, intensive case management, which increases as people's frailty and complex needs increase. It's a very old concept. Wintringham is not an old concept, but the notion of intensive case management for people who don't have normal supports.

**MR LIPMANN (W):** Wintringham was actually built on great old-fashioned concepts and it hasn't moved.

**MR FITZGERALD:** Yes.

**MR LIPMANN (W):** Can I just refer quickly back to your question before about what I thought was the industry concept, or homeless persons' industry, if there's such a - - -

**MR FITZGERALD:** If there's such a beast.

**MR LIPMANN (W):** If there's such a beast, and of course there isn't. I think that's the real issue. The other organisations will speak to you authoritatively, and we know them and we work with them. My understanding is that the only real link is an expression of frustration with ACAS and a growing expression of frustration with ACFI. For a long time it was suggested that maybe there isn't really a problem with ACFI because it's only really Wintringham that's complaining. Now, many more homeless organisations are complaining and I think, in fairness, it's not an adverse reflection on other homeless organisations. It's more that it's only natural that we were the one that picked it up first because we're the largest. We have no opportunity to cross-subsidise.

Helen came into my room within days of being there and saying, "This doesn't look good," and so it turned out. It took other organisations, some of them up until last year before they began to notice that there was a significant problem with ACFI. So I think you would struggle to get a universal view on block funding and I think I'm primarily here to advocate for Wintringham's viability, but part of Wintringham's charter is to advocate for older homeless people generally. I think that in the efforts of trying to create a solution you need to be focused very much on the older homeless people and primarily those organisations who are principally doing that work. If you try to widen it too much to all organisations who are prepared to put up their hand and say, "We'll take a few homeless people," you will find it difficult to get a model up that will work.

**MR FITZGERALD:** If we look at this and come to a conclusion that if you're a predominant provider for homeless men and women, block funding or some other direct form of allocation from a government is appropriate, you've then got the mainstream services that do provide a service for a limited number of homeless men and women or a very occasional homeless man or woman. So we're still left with the dilemma in those two cases of fixing - if I can use that expression - the ACFI and the other funding arrangements, aren't we?

**MR LIPMANN (W):** Well, it does, but I think the other issue is that the principle of homelessness itself is not the major problem. It's often a cultural problem; it can be a brain injury problem; it's a behavioural problem. There are plenty of Wintringham clients who spend a long time as homeless who would fit as easy as pie into any mainstream service, male or female. I think it's easy - and we use the term ourselves to classify it all as a homeless problem because it has some resonance in the community, but in fact there are often behavioural problems associated with a lifetime of homelessness which can create homelessness or be a product of homelessness.

**MR FITZGERALD:** Sure.

**MR LIPMANN (W):** I think, generally speaking, mainstream providers who would take homeless clients would probably take the softer end.

**MS MACRI:** Bryan, I'm just wondering if there had been any discussions with the department or even with Richard Rosewarne, for that matter, around the fact that obviously RCS was a good predictor of needs, and whether there was any thought of reverting back to an RCS model for a specific service such as your own. Has that sort of discussion taken place?

**MR LIPMANN (W):** Yes, we did have that discussion but it didn't go - - -

**MS SMALL (W):** We've waited for it.

**MR LIPMANN (W):** Yes, we did have that discussion.

**MS MACRI:** It didn't go anywhere?

**MR LIPMANN (W):** It didn't get up. I'd be surprised if you came up with a solution that someone - - -

**MR FITZGERALD:** You haven't thought of.

**MR LIPMANN (W):** No reflection on you; it's just that it's consumed us.

**MS SMALL (W):** The closest we came to a solution under ACFI was the notion of some supplementary grant for those looking after people who were homeless, and an additional category in the behaviours domain to acknowledge behaviours that weren't the simple ones that often are associated with dementia or with the elderly, to sort of try and grasp the funding needed for these very complex, often very violent behaviours, and not just when they occurred but when you were housing a client with a propensity to, or with the possibility that that would occur.

**MR WOODS:** But even a block funding model still requires the determination of what the funds are, and so a block funding model that had an RCS base to it might be a possible solution.

**MR LIPMANN (W):** We thought that one of the ways of doing it is just to take an average of the last few months of RCS scores, index that and use that as a basis.

**MR WOODS:** We'll take on board the challenge.

**MS SMALL (W):** CPI indexation.

**MR LIPMANN (W):** Have we got a couple of minutes?

**MR WOODS:** A couple of minutes. I've got a question but you make your statement first and then I'll see what I've got left.

**MR LIPMANN (W):** I'll just add one of the real concerns to us is the impact all this is having on the ability of homeless people to access services. That seems to be a major concern and I've reported it in this paper. The population of elderly people is obviously rising. The population of poor elderly as a consequence is rising. As a consequence of that there will be a population of homeless elderly that's rising. According to the 2006 census - which clearly was done at a boom time, so it's probably much worse than that - there are 18,000 homeless people. Wintringham is now struggling to get some referrals because of - well, we can only presume, I guess.

**MR WOODS:** That you've got through the ACAS.

**MR LIPMANN (W):** Yes, but I guess what I'm saying is that there is a growing problem. The White Paper on Homelessness identified that it was a key part of any social service system that homeless people should be able to access it. That clearly is not happening in aged care. This is a wonderful opportunity that you have to find a way that homeless people can access aged care services. You either come to a recommendation that says all of that work that was done in the past, particularly of Peter Staples, was wrong - aged homeless people have no right in aged care and put them into homeless services, which would be a terrible thing to do - or you say they have got the right to aged care services. If they have got the right to aged care services then you have to devise a system so that they can actually access them, and they can't at the moment.

**MR WOODS:** And you've elaborated on that in here. Just one that I want to raise briefly. Under the market approach to aged care requiring safeguards - and you make the point that in a purely market-driven approach you need significant safeguards, as you say, in order to protect players that cannot compete equally within the market. That's a perspective, but then you say, "We would argue that the elderly homeless are such a group." Well, the competition we're envisaging is not amongst the clients but is amongst the providers, and the client comes out with an entitlement to service and then it's the providers who are in the competitive situation of having to persuade or demonstrate to that person with the entitlement that in fact they're the provider who is best able to provide that care. So I was confused by that sentence, "We would argue that the elderly homeless are such a group", because they're not the ones who are competing. They're the ones who are now empowered. They're the ones who have the entitlement.

Let's then take that to the reality of a homeless person who has no assets, no income, and has complex needs, and then you need all the surrounding protections for them - in terms of they're not going to be able to make a co-contribution, they are going to need complex care, et cetera - and our other systems hopefully recognise and can provide support for that so they don't have to pay for housing; you draw on whatever pension that they were drawing down to contribute to their everyday living costs, et cetera. I won't go through all those. So is there something not clear in our report that caused you to put forward that proposition?

**MR LIPMANN (W):** Yes. I think it is a part of the report that is confusing. We have talked about it. Even up until 10 minutes ago we were still talking about it. We are not quite sure where it's gone, but we're also not too critical of it because we've raised concerns but we've also said that we have to see actually how it's all going to work. But I guess the summary, to us, is that there is a disinclination in the market to look after elderly homeless people.

**MR WOODS:** Sure.

**MR LIPMANN (W):** Then if you add a positive disincentive from a financial perspective, it becomes even worse. So what we're saying is that you need to have a positive incentive to pick up the aged homeless people. If you think you've done that, then that's fine. I couldn't see it and our staff couldn't see it. I know that was the intention, but I didn't - - -

**MR WOODS:** Okay, let's go back. Let's start at the positive disincentives. Hopefully we've overcome those in the sense that supported residents would attract an accommodation payment that actually reflects the cost of delivering the standard of accommodation - and we can have a debate about what that standard is, but let's not waste time today on that one - and that they get a care entitlement that is properly and transparently priced. So hopefully that's got over the positive disincentives, because they bring with them an accommodation payment and a care payment that meets their needs. In terms of the positive incentive, that's then the increment bit that we're talking about, where ACFI falls down and where RCS did something better. So hopefully we've at least got to the middle ground, and then there's the debate about what happens over and above that.

**MS SMALL (W):** I think maybe you cover it a bit in the draft report. The other essential difference is the lack of support. So the expectation that an aged homeless person could virtually hawk himself around to providers is - - -

**MR WOODS:** Oh, yes. So it needs the advocacy and the support. Yes, I understand that.

**MS SMALL (W):** And they have known systems like that in place.

**MR WOODS:** Sure.

**MR FITZGERALD:** We have, throughout the last couple of days, made comment about that, that in the final we need to be very clear about the support systems that support a whole range of different groups of people that allows them to even access the Gateway and how that works. So we acknowledge that we weren't very clear about that.

**MS SMALL (W):** Yes.

**MR FITZGERALD:** But there is an issue. In the entitlements that Mike has referred to previously, we are saying the case management would be a specific entitlement funded separately. So I would imagine that a very high percentage of homeless men and women accessing aged care would need some form of case management to go with that.

**MR WOODS:** As an interconnecting service.

**MR FITZGERALD:** So waiting to see them - you know, mainstream - and if it was block funded, that would be in the funding.

**MR WOODS:** Rather than using your CACP for the case management, the case management would attach then to service delivery.

**MR LIPMANN (W):** Yes.

**MS SMALL (W):** Definitely.

**MR LIPMANN (W):** And I think your colleague Paul, when we were talking in Albury, just did some back-of-envelope sums, and it's such a small amount of money over a $12 billion industry. I think the ATSIC community has demonstrated that it's cost-effective to take it out and look at it specially, and there are probably other groups, and I think we're certainly one of them, that if an agreed and appropriate way can be done - still maintaining the right of homeless people to have aged care services, but, as we've said regularly, rather than accessing mainstream services, organisations like Wintringham should be able to access mainstream funding.

**MR WOODS:** Okay. We have run out of time.

**MR FITZGERALD:** Thank you. That's been helpful.

**MR WOODS:** Thank you very much for your ongoing contributions to this inquiry.

**MR LIPMANN (W):** Thanks very much.

**MR WOODS:** We will pursue it, and if we need to come back to you with some other mental exercises we will do so.

**MR LIPMANN (W):** Yes, please do.

**MR FITZGERALD:** Thank you very much.

**MR WOODS:** Blind Citizens, thank you. Thank you very much. Could you please, for the record, state your name, the organisation you represent and the position you hold.

**MS ZAMMIT (BCA):** My name is Jessica Zammit. I'm the national policy officer with Blind Citizens Australia.

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

**MS ZAMMIT (BCA):** Sure. I might explain who we are first, because that might help.

**MR WOODS:** Yes.

**MS ZAMMIT (BCA):** Blind Citizens Australia is the peak national consumer body of and for people who are blind or vision-impaired. So we're not a service provider; we are a consumer representative body which is national, and our focus is on representing people who are blind or vision-impaired. Our governance is made up of people who are legally blind, so we have a very direct interest in the needs and wants of people with a vision impairment. Our key and core services are around individual advocacy, systemic advocacy, we do policy development, we work with all levels of government, and we also do consultation.

On a local level we also do peer support. So our members have formed branches and work on localised issues. Obviously we have a fairly vested interest in aged care, around the fact that a very significant proportion of people with a vision impairment are aged 70 and above. So my representation today is on behalf of Blind Citizens Australia, but also representing the Australian Blindness Forum, of which we're a member.

**MR WOODS:** Excellent.

**MS ZAMMIT (BCA):** I guess our core statement - probably in 50 words or less - would be that we're a little bit concerned that disability and sensory impairments haven't had as much of a focus within Caring for Older Australians as it should. Obviously there is the parallel inquiry into disability care and support. However, the sense that I can feel from that is that NDIS is seen as the coverall for disability - and it's distinctly not, particularly around people who are aged 65 and above.

We have some very deep concerns about how people who are aged over 65 will actually have their support needs met, and are a little bit concerned that there have been a number of cohorts which have been identified in Caring for Older Australians, which is great, but that disability doesn't factor as much of a mention as it possibly should.

**MR WOODS:** Right. We can pick up some of those issues, but if you turn to our draft specifically, what areas do you support in the broad and what areas would you like us to direct more attention to?

**MS ZAMMIT (BCA):** Sure. I guess in terms of what is being proposed, really what our major concern is - and what I'll probably be focusing on most today - is around what supports are envisaged to be covered by the aged system. One of the key concerns that our members have told us about is the fact that essentially blindness or vision impairment is seen as an ageing-related condition, so as you get older, naturally your sight will decline. That's kind of true, but not really a complete reflection.

There are a number of distinct groups. You have people who have been blind all of their life. Their ability to accumulate wealth is significantly less. Unemployment is at 63 per cent. There are huge issues around that; but then also around a person's ability - if they've acquired their sight loss later in life - to actually be integrated within the system. We've heard stories of individuals who have essentially sat in their room; who have been not been included in activities; who cannot navigate the aged care setting because its layout is not logical, there are obstacles everywhere; activities which are organised are not inclusive; materials are not accessible; information is not accessible. So they stay in their room.

So whilst there is a view of, "Let's look at this being about independence and wellbeing" - which is great and we support the principles of what is being proposed - it's not just about having a person sent a plan and having individual control. There needs to be a good conceptual understanding by the assessments around what are disability-related needs, and more so there needs to be confidence amongst people aged over 65 that they're going to get the same level of support that their friend at 64 may be getting through a National Disability Insurance Scheme.

We're talking about conditions that generally occur later in life, so our big concern - and we're putting in a submission to the National Disability Insurance Scheme as well and we're doing consultations at the moment around Australia; what is consistently coming up is the concern that 64-year-old Betty may be able to access aids and equipment. She might be able to get screen-reading technology on her computer so that she can read her mail independently. She might be able to access a CCTV to enlarge documents. She can access community transport and some home and community care. 66-year-old Mildred may not and we actually don't know what people are going to be able to access in the aged care scheme.

But, more importantly, there's a lot of funding and money being dedicated to an NDIS, which is great because disability services need it; but what happens to a person who doesn't qualify for an NDIS, who is 65 and a half, has just passed that threshold and has just acquired macular degeneration or another age-related condition?  Where is their confidence that they're going to get the supports that they need?  That's really our biggest fundamental concern.

**MR WOODS:**   At the moment, what are the predominant deficiencies in the aged care system that you would want to address as we then update it and reform it in the way we're proposing?  Is it the lack of funding for aids?  Is it the training of staff?  Is it the awareness of things like trips and hazards and obstacles?

**MS ZAMMIT (BCA):**   We can go one by one through all of those if you wish.  I would say, just starting with aids and equipment, at the moment there is very little if any funding for aids and equipment.  An NDIS may help that for people under 65 but for people over 65, the Macular Degeneration Foundation has been working for three years lobbying ministers around trying to get some funding for low-cost equipment. We're talking about magnifiers, we're talking about things that are so low-cost but would make a substantial difference.

**MR WOODS:**   And these are people who don't have the financial capacity in any way to contribute to or purchase?

**MS ZAMMIT (BCA):**   That's right.  Often they'll just be on an age pension or for many of our members who are legally blind, they may just be on the DSP blind. They may have no other income available to them.  If you're looking at purchasing, for example, screen-reading software so it reads information out audibly, you're looking at about $3000 for a licence.  If you're looking at a portable CCTV to read your mail, you're looking at about $2000.  These are things that are just as important - - -

**MR WOODS:**   Yes, those I can understand.

**MS ZAMMIT (BCA):**   Yes.  But also, I guess, it comes back down to, it's similar to the point that the gentleman just made:  aged care is a right.  If we're going to say that it is a right, a person with a disability or a person who is homeless has just as much right to be treated with dignity and respect and to get the supports that they need.  We don't hesitate to provide supports to people who are aged around respite, around all the other things that might be needed, yet equipment is one of those things that is seen as an optional extra.  You can write your notes down with a pen, you can use a computer, you can pick up any computer in a room you want.  Our members can't.

**MR FITZGERALD:** So that presumes - am I right? - that all of the disability schemes around Australia that provide equipment and aids to people that are legally blind cut out at the pension age? Or do any of them traverse the infamous age barrier?

**MS ZAMMIT (BCA):** It depends. When you talk about schemes, it's not like a person who's blind can go up to their agency and go, "Hi, give me a BrailleNote," and they'll get a BrailleNote. They won't. It will be, "We recommend that you get a BrailleNote and the BrailleNote costs X. Here is the supplier where you can buy it from." There are some grants in some states. Some states have in-kind support, so they'll loan out a piece of equipment for a set period of time. They may have subsidies that people can access. But it's not about, "Hi, you need a piece of equipment. Here you go."

Obviously when you get older, your needs are going to change and this is the other element of it as well. You know, it's not just one cohort of all people who have the same level of sight. People who acquire their disability later in life are less likely to learn braille, less likely to have a guide dog - all of those sort of things. They're less likely to accept their level of vision loss, they're less likely to ask for support, more likely to rely on carers. People who have been blind all of their life may have worked - but also higher unemployment rates - could have a typical family; you know, married, kids - and don't see their family as carers. So the needs are quite different in that regard.

With regard to your point about what else needs to be looked at, one of the key issues that we hear is about the awareness of workforce around disability. Once again, that issue of ageing - "This is an ageing disability. Once you're 80, of course you're going to lose your sight" - is completely detrimental. It has huge impacts on early intervention, so that means that if a person is losing their sight, they're not getting support early on to help them assist with coping with losing their sight. But also it's around the awareness of, "How do I assist a person with a disability? How do I actually ensure that they're included?"

One of my colleagues said to me, it's as simple as you want to go to the communal room and watch TV with the other residents. You're the only resident in there. You go to the remote. You don't know which buttons to press. You know, there's no audio described feature on the remote. You want to have a look at what the menu is but the menu is not accessible. You want to read a book, but there are no talking books, and so on and so on and so on. What we've found is that people are reluctant to complain. They're not going to complain if they're in a setting because they might get less treatment, they might get worse treatment or they may just be further ignored than they already are. So we have this Disability Discrimination Act that is not used. It's not used because it's reactive and people don't want to create a fuss.

**MR FITZGERALD:** The blind forum that you're associated with, that has the providers in there as well, doesn't it?

**MS ZAMMIT (BCA):** Yes.

**MR FITZGERALD:** Vision Australia and all those?

**MS ZAMMIT (BCA):** The Australian Blindness Forum is made up of service providers around Australia. Vision Australia is not a member of the Australian Blindness Forum.

**MR FITZGERALD:** It's not?

**MS ZAMMIT (BCA):** As of recently, they've chosen to be separate. But we work very closely with Vision Australia as well and with the service providers and equally I note they've put in a submission to this review around their concerns, which are fairly similar across the sector.

**MR FITZGERALD:** Good.

**MS ZAMMIT (BCA):** I guess the other element is, as I've mentioned, vision impairment is quite significant. What we'd love to see is sensory disability better reflected in the final model around firstly the awareness-raising of workforce, ensuring that the workforce is appropriately trained around disability. This isn't a one-off. Take out vision impairment even, we've got a significant population of people with a disability. All round, whatever forum I attend which is disability related, we constantly hear that concern about how the workforce accommodates a person's needs. So that's something that we think is extremely important.

The Aged Care Act also doesn't reference disability. Once again, this is a major cohort and we're a little bit concerned. That's beyond your scope and what you can do, of course, but I think it then makes it all the more vital that this report really strongly recommends a more seamless relationship with the National Disability Insurance Scheme and I guess provide a little bit more emphasis on some of the core things that need to be included. So workforce, big issue: ensuring that the workforce is appropriately trained and supported to accommodate a person with a disability.

In terms of funding as well - this is a part that I'm a little bit curious and a little uncertain on. The National Disability Insurance Scheme is looking at an extra $6.3 billion worth of funding to meet the support needs. But how will that transition to people who are over 65 years of age? If, as I mentioned in the example earlier, we have two people, one 64, one 65 and a half - - -

**MR WOODS:** Sure. We understand that.

**MS ZAMMIT (BCA):** Yes. Where does that come in?

**MR FITZGERALD:** Can I just make a clarification because that is the issue. You will have seen in the National Disability Insurance Scheme report that a person with a disability below the pension age will have a right to elect - - -

**MS ZAMMIT (BCA):** That's right.

**MR FITZGERALD:** - - -whether they stay in the disability scheme or they come into the aged care scheme. The issue of funding, which the client doesn't actually see is still to be resolved, so that issue of funding at the moment still needs to be resolved, which we will do before our final report. But in terms of the actual system you're under, you're right, you can choose.

**MS ZAMMIT (BCA)**: It's fine, you can transition.

**MR FITZGERALD:** But who funds which bit of it? That's still up for grabs.

**MS ZAMMIT (BCA)**: I guess in terms of both - well, particularly the Caring for Older Australians Report talks about a gateway, which we think is excellent. Once again, it's extremely important that that gateway is intuitive. It needs to be intuitive to provide sufficient information about not only aged care supports but also what else is available and being mindful of disability. The same goes with the home maintenance and modifications, so nationalising that. We think that's excellent.

I'd also ask for home and community care to be better. One of the key problems that we have is it is very much dependent, much as the report recognises, on where you live, what access to supports there are available. As one of our members said to us, "I needed the same supports at 65 that I needed at 55." People who are blind or vision-impaired who are wanting to live in their own home, which obviously has a benefit to the Australian community, need support with cleaning, shopping, home assistance, et cetera, which is extremely hard to get.

**MR WOODS:** Now, Home and Community Care of course would disappear as it currently exists but its functionality would get absorbed into this new model of care.

**MS ZAMMIT (BCA)**: Yes. The other area is around multiple disadvantage. The report does cover on that but the area that I wanted to raise was around dual disability.  Obviously in a range of sensory impairment we're talking about combined vision and hearing impairment.  Once again, that could be the gamut from a slight vision and hearing impairment to very significant profound needs.  We do some work with Able Australia, who actually are next door to us at Ross House, and they work with people who have very, very severe and profound disabilities, so who cannot communicate audibly, who may be able to communicate via tactile Auslan, which is once again very specialised.

The report does mention interpreters for people from a culturally and linguistically diverse background.  There also needs to be consideration, of course, of Auslan and tactile Auslan as well.  That population is really significant.  The Access Economics report that was done a few years back estimated that 730,000 people experience dual sensory loss and 97 per cent of that population is aged over 65.  So that's extremely significant.

Obviously with the aged care framework we're really keen, as I mentioned earlier, to look at early intervention, so ensuring that the workforce is appropriately skilled to recognise where people might be having some difficulties and making appropriate referrals to specialist service providers.  Once again, with the phasing out of block funding, that is an area where we're a little uncertain how people over 65 might be impacted.  Under 65, similar to what I was saying earlier, people will have an individualised package of supports.  They can purchase orientation mobility, occupational therapy, whatever they like, but if you're over 65 and a service provider is no longer block-funded, people who are aged may be required to pay for a service which currently is free.  So we have concerns about people who are living in the community or who are in an aged care setting - about their ability to pay for something that they're currently accessing at no cost, so that's a residual concern that we have.

In terms of assessments, it is about ensuring that once again the assessor is familiar with disability - really important - but also that assessments are accessible. One of the comments that was made by a colleague is that often assessments have a visual component.  If you can't complete that visual component it's very hard for the full assessment to be undertaken.  So we're really keen to ensure that if the National Disability Insurance Scheme implements assessment, which it will - and they're still defining that toolbox of assessments - that that would be transferable and possibly even used by the aged care setting as well.  Essentially the needs that you'll need under 65 will be pretty similar to those that you need just over.

Really I guess in terms of, more broadly, other issues that the commission might want to be aware of:  access to information, which I touched on briefly.  The assessment process needs to be accessible.  Information about the Gateway needs to be accessible.  It needs to take into account that not everyone will be able to access information in standard print or via phone, so looking at other methods such as braille, large print, et cetera - online.  Also around choice in where people access services, and I'm not sure if this has come up in your submissions but it's one that's come up in our advocacy service and it's around services that are provided - it probably comes under the Home and Community Care slightly but it is of relevance to this.

Aged care settings do provide activities but service providers also provide day programs.  We have had people who are blind or vision-impaired who want to access a specialist day program specifically for people who are blind, who have been told that they're double-dipping because their aged care provider offers day programs. Now, the problem comes back to what I've said earlier, which is - - -

**MR WOODS:**   If the day care program is not relevant.

**MS ZAMMIT (BCA)**:   If it's not relevant but, more to the point, if a person who is blind has other peers who are blind.  They want to stay connected to their community, they have friends there.  This double-dipping is almost incredulous because we're talking about such a small amount of funding and yet people are actively denied and told, "You cannot come," which is extremely concerning for us.

This one is a bit more contentious and it's around some of our members - and I wouldn't say that it's consensus by any stretch, but some of our members have raised the issue that there are no blindness-specific aged care facilities.  In a time where we're very much pushing inclusion, it seems counterintuitive to what has been done, but it does come back down to a lot of people - I say many have said to us that it's about being able to fit in and ensuring that you actually have peers who relate to your needs.

We recommend choice, we promote choice in where people can stay.  Whether we're talking about establishing blindness-specific aged care facilities is something else but it is a point that has been raised that that was something that was previously available, and at the moment people are just finding it really hard to find a facility that is accommodating of their needs.

**MR FITZGERALD:**   Sorry, when you say it was previously available - - -

**MS ZAMMIT (BCA)**:   Yes, we're talking probably about 30 or 40 years ago now.

**MR FITZGERALD:**   I was going to say there's not too many now.

**MS ZAMMIT (BCA)**:   No, not too many now.

**MS MACRI:** 30 or 40 years ago the Royal Blind Society - - -

**MS ZAMMIT (BCA)**: But I think part of that demand is coming from the fact that - I had a call not too long ago from a person who said that they had called six or seven aged care providers in their area and when they'd spoken to them and actually visited, they found only about two that they could use, because in the middle there's these beautiful aesthetic little waterfalls and lots of stuff which make it hard to navigate. It makes it hard to know how to get from A to B.

**MR FITZGERALD:** But can I ask this question? I don't want to interrupt the flow - - -

**MS ZAMMIT (BCA)**: No, please do.

**MR FITZGERALD:** - - - but where do people with vision impairment, particularly blindness, now go for aged care? I mean if there were facilities that were available 30 or 40 years ago, we've had 30 years - are they clustering in certain types of nursing homes, for example?

**MS ZAMMIT (BCA)**: I would say that - - -

**MR FITZGERALD:** Where are they?

**MS ZAMMIT (BCA)**: They're spread. They are spread out. I would say that people are trying to stay in their home absolutely as long as they possibly can.

**MR FITZGERALD:** Sure.

**MS ZAMMIT (BCA)**: The preference is people are wanting to stay in their home. They're just wanting the supports to enable it and that's where the flexible supports are so important. But no, there's not one place that they're going. They're going to places that are nearby and it's a bonus if there is another person or two who have a vision impairment.

**MR FITZGERALD:** We're about out of time, so is there any final comment you want to make very quickly? Otherwise we'll look forward to your submission and be able to look through that, but is there a final conclusion?

**MS ZAMMIT (BCA)**: I guess, look, really the final conclusion would be about ensuring that the NDIS is not seen as a coverall. We, in our submission regarding the National Disability Insurance Scheme, will be talking about age as well and really making a recommendation that there is a more seamless transition between the two.

We are just pretty concerned, to be pretty blunt. We are pretty concerned that at the moment there is a gap, and that people will fall through that gap, particularly around age-related disabilities. At the moment, it's still unclear where a person with age-related disability will fit in, and we're just wanting to make sure that people with a disability who are older are actually going to get the support that they need, at a comparative level to a person under 65.

**MR FITZGERALD:** Yes. That's a good point. Excellent. All right, thank you very much.

**MR WOODS:** Thank you very much. We appreciate your evidence.

**MS ZAMMIT (BCA):** Thank you.

**MR FITZGERALD:** That's good. Excellent, thank you.

**MR WOODS:** Jody Kerrins. Thank you very much. For the record, could you please state your name and, if you are representing any organisation, what that is.

**MS KERRINS:** My name is Jody Kerrins, and I'm an aged care nurse of 30 years' experience. I was working at Dava Lodge in Mornington which closed. I'm not representing any organisation. I am currently at the moment on a short-term contract with the ANF as an area organiser in aged care, but my submission is from a nurse in aged care perspective.

**MR WOODS:** Please proceed.

**MS KERRINS:** Thank you very much for allowing me to speak today. Just as a little background, if I can just start off, when I first commenced work in a residential facility, everywhere I worked there was a registered nurse division 1 on each ward on each shift. Most of the workforce consisted of enrolled nurses, and there was a small amount of nursing assistants. Nurses were then covered by an award, and that meant that if the nurse in the public sector got a pay rise, every nurse in Victoria got a pay rise as well, so there was this state of parity of pay in aged care as it was in the public sector.

Then the system gradually changed. As enterprise bargaining took over from awards, the wages gap increased, and that meant that many registered nurses left the system. As they left the system, it was determined that a new layer of staff was needed, and the personal care assistant was born. Now, I know they've got many different names, but I'm going to call them "personal care assistant" if you don't mind because that's the way I know them.

Initially these staff were well trained, and capable of carrying out the tasks allocated to them within their scope of practice. I find it hard to understand why in your draft report you determined against the national registration of PCAs, stating that it would exacerbate the labour shortage. From my perspective, PCAs make up the majority of staff in residential aged care. They are the ones who give the direct care to the frail elderly residents, and they are not required to have attained a national standard of education. RNs and ENs have to answer to a national agency, and prove that they have the skills necessary to practise their profession, while PCAs are not required to do anything now beyond a three to four-week course. This can mean that PCAs - - -

**MR WOODS:** That would be a minimum presumably.

**MS KERRINS:** Sorry?

**MR WOODS:** That would be a minimum.

**MS KERRINS:** It is a minimum, but I have worked with PCAs who have done a four-week course - two weeks in a classroom, and two weeks allocated to wherever they could get their work.

**MR WOODS:** And worked with other PCAs who have done a more complete course?

**MS KERRINS:** Yes, and it's - - -

**MR WOODS:** So if we could keep the spectrum, not just focus on the bottom, that would be helpful.

**MS KERRINS:** Yes. I've worked with both. I've worked with PCAs who have done a six-month course who are very well trained, and very competent within their scope. They are very annoyed that they now have to work with the same category of staff - PCA - as themselves, who they know and they are not skilled to do their work.

**MR WOODS:** Yes. So it's a question of adequate training.

**MS KERRINS:** So it's a question of training and categorising. You know, there has to be - and this is where we get back to the national standard. Applicants pay good money to providers to offer these short courses and give them the qualifications needed to work in aged care. With the current system, everyone loses. The applicants pay for a course which is not providing them with the skills necessary to do the job. The facility managers are not getting the workforce they need to provide the adequate care, because somebody comes in and they've got a piece of paper saying they're a PCA. Then there's an expectation that they have certain qualifications, and then, of course, when they get onto the floor, that's found not to be the case. Most importantly, the residents are the greatest losers because the PCAs charged with providing them with care are not adequately skilled to do so.

This could be fixed with national registration, because then the board would devise an accredited course which all PCAs would need to complete in order to be registered to practise, and this is what Paul spoke for before. I thought he'd pinched my report, to be honest. This would bring them in line with other healthcare professionals, and give them the professional status that they need, and that they actually want, because they are part of the workforce in aged care, so they should come under the same professional body as the other two layers of staff, because they're the actual ones who are providing the majority of the direct care.

More and more the ENs and the RN1s are working in a supervisory capacity, and I think Paul said as well, they are responsible for the people who are doing the direct care, and I've spoken to div 1s who have actually said that they're putting their practice at risk simply by working in aged care, because if the PCA does something that provides a negative outcome to the resident, nothing happens to them. It's the registered nurse on duty whom it falls back on, that they have allocated to this PCA work that they're not capable of doing. But it's not. It's the providers that are providing that workforce, and this is where we come to the focus of the problem that I've found in aged care; you're working with an unregulated workforce.

Examples of unskilled practice are not knowing how to safely transfer residents, using the appropriate no-lift measures; using underarm lifts which, apart from being outlawed and against the principles of OH and S, are dangerous to the residents. Shoulders can be dislocated on frail stroke victims by using this method, and I've seen it happen, and you pull them up, and you say, "You shouldn't be doing that," and they say, "Oh, why?" You know, they don't know. They haven't got the skill necessary, because they haven't done the appropriate training. No adhering to the principles of infection control - the simple act of washing your hands between attending to residents, and you say, "Hang on a minute." You know, they're going from one resident to the next, and you say, "No, you've got to go and wash your hands," and they just look at you, "Why?" You know, it's just simple things like that.

**MR WOODS:** So these are issues of training and skilling?

**MS KERRINS:** It is, it is, and it gets right back to the grassroots of what have they done in their training course, because - - -

**MR WOODS:** Yes. So if we address the training course, but the training course and the registration are two maybe related but are two separate issues.

**MS KERRINS:** If you had a national registration body that would direct the curriculum to a training course, that you would have to adhere to that standard in order to be registered, then it would encompass the two issues, the same as it does with an EN and an RN. I mean, we're three layers of workforce within the aged care sector, and the majority of the workers are not regulated and not registered, and this is the problem.

**MR WOODS:** The primary aim is to ensure that they're properly skilled.

**MS KERRINS:** And our focus is resident care; I mean, what is best for the resident. I mean, clearly it would be the better outcome for the resident if they were looked after by an appropriately skilled workforce.

**MR WOODS:** Yes.

**MS MACRI:** Absolutely.

**MS KERRINS:** So we're looking at ways of fixing that, and I think the registration and the skilling of these people would adequately control that issue. One of the other things that I've seen too - residents classified as a high-falls risk, and left unattended on toilets. Many residents have fallen and suffered fractures because they were not appropriately supervised by staff. Of course, this gets back to staffing levels as well, so you're looking at not only the skill mix, but you're looking at staffing levels and having the time to attend to the residents. I've seen not providing adequate hygiene to incontinent residents, thereby increasing the risk of skin impairment, pressure ulcers and rashes.

If PCAs were required to achieve a national standard of education, then proprietors and fellow staff would know that they were able to perform their duties to a satisfactory degree, and would not have to upskill them as what happens now, as part of their orientation.

More importantly, the residents would know that the person attending to them, to every aspect of their daily needs, would do so safely, competently and be appropriately skilled to do so. That is my primary function. I've seen the way aged care has deteriorated in the time that I've been in that sector and this is an opportunity to address that and to reverse that trend, and I do applaud you for what you're doing and hopefully it will achieve the outcomes.

The draft report has recommended that state and territory governments promote and expand the use of in-reach services to residential aged care facilities, and this is a good thing; I applaud it. It's happening now. However, this will only make a difference to residents involved if the permanent staff at the facilities have the skill and appropriate training necessary to provide monitoring and evaluation of the plan of complex care prescribed by the in-reach service provider.

I have seen wound consultants come into a facility, examine pressure ulcers on residents and write a complex wound management plan, dress the wounds with expensive dressing materials which last five to seven days, only to have the PCA remove the dressings in the shower the next morning. This is because they are simply not educated to an appropriate level needed in aged care. The residents are actually paying for these dressings and they're not utilised. So bringing in this outreach service to write up this care plan will only achieve a good outcome if the direct care staff are appropriately trained in the matters.

Residents often experience weight loss through loss of appetite, inability to feed themselves, et cetera. Nutritionists are consulted and come into the facility and write up a care plan. They order food supplements, high energy and protein drinks that the care staff then have to give to the resident and, again, it will only work if the resident actually gets the drink. I work night duty. I came on and many nights you would see the container - the Tetra Pak or the can of this very expensive high-energy drink - sitting on the locker top and it has not been given to the resident.

Now, that can get back to the fact that, again, we're looking at staffing levels, we're looking at people having to perhaps give supper to eight; one staff member to eight residents of an evening shift and having to fully feed them and give them their evening meal and their supper. So there are two components there: there's not having the skills necessary to realise that this is a part of the care plan of this resident - it's not just a drink, it is part of their nutritional supplement that they need to have again - and also having the time to do it.

There are any number of consultants available to assist in residential aged care that should only be used as an adjunct to the existing trained staff and not as a replacement for them. There is a definite need within this framework for the use of nurse practitioners, and I applaud your draft for including them in there. It's very difficult in a residential aged care service to reach a GP even during the day, but as I work nights and weekends it's very, very difficult; having a nurse practitioner available, having somebody there who can consult and who would have the ability to examine and to write a prescription for antibiotics, et cetera. The earlier you could get an intervention, particularly with frail elderly, the better, and instead of waiting until the doctor came back on duty on Monday it would be a much better outcome.

Also, it would reduce the incidence of residents being transferred to hospital, and this is something that would be beneficial to absolutely everybody. And this is what happens sometimes. I've seen it with residents: you can't get hold of the doctor; the family have insisted that they must be seen by a doctor; the locums won't come. The only other avenue that you have is to call an ambulance and send them to ED, and you know that it's not going to work, but you have to work within that arrangement with the family.

The draft report suggests that the accreditation process should be the mechanism by which inadequacies are rectified. My experience with the accreditation process is that it's not helping. I've been on duty when the accreditors have come in. I've seen them look at the paperwork, and this is the first day. If they come in for two to three days, the first day is spent entirely looking at paperwork, looking at the policies and procedures of that organisation, and that is important but my focus is on the resident and on the resident care, and those policies and procedures are only of use if they are transferred into the care of the resident and, through the accreditation process, I have not seen that happen.

I've seen facilities where they bring in division 1 nurses within the organisation for about a month before the accreditors come in and they go through all of the paperwork. The staff on the wards could be working short but you say, "Can we have some help on the ward?" "No. No, we're focusing on the paperwork," and I don't see that as a help, not for the resident; because whereas the paperwork is important, the accreditors go by the notion that if it's not written down it didn't happen, and I've actually brought the subject up to our management over some years that the paperwork component of the accreditation process is so onerous that we can either do the care or do the paperwork - "What would you like me to do?" - and I've been told, "Do the paperwork."

My focus is, well, I'm here to look after the resident; the paperwork can take a back seat. But that's what the accreditors seem to focus on: the paperwork, the policies, the procedures. They don't go out onto the ward and see how many staff are on duty; what the qualifications of those staff are; are they permanent staff or are they agency staff? I've seen in a facility I worked at that when accreditors were coming in, the manager would actually say, "Well, we'll have you, you, you and you on duty. It's your shift but no, we're going to pay you but you stay home." And this is not picked up.

**MR WOODS:** I'm conscious of the time. Are you able to wrap up some key points?

**MS KERRINS:** Yes. I'm just grateful for the opportunity to speak here today. But I believe that if our elderly citizens are going to be cared for into the future they need to have an appropriately skilled and funded workforce, and the only way I can see forward with this is to have mandated minimum nurse-resident ratios and to have a well-funded aged care sector. If that can be done by ACFI or by RCS or RCI or some combination of all three, then that must be tailored to the actual direct care staff. It's no good just giving managers or facility owners a funding level if that's not mandated to actual care staff.

I've seen a few years ago - if I've got a couple of minutes - where the federal government decided to address the issue of paperwork within the aged care sector and they allocated a direct one-off funding arrangement of $1000 per resident per facility. The facility I worked at had 90 residents, so they got $90,000. The facility or the management group as a whole got $1.2 million from the federal government to update their IT, to put in computers and software and hardware, computer screens, to take care of the funding; to relieve the care staff of that onerous arrangement of having to do so much paperwork.

We thought, "Fantastic. We're going to get computers, we're going to get PalmPads." Nothing happened; nothing. We got nothing at our facility. And I actually asked the manager at the time when we were going to get our computers and she said, "Oh well, we're not." I said, "Well, what happened to the money?" and they said they bought a computer for head office. It was $1.2 million of taxpayers' money. So it has to be geared to actual staffing. I'm sorry, I've taken up - - -

**MR WOODS:** No. Thank you very much. Thank you for coming forward and giving evidence. We appreciate that.

**MS KERRINS:** Thank you.

**MR WOODS:** Ms Irene Murphy, thank you. Could you please, for the record, state your name and if you are representing any organisation.

**MS MURPHY:** Sure. My name is Irene Murphy. I am a nurse practitioner and I also coordinate the clinical services of a community based palliative care service at Melbourne Citymission, and I was asked by our professional body and also by the Australian Nursing Federation to come and give evidence here of my experience.

**MR WOODS:** Yes, thank you. Please proceed.

**MS MURPHY:** Sure. I think that to say this, that I have extensive work experience in working with residential aged care facilities - I've been in palliative care for many years, and through the conduct of my work I have had the opportunity to work with clinicians working in residential aged care facilities - and I think that the issue of aged care is a very important one. I'm sure I'm saying nothing that you don't know already.

I also believe that it's a much more expanded issue within the health system of this country, because I also think that it really falls into the realm of social justice, in terms of what aged care is going to look like in this country, because at some point or another all of us - or some of us at least - will be a recipient of aged care. Let me tell you, I think there is a concerted effort that we should have to really raise the bar, because some situations that I see out there they don't look too good, and I think that it is an indictment on how we educate our health professionals that there are some situations where vulnerable people are at great risk.

One of the issues that I think my colleagues and my associates here have really alluded to consistently is the issue of workforce - and let's make no mistake, aged care is not glamorous, it's not attractive. Society in general, they don't want to talk about old age. That is something that might happen to other people. If you don't get old you die. So really it is as simple as that. I think that is the inferior relative of the health system in this country. I think that aged care issues are very irresponsibly reported in the media, when something terrible happens, and we all, very vicariously, agree with the sentiment that those people - the adversity that they face and how should this happen and so on and so forth - but we do very little about it.

I think that one of the main issues is the level of training that aged care workers have. I believe - listening to the submissions and listening to some of the reports - that unless really we are serious about proper nursing-patient ratios, adequate staffing levels, we're not going to really address the problems. Because we can say very clearly that in all other fields of nursing we really want expert and well-qualified people, but when it comes with aged care we perhaps - and I'm not saying this disrespectfully - go back to the notion, "Yes, you need about 70 per cent of caring and compassionate attitude and the rest follows." That doesn't happen. I don't see that.

I think that personal care workers, although they're very well-intentioned and some of them they do have some aspirations to remain in the aged care workforce, once they are doing their work for a number of months I guess there is a level of disillusionment, there's a level of feeling unsupported, because the people who are in charge don't have the time to support them, to coach and provide - as you said before - training on the job, so to speak. It doesn't happen.

The other day - and when I say "the other day", it would have been about 10 days ago - I went to an aged care facility. I needed to consult with this woman who was approaching her end of life. I walk in and I just turn the corner and this room - there was a single room. The door was widely open, the woman was being attended to in terms of her hygiene, she was lying on the bed totally naked. You see, although the careworkers are very good people, they hadn't really put one and one together in terms of privacy and the dignity of that person. So I closed the door, I explained respectfully that really this was not appropriate and the reasons why they needed to be very careful about this situation. I explain that and I guess I take the opportunity to try to mentor and to help people and provide a level of reporting if I see something - an approach or an intervention - that is not appropriate.

Registered nurses division 1, they get very concerned and naturally they want to fix some of the problems, but really they rarely have any time to even address those situations. We say that anybody with a bit of training can provide hygiene to an elderly person. I actually dispute that, because by the time you're 70 or 75 you might be managing a chronic illness already, a level of rheumatoid arthritis, respiratory diseases, you're already having problems with bone and muscle disturbances and probably your diet is changing, your level of nutrition and fluid intake is changing.

You might still consider yourself to be reasonably healthy, but sometimes because of that decompensation you go and try to lift someone and if you don't know how to do it properly, if you haven't had the appropriate training, you can very well dislocate the shoulder or any limb of that person. It does happen. It is not the fault of that personal care worker. It's the lack of training and lack of understanding.

I think that sometimes when I go to a registered nurse division 1 with a concern and with a possible solution and what we could do about it, the situation is such that that RN would say to me, "Irene, I spend 30 or 40 per cent of my shift dispensing medication, so I don't really think I have the time to do that." So, for me, in order to really solve that we really need to look very seriously at this issue of workforce, and the issue of national accreditation, the issue of these are the bodies that they need to really conceptualise; what is the minimum level of training that a worker can really exercise good care for that person who is vulnerable in a safe and effective way? And if an RN div 1 - who can provide quite a bit of supervision - is really dispensing six tablets per patient a day in a residential aged care facility of 40 residents, it's an extraordinary amount of time in that activity alone.

Also, in my perspective, there are some situations where I could see a client, a resident, I could formulate a plan of care, intensive analgesia, I could write it down, I could provide a level of education and coaching on the job, but if the personal care worker is not able to administer not even a tablet, there's very little we can do in terms of that person having the ability to have that timely medication.  So a number of times because there's not sufficient staff to provide timely medication - in this case, injectable medication - in situations where there's pain or any symptom of distress, unfortunately the resident ends up in an emergency department.  That happens quite a bit.

So, for me, through our service we do provide quite a bit of coaching and training, we do provide quite a bit of education, but because of, I guess, the transient levels of workers in aged care facilities, it's very difficult to really formulate some education and training that is sustainable.

The transient aspects of the workforce are such that sometimes I go to a place and I think, "Oh, this is really nice.  The person really has some aspiration to provide some good care.  Let's capitalise on this and let's just work something together to have some guidelines, some protocols about this and that and the other," and then I come back three weeks later and the person would have left.  Why?  Because of the working conditions, because of lack of support in terms of not having enough staff available to provide care.

You see, the acuity of people in aged care facilities I think hasn't been reported accurately.  You know, these people have a number of comorbidities and the level of medical activism that they have has allowed them to live for much longer than they should have, you know, 50 years ago.  So I think that is important to consider.  I also think that from the political perspective, all of us who might go to residential aged care facilities face the notion that a palliative approach should be implemented there and then.  I have not heard of any elderly person being enrolled in an aged care facility who after nine months leaves the aged care facility and rents a flat and lives independently.  You don't.  I mean you don't, and this is the reality of it, you know.

In order to really assess people effectively you minimise this level of unnecessary medical activism and in order to really triage people properly so they don't end up in an emergency department where they have to wait for about four hours - and a number of times they have an acute respiratory or urinary infection that in itself brings some delirium, so in a way they get agitated - very unfamiliar circumstances.  We need people who have actually time to strengthen their skills and have the time to go and assess these people without feeling guilty that they haven't completed all this paperwork they are required to do.  I think that it's very magnanimous that we do document - not magnanimous.  I apologise for the choice of word.  It's very important that we do document our activities, that we document what we do and the outcomes, because how can we then know whether our interventions are effective or not?

But let me tell you, it is the constant litany that I hear when I go to aged care facilities, "Look, we haven't got the time," and I would ask one of the nurses in charge, "Look, did you have time to fill in this pain assessment chart, because for 24 hours it would have given us a really good indication of what that pain picture is, because the person who's suffering pain has got cognitive impairment, doesn't know how to report it very well, so we rely on your assessment, you know."  But often that doesn't happen.

Also the issue of death and dying, if I can go to that end-of-life care:  again, every person who enrols into a residential aged care facility should start from the beginning to have the palliative approach, and largely we have to come in and do quite a bit of strategic work because people are largely very unprepared, you know, for the fact that people have lived with the burden of disease for many, many years and they're reaching the end stage of their lives.  So the moment you start mentioning words such as "approaching the end of life" or "terminal phase", less-skilled workers - and even some of the very skilled ones - become quite frightened about it because, again, it's an issue that permeates our society and largely also permeates the aged care sector - the fact that we're very resistant to talking about death and dying.

Go back to the residents.  Inevitably they get short-changed in having effective interventions because of the myth and because of the lack of knowledge, a lack of preparation of those clinicians around them.  Some of your recommendations to perhaps be more creative in the aged care workforce in terms of implementing new roles, such as the nurse practitioner, is very commendable.  I do believe that's very important in terms of providing a level of ongoing sustainable support to this particular sector of care where people might feel increasingly valued in terms of providing effective care for this group of people that is actually so important.

In a way, Westernised society could learn a little bit more about the value of the elderly person and the wisdom that person offered to our society.  Largely that doesn't happen a lot in some of the situations that I see.  I think that there are circumstances where I see that and I like to encourage that, but I think that we're not going to begin to understand and then solve the problems of aged care until all of us - clinicians, government officers and workers - understand that actually we resist quite deeply the issue that we are going to get older and we are going to actually require some services.  Until that happens and we demystify that - you know, I think we will be able to then say, "Yes, actually, aged care work is just as important as intensive care work."

**MR WOODS:**   Most of us have had parents who have been through it all and we've lived with that process - but yes.  Now, I'm conscious of the time.  Are there some concluding comments that you wish to make?

**MS MURPHY:**   I think that my concluding comments would be that national accreditation bodies should really be people designing cost-effective courses for personal care workers so they can have a level of skills that is appropriate to care for this very vulnerable population.  Look, this is probably out of ignorance but I believe if there is a professional body such as the Liquor - what do you call that body that looks after hospitality workers?

**MR WOODS:**   The LHMWU.

**MS MURPHY:**   Yes.  The personal care workers fall under that category.  I find there is a great discrepancy, that you put hospitality and workers who work with human resources under the same category.  I think that's much - - -

**MR WOODS:**   That's just a historic thing.

**MS MURPHY:**   Yes, but what I'm saying - - -

**MR WOODS:**   It doesn't reflect on the workers.

**MS MURPHY:**   Yes, but what I'm saying is that then, if you're able to provide courses that are cost-effective, then we can encourage people to stay in the workforce and to look at aged care as a career path.  That personal care worker might look into becoming an enrolled nurse and then an RN Division 1 because those bodies also need to evaluate the work and the activities of those workers, to evaluate effectiveness.  If there's room for further learning, naturally they need to evaluate that.

**MR WOODS:**   I think we all have a common interest in ensuring that there are well-trained, skilful staff delivering good-quality care.  I think that is a common view.

**MS MURPHY:**   Yes, so that is for me and also, as you know, the majority of the facilities that I visit, the personal care workers are just doing their job - as you put it very succinctly in your submission - as zookeeper, you know.

**MR WOODS:** That was a quote from someone else.

**MS MURPHY:** Was it?

**MR WOODS:** Yes.

**MS MURPHY:** What I'm saying is, they say to me, "I have no intention to stay here," because this is just a step on to a career that is often totally unrelated to nursing. But I think that if you really give it the value and the worth that this deserves, it will really encourage people to see aged care as a worthwhile career path.

**MR WOODS:** Okay. Thank you very much. I appreciate your presentation.

**MS MURPHY:** Thank you.

**MR WOODS:** Can we call forward Peter Sherman, please. Thank you very much

**MR SHERMAN:** Good afternoon. I'm fully cognisant that this is the end of the second day of hearings - - -

**MR WOODS:** That's fine.

**MR SHERMAN:** - - - and how tiring it might be.

**MR WOODS:** No, everyone gets treated with equal interest and respect.

**MR SHERMAN:** I promise I won't take long.

**MR WOODS:** That's fine. If you could, for the record, please give your name and if you are representing any organisation and what that might be.

**MR SHERMAN:** Certainly. My name is Peter Sherman. I do not represent any organisation but I do represent my father, who could not make his submissions himself, and immediate members of my family.

**MR WOODS:** Thank you.

**MR SHERMAN:** Insofar as the draft report is concerned, my submissions today are intended to draw the commission's attention not so much to what's in the report but what's not in the report. Having examined the terms of reference for the commission, the issue that I intend to raise and draw to your attention is the issue of Australia's international obligations in the human rights area. I have done extensive research of the draft report of the Caring for Older Australians inquiry and in the disability inquiry as well and, to my dismay, there is no reference at all to the international obligations in the human rights arena, there are no references to the human rights obligations in the federal arena, and there is no reference to human rights obligations on a state basis.

By way of submission as well, the commission may well be aware that last year there was a four-volume report delivered in Queensland with regard to the review by that jurisdiction of the Guardianship and Administration Act, and the overarching recommendation in that report was that we need to align our role with respect to older Australians to comply with the obligations that we have internationally and with the obligations that we have locally to all Australians and older Australians in particular.

I understand that there have been some four inquiries in the area of disability and age-related disability by this commission over the last eight years, and the nearest that any of the submissions came to exploring the human rights area was in the inquiry into the Disability Discrimination Act some eight years ago.  In that particular inquiry, legal advice was obtained from the Australian Government Solicitor as to various terminology and suggestions that perhaps the AGS could provide in that particular inquiry, and I would take this opportunity to urge this commission to seek advice from the Australian Government Solicitor's office as to how the proposed recommendations of this commission and, indeed, the inquiry into disability care, would complement and be integrated and make use of the legal obligations that Australia has and, indeed, that the commission may have as a public authority, for example, in Victoria and the Australian Capital Territory who have their own human rights legislation.

You may also be aware that there is a massive inquiry in Victoria into the Victorian guardianship and administration legislation, who have also delivered a draft report not long ago, and in my respectful submission it would be amiss for the commission to deliver its final report not taking into account the proposals or the new law that might be coming out of various states with respect to caring for older Australians, because caring for older Australians is at least a two-way street.  We've got to think about people.  It's about human beings.

It's about human beings who form part of the workforce, it's about human beings who are the recipients, and all of these people have rights, all of these people are entitled to a situation where the things that have just been described by various other members of the public making submissions to the inquiry - gross violations of human rights - they're called by a different name.  They might call it incompetence or they might call it a lack of training but, in my respectful submission, people admitted by public authorities into their care are entitled in law to be protected from violation of their human rights whilst in the care of those authorities.

I say so also having perused the lists of submissions made and the consultations that have taken place, and you may agree or disagree with me, but they appear to be flooded with submissions and views of institutions who are - - -

**MR WOODS:**   It's for any individual to put forward a submission.

**MR SHERMAN:**   Absolutely.

**MR WOODS:**   We don't seek submissions from anyone.  So this represents those who have come to us, not us having gone to them.

**MR SHERMAN:**   The reason why I mentioned it, and the point I'm trying to make, is that people who make submissions to this inquiry, or institutions who make submissions to this inquiry, either by way of statutory connections or by way of being funded by the Commonwealth, are public authorities within the law of, for example, the Australian Capital Territory and Victoria that have obligations under those human rights acts. They're the ones that we will look to to ensure that people in their care have their rights upheld.

I also wanted to mention that the Productivity Commission Act in fact provides - and I specifically quote section 8(a) of the commission act which states:

> (a) to improve the overall economic performance of the economy through higher productivity in the public and private sectors in order to achieve higher living standards for all members of the Australian community.

In my respectful submission, it is a positive statutory obligation for the commission to not forget that that is part of the commission's mandate when delivering your report.

**MR WOODS:** Very conscious of our mandate. But, yes, thank you.

**MR SHERMAN:** In the human rights context. Further, section 8(d) refers specifically to "facilitate adjustment" or to have regard to the need:

> (d) to facilitate adjustment to structural changes in the economy and the avoidance of social and economic hardships arising from those changes.

The point I'm trying to make is that it may well be that on some level the commission may feel restricted by the terms of reference. We are saying that there are other obligations in addition to the terms of reference.

**MR WOODS:** We always interpret our terms of reference in the context of our act.

**MR SHERMAN:** Lastly, on section 8 there is the specific provision in 8(j) which states "for Australia to meet its international obligations and commitments". So essentially perhaps, in summing up - I don't want to take any more of your time - I would say that it would be amiss, particularly in this state, in Victoria - and I'm conscious of the fact that the commission has a certain deadline by which to deliver the report.

I recommend that perhaps the commission should, firstly, obtain advice with regard to the extent of the elder law as it stands at the moment in a variety of states and in the federal arena as well and, secondly, pay particular attention to the reviews by various states of their own elder law which may produce new statutory pieces of legislation which may perhaps not work with recommendations of the commission.

**MR FITZGERALD:** Thanks for that. The commission is aware of the human rights obligations, and you're right: this report does not refer to those in any direct and overt way. Nevertheless, one of the things about human rights in these areas of human services - disability and ageing - is that human rights find their expression often in the delivery of services and the redress mechanisms that are available, so if I just look at that. What we would hope is that the service regime, the system that we're putting in place, absolutely enhances the quality of older Australians by improving the quality of care that they receive and their access to it. Equally, I would hope that their rights are enhanced by a new regulatory regime which has a new complaint-handling and review process in it.

In my previous life I was a statutory ombudsman and I had a specific responsibility for the recipients of community disability services care, so I understand what you're saying absolutely, Peter.

What I'm not sure is where you think we may have, or where our proposed system may in fact not enhance or not respect those rights, because from my observation, I would have thought the system we're putting forward, whilst no system is perfect, would basically meet the obligations both locally and internationally, but I might be wrong, so have you been able to look at our report and, not in detail, but highlight an area where you think we may, in fact, not have done that?

**MR SHERMAN:** I can think of two points, or two - I'll use the word "gateway" although I don't mean it in the literal sense. Our main concern is at the point of entrance into the aged care system. In our respectful submission, the accountability mechanisms that would be aware of the rights of those who are purported to qualify for the entrance into the system, or who are said to be in need of entrance into the system, actually have failed at that point, and whether or not there is any avenue or any possible avenue for a review instigated by those persons to test whether or not, for example, their commitment into the residential care is in fact a lawful one. That would concern the whole spectrum of professionals and others involved in the area of pre-admission, if I can call it that way.

My contact with the area of testing the legality of pre-admission and admission has uncovered an unbearable situation where a person who may have a fluctuating capacity is unable to garner resources, not natural resources, intellectual resources - either their own or of those around them - in order to trigger a review of what is being proposed to be done to them.

**MR FITZGERALD:** Is the answer to that, but, found in a couple of the recommendations we've made. One is to increase the level of individual advocacy that is available for older Australians, so that there is a person that can assist in that regard; and the second is at a different level to enhance the ability to access care coordination and case management, which are in a sense a means by which people can navigate the system, access it, and of course if there is need to, to actually make complaints. So whilst we didn't reference it in relation to a human rights framework, I would have thought just taking those two, they enhance the people's ability to be able to represent themselves with support in the system, and to appeal against decisions that are what they regard as adverse to their wellbeing, or as you said, could in fact be illegal.

**MR SHERMAN:** I hear what is being put forward. My concern is that even though that may well be possible, in situations where there is doubt in the air about the person's capacity to function intellectually, up to scratch if you like, a lot of other things come into play which either take over the management of that person, or purport to take over the management, and whose duties and obligations may well conflict, or their statutory roles may conflict with acting on behalf or in the interests of the person. In other words, their mandates are different. The person who would move in and take over the management of the person with fluctuating capacity is completely different, or the human rights point of view, let's say, of a public advocate would be diametrically opposite to the person's point of view.

**MR FITZGERALD:** All right. The report that you've got there from Victoria addresses some of those issues. I don't want to go through that report, but you believe that that addresses some of those issues?

**MR SHERMAN:** I will not - it would be too easy for me to say yes. I'll say that it raises those issues.

**MR FITZGERALD:** That's fine.

**MR SHERMAN:** It does not address it, but it raises those issues.

**MR FITZGERALD:** That's fine. Thank you for that. We'll have a look at that.

**MR WOODS:** We'll chase that up.

**MR FITZGERALD:** We'll have a look at that. Yes, that's good.

**MR WOODS:** Thank you very much.

**MR SHERMAN:** I think that just about does it.

**MR FITZGERALD:** Thanks, Peter.

**MR SHERMAN:** Thank you very much.

**MR WOODS:** We appreciate your presentation. There being no further participants scheduled or unscheduled available, we will adjourn the Melbourne hearings and resume in Hobart.

**MR FITZGERALD:** No, tomorrow.

**MR WOODS:** No, we won't.

**MS MACRI:** Where are you going?

**MR FITZGERALD:** We'll resume at 8.40.

**MR WOODS:** We will resume at 8.40 tomorrow morning in Melbourne.

**MR FITZGERALD:** That's true.

**MR WOODS:** There you go. I was ahead of myself.

**MR SHERMAN:** Speaking of Hobart, they're about to introduce the Human Rights Act in Tasmania.

AT 5.25 PM THE INQUIRY WAS ADJOURNED UNTIL
WEDNESDAY, 23 MARCH 2011