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TRANSCRIPT
OF PROCEEDINGS

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 WEDNESDAY, 23 MARCH 2011, AT 8.43 AM

Continued from 22/3/11

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MR WOODS: If we can commence the third day of the Melbourne hearings, and we welcome our first participants. Could you please for the record each of you state your name, the organisation you are representing, and any position you may hold.

MR MILDENHALL (DGAS): I'll start the batting. It's Bruce Mildenhall. I'm the chair of the board of directors of Doutta Galla Aged Services Ltd in Melbourne's west. George.

MR KOULIS (DGAS): George Koulis. I'm the CFO for Doutta Galla Aged Services.

MR JONES (DGAS): Denis Jones. I'm the relieving facility manager for Doutta Galla.

MR WOODS: Thank you very much. Thank you for coming and presenting evidence to this inquiry, and do you have an opening statement you wish to make?

MR MILDENHALL (DGAS): We do, and we would certainly like to begin by thanking you for the opportunity. We are probably the largest residential aged care provider in Melbourne's west, with a network of seven aged care facilities, plus one in regional Victoria, but we are a - - -

MR WOODS: Regional being where?

MR MILDENHALL (DGAS): Shepparton.

MR WOODS: Okay, thank you.

MR MILDENHALL (DGAS): The rest are spread around Melbourne's west - Footscray, Yarraville, Sunshine, St Albans, Moonee Ponds, Kensington - - -

MR KOULIS (DGAS): Avondale Heights.

MR MILDENHALL (DGAS): - - - and Avondale Heights, so around 500 beds in that network. We're a non-denominational community based organisation.

MR WOODS: Do you have any community care packages or EACH or EACH-D?

MR MILDENHALL (DGAS): No, we don't have.

MR WOODS: Okay.

MR KOULIS (DGAS): We used to, but we got out of that space. We weren't big enough to make it viable.

MR WOODS: Thank you.

MR MILDENHALL (DGAS): I guess one opportunity we offer to your inquiry is that as an organisation that extensively deals with a demographic around lower incomes and high cultural diversity, and very high levels of concessional residents in our network, we offer a perspective of, if you like, what it's like for a community based organisation without a large institutional backing, doing what we regard as some heavy lifting, if you like, in aged care in the west.

My background was that I was the local state MP in the area for 14 years until 2006, and then took up, if you like continued, that community involvement by becoming a member of the board. With me is our scarred finance director George, and our recent recruit Denis Jones who is at the moment a relieving facility manager, but as Sue has identified, extensive experience on both sides of the table in residential aged care in Queensland with Blue Cross.

So I guess probably the best use of our time would be testing some of your propositions and views with us, if you'd like to do that, but perhaps just by way of summary of some of the key issues that we wanted to bring to your attention from the deliberations that we've seen thus far, as we say, our broad structure has us with a very high level of concessional residents. Around 47 per cent of our residents are concessional entry. We believe we generally match the demographics of the west in terms of the percentage of our residents who are of a culturally diverse background, so it's around that 35, 40 per cent. It's interesting, one of the members in the audience today is our banker. I could say the name - - -

MS MACRI: He hasn't got a red tie on, has he?

MR MILDENHALL (DGAS): That's right. I've been involved in a lot of community organisations, and I chair two other fairly significant public enterprises, and the financial management and prospects and structures of this industry are very, very difficult, because it's very tight and very marginal, and without large institutional backing, without a large well-resourced asset base among our residents, we find it quite difficult to just keep the nose above water.

But our general response to the report is that we support the general thrust of the report, the general approach to regulation and the new structures that are proposed. Our key issues with it are the approach to diversity, the approach to the workforce, and the approach to financial sustainability. In terms of diversity in the

policy challenge, we support the attention being given in that area, but we don't believe it goes far enough. Obviously with our experience, we notice we're particularly sensitive to ageing residents reverting back to native language, and the significant challenges to us of providing an environment of dignity and respect to folks who can often only respond in one language, in one set of cultural forms and norms as it were, and need a particular approach to personal care.

MR WOODS: Can I just sort of get a bit of a map in my head on that issue? Would you describe your facilities as having clusters of particular cultural language groups of people, so that no one facility is dominated by a particular cultural group? But you might have a cluster of - I don't know, whether they're Greek or Italian or whatever they might be, but rather than isolated individuals, are you more likely to have groups?

MR MILDENHALL (DGAS): Yes, that's certainly our aim. We've actively set out over the last three years to engage with organised cultural groups - the major associations in the west, whether it's the Polish group or the Spanish-speaking and a range of others - and we actively seek out those relationships and set up, if you like, supportive networks around volunteers and access to the services that those organisations can often provide to support smaller or larger groups within our facilities, and where possible match those numbers with staff with those language and cultural sensitivity skills and menus and things like that. But given the structure of the industry and the other pressures on us, the success of that varies group to group and the numbers vary group to group.

MR KOULIS (DGAS): Just as an idea, we have 35 different nationalities across our seven facilities. So while we try and cluster it, it's still quite fragmented. Because of the numbers that we're talking about - you could have four or five Polish people in one very large facility and, as Bruce said, Spanish-speaking - we try and cluster as best we can. Some of the ethnicities are well organised, they'll have community based information centres that help guide the prospective residents, and we work with them to do presentations and discuss the information that they need. But it doesn't always work, because it's all based on location. A particular resident can only reside in a particular location and, therefore, they have no choice in terms of being clustered.

MR WOODS: Does that mean that with your networking, in part that relies on how well resourced the community groups are, by way of being able to provide volunteers and support workers and language translators and all of that? So in part are you having to draw on their resources to support your activities - not support, but to enhance and - - -

MR MILDENHALL (DGAS): Yes, it certainly enriches the relationship where

that's available. I guess our general view is that we're impoverished at both ends of that relationship. Neither of the groups have sufficient resources to perform that role properly, and nor do we have the ability to provide a supportive network for our residents given the current financial situation that we're in. I guess if we were to be specific with the report - - -

MR WOODS: Yes.

MR MILDENHALL (DGAS): - - - we don't believe recommendation 9.2 goes far enough. It deals with prices for interpreter services and professional development activities for staff. We believe the pricing of services should be more assertively conscious of the setting that a provider like Doutta Galla is in and reflect that.

MR WOODS: Yes. We get evidence from time to time of the fact of needing to import particular foodstuffs and needing to provide interpreters and the like, but it would be interesting to actually get some hard data. Sometimes these things can be portrayed as very significant, and then when you burrow down you find that they might be half of 1 per cent or a 1 per cent on-cost - which is still significant when you're teetering on the edge, I'm not downplaying that. But some orders of magnitude of these - if your hard-pressed finance officer was able to give some thought to that and if you were willing to give us some evidence, that would be excellent.

MR KOULIS (DGAS): I was just going to say I'll certainly look into it and try and see if we - - -

MR WOODS: Yes. Don't distract yourself too much from your day-to-day grind.

MR KOULIS (DGAS): Sure, yes.

MR WOODS: But if there is something you can pull out, that would be excellent.

MR KOULIS (DGAS): It is a significant cost, and quite often it might not just be those tangible obvious costs. It might just be a case where there is a language barrier - with the morning duties; just getting someone out of bed, showered, dressed, to breakfast - and it might be a case where you're not going to ring up an interpreter and say, "Can you come down here?" It's going to be a case of using those non-formal communication things, which will take longer to get that person ready. So there is an added cost whilst there isn't an obvious other resource that we can draw on to address that sort of working practice.

MR WOODS: Yes, those are exactly the sorts of points.

MS MACRI: Yes.

MR WOODS: So to expand that for us - and I'm not talking about a large treatise, but some nicely documented points on that would be excellent.

MR MILDENHALL (DGAS): If you had a research person who could perhaps engage with our senior management, who could do a bit more detailed work on it - but our staff is just reminding me there too it just generally adds to the complexity of setting up lifestyle support programs and those sorts of things. If you wanted to run these facilities as efficiently and effectively - under the current system - as you could, you would not embrace the complexities that we are endeavouring to do.

I speak to the cultural groups quite a bit, and my general message is that these folks have been generally - and your report notes it - under-represented in their access to services of this type, and we see it as our mission to have at least a proportional representation that matches the demographics with participation in our facilities; if not more, given the overall characteristics of the industry. So we are adding a degree of difficulty to our operations.

MR WOODS: But is the solution to have some additional component to the ACFI, or is it to provide additional support to the cultural groups who are feeding in? So where is the point of intervention and how would you make sure that it's well targeted and not just using up a lot of taxpayer dollar for minimum effect?

MR MILDENHALL (DGAS): Certainly from our perspective as an operator, the first port of call for us would be an ACFI model that's more sensitive to those characteristics. We don't believe that ACFI recognises ethnicity or culturally sensitive - language, lifestyle, personal care, those sorts of issues - in the model at the present time.

MR WOODS: Okay.

MR MILDENHALL (DGAS): As to the other end of the equation, you'll probably find some difficulty, I'd imagine, from the Commonwealth's perspective, providing grants to those organisations perhaps in the context of this study - but we'd certainly welcome that as well. One of the key challenges, just very quickly, is to the workforce. We've got a very culturally diverse workforce. We have significant literacy issues within our own workforce, where we struggle to keep up with the training challenge. Probably the key issue in that is that there's not sufficient funding to allow for backfilling for adequate training to occur - is probably one of the key issues. We just can't release staff to access a level of training that we would like

them to be able to participate in.

MR WOODS: The quality of the cert III?

MR MILDENHALL (DGAS): A significant issue for us. We're supplied by six RTOs in the area and there's probably two of those that we'd regard as providing applicants of an appropriate standard.

MR WOODS: Are they TAFEs or private RTOs?

MR JONES (DGAS): I think we rely on one of the TAFEs and the university.

MR MILDENHALL (DGAS): They're probably the two best.

MR JONES (DGAS): Yes, I think they're the two best. There's a multitude. Clearly some are fast-tracking their students and the industry would be able to tell you that. We use ACCV also because we're a member of that - get some reliability. My impression is that the cert III hasn't been revised for a long time so it hasn't caught up with the trends and it's certainly not tough enough on literacy and comprehension. Given that the sector operates on a documentation basis - it must for regulation of all care or communication - it's a major deficit that's emerging.

Most providers - and my experience elsewhere is that we overcompensate as employers for the deficits in the primary education, so we're using resources that we would prefer not to have to, at least the front end, and they're the key component of the workforce, the largest group, and that ultimately has an effect on retention, let alone the quality of recruitment. It's an area that hasn't been given much attention. I think you're aware of that. It's true you do mention other bits about management training. An observation is that in the last few years there's been a lot of scholarships and funding provided by the federal government, when really the subsidies potentially should pick up a component for training and then the responsibility rests first with the employer. I think it's come from the outside and we don't have a lot of control, yet we have all the accountability with the delivery of service, yet we can't control the product to the extent we should. I think that sums it up.

MR MILDENHALL (DGAS): Our final point is around - it's probably where I started - the issue of financial sustainability. To reiterate there, we think the final report should recognise diversity and its impact on financial sustainability to a greater extent than the draft report does. Probably another couple of specific comments on that section would be that we obviously need a daily accommodation charge or the costing system that you're proposing to be a realistic reflection of our actual costs.

We service probably the most socioeconomically challenged area of metropolitan Melbourne, although Dandenong has just overtaken major sections of the west in some of the SIFA rankings. We are building part of a housing initiative out in Dandenong. Our general view is that we're upgrading our facilities and building facilities. We've always gone for single rooms with en suites. We just don't see rooms with two and more beds in them as being anywhere near either community expectations or consistent with respect and dignity and the context that we'd like.

MS MACRI: Could I ask you: do you think having such a large differing ethnic community like your 35 groups, that that makes it harder for people to share rooms as opposed to if it was an ethno-specific nursing home? Are there cultural issues between the ethnic groups in terms of those - - -

MR MILDENHALL (DGAS): George could be more - because he talks to more families.

MR KOULIS (DGAS): I don't think it makes any difference.

MS MACRI: It doesn't make - - -

MR KOULIS (DGAS): Our newest facility is only two years old. It's in the heart of Footscray. 25 per cent of our rooms are shared rooms.

MS MACRI: Right.

MR KOULIS (DGAS): The primary reason for us going down that path was obviously focusing on the supported model that was identified a few years back being more economically viable. We also identified that there's going to be needs for couples coming in, so husband needs care, the wife doesn't want to stay home, they can both go in together. We've struggled to fill those rooms and quite often things change, so if one of the partner's care needs to change and they need to go to a different part of the building, then the wife is usually not wanting to be sharing a room with a stranger.

We try as best we can to talk to families about matching up individuals where we believe we can match up ethnic groups together or other similar types of personalities. So we always push that point and encourage families and also push the point about there being good care outcomes for people who share rooms when they have particular ailments.

MR WOODS: But the end result is?

MR KOULIS (DGAS): The kids, who usually make the decision, are not for it.

They're baby boomers who want - you know, "I want individual - I don't want my mum sharing a room and other strangers seeing what she has to go through," et cetera. So there's this real barrier towards that.

MR WOODS: So you're left with empty two-bed wards and short of singles?

MR KOULIS (DGAS): You'll have a double room with one person in it.

MR WOODS: That's particularly efficient, yes.

MR MILDENHALL (DGAS): I can tell you from personal experience I and my siblings are helping guide my mother through the acute section and she'll end in an aged care facility within a couple of weeks - would be our expectation. The shock that we've had of - - -

MS MACRI: Advocating in the system?

MR MILDENHALL (DGAS): - - - being with her in two-bed rooms and four-bed rooms in the acute sector, and the lack of indignity and the sort of impersonal sort of processing has been a real shock to us and to her, I think. That's the first time she's ever spent any time in hospital. If that was replicated in an aged care setting I think there'd be - - -

MS MACRI: But it isn't. We do it much better in aged care.

MR MILDENHALL (DGAS): Well, that's right, but it has been - just to reply to that, at a very personal level it's been a real dilemma for us. But probably the last issue, too, would be we're acutely aware, too, in our region of the inadequacies of the transitions between acute and the aged care sector. Trying to make those linkages work, and work in a timely way and in an efficient way, is a constant challenge for our senior management as well.

MR WOODS: A few of us have got some more questions and the next participants aren't here yet, so if we can use your time a little more.

MR FITZGERALD: They are here.

MR WOODS: All right, they can wait. Just to pursue - so you've got 47 per cent concessional and so you're getting the 28.72 a day and all of those sorts of things. Presumably you're getting bonds out of a number of other residents. You'd have a number of low care - or do you get extra service high care as well?

MR KOULIS (DGAS): 43 per cent of our total resident mix have paid bonds of

some form.

MR WOODS: What sort of average bond would you be looking - - -

MR KOULIS (DGAS): Our average bond across the group would be of the order of around about 210,000. I have to say most of our building stock is very new, so our average age of our buildings is about eight to nine years.

MR WOODS: Okay.

MR KOULIS (DGAS): So that's one thing. We're sort of ahead of the industry average. To give you an idea, most of our projects are capital deficit, so the typical model is that within two to three years of ramp up you've paid off all your capital and then it's just - - -

MR WOODS: Well, you've offset your capital.

MR KOULIS (DGAS): Offset, yes.

MR WOODS: I'm sure your bankers would prefer the distinction.

MR KOULIS (DGAS): We're nowhere near that model; far from it, in fact. It's because of this 47 per cent. You know, you have almost half your facility which is only getting half the true cost of accommodation. You can't cross-subsidise from anywhere else.

MR WOODS: So in the brave new world, if the recommendations - and if the final looks like the draft, you would get a higher per capita per day payment for your concessional residents that reflects the actual cost of whatever the standard gets to be set at, which is a matter of debate at the moment, but you would also then be able to continue to charge the market for the non-supported residents - whatever you thought the market would bear - but you'd have to offer a daily charge as well if you wished to offer a bond related to the daily charge.

What do you see as the likely consumer reaction? Do you think a lot of those who are currently paying bonds would prefer to pay a daily or weekly rental-type structure and if so what does that do to your finances, and does that lead you then to have to take on actual debt but which you would service from an income stream? What does all that look like to you for the future?

MR KOULIS (DGAS): Great question. It's quite simple for us. If there's no distinction between high and low and everyone has the opportunity, for us that's a benefit because we're going from at the moment - we did an analysis comparing out

2004 to our 2010 statistics and we found that, in 2004, 77 per cent of the residents who came to us came as low care, 23 per cent came as high care. In six years, that flipped on its head: 38 per cent came as low care, of which half is concessional, and 62 per cent came as high care. So all of a sudden, that's going to make a huge difference to us because the pool of bond payers is going to increase.

In terms of the concessional mix, if you split your resident profile into four categories, if you like - supported not bonded, supported bonded under both of those - and you do the analysis, it actually makes a huge difference to us. I did the numbers the other day. It worked out to increasing the pool by 30 per cent in terms of the number of residents who will be paying a bond or a bond equivalent by way of a daily charge.

MR WOODS: Do you find the opportunity of picking up daily charges a threat or are you fairly neutral to it?

MR KOULIS (DGAS): We're a bit guarded about it at this stage. We don't know the reaction by the market. At the moment people still have that choice, as you know, under bond, under low care.

MR WOODS: Well, yes, but they have certain incentives to head in certain directions.

MR KOULIS (DGAS): That's right, yes, so it all depends on - - -

MR WOODS: Which we're trying to remove.

MR KOULIS (DGAS): I guess it will depend on which incentives or disincentives will be removed, because there will be natural disincentives - so people just don't have the money to be able to pay. They might have just a house and no money, so they can't afford to pay the daily charge. They'll be forced to pay the lump sum. But there'll be others who already pay the daily charge because they can, so I'm still not sure. We don't have any stats to be able to work out which way the market is going to go.

MR FITZGERALD: But your expectation is that some people will continue to pay bonds?

MR KOULIS (DGAS): Yes, absolutely. Yes, out of sheer necessity. There's no choice for them.

MR WOODS: Well, they can draw on any equity if they have that in a home or something else, so they can progressively draw against that to pay a daily charge.

MR KOULIS (DGAS): Yes, they can.

MR WOODS: We're trying to remove the necessity factor.

MR KOULIS (DGAS): Yes. I guess my point is, there are two things. It depends on how the market changes in terms of offering products that enable them to draw on the capital. The second part was, who can pay that? At the moment, it has to be coming out of the financial resources of the resident. I note in your report it said that the resident and/or family can pay, so does that mean that the legislation will be altered so that kids can say, "Look, Mum has only got 200,000 but we want her to go into extra service"?

MS MACRI: Yes, absolutely.

MR KOULIS (DGAS): "We'll pay the difference. Don't worry about her financial assets."

MS MACRI: Yes.

MR WOODS: They can do that now. They can top up if they wish.

MR KOULIS (DGAS): Top up on a daily basis but not on a lump sum.

MR WOODS: Yes, I understand.

MR KOULIS (DGAS): So if that barrier was removed, then definitely there'll be an advantage because we get a lot of kids who come and say, "Look, we don't care what it costs. We want the best thing for Mum and Dad and we'll pay the difference."

MR WOODS: Of course you're only talking about the accommodation. We're not talking about the care?

MR KOULIS (DGAS): Absolutely; just accommodation, yes.

MR WOODS: I don't want to cut into our next participant's time, but that's been very, very valuable and we will follow up and chase your numbers and get your insights into how this will actually work on the ground for you.

MR KOULIS (DGAS): Thank you.

MR MILDENHALL (DGAS): We'd welcome that opportunity to work with you

on that. Thank you for the opportunity to present.

MR FITZGERALD: Thank you very much.

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

MR MANSOUR (ACCV): Gerard Mansour, chief executive officer, Aged and Community Care, Victoria.

MR ZANATTA (ACCV): Paul Zanatta, manager community living and policy, Aged and Community Care, Victoria.

MR WOODS: Excellent, thank you. Can I, on behalf of the commission thank you greatly for the contributions you have made to date, not only in terms of written form but the forums, the discussions, the participation. It has been excellent.

MR MANSOUR (ACCV): Thank you.

MR WOODS: We're very grateful and we have learnt a lot from that, so we'd like to put that on the record. It's been a very valuable contribution. You have an opening statement?

MR MANSOUR (ACCV): Thank you very much. Can I just clarify, about 10 or 15 minutes - or less?

MR WOODS: I think we've got half an hour for you.

MR MANSOUR (ACCV): So how long would you like me to talk for, about 10 minutes?

MR WOODS: Yes, that would be great.

MR MANSOUR (ACCV): I'd also like to put on the public record the enormously positive approach that the commission itself has taken. The fact that you've been willing to engage and road-test what is a major reform proposal has been enormously valuable for us and I must say, along the road, very challenging. There are some enormously positive parts of what I've described publicly as a bold vision for reform that's very much needed. We're, I think, in a fairly unique position in Victoria. Being the voice of over 90 per cent of all aged care services in Victoria, we're in an excellent position to try to consolidate and listen to the feedback from a whole series of different angles.

My first part of the opening comment is that there will be very shortly formal submissions from our two national bodies in the federation and what I'm going to do this morning is go to a couple of key points that we'd like to make, rather than replicating their overarching submission, so we strongly support and endorse both of

those submissions when they come. They go through in some more detail a few of the issues that we're talking about today.

The extensive and comprehensive Productivity Commission draft report, Caring for Older Australians, heralds, in our view, a much-needed breakthrough for a system long suffering from chronic underfunding. There can be no doubt whatsoever that effective and sustainable reform is the biggest game in town for our aged and community care industry. There's equally no doubt that the current policy settings are not capable of delivering a viable and robust aged care industry for the longer term. What is at stake is the capacity for our aged care industry to provide consumers with increased choice and access to receive aged care services and lifestyle support as and when they need it.

The aged care industry is passionate about the quality of care it provides for older Australians. The outcomes under our accreditation system demonstrate the most significant commitment by our entire industry not only to meet the needs of older Australians but to excel. However, under the current policy settings, our industry is not capable of responding to all the demands that will be placed upon it in coming years.

The Productivity Commission, in its draft report, has mapped out a vision for the longer term. ACCV, like our national body, supports the general direction of this reform agenda. I've publicly and to our members on a number of occasions referred to it as the commission building a table, and I've cautioned our members that we need to see this as a table, and you just can't pull a leg off it, and I think the commission should be commended for the way it's thought about the need to build reform from all different angles.

While finetuning is required in the final report, the Productivity Commission has laid out a comprehensive framework for aged care reform which, in our view, has the capacity for success if it's implemented in a partnership and collaborative model between government and industry, and I'll say a little bit about that in a minute. To us it's not just about a series of transition steps. It's about a change process, and it's one of the areas we're going to ask the commission to strengthen the dialogue a bit in its final report.

Such an implementation process - there would of course be a vital role for consumers, professional bodies, unions and various key stakeholders. ACCV endorses a phased approach to reform as outlined by the Productivity Commission through a staged transition plan. However, there are in our view some key changes which will be required to the staging of this plan, and these are contained in more detail in the reports of our national bodies.

Foremost in our mind is the need for fundamental connection between key elements, so that sequencing for change can occur effectively. We're suggesting that as the commission has looked at this from the point of view of criteria, we've suggested four fundamental tests that ought to be applied from our point of view to any reform process. The first and the foremost from our point of view is that it's a financially viable and robust industry; the second is a test of affordability for consumers, taxpayers and the government over the long term; the third is that there's an appropriate level of an entitlement based system; and, finally, that there's a test of access for all.

So our view is we've looked through that lens in responding to the report. We support the direction of the reform agenda contained in the draft report, noting there are various changes and enhancements we consider are essential to be reflected in the final report. We strongly support the proposition that the Commonwealth make a greater proportionate financial contribution, so that we can in fact have a robust industry. We also support the view that those that can afford to make a greater financial contribution ought to be able to do so, and the Commonwealth has a key role to provide for everybody in terms of what is a reasonable safety net. In our view, the biggest threat to the industry and the needs of consumers is that reform ends up looking all too hard for implementation, and only minor adjustments are made to the current system. We continue and will continue to talk publicly about the importance of that.

Today I'd like to focus on four key areas that we would like to talk about from a Victorian perspective. The first of these is a question about how the market model itself would work, and we've acknowledged and characterised the move from a current system, where the government controls supply, demand, pricing and regulation, to more of a market based system. Our view is that there needs to be careful staging and consideration about how we transition from one of those models to another.

We have been heartened by the acknowledgment by the commission in the report that a market model of course is not going to work in all instances, and in a number of places we've heard a naming of things like the rural communities, special homeless services et cetera. We'd like to see that teased out a bit more in the final report, and acknowledging some of the areas and the specific strategies that the Commonwealth might use in those areas. We'd like to see a little bit more of a conversation about the block-funding models, capital grants schemes and innovative approaches to capital raising and recurrent funding. We've suggested here, for example, that services in the smaller rural communities, services for the homeless, all those which other special needs groups, will still require some innovative approaches, whether that be block funding, recurrent funding solutions.

In terms of the transition phasing, we do think that there's more work in this area that's required, so that we can have a sense that the transition phasing is correct, and I'd like to talk about that a bit more in a minute. Getting the market system right - there's a further conversation that we're keen to have in coming weeks with the Productivity Commission about the whole issue of the financing of the new system, and the financial viability of the aged care system, and we are keen to be guided, in our view, by some independent financial modelling, and we're just finalising the elements of a project at the moment.

We're suggesting there are three areas in particular that we're focusing on as a result of our member feedback. The first is whether some refinements need to be made in the market model itself that's proposed; secondly, whether the transition provisions themselves need modification or strengthening; and thirdly, the vital importance of industry alignment or development, including exploration of innovative service design models.

I think that the greatest opportunity for the government and for our members is to see this as a way to enhance and modify their service models, and history says there's often a need for third party expertise, and I reflect for example when ACFI was implemented, there was a special project that was very valuable for particularly our small rural members, where they could get additional business expertise to assist their move in, and make sure they were doing something very simple as capturing the income that they should be. So our view is that in the report at the moment, in the final report, we'd like to see a bit more of a conversation about industry realignment and redevelopment to take advantage of the opportunities that are there.

We think that there are fundamental questions - and I note in your questioning of the people immediately before us - what are the implications of a move away from a lump sum model? How is that going to work in practice? We'd like to see more conversation about that issue with the commission in coming weeks. What are the implications for older people who have little or no accumulated wealth? What is the level of threat that the model does not operate as anticipated, and the outcome is undersupply in some areas and oversupply in others? How can this be best managed? What's the level of risk of provider failure and its associated negative impact on consumers, including residents?

I'm reminded in our existing model there have been elements and examples of market failure, and we have had in Victoria at least two occasions in my time as CEO where we've had to relocate residents away from a closed facility to another facility, and it's enormously controversial. It's enormously dislocating for those families involved and, most importantly, it has a negative impact on the public perception of our industry, and I think that often is underestimated from people outside the aged care industry - the critical importance of maintaining public confidence.

So we expressly support the creation of an industry redevelopment fund to actively encourage the aged care industry itself to adapt to a new model, and as mentioned earlier, we strongly encourage that the government sees that its role is to work in partnership and collaboration with the industry to work through a change process.

A couple of the areas that we'd like to make some specific mention of today: the first is in relation to the Gateway and the funding assessment. We've thought long and hard about the spirit and intention of the commission which we actually support, and that's the idea that a person has an assessment, has a concept of what their package of needs is, how they'll be met and funded in a way that allows them to exercise choice, so we certainly support that, but we see a risk that one of the strengths of the current system is the provider gets to know the resident better, and a disadvantage of the new model is, how would the Gateway be able to get to know a resident or a consumer well enough to get the system correct?

Our view is the solution lies in the concept of a provisional assessment; that you empower the aged care industry to have an opportunity to do a reassessment; that that reassessment would be binding; and then, as there is a validation and checking mechanism in place today, that would continue. Our view is that a balance between those two provides the ability for the Gateway to take the lead in the responsibilities that it needs to, to allow consumers to exercise choice, but allows the provider the safety net that if the assessment isn't accurate because of the simple reality that they don't get to know the resident well enough, then our members can have a right to do a reassessment.

MR FITZGERALD: I don't want to stop your track, but I want to understand. Are you talking about that in relation to community based services, or are you talking exclusively in relation to residential?

MR MANSOUR (ACCV): The whole lot; the whole lot.

MR FITZGERALD: The lot, okay.

MR MANSOUR (ACCV): So it's seen as a system design mechanism, that in all places exactly the same thing may arise. The social needs of a consumer may be underestimated in a particular area, and they may need to be strengthened.

MR FITZGERALD: All right. We'll come back to that when you've finished, thanks.

MR MANSOUR (ACCV): From a Victorian perspective, one of the fundamental

questions is, how do you make the building blocks work in light of the fact that the Victorian HACC system remains currently outside Commonwealth control? Our view is that the approach by the commission in the draft report is appropriate, and that the HACC service must be part of the building blocks model, so we strongly support that. The question then is how do you operate the building blocks in relation to both Victoria and Queensland. I'll talk a bit more about that during our conversation. Our view is there's only a couple of options but the reality is that the building blocks cannot work effectively in either Victoria or Western Australia unless the HACC issue is addressed directly.

The second-last point that I'd like to make is that our view is that the building blocks model currently underdoes, a bit, the critical importance of lifestyle and social inclusion, both in residential and community care settings. Our sense is that the fairly simple solution is literally just to acknowledge that it's its own element, just as there are various building block elements like acute, but the recognition that social support, lifestyle are critical elements, and I think we all know that. There's nothing more disabling in some instances for an older person than to feel highly isolated in their environment and disconnected. It has enormous impact on the health and there's an enormous amount of research that shows that.

The final point is the critical issue of what we call special needs groups right across Victoria and they fit in a series of categories. There's our entire rural community and rural service system. How do we make sure that that operates effectively where a market isn't going to operate in the way that it will in various other places? How do you make sure it works in all metropolitan areas, not only the areas that would be regarded as more middle-class or wealthy but in the less well-off areas? And a particular focus on particular client groups: whether they're from a non-English-speaking background, mental health, disability or homeless, the system must work for all, and so we'd be keen for some strengthening about how the market model accommodates that in its design framework.

In conclusion, we strongly support the fundamental direction and we think that our contribution is more characterised as refinement and finetuning. Thank you.

MR WOODS: Excellent. That is a very helpful focus on some specific issues while giving support to the broad architecture. In terms of transitions in the implementation program, we didn't - and deliberately didn't - spend a lot of time finetuning that because we wanted to make sure that the architecture was basically sound, that the table would stand up and that all legs were appropriately strengthened. But having got largely to that stage, yes, we are happy to work through the implementation side. But there are a number of other issues before that. Do you want to start, Robert?

MR FITZGERALD: Just start with the HACC one. First we'll cover the finance and then HACC. Yesterday we had a presentation from the Australian Services Union and we will have representations from the Municipal Association of Victoria and I've addressed one of their forums already. It strikes me, in relation to the Victorian issue, that the large concern is the role that local government plays in the delivery of HACC services. Given you're a Victorian organisation, you can probably comment on this.

We would share your view that the HACC program per se would disappear in order for the building blocks to replace it. That does not mean the actual services disappear. It also doesn't mean that local government couldn't continue to be a provider of those services in the same way that not-for-profits or for-profits operate those services. But it does seem that a stumbling block in Victoria is the model that you have in the delivery of services for local government, which we readily acknowledge delivers reasonably good outcomes relative to other states. We acknowledge that.

So just on the HACC issue, what is the way forward, do you think, in relation to Victoria? WA is a slightly different scenario but here it is absolutely locked into the local government structure and, again, we're not saying the services don't get provided but certainly assessment would need to come through the Gateway and the program itself would disappear.

MR MANSOUR (ACCV): This is an area where I'll acknowledge that we have a difference of opinion to some of our colleagues in other places, and our view is that we must build the national system, and the only way to build the national system is to do one of two things. We either run a parallel equivalent system in Victoria, and somebody is prepared to invest in the creation of that and literally work out a way where you can pick up the entire spirit and concept of the building blocks model, retain a framework of local government involvement and move forward, and I don't see, with all the great innovative thinkers around, why that couldn't be done. I think it would be a cost issue. There would clearly be a cost involved in replicating a service system.

Our caution down that road is let's not forget that it is a country and that a number of our members operate services that border with other states, and so how is it going to be if you're operating in Albury-Wodonga and some of those other interface areas? Let's not forget that a number of our members operate across state boundaries. So we would see the preferred model is that the threshold issues between local government, state government and Commonwealth government were actually resolved, that those parties come together and work out a way where the strengths of the current system can be retained.

I would say that, just as we mapped out earlier some criteria, we think that's the way forward; that you acknowledge there is a strength of the current Victorian system. How do you maintain that in a new system and how do you make sure that the contribution, which is essentially through ratepayer payments to local government - how is that maintained in some form and not lost in Victoria? So our view would be that it can be resolved but it has to - I think that it's going to make it extremely difficult to operate a new model if you leave HACC out of the building blocks.

MR FITZGERALD: HACC has to be addressed in Victoria and WA in order for this model to work. You're absolutely right. The second part is that - and this might just be my last question on that - some of the current services delivered under the HACC program would be amenable to direct allocated funding or block funding. In the report we've asked for feedback on that in relation to, for example, community transport, perhaps meal preparation. Some of the social inclusion and social support programs, which we've not done enough of in the report, would lend themselves to those models which are currently operated by local government. They could remain potentially within the current service system.

Then there's a group of services within HACC which would be entitlement funded and open to competition. Does that lend itself to easing some of the concerns there would be in Victoria if we can actually identify that some of the programs effectively, whilst the HACC program disappears, remain largely unchanged but there would be others that would absolutely have to be opened up to a more competitive environment?

MR MANSOUR (ACCV): That's absolutely true. If you look at some of the things like activity group programs, for example - very well respected, very effective. We would see that they lend themselves clearly to a block-funding model and they could continue and it would be very counterproductive to try to unpack that and try to get it to a unit model. It's simply not going to work as effectively. Other services, when you look through the consumer lens, are more about an input for the individual older person, and what we all want to avoid is the fact that two or three people are walking in and out of the house, providing similar services at different times.

MR WOODS: Absolutely.

MR MANSOUR (ACCV): That's the caution for everybody that's looking at it from a HACC - almost like a protectionist model. Let's not forget that what the commission has done is said, "Let's put the consumer in the middle of our thinking," and if we do that I'm confident that we can still work out a solution.

MR FITZGERALD: Thank you.

MS MACRI: Your comment about the provisional assessment coming out of the Gateway: one of the things that we have built into that is the capacity for a reassessment if the provider has deemed that the Gateway hasn't got it right. I just wonder about a provisional assessment for everyone on the increased workload and whether you would be happy if the Gateway was doing that initial assessment and if the provider deems that, yes, that's fine and that's where the person is at. We are talking about ACATs, as they currently are - or ACASs here - using the act for your similar instrument, not the instrument that they're currently using. So if the assessment is deemed to be pretty accurate and right, business just goes on. If it's not, there's an appeal or a reassessment mechanism for that to occur within a fairly short period of time. Would that satisfy - - -

MR MANSOUR (ACCV): To be honest, no. What came up in a lot of our conversations is the fundamental importance of the investment our members make in getting the assessment right - getting to know the resident, matching the care needs and the lifestyle needs with the individual. So we also thought about what it's going to look like. Imagine it's a residential setting and the person has been there for six months. You see a fundamental change. What's the value proposition of bringing the Gateway people back in? You know, our people are there. They're living and breathing, they're providing support. I would have thought it's a far more cost-effective model for the Commonwealth to allow our members a similar level of responsibility they have now.

There has to be - clearly it's government funding - a protection system. I think everybody would acknowledge the validation process now is pretty refined and works pretty effectively. So we're trying to marry the two in our view, and whether it's labelled provisional or not, or whether it's labelled, "This is an assessment" - and I understand your point - if it seems that it's a lesser level of assessment, that's not our intention. Our intention is the provider has a right to reassess and they have a right - in moving forward in the same way they do now. We think that works well and there's no point in throwing it out.

MR WOODS: All right, but you talked there about six months. I think we'd all agree that if after six months there's a material change in circumstances different from the initial assessment, then obviously the provider would notify the Gateway and say, "There's been a material change and we think that that person is now at this level of care services, not that level," and on a risk-adjusted basis, a risk-managed basis for the validation process, the good operators, the Gateway would say, "Yeah, that's fine, continue on and we'll just do our normal checks in the due course of time," but for others they'd say, "That's really interesting, but we'll send somebody out, thank you, and we'll go and do a validation before it actually gets changed."

MR MANSOUR (ACCV): We understand, yes.

MR WOODS: So it would be depending on the circumstance of the operator. So the six-month time frame, yes, I can't see any problem with. It's the two to three-week problem that we're trying to address. Whereas the ACATs used to have one set of criteria and they'd give somebody a high or low and then - - -

MR MANSOUR (ACCV): Absolutely.

MR WOODS: - - - the operator would assess them according to the ACFI - and whether it's an ACFI, or a CACFI for the community, whatever it is - if that's being done by or on behalf of the Gateway and they're not going to have their own staff necessarily in all places - they will contract out, they will have panels - and on day one they will probably just use the ACASs and then iterate and change, but they would be using the same criteria and the same toolkit that the provider would use.

So I wouldn't want to say you'd walk out with a provisional and then the provider does the same thing in a couple of weeks' time. But if there's a material difference, that the provider looks at them either in their community setting or the residential setting and says, "Hang on, they've missed something out. There's a fundamental mismatch," obviously you go back and you say, "Hang on, that's not working for this person, and here are the reasons why."

MR MANSOUR (ACCV): My suggestion is that there's a road between the two that achieves them both. The Gateway itself is going to have enormous pressure simply because of the increasing number of people accessing services, and a lot of the feedback we received was a fear - particularly in outer areas, outer Melbourne and rural areas - as to how are they going to have a local presence? It's an enormous resourcing challenge simply to do that.

Our view is that the reassessment arm that at the moment sits with providers is best to sit there. It's about empowering an aged care provider. We strongly support the same tool. Once that issue is removed we don't see a value proposition to call the Gateway back. Allow providers - because they currently apply a tool, they would apply the same tool. To us it's a clever efficiency in the system. It gives our members the confidence that we get to know the resident and if things have either been overlooked or their needs change - it could be both of those; it could be that the way a person presents in their own home with the family support systems is a bit different when they come into residential care. It could be that and it's just that that's the reality. It could be they change quickly, and that can also happen. Allow the provider to exercise that reassessment.

MR ZANATTA (ACCV): I think there's a critical issue that, if you really look at

it, assessment that leads to care planning is actually longitudinal when it takes place in both a residential facility and also when it takes place in the context of a package care program. In a package care program at the moment, however, you've got a window of money, which is the amount of the package. You're actually going to move community care funding to a much more finely tuned, incremental model.

If you talk to any service that works with clients who by the time they've progressed to a package their needs are complex, it actually takes time to build relationships with clients and actually to build a profile of what their needs are and to build a plan of care. Social activities are a classic example, where people initially say, "I'm fine. I just want to stay in my little house. Yes, someone can come in and clean my bathroom," but they don't really acknowledge that they're struggling in other ways. That actually takes time.

So, yes, the funding determination, as it occurs at the ASGA level, could end up either being an overfunding to try and compensate for the possibilities that arise, or it could well be, in fact, an underfunding, and so it actually becomes an inefficient approach to try and accurately determine needs, which in any long-term social care model requires a longitudinal form of assessment. It's not an acute health model and so therefore you don't use point-in-time assessments for high-acuity acute needs. For long-term social care you actually need longitudinal assessment.

MS MACRI: One of the issues to come forward is around documentation, validation, accreditation. It's been the same story for as long as we can remember. Part of this was reducing that regulatory environment in terms of the validation and we're getting considerable feedback, both through submissions and presentations from various nurses, that even though ACFI was supposed to sort the documentation out, we're fast moving again to the system of the RCS generating documentation and excess validations again. So I think one of the things that would be helpful for us is to look at how you get that balance of trying to get an instrument, an assessment out there, the funding attached, without the related validation documentation process that's absolutely plagued the industry for 20-odd years.

MR MANSOUR (ACCV): Absolutely understand and fully agree with that. That's why we're trying to find that midpoint and provisional - and I absolutely take the point. The intention isn't that it's less valuable - and maybe we've used the wrong word there - but the intention is that once the provider commences the relationship, they have the opportunity themselves to do the reassessment. So maybe the language is wrong there. It's more from that point of view. Let's not call the Gateway back in to reassess when we actually know the resident. We just think that's building in a different sort of inefficiency. If our members choose that the Gateway assessment is fine, they don't feel the need to reassess, then there's no extra burden.

MS MACRI: Yes.

MR MANSOUR (ACCV): The trigger will be, "I feel that this match is not occurring," so I'll have to have done some work to identify that anyway. "Now I've got to pick up the phone, bring someone else in, do some assessment."

MR WOODS: That would only be on a risk-managed basis. You would only do it for those providers who you weren't confident were always completely accurate in their reassessments.

MR ZANATTA (ACCV): Yes, we've certainly heard that too.

MR MANSOUR (ACCV): We'll probably have less confidence going forward, after you leave us, about how bureaucracy operates.

MR FITZGERALD: That's true. I think the points you raise are very valid. In relation to residential, you're absolutely right; we need to be careful that we don't bring the Gateway back in unnecessarily.

MS MACRI: Yes.

MR FITZGERALD: We agree.

MR MANSOUR (ACCV): That's the point.

MR FITZGERALD: The community one is a little more complex, given that we're talking about an entitlement based system which will be reasonably prescriptive in terms of the entitlements that you're entitled to. So I think it may be that we come up with slightly different approaches for the community as distinct from residential.

MR ZANATTA (ACCV): Yes.

MR FITZGERALD: But I think your point is valid; we don't want the Gateway re-engaged unnecessarily.

MR ZANATTA (ACCV): No.

MR FITZGERALD: Because there's a huge cost to the government of doing that and there's a huge cost to everybody else in the system. So I think the point is very valid, but I wouldn't be surprised if we came up with one approach for residential and a slightly different approach for community. But we can look at that.

MR MANSOUR (ACCV): I understand, yes.

MR FITZGERALD: Given that packages are disappearing, so we don't have the provider that has a package any more.

MR ZANATTA (ACCV): No.

MR FITZGERALD: We just need to think that through.

MR ZANATTA (ACCV): Commissioner Fitzgerald, we also entirely understand the purpose: that to initially in fact assess and allocate an amount of money to a person is absolutely in the spirit of enabling the consumer then to go along to a provider of their choice and select a service knowing that they have an entitlement to those services. So we don't want to detract from that either.

MR WOODS: There are a whole range of other issues, but can I just pick up one - and I'm conscious of the time. I think we can have a further conversation and work out a set of words and processes. You talked about innovative service design models. Can you just give us a little picture of what some of that might look like, some of that thinking, and then again we might be able to have a later conversation.

MR MANSOUR (ACCV): One of the challenges we all have is that different elements of system reform are occurring in different places. So we've got a whole conversation about health and hospital reform and on the other side we've got interface issues that you yourselves are dealing with around disability. We sit in the middle. Take for example in Victoria. Today there are very few proportionate transition care packages being delivered into the aged care setting. There are very few, almost none that I know of, subacute services operating here in Victoria delivered through aged care settings. Our view would be that there needs to be another conversation about innovation and design where you can choose which area of a market or a continuum you focus on.

MR WOODS: Absolutely.

MR MANSOUR (ACCV): At the moment, the model itself isn't supportive of that. So if I want to build an aged care service that's essentially a residential location with an independent retirement area, low, high-care area, a transition area and a subacute area, well, the hurdles I've got to get through to do that are enormous. So our view is, there is enormous efficiency capacity for government if our industry can be enabled to look at those connections with the other parts of the service system.

At the moment our concern is that the silo conversations aren't embracing that, so we've suggested a section in your report that acknowledges some connections - and enabling us to have that conversation. We'd suggest there are two sides of it.

One is the system, the other is enabling providers. People operate in a supply-demand controlled environment: you'll learn that thinking, you'll learn that language. Sometimes you need some jolt to think outside the square.

MR WOODS: That's exactly the vision that we want to promulgate through the industry in talking to providers. Some providers get it and they say, "Oh. So I've got a facility and I can then draw on different parts of the market to provide services and I can add on ILUs and I can provide community support and outreach," and so their eyes light up and they're starting to say, "Hey, this could be excellent." Others are saying, "Oh well, what will the package look like and what will happen to this and that?" and don't get it. If you were able to expand your thinking on that, because that is an area where we do need to communicate with providers so much more - but if it's coming from industry, some of that vision for the future, that will help spread that message, so a supplementary piece of paper that just spells out - that would be excellent.

MR MANSOUR (ACCV): Yes, we can do that.

MR ZANATTA (ACCV): And I think at least two conversations need to take place, obviously one with the state governments who obviously have dollars - say in Victoria we have a subacute program.

MR WOODS: Yes, subacute, transitional - - -

MR ZANATTA (ACCV): But also the Health Insurance Commission with regard to health insurance funds, seeing that it is actually in their interest to explore that modelling partnership with the aged care industry.

MR WOODS: Rehab, restorative care, short-term residential - - -

MR MANSOUR (ACCV): Exactly. We'd be very happy to take up that opportunity.

MR WOODS: Because we want people to be dealt with in the context of their current needs with a view to, wherever possible, getting them back more independent and more socially engaged; so how the facilities and how the community support services can help create that future would be excellent.

MR FITZGERALD: We're out of time, I notice, but I just want to take up this financial - about the accommodation bonds and so forth. You've raised a number of questions which are all legitimate and we're looking at them. We've had three providers from entirely different backgrounds present at these hearings so far in Melbourne. All of them have come to almost the same conclusions: that they

support the notion that the client, the consumer, should have the choice of whether they pay a periodic charge or an accommodation bond; they agree that by spreading the ability to charge accommodation bonds across the whole of residential aged care facility it will actually lead to obviously a decrease in the quantum of the bonds; and all of them believe that, even with our government's proposal, some people will continue to choose to pay bonds, even though the incentives in relation to the aged pension and that have been dealt with.

Is that your view at the moment: that by and large - and I know you've raised the question, but the sense we're getting from providers, with some exceptions, particularly in other states, is that the model we've put forward of consumer choice about periodic charges, about spreading the ability to offer accommodation bonds across the whole scheme - - -

MR WOODS: And higher supported accommodation.

MR FITZGERALD: And higher supported accommodation. While no-one can actually say how it will work, because we just don't know in terms of percentages, but we're not getting a feedback in Victoria that there's huge concern about that. Obviously each individual organisation has to make an assessment based on their own business model, but so far that seems to be the response. Is that your sense?

MR MANSOUR (ACCV): A little bit different. I'd say two things. One is a bit of an unsatisfactory answer and the other is that at the moment I don't know, and the part that I don't know is how many of our members have come to terms with that level of assessment. This is such a comprehensive reform package. The number of times that you have to sit in a room and absorb all the different elements and the pieces and how it would operate and then go back and do the modelling - actually, to be honest, there's only a small group of our members that are leading, that have done that amount of thinking.

There are a lot of people that have now raised those questions and I'll put them as questions: will the system work? Is it appropriate to want to really move away from a lump sum to a daily payment? That's the subtext that's sitting in the report, an assumption that that's good and that will happen. I'm not convinced. I don't know and that's why I want to get some proper modelling. I want to have an informed opinion about that, so at the moment my answer is, the jury is out but we'll get to that in the next few weeks when I actually see some data.

So is it about simply adapting our business models and it's a management transition issue, or should we see some refinement? For example, do you reverse it? Do you say you start from the assumption that a provider can nominate whether they pay a lump sum? You know? I don't know the answer to the question and so I'd

rather not make an uninformed statement.

The second is that I think there's an acceptance that there needs to be more consumer choice; absolutely. I think that's widely understood and accepted and that providers, whatever happens, are going to adjust their business models accordingly. I think that's accepted and supported.

MS MACRI: Some of the people that have presented are now looking at their businesses in terms of five, six, seven years ago as a proportion of low care to high care. That's absolutely flipped and in terms of non-extra-service facilities, there will be in this going forward the capacity for a greater pool of high-care residents with the delineation between high and low going, and in consequence a higher pool of people that you can draw additional income from through the daily charge or bond.

MR MANSOUR (ACCV): Correct. Fully understood.

MS MACRI: I think that that financial modelling going forward is absolutely critical, but understanding the model is changing hugely and there is a pool being opened up that previously wasn't there.

MR WOODS: Also, we don't have a bias towards the daily charge. We're trying to create a neutral environment but ensure that the daily charge, or weekly rental or whatever, is there as a clear option that they can choose from, but we're not trying to stack the decision in its favour. We're just trying to make sure that it is a legitimate and available option that everyone has, and then if providers also wish to offer bonds, so be it, on an equally mutual basis.

MR MANSOUR (ACCV): We understand that and we do draw that subtext. It's a question, though, of how will the market behave, "market" being people. Will people more likely, in that model, drift to a daily payment rather than a lump sum? Trying to get those predictions - is it about degrees on a continuum? It may be, in the end, a transition issue. It may be about how do you move from a lump sum model where you've got - because there are risk scenarios. The models that are most at risk aren't the people that have accumulated assets that are sitting in a bank account so they're going to adapt because they're going to be able to repay the current bonds when they fall due.

The fear is, I have spent the money because it's in my facility, and there's a fundamental shift in the market quicker than I predict and I don't have the money to repay bonds at some point. So is it just a transition issue or is it that we come back and say, "Look, there needs to be some small finetuning in this area"? That's why I'm saying at that particular point, we want a bit more time.

MR WOODS: That would be great and we'll follow through with you as that progresses.

MR FITZGERALD: We are absolutely out of time, but I just want to ask one question on your redevelopment fund.

MR MANSOUR (ACCV): Yes.

MR FITZGERALD: How specific will you be in your submission on what that would cover? Aged care is littered with the government having bits of money in different buckets to achieve different purposes. So if we're going to have a new bucket, we need to be very clear what it's for.

MR WOODS: I assumed that was an industry-funded redevelopment fund. We've just been tricked.

MR MANSOUR (ACCV): No. What most of us do in life, I think - and whether it's a business that's selling widgets or whether it's a service industry, a lot of change fails because people don't invest in the change process. I'm saying don't assume that the industry will automatically adapt. There need to be some incentives. Life says there are always carrots and sticks. Carrots are helpful. So we'll put some more thinking into that area and we'd be very keen to put a supplementary submission about what that might look like. It's not about a waste of taxpayer-funded - - -

MR WOODS: No.

MR MANSOUR (ACCV): The money for the previous project with ACFI, I think it was only in a small number of millions, but it played an enormous contribution for a lot of small rural services to get it right.

MR WOODS: We agree. Thank you.

MR MANSOUR (ACCV): Thank you very much.

MR ZANATTA (ACCV): Thank you, commissioners.

MR WOODS: If we could call forward our next participants from the Ukrainian Elderly People's Homes, thank you. Could you please for the record state your name, the organisation you represent, and the position you hold?

MR SHELDON-STEMM (UEPH): Mark Sheldon-Stemm, Ukrainian Elderly People's Home, and I'm the general manager.

MR WOODS: Thank you very much, and thank you for your earlier submission which was very helpful to us. Do you have an opening statement you wish to make?

MR SHELDON-STEMM (UEPH): Yes, if I can.

MR WOODS: Please.

MR SHELDON-STEMM (UEPH): I've addressed the specifics in the report, but I really want to talk about the aged care system and how culturally it fits our clients and fits our cultural group. I want to talk in three parts on that. One is entry into the system, the second is the actual care system itself and the third is the financial viability as a provider to sustain care. I guess I'm talking partly on behalf of the consumer, and also as a provider.

Can I say that the current entry system, and the conversation you just had with ACCV about the Gateway - in our recommendations we recommend you get rid of the Gateway because currently the ACAS or ACAT system is a nightmare for people from an English-speaking background or an Australian background. It's extremely long. Assessments take a considerable time. It's difficult to navigate through the system, and we have a number of people who come to us assessed as low care and within a week they're high care, so we have to go through the whole process of reassessing them.

For a cultural group such as ourselves, the nightmare is magnified even further, because there are no cultural services at entry. There's nobody to basically help these people through the process in terms of understanding what's available. We do as much as we can from a provider's point of view, so we tend to be the stopgap. So we spend a considerable amount of money and time in informing those who do want care, you know, what is the process, what you have to do, and many times they say, "We want to come in to you." We say, "Well, have you had assessment?" "No. What's an assessment?" So, okay, we go and we inform them and their relatives what the assessment may be and then invariably a month later, "Have you had your assessment?" "No. We're unable to contact people or find our way in." So I've got to say, the actual entry system to aged care is a nightmare in itself, and our recommendation - - -

MR WOODS: That's what we're trying to overcome.

MR SHELDON-STEMM (UEPH): Well, I'd delete it. Just simply get rid of the Gateway system, and - - -

MR WOODS: So people would just go into providers and you get taxpayer-funded support automatically.

MR SHELDON-STEMM (UEPH): Do exactly what ACCV said. You know, people come into providers and basically the providers do the assessment.

MR WOODS: That's not what ACCV said. They said you have the Gateway, and then the provider if there's a mismatch between the assessment and - - -

MR SHELDON-STEMM (UEPH): Well, perhaps I'm misquoting them, but I understood that they were basically saying, "What's the purpose of the Gateway?"

MS MACRI: No.

MR WOODS: No.

MR SHELDON-STEMM (UEPH): Well, unless you make it easier for our cultural group to basically access that entry group, then the - - -

MR WOODS: Yes. That's what we're interested in.

MR SHELDON-STEMM (UEPH): Inside the care system, which is the second component, again our cultural group doesn't understand community care, low care, high care. It's just care, so it's very difficult for us - - -

MR WOODS: So are our reforms helpful in that respect then, by removing distinctions between high and low and all that?

MR SHELDON-STEMM (UEPH): Yes, absolutely. Yes, although we have some reservations, as we said, about the market model, and about how our group might talk about that in the third part. But in this particular part, I think there's a real issue in terms of being able to break down those barriers, and allowing them to access services as most appropriate, and your report addresses those. If I flip to the third one, which is the actual system for payment, our concern is most of our cohort of Ukrainian people and Eastern European people for the next 10 or 15 years will basically be pensioners. They won't be self-funded retirees. They won't have the money basically for a user-pays system, or for us to charge more than what their pension is or whatever.

MR WOODS: No, and there's no proposed change to any of that.

MR SHELDON-STEMM (UEPH): No, but I have concerns in terms of allowing it to be an open market because they're a group of people who aren't used to parting with their money either, so they tend to be fairly conscientious when it comes to their cash holding, so from that point of view if we say that the government has set these particular fees, then they will adhere basically to what the government - but if you then start negotiating with them, I know what will happen. The price will get negotiated down and we'll struggle to actually receive the funds that we receive now.

MR WOODS: The care funds aren't negotiable.

MR SHELDON-STEMM (UEPH): No.

MR WOODS: The care funds are set.

MR SHELDON-STEMM (UEPH): Yes. Well, I mean, I thought about this and I asked a question at the conference in Albury to Commissioner Macri and your colleague, and the idea was, "Well, the care funds are here, but the co-contribution from the resident is there." From a business point of view, just add the money together. I mean, it doesn't matter where the money comes from. If you receive X amount for a resident, or X amount, then you build your business model around that.

MR WOODS: But that's what the provider would get. The provider would get the one lump sum, but they'd get it in two parts. They'd get the subsidy that comes from the government and the co-contribution that is prescribed for the resident according to their means. So your amount doesn't change. If that's their care needs, that's the amount that you get in total.

MR SHELDON-STEMM (UEPH): Then there's the accommodation part.

MR WOODS: Accommodation is a separate issue, the standard of accommodation that you offer, and it's a - - -

MR SHELDON-STEMM (UEPH): As the provider, I'll add the two amounts together and provide the best care I can in terms of circumstances, so I don't know that you can actually do - I mean, it's almost a Chinese Wall between the two, I think, in terms of that, so I receive so much per resident per day. I've got to build buildings, pay for those, pay for the services and so on, so I'd look at the total pool of money rather than saying, "Well, that one is for care, that one is for services and that one is for accommodation." I just think in an open market situation most businesses don't split their various costs in that way. They basically provide an overall price for

their market.

MR WOODS: What sized facility is it? I was looking through your submission to try and - - -

MR SHELDON-STEMM (UEPH): We're only 47 low care, but in six months' time we'll be a 102-bed high/low care, and your report comes at a very important time for us because we're about to take $1.8 million to $2 million in bonds over the next six months, in terms of taking more low care and high care, and the idea of deleting bonds is - - -

MR WOODS: Well, again, we're not proposing to delete bonds. Bonds remain an option, but people have an option to either make a daily payment or bonds.

MR SHELDON-STEMM (UEPH): I understand that.

MR WOODS: So you would work out your financial structure. So you've got 47, did you say, at the moment?

MR SHELDON-STEMM (UEPH): 47. We go to 102 in six months' time. We're in the process of building now.

MR WOODS: An additional 102 or a total of 102?

MR SHELDON-STEMM (UEPH): Total 102.

MR WOODS: Total of 102. What do you think would be the rough proportion? I mean, we won't have high and low, but at the moment in terms of where it would look for you.

MR SHELDON-STEMM (UEPH): Of those 102, about 75 will be high care, and about 27 will be low care.

MR WOODS: That proportion, even for your current 47 has been drifting upward over time?

MR SHELDON-STEMM (UEPH): Current 47, yes. About 20 are high care and about 27 are low care.

MR WOODS: Which is different from what it would have been six, eight years ago, or more?

MR SHELDON-STEMM (UEPH): Yes.

MR WOODS: So people are staying in the community longer and then coming in.

MR SHELDON-STEMM (UEPH): Yes. We don't have any community care. We have applied on a number of occasions, but have been unable to successfully - - -

MR WOODS: So would our reforms be an opportunity for you to be then providing care for those who can and wish to remain in the community?

MR SHELDON-STEMM (UEPH): If it's financially viable, yes.

MR WOODS: True. If the care price reflects the cost of delivery of care, then that neutralises that.

MR SHELDON-STEMM (UEPH): Yes, sure.

MR WOODS: But is that an opportunity for you to expand, to start to provide services to the Ukrainian and Eastern European groups?

MR SHELDON-STEMM (UEPH): Yes. That's the positive part of the report, that basically it opens up a market. But the matter in which you open it up also has its dangers as well. So I've got to weigh up the two sides. Yes, you're allowing us to move out in the community to service more Ukrainians, more Eastern European people, but at the same time it's a business model which we've got to make sure we can sustain as such. That's what my concern is in terms of the report, that a I don't know how a completely open market model will actually - I do have an idea, with our own Ukrainian people, that they will drive prices down, because they're very hard-nosed people and funds are fairly short with them, and a lot of Ukrainians in the community now pay very little for CACPs or anything - - -

MR WOODS: If their wealth and income is not high, then they won't be required to pay the high co-contribution, but if they do have high wealth, then they will be - - -

MS MACRI: Like everybody else.

MR SHELDON-STEMM (UEPH): But in the Ukrainian two-tier system, where down the road - who takes people who have perhaps - a higher wealth group - provides services which - - -

MR WOODS: No, no.

MS MACRI: That happens now with extra service.

MR WOODS: The total service amount is the same.

MS MACRI: You've got your extra service model now.

MR SHELDON-STEMM (UEPH): Yes, but the extra service model is what percentage of the market? It's not a huge percentage of the market in terms of services.

MR WOODS: Okay, but on the service side - if we take community service for two different people who are assessed as needing the same bundle of services but one is higher wealth and one is lower wealth, the amount that the provider gets will be exactly the same for both people but the co-contribution within that amount will be different.

MR SHELDON-STEMM (UEPH): Yes, right, and for us culturally that's a problem, because as your report identifies - and I said this to Commissioner Macri at Albury - you've reduced cultural care to "language", which is truly not about cultural care.

MS MACRI: No.

MR WOODS: No.

MR SHELDON-STEMM (UEPH): Therefore, our costs for actually providing those cultural-specific services is much higher.

MR WOODS: That's a useful part of the conversation that we'd like to explore with you.

MS MACRI: Yes.

MR SHELDON-STEMM (UEPH): Yes, I know, but that's what I mean. Should we go to an open business model and not at the same time provide some component for us to provide that culturally-specific care, then - - -

MR WOODS: Yes, okay. What does that look like? Can you describe to us where those additional cost components are and what their magnitude is? Maybe you can't do it today, but if you could - - -

MR SHELDON-STEMM (UEPH): Yes. For us Christmas and Easter is huge. Christmas goes for about a month in the Orthodox Church. The same with Easter.

Easter goes for about three or four weeks. So there's a series of dinners and celebrations which we've got to put extra staff on to cater for, and food and so on. So that's fairly significant.

MR WOODS: Yes.

MR SHELDON-STEMM (UEPH): Bringing in people who are culturally-specific: you can't just bring a group of singers in, so you have to bring - again, that's a fairly costly exercise. And issues for us, I suppose, are just outings and things like that. We're fairly restricted as to where we can take our people. So again there's a cost associated with that. You just can't take them down to the park and have a barbecue, because culturally that's not where they're at.

MR FITZGERALD: Mark, are you aware of any studies at all done in Victoria or Australia that have compared the cost of a cohort of non-ethnic-specific residents and a cohort of very ethnic-specific residents? In other words, ones that need - - -

MR SHELDON-STEMM (UEPH): No, I - - -

MR FITZGERALD: We've heard this for a very long time. I don't doubt that there are some cost differentials, but taking Mike's point, I've not seen any study yet - - -

MR SHELDON-STEMM (UEPH): No, I don't think there is, and it would be helpful for something like that to happen actually so that we can in fact identify exactly those cultural costs. There's also the cultural cost in the day-to-day operations. And our staff are multilingual; we have staff who can speak Ukrainian, staff with a Spanish background, Filipino background and so on. So sometimes we have to actually apply more staff, in terms of the Ukrainian-speaking ones. If we have a difficult resident or a difficult group of residents, we need to allocate them so that there's not a cultural language barrier between them as such. There's a cost involved in that.

So I could work down through my whole cost structure and say, "Here, here and here is where it actually costs us extra money to do what we have to do." It's about maintaining those residents' wellbeing, their feeling of being at home, which again is the cultural setting that we have. Sometimes their behaviours are a little bit difficult at home, but that's just the nature of the culture as such.

MS MACRI: Yes, that's come to us around that cost of staffing and from some of the other people that have presented.

MR SHELDON-STEMM (UEPH): Yes, ethnic groups as well.

MS MACRI: Yes.

MR SHELDON-STEMM (UEPH): So that's why if you take that and then you go to the other side - which is the open market model - I just don't know how it will actually work in terms of that.

MR WOODS: You'll be able to expand your services to a wider range of groups who can meet those needs.

MR SHELDON-STEMM (UEPH): Yes, but one of the greatest market failures business is expansion. A lot of businesses actually go broke.

MR WOODS: That's your choice. Nobody is forcing you to expand.

MR SHELDON-STEMM (UEPH): No, I realise that.

MR WOODS: But if you can find an opportunity and you feel that you can service it properly, then that becomes open to you.

MR FITZGERALD: Dealing with the transitional issue - it's easy to talk about everything in transitional issues - in a sense I don't know the profile of the Ukrainian community in Victoria, but I assume that over time it increases.

MR SHELDON-STEMM (UEPH): The next five to 10 years.

MR FITZGERALD: And the ageing within that increases.

MR SHELDON-STEMM (UEPH): Yes.

MR FITZGERALD: So even if you were concerned about the impact of community services, community care, on the residential model, long-term all of the statistics show that there will be an increased demand for residential services. Our own report indicates a very substantial increase in residential services over the next 40 years. Something in the order of 600,000 people will need residential care by 2050. So whilst I hear this concern about the impact of the community services at the moment, the numbers don't actually support that concern. So is it just a temporary problem? Because really, the need for residential care actually increases quite substantially, and it would increase in all of the communities - with one exception. If we have a cure for dementia, then that would change the numbers entirely.

MR SHELDON-STEMM (UEPH): That's right.

MR FITZGERALD: But given that that's not going to happen quickly - - -

MR SHELDON-STEMM (UEPH): Not in the near future.

MR FITZGERALD: - - - I can't see where the concern of the industry, longer-term, is. I can see it short-term, but I can't see it longer-term.

MR SHELDON-STEMM (UEPH): I think it draws back to our original submission that you should be looking at aged care in three horizons. You talk about the transitional, but the next five to 10 years we'll have a significant growth in the number of Ukrainian people.

MR FITZGERALD: Sure.

MR SHELDON-STEMM (UEPH): After that it drops off significantly, in terms of that was a group that came over here just after the war or repatriated after the Iron Curtain had fallen.

MR FITZGERALD: Sure.

MR SHELDON-STEMM (UEPH): So in 10 years' time I would come back and say, yes, the cultural issues we face will be different, because the area that we're in, which is Brimbank Council area, 75 per cent of people over the age of 75 or 80 are from a non-English-speaking background. So we're moving more to that market, in terms of providing multicultural care as opposed to specifically Ukrainian. So if you were to say, "Give me an aged care system" - well, give me one for the next 10 years, and then after that give us another one, and then after that give us a third model - and I just wonder whether trundling out the one model for the next 30 or 40 years now is actually the best solution.

MR FITZGERALD: I think the way we'd see it is we're absolutely not trying to come up with the model.

MS MACRI: No.

MR FITZGERALD: What we're trying to do is come up with the funding that allows the industry and consumers to shape that on an endlessly changing base.

MR SHELDON-STEMM (UEPH): Yes.

MR FITZGERALD: Because what we've said is - we've said this to the unions in relation to industrial - there is no longer a black box. There is no longer a box called

"low care/high care".

MR SHELDON-STEMM (UEPH): No, that's right.

MR FITZGERALD: Residential aged care will look very different. What we are saying is the government shouldn't in fact be the planner of that; in fact it should be a responsive system. So in 2050 what we know is that 600,000 people will need residential care. What the actual residential care looks like will be vastly different.

MR SHELDON-STEMM (UEPH): It will be different because you'll have an entirely different cohort of consumers.

MR FITZGERALD: But you will shape that, not us.

MR SHELDON-STEMM (UEPH): Yes, we will, but the consumers will too.

MR FITZGERALD: Yes.

MS MACRI: Absolutely.

MR WOODS: Yes, exactly, and that partnership is between consumers and providers, not the government.

MS MACRI: Yes.

MR SHELDON-STEMM (UEPH): That's right. That's why I think that consumer-directed care over the next probably five or 10 years will be fairly minimal, because it won't be the consumer. It will be their relatives or their sons and daughters.

MS MACRI: That's true.

MR SHELDON-STEMM (UEPH): Then when the baby boomers turn up - - -

MR WOODS: That's right. They will start - - -

MR SHELDON-STEMM (UEPH): - - - then basically they will be demanding exactly what they want.

MS MACRI: Yes.

MR SHELDON-STEMM (UEPH): But we're not in that cohort at the moment.

MR WOODS: No.

MR SHELDON-STEMM (UEPH): I guess my reservation from the recommendations is that we're moving perhaps too quickly to that path, rather than transitioning into what it may look like in the future.

MR WOODS: Okay.

MR SHELDON-STEMM (UEPH): If you go to the last point, in terms of us as a provider, and you're talking about some opportunities, there are opportunities there, but there's an equal amount of dangers, if you understand what I mean. Just saying, "Look, you have an open market. You can go where you like," is fine, but dealing with the cohort that we're dealing with, are we actually going to be able to build a business which will go into the future? That's my major concern.

MR WOODS: Okay. We're certainly not wanting the industry as a whole to not be viable, because it's the industry that provides the care. But what we won't do is develop a system that protects every single individual current provider into the future. They've got to find their own way in the system, but we've got to make sure that the broad architecture is such that there is a viable care delivery that happens.

MR SHELDON-STEMM (UEPH): I think that the system of care at the moment, the actual care in Australia, is extremely consistent.

MR WOODS: Yes.

MR SHELDON-STEMM (UEPH): So what we're doing is tinkering with parts of the system. I want to go back to where we started from, and it got interesting: this Gateway. I really think you need to address - because it is the bureaucracy. Even if you change the instrument to the ACFI instrument, I can tell you it will not be administered either appropriately, timely, or in some sort of connected way for our cultural groups.

So you need to deal with that in your report: you either delete the Gateway or set up systems to allow it to be very efficient, because you hear stories all the time. I was talking to someone yesterday who has a friend who's 57 who's got MS: 35 days to get an assessment. Eventually, when they got an assessment, then they gave them a list of six places to go and look at and none of them were appropriate. So the whole entry into the system is extremely difficult.

MR WOODS: Yes.

MR SHELDON-STEMM (UEPH): And that's from a non-cultural background as

opposed to a cultural background. That's why one of the recommendations is that the government actually partners community organisations, ethnic community organisations, to overcome those issues in terms of entry somehow.

MR WOODS: Yes. We understand that point. That's quite valid and we're happy to look closely at that.

MR SHELDON-STEMM (UEPH): To look at that, yes.

MR WOODS: Thank you very much. Any - - -

MR FITZGERALD: No, that's fine.

MR SHELDON-STEMM (UEPH): All right, nothing else?

MR WOODS: We appreciate that.

MS MACRI: Yes. Thanks.

MR FITZGERALD: Thanks very much.

MR WOODS: We'll have a brief adjournment and return at 20 to.

MR WOODS: Could I ask our next participant, Erica Kurec, to come forward please. Thank you very much. Could you, for the record, state your name and if you are representing any organisation and what that is, and your position within it.

MS KUREC: Good morning. My name is Erica Kurec. I'm a registered nurse with over 20 years of aged care experience. I represent myself today and aged care nurses in my position as president of the Aged Care Nurses Special Interest Group.

MR WOODS: Thank you.

MS KUREC: And I'd like to think that I represent the people that we care for. Thank you for this opportunity to present this morning. My principal concern is that the Productivity Commission has not adequately addressed the fundamental issues facing the ageing Australian at his or her most vulnerable, in the critical stages of end of life in residential settings. I congratulate the Australian government in setting up this commission in order to reform the industry for the benefit of all stakeholders. However, aged care reform must begin and end with a spectrum of services with the vision of a frail elderly person requiring assistance with all aspects of daily life - personal, cultural, social, clinical, emotional and spiritual - so that their remaining years, months or days are lived in dignity.

The infrastructure for the provision of assistance and care services must be built around this vision, so the ageing, very, very frail person at their most frail must be the core of the vision and all the services radiating out from that.

MR WOODS: And that's exactly what we've achieved with our reforms - is our aim.

MS KUREC: Hopefully. I believe that to provide quality care as a person ages bestows respect and dignity that is the right of every ageing Australian who is a unique individual with personal needs and expectations. I'll refer to points and headings in my submission with the following remarks, so I'm actually filling out now the detail.

MR WOODS: Yes, thank you.

MS KUREC: Given the industry's present struggle to deliver quality care, I on behalf of nurses and care staff I represent recommend the following. Staffing: in order to lift the profile of aged care nursing and to attract quality educated staff who will stay in the workplace, radical changes need to be made in attitudes towards skill levels of staff employed in residential aged care facilities.

MR WOODS: Sorry, can I just clarify? Are you only talking about residential

aged care or are you talking about care of older Australians?

MS KUREC: Caring for older Australians, whether they're in the community but in a facility, but I'm thinking specifically about the people who are at the end stage of their lives, so they're at their most vulnerable.

MR WOODS: Many of whom still do that in the community, rather than in a facility.

MS KUREC: They can do that in the community but because my experience is in facilities - - -

MR WOODS: Okay, yes.

MS KUREC: Generally people nowadays, of course, are staying at home because of the services available until the last minute. Then they come in. When they come in we have to make sure that the services that they require are absolutely spot on.

MR WOODS: Yes.

MS KUREC: And so caring for ageing people who are now living longer, many with chronic medical conditions, requires expert skill. This can only be obtained by adequate education and training which is provided in a regulated and certified course of study prescribed by national bodies such as the Australian Nursing and Midwifery Accreditation Council. What we want to make sure is that there is sufficient numbers of staff on duty at all times, whether it's in the home or in the facility but specifically in the facility, and that there is a skills mix with a ratio mandated for staff to residents. This system already operates in the Victorian public aged care sector, with research showing that it works well, particularly in attracting and retaining staff.

An important component is wage parity. At present the gap is significant, yet staff that I'm familiar with do not complain even though the personal care workers earn barely more than the minimum wage for difficult, demanding and rigorously regulated work that they do, but they do it because they realise how important this work is and their relationship with residents is foremost. It's imperative that the current practice of sourcing cheap labour from employment agencies be stopped in fairness to both employee and resident.

Personal care workers must undergo training and registration as healthcare workers in recognition of their acquired specialised skills in caring for ageing people. This can be achieved in the same way as registered and enrolled nurses, creating a professional class of worker with access to a career path through further study.

Wages need to be improved and paid accordingly to skill levels obtained. It should be a requirement that carers have a good command of spoken and written English, as communication between carer and resident is crucial for effective care provision. It's also a given that good communication is necessary among staff so that correct information is given and heard, especially at handover time.

Now, resident-to-staff numbers. A resident-staff ratio is required to overcome the current system of a skeleton registered staff supplemented with personal care workers. Time is needed to give care to people with multiple deficits. People cannot see, they cannot hear, they cannot stand, they cannot walk. You can't just say, you know, "Hello, Mrs So-and-so, you need to have a shower."

MR WOODS: We understand that.

MS KUREC: You know that. Chronic conditions such as arthritis, respiratory disease, multiple sclerosis, Parkinson's - not to mention dementia: time is needed to approach these people to prepare them for daily living activities as resistance is the usual response to a hurried manner and, when a carer has eight or nine people to feed and shower and dress by a reasonable hour or when determined by resident preference, it's nearly impossible. We have to remember, too, that facilities accommodate large numbers of residents and, if there is a ratio that's more than one to six, planned care outcomes are compromised.

When a resident becomes ill or falls or some other adverse event occurs, the situation intensifies because there's so little margin for exceptional events. As nurses, we would like to see resident-staff ratios introduced and mandated so that we can actually give the care needed in a manner that's not rushed or harassed by too many pressures. Residents feel this and they often apologise when they ask for care, saying, "Oh, I'm sorry, I don't want to be a nuisance," even when that need is urgent, like needing to go to the toilet, or pain relief. Can you imagine how this must feel for a person, especially when it happens over and over again?

Now, I'm just going on to medication. Medication is just a huge and very critical component of nursing. Most residents are on massive amounts of a medication, most of which are very powerful drugs. Registered and endorsed ENs are the only authorised staff to give medications in accordance with the QUM guidelines - I can't remember what "U" stands for - and Australian Pharmaceutical Advisory Council. So why, we ask, is the current situation tolerated of PCAs administering meds when they have no knowledge of what the medications are, why they have been prescribed and what the risks are? So it's absolutely critical that we have registered staff on duty round the clock.

Now, with formal carers, as stated in my paper, certificate III in aged care over

six months or 20 weeks is the least that we require, with at least 120 hours of clinical placement supported by a mentor or supervisor. Currently people come to us that have had a few weeks of concerted training. They come onto the ward, they know nothing. They know very little and the existing staff, who are already burdened with trying to provide the care that they need to give, have to then monitor these people, follow them about, supervise them and in fact teach them what they should have been taught in the course.

This is, frankly, dangerous. People who come in in these situations, they actually do cause accidents and problems which are then - you know, multiply the intensity of the workload and also the cost to the community.

MS MACRI: Could I just ask you there: we heard from someone this morning who - I mean, we've heard this story infinitum.

MS KUREC: Yes, I know you have.

MS MACRI: The person we spoke to this morning talked about the fact that there were six RTOs within their area but they only utilised two because they knew that the other four were not sending out a well-educated person.

MS KUREC: Yes.

MS MACRI: So if there was some self-selection, would you see some of these RTOs going out of business if the industry better self-selected which RTOs they used?

MS KUREC: It depends on the provider and it depends on the management. We have people coming from a number of sources and some of them are good. You know, they're good in that they teach their students well, they send over a mentor who spends time with the student and makes sure that the student knows what they're doing before they're allowed to care for the resident, but that depends on the management. Sometimes the management really isn't as keen to follow up with these things. They just want a name on the roster. They want a body on the floor, and we have found this time and time again. I think management is much more concerned with the day-to-day running of the business and financial side of the facility and all their bureaucratic responsibilities, and they leave the concerns and issues that nursing staff have to face to the nursing staff.
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MR WOODS: But what's the role of the DON in that situation?

MS KUREC: Well, I tell you - - -

MR WOODS: I mean why isn't the DON sort of saying, "Well, hang on, I only want - - -"

MS KUREC: The DON - once upon a time "DON" was director of nursing.

MR WOODS: Absolutely.

MS KUREC: Yes. No longer. The DON has now become a manager and a bureaucrat. Really, in my experience - with all respect to the people that I've worked under, who happen to be males - it's been so long since they've practised as a nurse and they've become so embroiled in the bureaucratic processes involved in running the system, they're more concerned about that than the staff. And I suppose the more competent the staff are, the more they leave the staff to sort out their own problems. This happens time and time again. I really do believe that there ought to be a better - you know, that DONs really need to reconsider their positions because really their interests should be on the nursing side.

MR WOODS: The care delivery.

MS KUREC: That's right, the care delivery for both residents and the staff, but often - well, in my experience, and I've worked in a number of facilities and for long periods of time, too - I found that the bureaucratic process takes over and that's possibly because there's no other option. There's so much to do. In my facility there's no nurse manager. When I was on duty I was in charge, so everything that needed to be done, I had to do. I'm a registered nurse so I did the medications and, fortunately, in my facility there was a registered nurse on duty round the clock for every shift, so the registered nurse did the medications but that took me two or three hours actually, simply because all of our residents are very, very frail, very dependent.

By the time you get to them, put them in a position where they can actually take the medication, et cetera - in the meantime I've got staff coming to me and saying, "So-and-so's fallen and So-and-so's not looking too well," whatever. Then I have to initiate any doctor referral, any tests that have to be done. And then of course doctors come in right in the middle of something. You've got residents wanting attention immediately. We've got somebody who's fallen over here; there's a relative who definitely wants to speak to you right this minute. There's this going on all the time.

Now, under these circumstances it's very difficult to give the care that you want to give according to the needs, and the only time that I can actually talk to a resident is when I'm doing wound care because during medication they've got a spoonful of tablets in their mouth and they can't respond to me. But in wound care

it's the only time that I can actually talk to somebody and get their response, because I'm so busy doing everything else, let alone the documentation. Never going off duty on time, always spending at least an hour - and, as another nurse spoke on Monday, this is unpaid overtime. I probably work one day a week for free for a facility, and I just want to bring in a concept which you may have actually heard of. It's called "sacrificial mothering" and it's something that I think the nursing profession has depended on for a long time: expecting women to work above and beyond their means - well, do maximum work for minimum resource.

MR WOODS: And then do more.

MS KUREC: However, I'll just get back to my paper now. The thing that leapt up from your draft report was - yes, we've talked about the clinical placement and everything - haven't I? In the draft report it states that, "Personal care needs associated with ADL, such as showering and feeding, do not generally require a high level of skill or expertise." Well, I disagree completely. Residents get very upset and agitated if they're approached by somebody who is not confident in attending such personal and intimate needs, such as showering. Imagine a naked frail elderly person at the mercy of some stranger.

MR WOODS: Sorry, that's a misinterpretation of the phrasing that we used. We were talking about clinical skills, not personal skills and care skills.

MS KUREC: Yes, but showering and feeding - - -

MR WOODS: I mean, we understand the point, so I wouldn't pursue - - -

MS KUREC: And, as the gentleman spoke before about cultural sensitivities, the cohort of people who we're looking after now are people who are in their 80s and 90s now. They're very, very sensitive to personal exposure of any kind.

MR WOODS: Yes, fully agree.

MS KUREC: Maybe the baby boomers won't mind prancing around without any of their clothes on, but - - -

MS MACRI: I don't know about that.

MS KUREC: However, this is why it's really important for staff to know exactly what they're doing. As to feeding, an unskilled carer can cause choking, pneumonia through aspiration and ultimately death if they don't feed the person properly. I've seen staff giving fluids to people who are lying flat in the bed and I suggest an experiment to them, which is something that you might want to try sometime; next

time they're lying down, to swallow fluids. It's impossible. It's impossible.

MR WOODS: We understand.

MS KUREC: So there is great skill involved in caring for an elderly person. The industry specifically and society generally need to recognise this if reforms are to be seriously addressed. Now, the workload issues: excessive workloads have implications and consequences in every area of aged care in a facility. Staff become exhausted, take sick leave, leave through burnout or dissatisfaction, leading to high turnover, agency staff, staff shortages. Providers are forever recruiting, paying for agency staff, and they're always reminding us that there's no money for staffing and extra costs associated with less than optimum care outcomes, such as wound care.

For the residents, staffing stress and shortages increases anxiety, agitation, behavioural issues, falls, skin breakdown causing pressure areas and wounds, and wound care, associated pain and cost, poor nutrition and hydration, weight loss, omission of planned care provision such as exercise, immobility leading to mobility decline, urinary tract infections, clinical deterioration, hospitalisation. So there's this sort of downward spiral, so the money saved by not employing skilled staff is then actually pushed out into the community.

Increasing admissions of residents for palliative care: we're now finding that all our new residents, or a great number of our new residents, are coming in for palliative care and end-of-life care. They come in from hospices and they've gone from home to the hospice and they've come to the nursing home to pass away their final days. When they come in with cancer or a COPD, they require intensive nursing care, so it is a sort of situation where you're already busy enough with the existing residents, and then you've got this person who requires full - it needs one on one, and in a very careful and considered way, because this person is coming to the end of their life, and they're in great distress. They need medication. They need a lot of supervision, and they need skilled staff to provide this care.

Not only do you need to provide the care to the resident but you have to involve the family as well, and that sometimes actually takes more time, so it's really critical that registered, trained staff are on duty around the clock, so that the proper care can be given.

MR WOODS: I'm conscious of the time. Are you able to come to your final points, because we have to - - -

MS KUREC: Okay, sorry. Yes, the final point. Anyway, we feel that the Aged Care Accreditation Agency is really not as supportive as it could be, and what it could do is actually take into account the provision of resources required for what it

demands. It sets the standards and outcomes, but it needs to provide the resources. They come in, they see, they look at the documentation, but they don't see the conditions under which people are trying to give the care.

I also think that ACSA, contrary to probably the ANF, is actually in a position to set staffing ratios, because care for advanced complex care needs are universal, whether it's in the Northern Territory or in Victoria, and we've got a lot of documentation already. There's a lot of data already from ACFI, from RCS and everything about what people need, so the resources ought to be very easily determined, and they really need to be factored in and mandated. Also I think that the new Australian Aged Care Regulation Commission can only fix the price of care if there is a mandated staff-resident ratio because how on earth are they going to fix the price of care if they're going to leave the staff provision to facilities who - - -

MR WOODS: Yes. They will need to have a view on what is the skill mix required to deliver that care.

MS KUREC: Well, as I say, it's important to realise that - well, once again, with the universal needs, and plenty of evidence of it, there shouldn't be any problem.

MR WOODS: Although the ANF is doing its own work in this area to try and expand on that.

MS KUREC: Yes, good.

MR WOODS: We're across all of that and we're looking - - -

MS KUREC: Good. Well, they're representing what nurses are - - -

MR WOODS: Yes.

MS KUREC: From our experience, our knowledge and experience over the years.

MR WOODS: Yes. We are working with them in that.

MS KUREC: In conclusion, I believe that unless the workforce issues are addressed, genuine reform of the aged care industry will not eventuate. The commission needs to recognise that caring for ageing people with multiple needs needs skill and expertise, and must ensure that any new system will enshrine registered nurses including practice nurses, enrolled nurses as well as properly-trained registered health care workers who are accordingly remunerated, with a provision of further study and skill development. The recruitment and retention of staff to give quality care will follow, as the industry gains a more

favourable profile. Even though people are coming into residential care at later stages, with all the attendant needs and conditions, it is imperative that resources such as funding for registered staff, skills mix and staff-resident ratios are mandated so that, as we age, our welfare is guaranteed.

MS MACRI: Thank you.

MR WOODS: Thank you very much.

MR WOODS: If I could ask for the next participant, Deborah Knapp. Thank you very much. Could you please state your name and if you are representing any organisation.

MS KNAPP: My name is Deborah Knapp, and I'm representing myself. I do work currently in a private organisation, but I have mostly extensive aged care experience with agency work and have just been in this position for a year, where I'm working now.

MR WOODS: Thank you.

MS MACRI: Can I just clarify: are you a registered nurse?

MS KNAPP: I'm a registered nurse, yes, and I work as a charge nurse. I was asked just to give a couple of pages of written - - -

MR WOODS: Which we have received, thank you very much.

MS KNAPP: Yes - of things that I have experienced in aged care. One of the issues that I basically find in the large facility that I'm at, which is a 192-bed facility, is that when they're running short of staff - we usually have three RNs in the afternoon shift, and there will be one of us - they will not employ agency staff to support you, because they say it is hard to orientate agency staff for the shift. You're better off without them. Now, when I worked there initially six years ago, my first shift there was by myself as an agency nurse, so that argument is out the window, but they still make you work just one to 192 people, which is a heck of a load when you've got the staff, and you've got any other problems that can arise. You have to also deal with doctors, of course, and families and issues. Luckily not too many dramas happened at the time.

One other area is of great concern in that facility at night. It is divided into five sections at night, and they have basically two staff per section - PCAs. One dementia section has just one only which we are trying to get a second person there for safety reasons, but in what used to be the low care area, now with ageing in process has more high care people.

MR WOODS: Higher acuity.

MS KNAPP: Yes. Often there is just one staff member there at night on their own, and they are still expected to do the in-house laundry for the other facilities at night - very unsafe, leaving that person away, unable to attend any residents when they call for bells and things like that.

MS MACRI: How many people in the low care section?

MS KNAPP: 51. And it happened again last night.

MR WOODS: They wouldn't have been low care by now.

MS KNAPP: Last count there were 47 high care, and the rest were low care. Even your low care people still need some attention.

MR WOODS: Yes, absolutely. Yes.

MS KNAPP: And they get very angry if they're ringing their bell for ages, and this one poor nurse can't get to all of them. They try and use the supervisor who is on at night. There's only one supervisor to help, but you cannot be there as well. I also work day duty and cover the night duty shifts as well, when the two regular night duty staff go on leave. I had a discussion with the night duty nurse last night. She's basically fed up with the way things are going, and said she would rather have two RNs at night, and even take some of the floor, so she's going to approach the manager and see if she can get something done about that. That's the first time she's actually spoken to me about her being unhappy with being just one person there at night. So that was another issue at night. You're just one there at night.

MS MACRI: Yes.

MS KNAPP: Yes. So what people do with this particular section is they just drop the shift, and they'll often pick up a job elsewhere in another facility to cover the loss of money, and we lose good staff. So that's their answer to that. They often have staff moving during the day on a regular daily basis from one section to another, which makes them very unhappy. When I talk to them, they say they would like to stay in an area for a month, get to know the residents, and then move, because the policy is you have to know the whole facility. Well, you can't do it by sending a different person and it's very hard on the resident to have a different person who doesn't know them.

MR WOODS: Absolutely.

MS KNAPP: This is where we get our skin tears, our falls, all these sorts of things that happen because you've got rid of the staff, and they do not have time to read the care plans. There are 20 care plans to read. If they're only there for one day they're not going to have a chance to do it. They're told, "Read the care plans," and that's their handover. It can't work and it doesn't work. So the staff become disgruntled, they move on. The wages for the PCAs are really quite poor, as we've already said, and some of the staff work two, sometimes three different jobs, to get a reasonable

income for their families. This puts a strain on their family relationships. Their children miss their parental guidance and couples have a strain on their relationship as well.

But, also, there's no loyalty to the one facility because they can take a sickie at one of them and they've got their two other jobs anyway and it doesn't matter if they've missed one shift at one. So the checks and balances of ours or the couple of facilities where they're at - they're also getting the sickies coming through. The policy of avoiding the use of a regular agency is an issue because, if you have regular agency who come to the place, they get to know it quite well, they become a backup for the staff and they know the residents, and you can often get the same people coming backwards to you - often and frequently, which is what happened to me as I was working eight years of agency work in the western suburbs with aged care, often going back frequently to the same place for six or seven weeks at a time, and it was good continuity.

MS MACRI: Got to know the place, yes

MS KNAPP: It worked quite well. I also believe that we should license our PCWs and have them registered and then they would be accountable for their actions. Everything at the moment is that they can just pass the buck and, if something happens, report it to the RN, write it in the notes; often don't even tell you they've done that, so you can't follow up what's happened. Then someone picks the folder up and reads the notes and says, "Hey, this has happened. What did you do about it?" if you weren't even told about it in the first place, you can't act on it. So you've got to rely on your staff.

We've got a lot of things. I did one shift last night - one shift in the middle of the week. I had personality clashes with two staff members who have worked together for five years, who are normally friends, that had a falling out, so I had two screaming - at different times - down the corridors. I'm pulling them into the office at separate times, spending my night counselling my staff, which is part of my job, and had one threatening to walk out. The policy is there, if you walk out you walk out of your job, so stop and think about what you're doing, and we resolved the issue. But these are the sort of things that come up that are not part of any process to show that that's what you do in your job, but they do occur.

We have a lot of people at the end stage of their life and handling the families - which is a very rewarding part of our nursing life - and to do that well is very, very rewarding at any time, day or night. So I would just encourage the nurses to get on board and to learn as much as they can. We are, in our facility, taking on cert IV - the certificates have started.

MS MACRI: Great.

MS KNAPP: So that will be great.

MR WOODS: That's very good.

MS MACRI: Yes.

MS KNAPP: We have a number of div 2s, or ENs they're called now.

MR WOODS: Yes.

MS KNAPP: They're fantastic and that's improving our load. When there's been no RN available to work - and this has happened when I've worked agency as well - I've been asked to do a double shift. I hope it doesn't happen too often. My husband doesn't like it.

MR WOODS: I can understand that.

MS KNAPP: And you don't get any extra money for doing it, but it's your duty of care. You have to have an RN there. I've also had first-hand experience of facilities that have no RN on duty and so the EN is in charge at night mainly and the RN is to be contacted by phone if there's any issues. Often that person doesn't like being woken at 2 o'clock in the morning or sometimes they don't even answer their phone, so you don't have the backup.

But, anyway, apart from all these issues - I may seem to have given you a negative outlook - it's vital to have favourable working conditions to retain experienced staff of a mature age and I find aged care nursing is a rewarding career.

MS MACRI: Thank you.

MR WOODS: Thank you very much and we share your sentiments about the rewarding career.

MS MACRI: We're pleased we've got passionate nurses out there looking after things.

MS KNAPP: I'm a member of the ADF nurses group and we have - what's our motto, Erica, passion?

MS KUREC: Passionate about caring.

MS KNAPP: Passionate about caring.

MS MACRI: That's great.

MR WOODS: Absolutely. Thank you very much.

MS MACRI: Thank you.

MR WOODS: Elizabeth Brooke? Thank you very much.

PROF BROOKE (SU): Thank you.

MR WOODS: For the record, could you please state your name and whether you're representing any organisation.

PROF BROOKE (SU): My name is Elizabeth Brooke and I'm director of business work and ageing, Centre for Research at Swinburne, and an everyday consumer as well.

MR WOODS: You have an opening statement you wish to make?

PROF BROOKE (SU): The reason why I came today really was to talk about chapter 11.3, "Delivering care to the aged", and I'm interested in the formal care workforce, and you have a term of reference which is, "Systematically examine the future workforce requirements of the aged care sector." I don't have to go through it; you know it.

MR WOODS: We do know it.

PROF BROOKE (SU): What I'm really keen to get across is that there is a need for an active approach to workforce planning and you need, rather than - yes, there are recruitment and retention issues which I'll talk about further, but in fact there needs to be a workforce development framework and I'm not sure whether there's an exclusive one, but one which sets targets and which has a methodology behind it, which is a quality assurance methodology which you can test before and test afterwards.

So that's really my mission. Martin and King, as you know from their book, report that 70 per cent of community care aged staff and 60 per cent of residential care workers and 40 per cent of new recruits are aged 45 and over. So I'm very much interested in workforce ageing and in models to retain the older workforce, so that is reason again for my interest.

MR WOODS: Just on that, that's an interesting point because people often remark on the demographic and say, "Look, we have an older population who are doing aged care, and when they all retire in the next 20 years there will be nobody coming in," but in fact a characteristic of this workforce is that people come into it in those older years.

PROF BROOKE (SU): That's right.

MR WOODS: So it's self-replenishing within that older group.

PROF BROOKE (SU): Exactly so.

MR WOODS: And that's a whole different perspective to saying, "Oh my goodness, they're all going to exit and there's nobody underneath." So picking up that point, it's very important to understand this workforce.

PROF BROOKE (SU): Yes, absolutely, and I think also there's better use and utilisation of the existing workforce, so you improve their workability and their employability, and I'll talk about that a bit more.

So there are some issues around quality of care, and I think that there would be a brilliant project looking at this, because I think that the quality of the workforce is integrally related to the quality of the care, and some quite interesting productivity associations could be made there. But also there is the unreliability of the core staff, agency staff complement. What's happening is that nursing homes are more and more relying on the contingent labour force, and there are issues around transfer of knowledge, of familiarity, of care, knowledge of the working environment; there's so much time in handover and administration, we're reducing this for care, because the outsiders have to be brought into the organisation.

MR WOODS: Sure. You mentioned or you just said an increasing reliance on the contingent workforce, ie agency staff.

PROF BROOKE (SU): Yes.

MR WOODS: Have you got some actual hard stats on the proportion of shifts covered by agency versus the facility's staff and what those changes are over time?

PROF BROOKE (SU): I'll have a look at my data and send it to you.

MR WOODS: Because that would be quite fascinating.

PROF BROOKE (SU): Martin and King say that 38 per cent of agencies use agency staff.

MR WOODS: True, but it's the longitudinal issue - - -

PROF BROOKE (SU): The longitudinal one, yes.

MR WOODS: - - - as to what's happening over time that would be quite interesting.

PROF BROOKE (SU): I think so. I think there's a - - -

MR WOODS: Yes. We've sort of got a lot of anecdotal evidence of well-managed facilities - - -

PROF BROOKE (SU): That don't use - - -

MR WOODS: - - - where you go and say, you know, "And what's your agency staff?" "Oh. Well, yeah. No, we did actually have to rely on one, you know, a couple of months ago because of this particular circumstance."

PROF BROOKE (SU): Yes.

MR WOODS: But as a general rule they have their regulars, and they have a pool of others that they draw on but who know the facility and who maintain contact; and yet others, their agency staff utilisation is very high, and all their high turnover and handover.

PROF BROOKE (SU): So we know that the costs of the agency staff are much higher.

MR WOODS: Absolutely.

PROF BROOKE (SU): So there are productivity issues there, but there's sort of in-built breakdown in these systems because what they say is, "We're basically permanent staff," and yet those inconsistencies - I think it's a very interesting project to track.

MR WOODS: Absolutely.

PROF BROOKE (SU): I'll see whether I've got something over a year on that change.

MR WOODS: Yes.

PROF BROOKE (SU): Also, there are ambiguities around recruitment, but certainly DEEWR say that significant staff turnover in aged care work has been reported, forming 98 per cent of the reasons for recruitment. That's just a DEEWR statement because there's an ambiguity in the literature around whether in fact there is a labour shortage, and it's complicated by all sorts of things, even by the statistics and how they're collected, and which groups they cover, and the ABS - all that stuff. The ABS categories don't do it. Carers of the disabled are included with aged care,

so there are some issues there.

MR WOODS: You would have seen in our report how we struggle to try and pull stuff apart, and to - - -

PROF BROOKE (SU): Yes. I think the ABS needs to do something with their work on it - sorry, and the - - -

MR WOODS: You're allowed to say that.

PROF BROOKE (SU): You're not, are you?

MS MACRI: Yes, and you're absolutely correct. I mean, there have been some attempts through the NILS report and especially around aged care again, but it's - yes.

PROF BROOKE (SU): You spend a lot of time trying to break it down and look at what happens.

MS MACRI: Yes.

MR WOODS: Good luck.

PROF BROOKE (SU): Okay. I'm going to have to move because I don't have that much time.

MR WOODS: Please, that's all right. Keep going.

PROF BROOKE (SU): All right. So I've been funded - I've got a workability aged workforce development framework. I've been funded. My project is called METEOR - Matching Employees to Training to Ensure Ongoing Recruitment and Retention. It's on the web under meteorworkability.com.

MR WOODS: Give us the link. We'll chase it up.

PROF BROOKE (SU): Okay. It's been funded by VicHealth for five years and by Wicking, which is an ANZ trust, so they've actually put substantial dollars into this. Wicking was trials of more effective means of recruiting, training and retaining aged care professionals, so in fact this is the last year of the project. Year 5 finishes this year. So, anyway, I'm trying to develop an auspice which actually includes WorkCover and includes aged care agencies and health, and that's what I'm developing. So it's based on the workability framework developed by the Finnish Institute of Occupational Health which has been applied in Finland since the mid-80s

- FIOH. Prof Ilmarinen I've been working with for many years.

Basically, what is workability? It's an evidence based measurement which refers to the balance between an individual's capacities and resources and the demands of his or her work. It's a multidimensional concept, and it goes into workforce retention far beyond occupational health, so it's multidimensional. There's a house which I could have brought actually - a house model. It's got health and lifestyle on the bottom, which is significantly responsible for effects in high workability. There is training and competence on the top of that. Above that there are values and attitudes, and above that there are work structures which are the leadership, which is the work schedules, which is the organisation of work, which is the mix between staffing, the use of teams or whatever organisation. So it's a model.

I've been using workability index which is the Finnish index. It's a quality assurance tool which measures subjective perceptions including current workability, lifetime best, expectations of workability two years from now. It's got health indicators, diagnostic indicators, mental health and physical health indicators. It's a validated tool which is used internationally in other areas, and I took the tool and I applied it in aged care, so I've actually adapted it. But we're talking about an international network of people using this tool, and modifying it.

MS MACRI: So is that tool being used at the moment, or have you piloted and trialled and - - -

PROF BROOKE (SU): Yes. Trialled it and piloted and validated it statistically, and basically applied it within a setting, and I have a sort of evidence based outcome, so I for example have presented to aged and community care workforce taskforce in Victoria; Health Innovations. People ask me to come and give talks on this, and I have a PowerPoint display which I generally show with statistical sort of validation of changes in workability, which I'll get to.

MR WOODS: Can you email that to us?

MS MACRI: Yes.

PROF BROOKE (SU): Sure.

MR WOODS: Mark will talk to you afterwards and you can sort out links.

PROF BROOKE (SU): Okay. It's embedded in an organisational survey which is multidimensional, so a lot of it is from European Union validated instruments, Scandinavian instruments, and it looks at emotional demands. It's very comprehensive. It looks at workplace control, autonomy, leadership. We've

embedded the workability index in it, so if you're looking at aged care as a work organisation, we're really looking at, well, what are the factors that predispose to retention, or to early exit in aged care employment?

So in the workforce development project, basically I've actually got training which I've developed, the workability index and that comprehensive survey administered pre and post, and a set of interventions. So when I say "active" it's going to be variably implemented in different organisations; for example, we're not just saying, "Well, it's going to be health intervention in weight reduction or exercise." It's going to be generated by the diagnostic tool, but also it's going to lead to an intervention and an outcome. Catholic Homes, for example, are proponents of this. I've worked in a facility there, and they're extremely keen. They've written to government ministers about this, and they're a very large organisation. They promoted it. I don't need to promote it. But other organisations are also using it too. I mean, I can go on and on about it. I'm using it in unemployment as well.

MS MACRI: Yes.

MR WOODS: We'll follow it up.

MS MACRI: We'll follow it up, yes.

MR WOODS: So I've written an article in an academic journal which I'll leave.

MS MACRI: Great.

MR WOODS: Thank you.

PROF BROOKE (SU): Yes. So the case study has got 70 high and low care beds, and in the initial - we identified factors in low workability. These factors in low workability were working beyond mental and physical capacity, which are items in the questionnaire; being stressed, items in the questionnaire - these are all statistically significant - and there were factors in high workability which were to do with respect and self-esteem and colleagueship and work as a community. So there were a lot of positives which were positively related to mental health in that organisation, then there were the negatives.

MR WOODS: Sorry, just before you go on: you applied this all the way down through RNs, ENs, personal care workers?

PROF BROOKE (SU): Yes.

MR WOODS: Starting with the DON, or starting with management if it wasn't

the DON?

PROF BROOKE (SU): Everybody, and qualitative - - -

MR WOODS: And then you stratified the different results according to their position and - - -

PROF BROOKE (SU): The Finnish Institute, it's not an individualised - it's not a case management - - -

MR WOODS: No, but whether there are - - -

PROF BROOKE (SU): But, yes, you're asking a more - - -

MR WOODS: Sorry, you pick up.

PROF BROOKE (SU): A more penetrating question is different strategies for different groups.

MS MACRI: Yes.

MR WOODS: Yes.

PROF BROOKE (SU): In a very large organisation - or if you were doing it cross-sectionally across organisations - you might take out the DONs and apply it across nursing homes. You know that the DONs are going to be under time pressure; they're going to have a high pace of work; they're going to have conflicting demands because they do both organisational and instrumental tasks.

MS MACRI: Yes.

PROF BROOKE (SU): Yes, so there's all that stuff, but - - -

MR WOODS: That's why they get paid.

PROF BROOKE (SU): It is, at that high rate relative to the rest of the health sector. But I think one of the things about it is its privacy, its confidentiality. In Finland it's being used because it's potentially non-adversarial. In Australia we have ethics requirements whereby there's confidentiality; it's presented as an aggregate report. So we actually write an aggregate report to protect individuals so that we don't - all that stuff.

MS MACRI: Yes.

PROF BROOKE (SU): So some of the interventions - and these were the ones that did not exist before the survey - more staff hours, organisation of workloads, and we're looking at things that combat working beyond mental and physical capacity: more staff hours on the rosters, a.m. and p.m.; increased numbers of PCAs in high care, to allow working in pairs, teams of two; increased staff from 3 o'clock; reorganising workloads and roles based on PCA feedback. So there was that sort of cluster. We tried to see whether we were going to get significance in those clusters.

Ergonomics: seriously, they didn't do the range of things. What could you do? I think you could do ergonomic design stuff. They did task rotation to vary demands, workplace design. It wasn't a strong element. Training refreshers: there's a whole lot of compliance training that was done, and the workability training they did - and they all really liked that of course. Management appreciation and respect: they gave awards, they gave subsidised meals, they had outings. Relationships between staff: they did empowerment of PCAs in relation to nurses. They had training in that - which is quite interesting, because there's a lot of - how would I say it? - relationship tension between levels of training and types of work. I don't know whether I heard that person talking about it, but there are training solutions and interventions.

So when you compare the workability index - we did the entire survey, that huge comprehensive survey, before and after - we needed a much larger sample to get statistically significant differences across, because we had a lot of items.

MS MACRI: Yes.

PROF BROOKE (SU): But we found that if you aggregate the WAI against the before and after it increased by four units. So it actually moved from sort of moderate to high/moderate - what was it? - from about 29 to about 32 or 33. That was quite a good result, because internationally the research often doesn't show such a clear advance. So we see that. The interventions we've combined to see - - -

MR WOODS: Sorry. Is that a consequence of the low base that we're starting from relative to international, or a consequence of the importance of application of the index and the subsequent work change? I mean, a change can be for all sorts of reasons - - -

MS MACRI: Yes, it is.

PROF BROOKE (SU): 200 per cent on one or - - -

MR WOODS: Yes, right.

PROF BROOKE (SU): It can be, yes. It can be all those things.

MR WOODS: Yes. Move on, thanks.

PROF BROOKE (SU): First of all, there are ceiling effects in the use of this in Australia - - -

MR WOODS: This is fascinating stuff, but I should explain to you - - -

PROF BROOKE (SU): Okay.

MS MACRI: Yes.

PROF BROOKE (SU): It's a complicated answer, so I can't give it - - -

MS MACRI: Yes.

PROF BROOKE (SU): So the interventions implemented were a statistically significant association between increasing the numbers of PCAs in high care and high WAI. It makes sense.

MS MACRI: Yes.

PROF BROOKE (SU): If you put more people on the floor - - -

MR WOODS: Intuitive.

PROF BROOKE (SU): That wasn't the only thing. They did massage and Tai Chi. They did all of these other things. Other organisations internationally, they do things like exercise programs for two weeks, walking - we've done this too in another organisation - pedometers, measuring BMI and waist circumference. But the thing about these interventions are that they're narrow - and walking doesn't solve organisational stress through pace of work. I suppose my underlying message is that any intervention or workforce development needs a multidimensional framework which is linked with quality assurance. I'm actually working on a steering committee in South Australia, Aged and Community Services South Australia.

MR WOODS: ACSA.

PROF BROOKE (SU): They started, last year, a project using workability, but they're doing it - this is organisationally situated. They're starting to do some work, which is great. But I think what we're looking at here is a model which is - how do I say it? It's an organisational model - - -

MS MACRI: So are you doing that with a specific aged care organisation besides ACSA South Australia?

PROF BROOKE (SU): I'm just on a steering committee there.

MS MACRI: Right.

PROF BROOKE (SU): I'm basically working here with Catholic Homes.

MS MACRI: Yes.

PROF BROOKE (SU): But I've got a sort of retinue of other organisations to work with. I'm very keen this year to lift the model.

MS MACRI: It would be good to get some comparative data outside of the one organisation you're working with.

PROF BROOKE (SU): Exactly.

MS MACRI: Yes.

PROF BROOKE (SU): When I presented to Aged and Community Care Victoria there were a few there who were keen. There are quite a number of them. I've just been busy.

MS MACRI: Yes.

PROF BROOKE (SU): But it's an undertaking, because it's an in-depth project; each one is a project. No, I agree. So just about productivity: we know that through ageing, people's workability is going to decline. You have to do something. So the finished data shows you that of 5000 people, people 70 to 74 years have limited workability; 80 per cent of them do, whereas only 10 per cent of them do at 40 to 44. Something needs to be done with an older workforce. It can't remain - how would you say it? - a doing nothing option. So they've done a cost-benefit analysis based in Finland. It was applied to 200 companies of various size from various branches, and there was a cost-benefit ratio of between three and 10. That's in Finland. But they measured reduction of absenteeism and reduction of work disability and an increase in productivity, however they measured it.

I wrote an article for the International Journal of Manpower in 2003 based on the Department of Human Services Victoria, and I did a cost-benefit analysis of mature-age workers which adds up the costs of recruitment and training, absenteeism

and workers compensation. So for every older person who leaves we talk about replacement cost - and that's in the International Journal.

MR WOODS: Good, thank you.

PROF BROOKE (SU): And I know some banks are using it, so - - -

MR WOODS: Yes. Well, again, Mark will pick up that.

PROF BROOKE (SU): So, in conclusion, the submission proposes that a systematic workforce development and quality assurance framework, based on the Finnish Government workability program, be implemented to recruit and retain a supply of the predominantly older aged care workforce.

MR WOODS: Thank you,. That was fascinating. We will pursue - - -

PROF BROOKE (SU): Okay.

MS MACRI: Yes.

MR WOODS: So if you could talk to Mark.

PROF BROOKE (SU): Okay.

MR WOODS: If I can have a break for one minute and then we'll bring forward our next participant.

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

MS PETROV (CCDA): I'm Ljubica Petrov from the Centre for Cultural Diversity in Ageing and I'm the manager of the centre.

MS GUCCIARDO-MASCI (CCDA): And I'm Tonina Gucciardo-Masci, and I'm the project officer. I'm working with Ljubica at the centre.

MR WOODS: Excellent. Talk to us.

MS PETROV (CCDA): Thank you for the opportunity to be here today and to provide our feedback to the draft report. We have submitted an initial paper and have now come to make some comment on the nature of the way special needs groups are being addressed in the draft report, and specifically I would like to make comment in relation to the non-English-speaking background special needs group.

Firstly, I would just like to highlight our positive response to many of the recommendations and many of the issues that are addressed in the report; namely, the need for interpreting services to be introduced and cultural awareness training, culturally appropriate assessment tools which are also mentioned, and looking at how more effectively staff with bilingual skills - how those bilingual skills could be more effectively utilised in aged care services. So those were the real highlights for us.

One of the areas that we did want to make comment on is the way the report discusses the special needs groups and the way it defines special needs groups, which is a bit of a concern for us. For example, in general exploration of how aged care services need to address the needs of the elderly, especially in the framework for assessing aged care, what is highlighted is person-centred care, people's needs to be able to make choice and to have control of their lives, for people to be treated with dignity and respect, and for ease of navigation of the aged care system. Those are really vital areas that I think need to be explored; how they impact on all special needs groups.

What has happened in the report, I think, the special needs groups are covered in an additional chapter, while in fact I think what might have been a bit more beneficial is for the special needs groups to be actually considered across the whole of the report.

MR WOODS: Just on that, we're assuming that a lot of the reforms that we're proposing will benefit those groups anyway, so we didn't see the need to keep saying, "And of course this will benefit people with cultural diversity or whatever," so we didn't sort of keep adding that layer but what we tried to do is say, "What else do

these groups need?" If you feel that there's a need to sort of keep reinforcing the message through the rest of the report, that of course this applies to and will benefit people with cultural diversity or linguistic needs or whatever, we can do that, but I'm not sure it adds a lot.

MS PETROV (CCDA): I don't necessarily mean that for every recommendation that's made across the report we need to say "and people from culturally and linguistically diverse backgrounds". I think an overarching statement about the fact that for people from culturally and linguistically diverse backgrounds all of these areas that are important for all elderly people are as important and they need to be - - -

MR WOODS: Yes.

MS PETROV (CCDA): And the reason I think it's important to emphasise that is that currently people from non-English-speaking background and their needs actually are quite often considered as not within the - - -

MR WOODS: As marginal, not mainstream.

MS PETROV (CCDA): As marginal anyway.

MR WOODS: Which we don't want.

MS PETROV (CCDA): Which we don't want. So, for example, in residential care, unfortunately their needs are predominantly considered in relation to standard 3.8 in relation to lifestyle. However, the sum of a person's needs and who they are permeates across all of the standards and is of consideration across therapeutic standards. That's what I was trying to say there.

MS MACRI: Yes.

MR WOODS: Yes, we can understand that.

MS PETROV (CCDA): Okay, so one of the specific areas that I wanted to make comment on is I think a slight bit of confusion in the way the report defines special needs groups and culturally and linguistically diverse special needs group. According to the Aged Care Act, the culturally and linguistically diverse special needs group refers to people of non-English-speaking background, and yet here in the report, in the draft report, it also mentions younger people, people with disability and LGBTI community as well, as well as older refugees. I think sometimes that causes confusion as to which group one is speaking about and what their needs are. I think that one can also then explore so many more groups.

So what I want to say is that all of these groups might require to be considered as a special needs group but under the culturally and linguistically diverse backgrounds it would be clearer if we stuck to the Aged Care Act's definition.

MR WOODS: We'll contemplate it.

MS MACRI: What were your thoughts around that? One of the things that's come up over the three days is in fact some people from CALD backgrounds have said they're not really special needs, they're additional needs and they're part of general society with some additional needs, as opposed to being seen as special needs purely and simply because they're from a CALD background.

MS PETROV (CCDA): I think the special needs definition comes more not from people being special and different; it comes from lack of access to services and under-utilisation of services. So I guess if the special needs definition prompts initiatives, that will enhance access to services and to more culturally appropriate services.

MS MACRI: But if additional needs and cultural diversity were used, would you see that as picking up? I mean, I don't - Mike might not agree or agree, but I'm not quite sure that we want to, in terminology, be just constrained by the Aged Care Act.

MR WOODS: No, absolutely not.

MS PETROV (CCDA): No, exactly.

MS MACRI: Because obviously the reforms are going to require substantial change to the Aged Care Act, and we certainly don't want to just be constrained in terms of terminology with the Aged Care Act, so some thoughts around some of that from yourself and your organisation would be - - -

MS PETROV (CCDA): I can give it more thought, and maybe get back to you.

MS MACRI: Yes.

MR WOODS: Let's assume the Aged Care Act gets pulled apart - - -

MS PETROV (CCDA): Okay.

MR WOODS: - - - and we don't keep the sort of terminologies and structures and rigidities that are in the act, but we try and address the needs that are presented by people.

MS PETROV (CCDA): Okay. Then, perhaps looking at if from the perspective of person-centred care and defining someone as part of a community.

MR WOODS: Absolutely.

MS MACRI: Yes.

MS PETROV (CCDA): One can keep defining all sorts of communities and groups as a special needs group, because of their belonging to that particular group, be it based on ethnicity, religion, sexual orientation or anything - have particular characteristics. But I think it's really important to ensure that the person-centred care is more emphasised in relation to, and be inclusive of all of those members of those different groups.

MS MACRI: Yes.

MR WOODS: Yes, we agree.

MS PETROV (CCDA): So you agree.

MS MACRI: Okay?

MS PETROV (CCDA): Good, okay. So my next point is the fact that people from non-English-speaking background, and this might just seem like a bit of an exercise in semantics from my perspective, but I would like to make this point. The lack of access to aged care services, or the lack of information in relation to aged care services is kind of attributed to their lack of proficiency in English. I would like to see a shift toward the cause being lack of information being made available in languages other than English, rather than people's lack of proficiency in English.

MR WOODS: Yes - not that they have to access it in English, but that the information is provided in a language they can access.

MS PETROV (CCDA): Yes, so that shift is made because that way people will then say, "Oh, we need to provide information in languages other than English," rather than say, "We can't do much about this. They don't speak English."

MR WOODS: No. Can I just raise briefly, and I know we've got time constraints, but an interesting point is that quite often the statistics which demonstrate that people from cultural and linguistic diverse groups are not as represented in, say, resicare, is because their communities are stronger and tighter, and prefer to assist them at home. To some extent, there's some truth in that,

particularly for certain cultural groups, but the other side of it might be that that's a consequence of them not having the information and knowledge and access to services.

MS PETROV (CCDA): Exactly.

MR WOODS: So some of the statistics might in fact be being misinterpreted as saying, "Well, they want to stay at home even more so than do those who mainstream speak English."

MS PETROV (CCDA): Yes, exactly.

MR WOODS: So there's an interesting little tension in that.

MS PETROV (CCDA): There is. One of the points that I have made, and I've left the paper with the gentleman out there - - -

MR WOODS: Thank you.

MS PETROV (CCDA): - - - is lack of data, and lack of evidence based research to explore those issues, and it is known that people from a non-English-speaking background access specifically residential care at a crisis point.

MR WOODS: Yes.

MS PETROV (CCDA): So it is really not part of their decision-making - - -

MS MACRI: Of the journey, yes.

MS PETROV (CCDA): - - - not a continuum. It is a crisis, so I think that there is some - your point.

MR WOODS: Excellent, so we'll pursue that on the paper.

MS PETROV (CCDA): We agree, okay. The next point that I wanted to make was in relation to the way the draft report discusses ethno-specific and mainstream services. There seems to be an assumption that somehow ethno-specific services are preferred, and they might be in some cases, but also that it's with those services that the expertise lies for the provision of culturally-appropriate services. We would like the commission to consider the need for all services to equally be addressing the challenges proposed by, you know, non - - -

MR WOODS: Number 3.8, they should, but - - -

MS MACRI: Yes.

MS PETROV (CCDA): Well, a very small number. In Australia there are 2780 residential aged care services, and only 31 are ethno-specific. So to give such high prominence as the report does, especially in the discussion, in the special needs section, to ethno-specific services, I can't - - -

MR WOODS: As distinct from mainstream services that have clusters or even in some cases just individuals of particular cultural or linguistic backgrounds.

MS PETROV (CCDA): Clusters is a model that is more kind of utilised or implemented in various states, and in others it isn't, but most aged care services, I would say in 2011 would have one, two, three - - -

MR WOODS: Absolutely.

MS PETROV (CCDA): - - - or many people from culturally and linguistically diverse backgrounds, and the same number of initiatives need to be implemented, be they for one or 20.

MR WOODS: Yes.

MS PETROV (CCDA): I think other people - I've been listening to some of the other presentations - have highlighted the lack of data or research available, and in the area of the needs of the non-English-speaking elderly it is very much lacking in - there's very little evidence based research, and also most of the research is conducted in relation to ageing or aged care needs, which in general fails to address or study the area of cultural diversity within the study. So I think a comment could be made in relation to that.

Bilingual staff skills: like I said, in the paper what we have highlighted is perhaps the need for mention to be made about the need to assess staff skills, to provide training, and overall management of those bilingual skills, and utilisation in an aged care service. We've developed a guide to working with bilingual staff in aged care services, that explores this in more detail. We're happy to forward that to you - - -

MR WOODS: Yes, please.

MS PETROV (CCDA): - - - because that might have some aspects that you might want to draw on.

MR WOODS: Thank you. If you talk to Mark or Rosalie afterwards on the way out.

MS GUCCIARDO-MASCI (CCDA): Because it's about looking at this as value-adding to the workforce.

MS MACRI: Great, yes.

MR WOODS: Absolutely.

MS GUCCIARDO-MASCI (CCDA): A lot of the time their skills go unseen and they could be actually quite useful as skills in this particular context, especially where we're dealing with language barriers, and it's not formalised and it's not very structured, and there's little understanding around it; how to utilise it more effectively, this skill.

MR WOODS: Thank you.

MS PETROV (CCDA): I think we've already covered the next point that I had. It was in relation to monitoring of quality, and it needs to be monitored across all standards, across all aspects of service design. Also, involvement of clients of non-English-speaking background in the interview processes around monitoring of quality of care needs to be also considered. I would just like to congratulate the commission for highlighting the need for language services. I have worked in the aged care industry for 17 years, and it's never soon enough. Thank you.

MR WOODS: Can I just clarify: the Centre for Cultural Diversity in Ageing, can you just give me a little thumbnail sketch of where you fit into the broader framework?

MS PETROV (CCDA): Yes. The Centre for Cultural Diversity in Ageing is a Victorian based organisation, and we provide training to the aged care industry in relation to provision of culturally-appropriate care. We support communities to better understand aged care services, and we do that through provision of information in languages other than English on our web site. So we are predominantly receiving funding from the Department of Health and Ageing through the PICAC.

MR WOODS: I was going to ask the rude question about where you were getting funding from.

MS MACRI: Yes, and there are similar bodies in each state.

MR WOODS: Yes.

MS PETROV (CCDA): Yes. So Partners in Culturally Appropriate Care initiative; there is a PICAC funded initiative in every state and territory; and we also work - - -

MR WOODS: Yes, so you're under that umbrella?

MS PETROV (CCDA): We're under that umbrella. We also work very closely with all of the Community Partners Program funded organisations. The only different role that we here in Victoria have is that we work closely with all of the other organisations, because we through our web site are a national resource for the aged care services, as well as for community services.

MR WOODS: Okay. So that's your centre of excellence, so to speak.

MS PETROV (CCDA): Yes.

MR WOODS: Which is coming through what you're talking to us about.

MS MACRI: Yes, very good.

MS PETROV (CCDA): Thank you.

MR WOODS: Sue, anything else?

MS MACRI: No.

MR WOODS: You've obviously - - -

MS MACRI: We've worked together on the Aged Care Planning Advisory Committee.

MS PETROV (CCDA): We will send you the information that we mentioned

MR WOODS: That would be very good, if you could touch base with Rosalie and Sue.

MS PETROV (CCDA): Thank you.

MR WOODS: Thank you very much, it was very helpful.

MR WOODS: I understand we have a brief presentation from Kylie Draper to fit in before lunch. Could you please state your name and any organisation that you're representing.

MS DRAPER (EPC): Yes, my name is Kylie Draper. I'm the nursing medical services manager of Eastern Palliative Care. We're a not-for-profit, specialist palliative care service and we provide care to people in their homes, whether their homes be a private home or an aged care facility.

MR WOODS: Where they live?

MS DRAPER (EPC): Yes. I've worked as a nurse for 21 years and 18 of those years have been in palliative care, both in an inpatient setting in a hospice and in the community. The organisation I work for is the biggest community palliative care provider in the state and we cover the whole eastern metro region. So I've been a registered nurse on the road, going out and visiting facilities and I've been a clinical nurse consultant dealing with nursing homes, aged care facilities on a daily basis in the past and now I'm doing the nursing manager's job.

MR WOODS: So that's a CNC from a hospital base?

MS DRAPER (EPC): No, from the community organisation. So I've submitted my submission and I just wanted to make a few points about it. I think a good way to do that is probably to talk about some vignettes, some experiences we have with aged care facilities, just to give you an idea of what we encounter in the community.

MR WOODS: So will these be representative of the good and the bad?

MS DRAPER (EPC): Yes, they will be representative. So, for example, there's one I particularly want to talk about, a client whose name is Mary. She's 96 years old. She's a resident of a high-level nursing care home, with metastatic bowel cancer. We've been visiting daily to renew her syringe driver, which is delivering narcotic medication to promote her comfort. She's deteriorating rapidly. Her pain relief was adequately managed and the staff resisted attempts to be educated on how to manage the syringe driver independently without our specialist service going in to do so.

MR WOODS: The staff - the RNs and the ENs?

MS DRAPER (EPC): That's correct, yes. We received a page from the nursing home at 7.30 in the morning to say the client had died and there was no need for our service to attend that day to refill the syringe driver, but at 1 o'clock on the same day an EPC nurse ducked out to the nursing home to see how things were going, to

collect the syringe driver and return it to stock. When she arrived at the nursing home, the client was still in the same position that she'd died in at 7 o'clock that morning. The syringe driver was still attached and operational into the deceased person. The relatives were present, in a distressed state. Rigor had set in, the client was cold and the syringe driver was operational under the bedclothes.

There was only one RN in the multilevel facility and she'd been too busy with residents to attend to the deceased. From our perspective, one of our values is dignity, excellence, compassion, partnering, and examples like this we find particularly upsetting - and that's not to take away from the nursing homes that do a fantastic job, because they're certainly out there. So from our perspective, one of the things that impacts on our ability to provide good quality palliative care in aged care facilities is a lack of qualified RN division 1s who are able to administer medication when required.

MS MACRI: Can I just ask you in that, besides a lack of numbers, are you finding with the div 1s there's a lack of skills and expertise in turn?

MS DRAPER (EPC): Absolutely.

MR WOODS: And confidence?

MS DRAPER (EPC): Absolutely.

MS MACRI: And confidence in - yes.

MR WOODS: So even though they may have got their particular proficiency, the reluctance to undertake - - -

MS DRAPER (EPC): Yes, and I think that oftentimes we go into these facilities and educate the staff, one on one when they've got a client that we're looking after as well. We often find that when we go back to that facility, it might be weeks or a few months later, that that person is no longer there and there's a different staff member, so the high turnover of staff impacts on our ability to support people in that role. It also impacts on their confidence when they get a palliative patient because they don't have the confidence to manage in that situation.

MS MACRI: Yes.

MS DRAPER (EPC): The other thing we find is that there's a real lack of support from management of aged care facilities for these people to get the education and the skills that they require. We actually run community ed, which is a two-day course for registered nurses. They come in and do our palliative care course. There's a cost

attached with that, so often facilities - - -

MR WOODS: Costs roughly in the order of - - -

MS DRAPER (EPC): It's per person, so I think it's round about the $200 mark per person. It's not a significant cost.

MR WOODS: So not a big outlay, no.

MS DRAPER (EPC): So oftentimes facilities will pay for their staff to be educated, and they tend to be the better facilities. We recently had a group of nurses from a nursing home who wanted that education and were seeking it. The management wasn't supportive at all, wasn't prepared to pay for it, so the nurses actually paid for their own course. So we offered the course to them at a reduced rate, knowing that they were paying for it out of their own pocket. That's really disappointing and there are certain facilities which we know we go into very frequently and we've had discussions with management and they're often not keen to put the money into educating their staff and upskilling them, which is disappointing. So well-trained and well-prepared RNs and a palliative approach

Oftentimes, we get a flurry of referrals sent to our service when facilities are having accreditation, because they need to be seen to be doing the right thing and a specialist palliative care service provides services to people who have complex needs that are unable to be managed by regular, reasonable means, but they tend to refer everyone - "This person is for palliative care, this person is dying."

MR WOODS: It's a bit like the ambulance shuffle to the ED.

MS DRAPER (EPC): Yes, and in my opinion probably 100 per cent of people in nursing homes are dying and they should be having a palliative approach to their care.

MS MACRI: Yes. I mean, I might add, the Department of Health and Ageing have done a lot of work in putting out books and educating - - -

MS DRAPER (EPC): Absolutely. You're right, all the APRAC stuff.

MS MACRI: - - - on the palliative approach; that whole initiative.

MS DRAPER (EPC): Yes. We actually delivered a lot of that APRAC education. The book is in all the facilities and, as a CNC when I go out to these facilities, I'd say, "Where's your APRAC book? Have you referred to that?" "Oh, it's on the shelf in the DON's office," and gathering dust. That's the reality of what we see out there

in the homes. The consistency of staff we've talked about. We also have real issues around GP support in nursing homes. There's one vignette here of a patient who had colon cancer, had a fistula. The staff thought it was the client's anus, so they failed to detect that there were issues with that person. The GP was called on several occasions to come in and support the specialist palliative care service and the staff. The GP was on holidays and then once the GP got back, it took another two weeks for that GP to get involved. Then often there's a real opioid phobia amongst the GPs.

MS MACRI: Absolutely.

MR WOODS: Yes.

MS DRAPER (EPC): It's really disappointing for the RNs that work in those facilities sometimes, and other staff, because they're with the patient all the time. They obviously, some of them, know when someone is in pain. They suggest to the GP, "This person needs some morphine to keep them comfortable," and the GP says - well, doesn't really trust their judgment, which is probably very demoralising for them and affects their confidence, so they then have to refer to the specialist palliative care service to call us in; like calling in the hounds, so to speak.

MS MACRI: So how do you deal with that? Do you go one on one with the GP?

MR WOODS: Do you have nurse practitioners who can - - -

MS DRAPER (EPC): We do have a nurse practitioner candidate but generally our CNCs go in and do a thorough assessment of the client and with that information they then liaise with the GP about what medication would be appropriate in this situation. We also do other things like get the staff to set up a pain chart to monitor the client and suggest a variety of interventions to try and manage the situation. We have palliative care consultants, physicians, and we sometimes have to get them to liaise with the GPs, if there's resistance. There have been occasions where we've had to have people removed from facilities and placed in a hospice bed because the symptom and pain management hasn't been adequate.

MS MACRI: And you just can't get the GP involved?

MS DRAPER (EPC): That's right.

MR WOODS: Is part of the solution to have more nurse practitioners within your operation? They've still got to liaise with the GP.

MS MACRI: Are they able to - see, they can't initiate schedule 8s, can they?

MR WOODS: No, that's right.

MS MACRI: Or can they?

MS DRAPER (EPC): Well, they can, but they need to be supervised by a palliative care physician.

MR WOODS: Supervised? Yes.

MS MACRI: Yes.

MS DRAPER (EPC): Yes, that's right. So I think one of the good things would be to really educate all the registered nurses in facilities. We have real difficulty with facilities where there are unlicensed workers; PCAs, PCWs, whatever you want to call them. We find that they don't have a good understanding of assessment - - -

MR WOODS: No.

MS MACRI: Yes.

MS DRAPER (EPC): - - - they don't have a good understanding of evaluating whether the intervention has been effective; and some places stick to the rules and other places don't, in terms of S8s and PCAs giving out medications. We often have to adapt the opioid that we'd prefer to choose for that client to fit in with a lack of trained staff, qualified staff in that facility. So sometimes we'd prefer for the person to have oral morphine liquid, but because the PCW unlicensed worker is not able to measure out the dose, we then have to think about putting the person on oxycodone that can be put in a dose administration aid - which isn't always ideal, especially for certain symptoms.

MR WOODS: Yes. No, we understand.

MS DRAPER (EPC): So we think that there should be more resources for specialist services to be able to support aged care facilities to help them to implement end-of-life care pathways. We do a lot of consultation, a lot of education, and it would be good for the specialist services to have more resources. We could actually use an extra two EFT-registered nurses at our facilities - or CNCs - and they would still be kept busy with the number of referrals that we get.

MR WOODS: What broad area do you look after? What geographic - - -

MS DRAPER (EPC): So from Kew - do you know Melbourne at all?

MR WOODS: Yes, enough.

MS DRAPER (EPC): From Kew to Warburton East. So the entire Yarra Ranges - it's a high-density area.

MR WOODS: Yes.

MS DRAPER (EPC): So it's a huge area really, the whole eastern metro - they call it metro, but we do go fairly rural as well.

MR WOODS: Yes.

MS MACRI: Who funds your service?

MS DRAPER (EPC): The Department of Human Services fund our service.

MS MACRI: Yes, okay.

MS DRAPER (EPC): So we could certainly use an extra two full-time people, and that would be just on consultation, education and support of nursing home staff.

MS MACRI: Right, yes.

MS DRAPER (EPC): We've actually had a 68 per cent increase in the last six months in referrals to our service from non-government and government-funded aged care facilities.

MS MACRI: Right.

MS DRAPER (EPC): So from my perspective, aged care staff - palliative care should be a core competency for all of them, because that's essentially what they're doing.

MS MACRI: What they're doing, yes.

MR WOODS: Especially now, and increasingly so.

MS MACRI: Yes.

MS DRAPER (EPC): My other concerns are around the case-mix payments for end-of-life care. I think it must be mandated that they should be used for employing RNs in the terminal phase of people's illness. I think it would be a real shame if those extra payments just went into coffers and weren't actually used for what they

should be spent on, which is making sure that there's RNs to administer medication.

MS MACRI: Yes.

MS DRAPER (EPC): Certainly there's a few hostels that we have dealings with that are excellent at this. When someone is in the terminal phase they will bring on an RN to manage that situation - and usually it's only for a short time, 24 to 48 hours. But I think it should almost be mandated that that money should be used for what it should be used for.

MR WOODS: Yes.

MS MACRI: Yes.

MS DRAPER (EPC): Because essentially that means the person can then remain in the aged care facility to die - - -

MS MACRI: Absolutely.

MS DRAPER (EPC): It means they're not taking up a hospice bed. It means they're not taking up an emergency - - -

MR WOODS: They're not being disoriented.

MS DRAPER (EPC): That's right.

MR WOODS: They're not going through the trauma of change. The family know where they are and - - -

MS DRAPER (EPC): That's right, and we're not promoting more suffering on their part, and it's much easier.

MR WOODS: Yes.

MS DRAPER (EPC): And I think some of that money should also be mandated to be utilised for training and education for those facilities as well. I think we need to think about the career pathways and the regulation of unlicensed workers. We should be investing in people who are passionate about aged care - because they're few and far between - and providing them opportunities for transition from PCA to division 2 to division 1 with scholarships, grants, whatever, so that we can have a better-trained and educated workforce. It's a growing population, as I'm sure you're well aware - - -

MS MACRI: Yes.

MS DRAPER (EPC): - - - and our work is just going to triple over the years. So end-of-life care should be recognised as core business, as I've said, and workforce and service development plans should acknowledge the responsibility of aged care facilities to provide end-of-life care. This responsibility includes employing the right staff mix; for example, RNs who can administer pain and symptom medication. We often encounter the situation where someone needs breakthrough pain medication; so we might have them on a slow release opioid that's controlling their pain, but then they might have pain overnight and need an extra breakthrough dose of medication.

MS MACRI: Yes.

MS DRAPER (EPC): Often there are not the staff in those facilities to administer the medication, so the person may well - - -

MR WOODS: Or even to fully understand where the person is at.

MS DRAPER (EPC): Sorry?

MR WOODS: Or even to fully understand where the person is at in terms of their pain.

MS DRAPER (EPC): That's right, and then to be able to assess the effectiveness of the medication if it's ever given.

MR WOODS: Yes, precisely - the whole bit.

MS DRAPER (EPC): So we do find that oftentimes clients are waiting a long time for medication in facilities. Often there's only one registered nurse, and so they might be waiting an hour or more for pain relief when they're having an acute episode of pain.

MS MACRI: Yes.

MS DRAPER (EPC): It's not just pain of course.

MS MACRI: No.

MS DRAPER (EPC): It's nausea, constipation, dyspnoea, all the other symptoms that people experience.

MR WOODS: Let alone if there are language barriers and the whole bit.

MS DRAPER (EPC): That's right, yes. So we think access to palliative care services - the referral process also needs to be looked at. I think it's disappointing when facilities send in a flurry before accreditation. I think it should be something that's monitored so that they're doing good palliative care all the time not just around accreditation - and there almost needs to be a pathway whereby certain things can be managed by the aged care facility, should they have the responsibility to manage the palliative approach, and should be addressed through primary care services or at the facility and the GP, and then a more intermediate approach, and then a more complex approach for which they refer to specialist palliative care that they're not able to - - -

MS MACRI: Yes, for some in-reach services.

MS DRAPER (EPC): Yes.

MR WOODS: Do you have any statistics? You talk about the flurry pre-accreditation - which intuitively I understand - but it becomes much more powerful if you can show peaks and troughs - - -

MS DRAPER (EPC): From individual facilities?

MR WOODS: Yes, without naming them and things, but - - -

MS DRAPER (EPC): Yes, we have excellent data. We've got a full electronic health record that - - -

MR WOODS: It's just that a little table that actually demonstrates the point is much more powerful than an anecdote of - - -

MS MACRI: Yes.

MS DRAPER (EPC): Yes.

MR WOODS: - - - there's a flurry around this time when everyone says, yes, of course that's true - but then dismiss it.

MS DRAPER (EPC): We have an intake team that receives all the referrals, and we count all those referrals and get reports on them all and everything like that, and they'll say to me, "This particular nursing home has referred six people this week," and then the intake team will have a discussion with them and they'll say, "Yes, we're about to have accreditation so we're referring all these people." So certainly in different facilities - - -

MR WOODS: But if you could give us something more concrete, it is more powerful - - -

MS DRAPER (EPC): Yes.

MR WOODS: We understand and accept your point, but it has much more power if you can actually demonstrate the point.

MS MACRI: Yes, and we understand the confidentiality issues.

MS DRAPER (EPC): Yes.

MR WOODS: Yes, we're not talking individual - - -

MS MACRI: We're not talking individual, but it can be nursing home X and - nursing home Y and - - -

MS DRAPER (EPC): Yes.

MS MACRI: So that, for us - I mean, we're an evidence based organisation and it's very hard to take up anecdotal - - -

MS DRAPER (EPC): Stuff.

MS MACRI: - - - stuff.

MS DRAPER (EPC): Yes.

MS MACRI: So if there's a little something there concrete - - -

MS DRAPER (EPC): That we could pull together.

MS MACRI: Yes.

MS DRAPER (EPC): I'm sure I could try and pull something together.

MS MACRI: Yes, it would be good for us.

MR WOODS: Also, you were talking about when you're attending facilities and, in your clinical view, this is something that a properly trained RN who is competent would be able to do. If that represented 20 per cent of your presentations at facilities, or 30 per cent or whatever it is - again, we don't want to have you spending hours sort of combing through stuff, but - - -

MS DRAPER (EPC): That probably would take hours.

MR WOODS: Yes, but the more you can give specifics the better we can target the policy recommendation because, again, a statement to that effect - we fully believe what you're saying, but it's hard to then measure magnitude and consequence and actually deliver some policy solutions.

MS DRAPER (EPC): Yes.

MR WOODS: But if you've got some evidence around it, it just makes it so much easier for us.

MS DRAPER (EPC): Yes, I'll see what I can pull out, but unfortunately we've almost kind of accepted that with some facilities that's the status quo.

MR WOODS: But that shouldn't be the case, and the more evidence we've got the more we can target some policy recommendations.

MS DRAPER (EPC): Things like putting in catheters, I think every registered nurse should be competent with.

MR WOODS: Absolutely.

MS MACRI: Absolutely.

MS DRAPER (EPC): Putting on a stomahesive bag, everyone should be competent with.

MS MACRI: Absolutely.

MR WOODS: Yes, totally agree.

MS DRAPER (EPC): And we've been certainly called out to facilities to do those tasks.

MR WOODS: Yes, but if we knew that 30 per cent of what you are being required to do should be done by competent and confident RNs - or ENs in some cases - then that would be a very powerful thing that says if your budget - if you could have 30 per cent more time doing what you actually should be doing, then you don't need your other two EFTs.

MS DRAPER (EPC): Yes.

MR WOODS: You're just actually doing where you fit in best.

MS DRAPER (EPC): You're right.

MR WOODS: So that would be helpful.

MS DRAPER (EPC): Yes, I could certainly look at 10 clients or something and just come up with a bit of a percentage around - - -

MR WOODS: Yes.

MS MACRI: Yes, a bit of a synopsis around it would be great.

MS DRAPER (EPC): Yes, certainly.

MR WOODS: Mark will touch base with you and give you contact details.

MS DRAPER (EPC): Excellent.

MR WOODS: Any concluding comment? We are running out of time, but - - -

MS DRAPER (EPC): Yes. In-reach services are good, or outreach - whatever people call them.

MR WOODS: Yes.

MS DRAPER (EPC): They often make recommendations that staff often don't have time to implement. So that would probably be my closing comment.

MS MACRI: And we've got the message around. I mean, in-reach works, as long as the staff are there that are competent and capable. It's no use coming in and ordering something or putting out a care plan - - -

MR WOODS: If a day later it doesn't happen.

MS MACRI: - - - and walking out, and the staff don't have the capacity or the confidence or the skills to implement it.

MS DRAPER (EPC): That's right, yes.

MS MACRI: Which is a little bit around your drug stuff.

MS DRAPER (EPC): We kind of work quite closely with the outreach-in-reach teams, so if we think it's more appropriate for them to go in, well, then they'll go in or we'll go in.

MR WOODS: Absolutely. That would be great. Thank you very much.

MS DRAPER (EPC): Thank you.

MS MACRI: Thank you.

MR WOODS: We will resume at 1 o'clock.

(Luncheon adjournment)

MR WOODS: For the record, could you please state your name and also, if you're representing anybody, could you tell us if you are or whether you're coming as an individual.

MS OWEN: My name is Mary Owen and I'm not exactly representing my organisation. The one I'm involved with that's concerned with this is the Older Women's Network.

MR WOODS: Excellent.

MS OWEN: There is an Australian - I put in a submission to the Productivity Commission on behalf of OWN Victoria but the national body was slightly put out because we hadn't sent it there first, which was quite right, so I don't want to say I'm - - -

MR WOODS: That's all right.

MS OWEN: I've said here this is a very unprofessional submission which is based on my own experience. Somebody said, "You know, you ought to go to this," and I haven't got proper background and stuff.

MR WOODS: It's fine. We're interested in what your views and thoughts are.

MS OWEN: Yes. Well, what I thought was that there are two stages of mental health which are of concern to this government and one is of course funding to cope with the immediate problem of those of us who are already old and may be suffering from dementia or depression or some other more drastic disability. The other is reducing the future numbers of such folk by preventive measures to cope with mental abnormalities in the young, so that's what concerns me. The most essential requirement, I think, for old folk is a safe familiar place to live.

MR WOODS: Absolutely.

MS OWEN: And those with mental health problems also need special care. Now, when it was decided to move the inhabitants of what used to be called the Mont Park lunatic asylum out into the community, many thought it was a good thing and so it was in some ways. Being shut away from the rest of the community with no control over one's life must have been terrible. However, most of those concerned had had no experience of managing for themselves and that caused problems later. What they needed and what is needed today is care from one or more adequately trained and experienced carers. Sometimes this can be provided where they are already living, as in mild dementia, but all too often older folk are dependent on family to care for them and it's often beyond the family's capacity to do so. The ones we see -

well, in some cases I know of people who are caring for children and caring for their parents as well, you know.

MR WOODS: Absolutely.

MS OWEN: This is from the experience of OWN and other people. The cost of residence in a good special care residence is prohibitive for most ordinary families but the burden of maintaining their children usually requires two income earners, even when they are having grandma to look after. The cost of providing appropriate care for our ageing population I think should be shared by all of us when we're earning money, and that is the government via taxation. The government should stop giving tax concessions to private health insurers, which is beyond the means of aged pensions.

I paid for private health insurance for 46 years. When I started with the Hospital Benefits Association it was during the war. My husband was away in the forces and it cost me threepence a week. I think I was earning about three pounds a week. When he came back out of the forces it cost sixpence a week for the family. I had three children, all produced in private hospitals. It cost me nothing. Nothing for the hospital; nothing for the doctor. It was all covered by that. But what we've got now is the government gives the tax concessions to private health insurance which is beyond the means - I can't pay any more. I can't afford it after 46 years. Now I might need it, I can't afford it. 80 per cent of that money that they forgo in the tax concessions goes to the top 5 per cent of income earners, and so what I'm saying is governments should change their way of doing things.

It's only comparatively recently that mental health problems such as bipolarity, schizophrenia and depression have been recognised as illnesses; that is, not wellness. If more attention were paid to such conditions in early life, it is likely that there would not be nearly so many problems or so much expense in old age. Now, for the young it is important to recognise the signs of mental health problems as early as possible. That means schoolteachers, church or Cub leaders, doctors; all need training to recognise the symptoms of less obvious problems such as bipolarity, schizophrenia and depression.

Bipolar children are often seen simply as naughty, disruptive and generally a nuisance in class; also children with what is now known as Asperger's syndrome. I didn't discover that my daughter was bipolar until she got to Melbourne University and was sent to the psychiatric department for help. It was called manic depression in those days and it's a very good description because that's what she was.

MS MACRI: Yes, highs and lows.

MR WOODS: Yes, understand that.

MS OWEN: Brilliantly clever, you know, will do anything and then bang, down they go, and go and do something stupid. She's been sacked from more government departments than anybody I know. She was a qualified neuropsychologist in the very first group - she was accepted - that they had at Melbourne; six of them. There are now very few schools designed here specially for such children but they cost a fortune, you see. Well, I know of one in America which made a huge difference to living and learning for my grandson, who's the son of this daughter, that went off and married a chap whom we now think he's got sort of social disorder problems.

The son has Asperger's syndrome and at the age of three, when he was in Western Australia driving in the car, he was reading the signs of the street names and one of them was - I've forgotten the name of it now, but a really difficult name that he read. I couldn't believe it. But until last year he was always in trouble at school and frequently sent home because the teacher couldn't cope with him, and if his mother was not home he was just sent home and there was nobody there, nobody to look after him.

On the other hand, as I said, he was brilliant at maths and reading things and remembering long quotes of unusual things, and so the teachers thought he was just being naughty when he started putting on an act, you see. Last year, after spending a fortune on specialists, counsellors, et cetera, his mother found a school specialising in such children in San Francisco where they live. Since he started there he has scarcely looked back and came top of his class in several subjects. You know, he hated going to school, he put on a turn, and now, for the last year it's just been marvellous. So they daren't leave America and come back to Australia until he's finished his schooling because they don't know of any such schools here. I think there may be a couple but the federal government should ensure - I think - that there is appropriate schooling available under the state system for all who need it.

As it is, you have to be wealthy to give your children a basic education to prepare him or her for employment and an ability to care for him or her self for the rest of his or her life. I can't come at "its". It doesn't sound right - or "their". Without such preparation, life in old age can be dire and I think government should cut those tax concessions to the wealthy for private health insurance, private education and private superannuation - I made a mistake there - and redirect the savings to measures which would help to prevent inequalities in education, health and a decent standard of living later in life. That's basically what I think. They just have to do it differently and if we can't correct it early in the piece I think it's going to be a lot more trouble later on. That's basically what I have to say. I've left off the end bit but that doesn't matter.

MR WOODS: You've got time, if you want to add something.

MS MACRI: So, Mary, your concern is around if we don't do something about the younger generation we're going to have a huge problem at the other end of the spectrum in terms of aged care and mental health.

MS OWEN: Yes. I mean, I'm one of the lucky ones. I've just turned 90. I'm still living in my own home and, okay - I mean, all right, that's my main problem. I look ahead and I see all these young people suffering depression. That boy that the police killed, you know - just terrible. Never should have happened. He needed help and care and that's what we're not providing. It isn't recognised - people aren't trained to. We should be putting the money into training teachers, healthcare people, seeing that there's enough of them. Our hospital is wonderful, the Sandringham Hospital, but they're so short-staffed. The medical clinic I go to, they're all wonderful but they can't afford to spend the time with you.

Our old Dr Mackenzie used to come around and sit, and not just look at Mum but - I mean, you'd get the doctor for your children. You never got them for anyone else. You couldn't afford it. It cost 10-and-six in those days and I think it cost extra if they came to the door. But the doctor, when he was there, would see - "And how's Mum, and how are you today, and how's Dad?" You know, he'd check up on the whole layer and they could get a feeling of what things were going wrong, and somehow this is what I think is needed. If we really want to change the system, and our Prime Minister says she wants to reduce the gap between the rich and the poor, the needy and whatever - and I think she's genuine but this is the way we have to do it. We've just got to stop handing out tax concessions to the wealthy.

The word I wrote in there, instead of "superannuation" I wrote "insurance" twice, so I'll have to correct that for you.

MR WOODS: That's all right. It will be on the record.

MS OWEN: Any questions?

MR WOODS: In terms of your own personal situation, do you get any or do you need any care and support services?

MS OWEN: I am wonderfully lucky, partly because I've worked with so many wonderful women all this time, and a few quite nice chaps too as a matter of fact.

MS MACRI: There's a couple around there.

MS OWEN: Yes, there are.

MR WOODS: Not me, but - - -

MS MACRI: I'm sitting next to one.

MS OWEN: What's his name?

MS MACRI: It's Mike.

MS OWEN: Well, I'm constantly conscious of how lucky I am (a) that I still have most of my marbles - only that I get things stacking up and I seem to be always doing too many things at once. My stepmother told me many years ago, "You should just do one thing at a time," but that's the way it is because there seem to be so few people doing anything. The medical clinic is excellent and they give you all the help you need. As I pensioner I only have to pay - it's gone up now to $12. It used to be $8, then $10, now $12. I don't begrudge that at all. I belong to a group called TADAust, which is now called ONEseniors, and I pay $20 a week. I now get broadband on my computer plus all my telephone calls, rather than pay it to Telstra.

Now, that's the other thing I didn't put in there. I think government should retain essential services and not flog them out to private industry. The telephone I consider is an essential service for elderly people, people marooned in their homes. Water, electricity, gas. I think government should be in debt to provide infrastructure that's going to last. Public transport of course is an absolute disaster. I'm lucky I live in Sandringham. I can hop on the train and go to the city, no problem, but I would suggest - and I haven't written this - the government should look at these developments and they should do what they used to. Remember they built Housing Commission houses?

MS MACRI: Yes.

MS OWEN: And in that area they should have kindergarten and aged care facilities so that you can go into a place where you've lived all your life. This is the thing. We were discussing yesterday how people hate the idea of leaving their own home and going into care.

MR WOODS: Absolutely.

MS OWEN: It's not just that. It's leaving everything that you know.

MR WOODS: Yes, it's leaving your community and your friends.

MS OWEN: If you had a place in your district where you could go when you

needed temporary care sometimes - as some people do, but it should be within your means; people can't afford it - or a little care, and then pass on to full care, all in the same place. And we should remember, as I reminded the yesterday lot, that it's only a very few of us who end up in a nursing home. The great majority of people are able to stay in their homes.

I look out, and the garden is overrunning and everything is getting out of control, and every year I have to weigh up and say, "Can I manage it?" So far, yes, because I'm lucky. I have no children living here and no grandchildren. My son is the nearest. He lives in Perth with two grandchildren. There's a daughter in San Francisco. The other one has been living in Italy. Now, she's just arrived because she couldn't get work in Italy. She's got a job at Deakin University at Waurn Ponds and she has to live in Point Lonsdale - the car's fault. It's all those things, you see. So I've nobody here, but I am very lucky.

MS MACRI: What do you think is important about keeping you in your own home and your own environment?

MS OWEN: Well, I think local councils, and ours is pretty good, the Bayside lot. They provide for me, but other people need more than I do. The public transport is the thing. We must have pick-up buses for people. I'm still running a car. I don't go for such long trips as I used to, but I still drive around; but not everybody does. That is, I think, essential. And we - not me, but people who have got more problems, especially if it's on the mental side - do need to have somebody dropping in regularly to check on them.

MR WOODS: Yes, absolutely.

MS OWEN: Yes. I mean - and I say because there are comparatively few of us - I think we as a community through the tax system should pay when we're earning. I think instead of superannuation we should have a compulsory retirement levy which should be a percent of your income when you're earning, but then we should all get the same amount out, not graded according to what you paid in, because you may be doing very nicely - and I did quite nicely for a short time in my later employed life - but then comes a time when you need the help too.

It's the same with this emergency tax that I think we should have. The disasters we've had lately you wouldn't read about, and surely we should all pay according to our means because we never know who's going to be the next. And it's with mental health particularly. I look at people like Blanche and a couple of others that I've known - no, not Blanche, the first one.

MS MACRI: Hazel Hawke?

MS OWEN: Yes. I used to go and work with her and help her do things. So you never know when it's going to happen to you, and that's my thing. We really should take on the essential services that we should provide, and have compulsory taxes like the old Medibank that we used to have, which used to actually cover things.

MR WOODS: Okay. Well, we have others, but thank you very much for coming and giving your evidence.

MS OWEN: I'll give you this. I'll alter this and I'll just - - -

MR WOODS: That will be fine, and if you talk to Mark at the end of the room there, he'll look after you. Thanks very much.

MR WOODS: Robyn Browne. Thank you very much. Could you please for the record, each of you, give your name and if you are representing any organisation, what that organisation is.

MS BROWNE: My name is Robyn Browne, and I'm really here representing myself, a personal submission, but will be putting in something in writing which we haven't yet had full time to do - - -

MR WOODS: That's all right.

MS BROWNE: - - - with Debbie and a friend who couldn't be here today.

MS MEDLEY: I'm Debbie Medley and I'm just an individual who looks after my mother-in-law as a full-time carer.

MR WOODS: Thank you very much. Please talk to us.

MS BROWNE: Thank you. Thank you for the opportunity today because it's really a bit daunting but reassuring as well. I was here on Monday and there were some stories then which I found were emphasising the sort of things that we as home carers for parents do feel strongly about. I thought I might start with just a brief couple of sentences, or two or three, about my background.

I was a personal carer for my late father at home. He passed away about three years ago. Prior to that he was diagnosed with dementia in late 2000, and in 2001 we went on to a CACPs package for about four years, then onto EACH, and then my problems started, really started.

MR WOODS: Did you say it's an EACH or an EACH-D?

MS BROWNE: EACH. I could not get an EACH-D. I have a million and one impressions, I think, formed over that time, with my own experience, from many conversations casually and with friends formed along the way, like Debbie, a more recent acquaintance. The other friend who couldn't be here has looked after her mother, now passed away. We connected about four years ago through need - dire need, I think - and so it becomes really hard to know where to start. You jump in the middle and then just try to fit things into place.

MR WOODS: Yes. Talk to us.

MS BROWNE: I've given you a summary list. That's the best I could do at the time. We only came to know this was in process fairly recently, and because of various daily life responsibilities, commitments, demands, et cetera, haven't been able to put

it together, so I've asked about that and we intend to put it in writing.

MR WOODS: Yes, that's fine.

MS BROWNE: I have previously myself submitted to the Carers Inquiry, the CIS review which was done in 09 I think it was, and late last year a forum on the EACH packages, consumer-directed care, so on Monday again it was interesting to hear the providers' points of view. I thought the three nurses who spoke on Monday really spelled out exactly the sorts of reasons that we as in-home carers, striving to keep our parents or partners - I must say, I'm not in that situation - they spelled out the kind of anxieties that we have held for a long time about the reasons we don't or hadn't put our parents into respite, unless really, really necessary, and why we certainly didn't go towards placing them into facility care permanently.

MR WOODS: While recognising that there are some excellent facilities - in fact, the majority of facilities.

MS BROWN: While recognising that, yes.

MR WOODS: So there's a danger of skewing the impressions to, "Let's find the worst possible example," and putting that on the table, and not recognising the very good and excellent quality of service that others provide.

MS BROWNE: I have actually made note of this along the way, that it's important to recognise that there are many good things happening in aged care. I hate the phrase "aged care". I think "elders" implies wisdom, which "aged care" doesn't. It's got a rather negative tone about it these days. I have seen a few patches of gold, but many patches of blue, and that's certainly why I'm here and why others I know speak as they do, because it should be.

I saw a film Made in Dagenham the other day and it said it very succinctly. The husband was standing there saying, "But I don't beat you. I bring money home. I put food on the table. I do this and I do that and I do the other, and it's the right thing." And she, being one of the 1968 strikers for women's rights and pay in Dagenham, said, "That's not the point," or words to that effect. "That should be the case. That should be the norm, so don't praise yourself for doing what's good and right anyway," and off she marched, and I thought, "Yes, that's why we argue as we do."

Then on Monday on the news, there was a young Japanese woman reporting on the local morning show. She said that, in the aftermath of the frightful situation in Japan, it's interesting that young people over there are apparently showing themselves as being really caring and concerned for older people. She said,

surprisingly I think, that it was notable that they are really concerned about the many elders who have been affected, who lack underwear, who lack a place to have a bath, who lack the normalities of daily life now that they had perhaps two weeks ago, and I thought, "Wouldn't it be wonderful if you could go out on the street and ask a few people of various ages" - because I think younger people have a wonderful sense of care and concern which perhaps my peers don't, in many ways, for the older sector of our society. It's not happening, otherwise we wouldn't be here, I think.

One of the points that I wanted to really focus on today was my experience with the complaint procedures and processes; the resolution scheme as compared to the current investigation scheme. The other points I've noted are respite, training, the packages in tandem with the approved providers, and then personal, how it's affected my late father and myself. But, you know, I could sit here forever.

MR WOODS: You have six more minutes, so if you could - - -

MS BROWNE: So I just would rather you ask me questions than - - -

MR WOODS: Well, if you can focus on some of the key messages that you want to give, and also if you could illustrate some of the blue patches and some of the gold bits so we can get some balance of what's good, what's not good.

MS BROWNE: Right. I'll do my best. I've talked to various people prior to today as to what they would like to say if they were here, and one of the things that comes up quite often is that we want services and so forth provided with us, not for us, because with organisations, the organisational sector, commercials, not-for-profits, there seems to be an overriding sense of, "We'll do it for you," but we want it done with us, and there's not enough "with us" going on.

MS MEDLEY: Also, while Robyn is saying about that, I'm just new to this. I've moved from interstate, from Adelaide to Victoria. I've given up full-time work to become a full-time carer for my mother-in-law who lives with us. When I moved here, I had no idea where to go. Nobody could put me on the right track. I rang people. No-one could say. And that's my biggest thing. There must be plenty of people out there. Where do we go to get help for our loved ones and for ourselves? There's nothing out there.

It's taken two years for me, going through all these channels, and I've finally found lots of people. Someone said to me, "The first person at call is your doctor." Not all doctors want to help you. They want to see if everybody is all right, but you have to do all the legwork. They don't want to. They will write something out but they don't want to help you.

Now I'm going through councils. The councils are great. They will help you. Lots of councils are looking at the aged because that's what they're really concentrating on. They're looking at the young people, but they want our older population to enjoy their lives so we haven't got the burden. I just think there are so many people out there who look after their parents, look after their loved ones and they don't know where to go. That's my biggest thing.

MR WOODS: Hopefully our Gateway proposal, where it is widely disseminated and everyone knows that that's where you can go and they will actually work with you to identify your needs and the needs of your carers, will assist.

MS MEDLEY: But where is that gateway? I came over here, I walked into my neighbourhood, "Okay, where do I take Mum? Where do I go?" I don't drive, so here's another point of view. I have to catch public transport everywhere I go.

MR WOODS: But it would start with phone calls and web sites and would be broadly disseminated.

MS MEDLEY: That's right. That's what you're saying. But where do we look first? Where? Not everybody's got the Web. Everybody's got phones now. But where's the first point? I've come over. Where do I go?

MR WOODS: That's what all your GPs would know, all your councils would know. So, yes, you have to go somewhere, but whether it's the post office - - -

MS MACRI: Yes, it's not going to jump out at you.

MR WOODS: Yes. Nobody is going to find you individually and say, "Here is the number," but everywhere where you interact there will be that information that feeds in for you.

MS MEDLEY: There's the point with the interaction. Like I said, some doctors check you out, make sure everybody is all right physically, but they don't know - Mum has got very bad dementia and she's going downhill now. I am now getting Mum into a dementia group. I didn't even know it existed.

MR WOODS: No. I understand that.

MS MEDLEY: I'm just new and I'm very passionate. I think if it wasn't for our older generation we wouldn't be here. That's the way I have to look at it and that's what I tell everyone.

MR WOODS: Yes.

MS MEDLEY: I'm sorry, I'm just very emotional.

MR WOODS: No, that's fine.

MS MACRI: The other thing is too - and I'm not quite sure about Victoria but certainly in New South Wales where I live - you pick up the phone book and right through the front are all the services around aged care: the Department of Health and Ageing, Centrelink, all of those organisations. Whilst it may not be a perfect system in the telephone book, both in the White and Yellow pages are pretty well set out the services for young people, hotlines, the whole box and dice.

MR WOODS: Yes, it's all set out.

MS BROWNE: Could I just add something there? On that point, I take your point and Debbie's too. Debbie is at a disadvantage. I only got this on Monday and the other two of us haven't been able to - I was up till 4.00 this morning trying to sew the Gateway up and so forth, and I find it really interesting and I think it's terrific. A lot of the proposals sound to me as though they are really going to be heading in the right direction compared to what we've had and have at the present time in various ways, so Debbie and others will - - -

MR WOODS: Yes, we understand.

MS BROWNE: The other thing is that, sure, the lists are there and you get to learn where they are and you can short-cut it. The problem we have, which I think we're getting into, is the real personal daily living situation here of how do you deal with it? I said to someone the other day, the carer, that I dealt with my father who had dementia, but he was really okay; I was able to keep him at home. Dad was very intelligent, intellectually; not formally educated, but a very clever-thinking man, ahead of his time probably had he had the formal education, very involved et cetera, and a gentle-mannered man. So I was lucky. I was able to keep him home and he knew me right through. He died at 92.

But he became immobile, thanks to a hospital - a good one, private - where he slipped off a chair. We had just not long ago - through 04-05 - got him off my personal gruelling rehabilitation process after a hip fracture. Those processes of dealing with the day-to-day exhaustion - you've got the person you're caring for there; you've got the phone ringing here or you're needing to use it; you've got a pot on the stove there; you've got someone knocking at the door; you've got some agency or other organisational person coming, and you don't have support. We do not have enough supports. We have supports in theory. In practice they are very, very wanting, in informal and in formal ways.

You lose your family. I am an only child, not partnered. So I'm single, no partner, therefore those normal supports are not there. Your friends? You lose your old friends because they don't really want to know what you're doing, because either they haven't done it or they don't want to think about it until they have to. You pick up friends along the way. So, getting back to your point, the ability to look at those resources is very, very stretched.

I couldn't count the absolutely countless number of calls I have made, and Cheryl as well, sort of separate and together - and Debbie; we're working into it - to be told, "Oh look, we don't deal with that. You have to ring so-and-so," and then your "simple" becomes "very, very complex". And you have no fall-back system: no safety net, no nothing. You just keep soldiering on. The only way you do it is by not sitting in a corner and thinking about it, or not thinking about it much at all, just charging ahead.

This has all come out in many carers' submissions and so forth, so I didn't want to dwell on that, but it was really to balance that a little bit I suppose. What is there in theory becomes very, very limited in practice. And as past carers? That's another life story as well.

MS MACRI: We hear you, because it's not an unfamiliar story.

MS BROWNE: No, that's right. It's been told many times before.

MS MACRI: That's not to say that it becomes any less important to us. It is important to us. I think the important thing about the reforms and the report are around the issues that you've raised. You want people not to work for you but to work with you - in practice, not in theory - and consumer-directed care, the entitlement. We've made consumers the core of our focus in the report, so I think in terms of your experiences, hopefully the direction we've taken in that is resolving some of the issues that you've had.

The carer issues and the isolation and that feeling of isolation - and I feel that in you - I also understand that. I think again what we've tried to do with the Gateway, or what we've recommended is of course - and we've again recognised the importance of carers - that in fact when somebody does engage with the Gateway, it's not only about just assessing the client or the resident; it's also about assessing the carer and their capacity, and doing care coordination so that going forward people like yourself are not going to feel so completely and absolutely isolated, so that when you get your entitlement and you go to your care provider, you will have a case manager who will be working with you and your mother-in-law. So I think the report is taking us through a fairly significant change from the way things were done

to the way that we're recommending that they are - - -

MS BROWNE: Coordinated and fortified.

MS MACRI: Yes.

MS BROWNE: Before we run out of time, could I make some comment about the complaint procedure process.

MS MACRI: Yes.

MS BROWNE: Maybe I'll just make some quick points and you can pick them out, if you care to. Firstly, respite: Cheryl would like me to mention that particularly, because she has experience with the disability scheme, and I take note that you're going to make further comment under the Disability Insurance Scheme, which will be interesting. Because her mother was far worse off than my father, was totally dependent - although Dad was immobile - she said flexibility of respite dollars is crucial. This is as a I understand it from what she's said, and without she reading that: disability dollars for respite can be transferred between the facility and home or from the facility; it can be used in the home. We can't.

Now, they it seems are under the one portfolio. Ours is under separate portfolios for elders, old age care. So you've got FaHCSIA and you've got Health and Ageing, so there's a split. Whether that's the reason for it, I don't know, but we cannot - - -

MR WOODS: We'll be talking about an entitlement to respite: that you then get respite from the providers who you choose, and you have a good relationship. So we get rid of all of those.

MS BROWNE: Good relationship: that takes me onto another point.

MR WOODS: Please.

MS BROWNE: To give the balance, I had four years of excellent dealings with provider A under CACPs. We transited to EACH and from that point, as I said before, it went downhill and didn't really stop.

MS MACRI: Did you have to change provider to go to EACH?

MS BROWNE: Yes.

MR WOODS: Won't have to under these reforms.

MS BROWNE: Terrific. It has changed to some extent in the meantime. But because I was pursuing from the outset, things were just not right, as my first case in the system indicated clearly, because I achieved eight out of nine points that were against the provider, in short. It went from the scheme to the commissioner and back, and this was just exhausting. It was gruelling. My problems were that I was pressing for explanation on financial issues. My concern currently is, regardless of the system that's put in place, the new system, that the balance will come to us - and consumer-directed care is not going to be for everyone, we know that. But those who can, terrific; those who can't or those who want to try, would like to, we all need support in various ways. We need support to bring the reins from them to us because that was where I fell into deep, deep, trouble.

I just kept pressing and pressing and asking questions and I still find - I was told the other day - and I'm trying to be general; I will not be specific - "Did you ask the commissioner to query the processes, investigate the processes?" and I said, "I can't believe that in the dozens and dozens of pages and umpteen conversations I had between one and the other, forwards and backwards, over a period of years and the tome of responses I got, the paper war, I can't believe that wouldn't have been done," and the answer was, "Well, I don't think it was." I said, "Are you telling me that I now have to go back again and ask the commissioner to investigate the processes the scheme used three years ago?" "Yes," was the answer. Now, I spell this out in words. So we need safeguards against the problems. Given that there are lots of good - and I'm sorry, I haven't really dwelt on many golds, have I?

MS MACRI: That's all right.

MS BROWNE: But the time, et cetera, and we'll put more in writing hopefully. But we need the safeguards.

MR WOODS: Yes.

MS BROWNE: We who don't have the organisational set-up, we don't have the resources to submit to you or to anyone, we just have our own energies and 24 hours in the day, and we have people who are offside. In theory, they will be there with us, not for us. They will be set up. There will be bureaucracies and organisational stuff. I still am praying that it will change in practice. The balance will come to the other side, to the consumers more. And, if not, then we need a solid complaints scheme that doesn't conduct a paper war. The crux of my difficulties now, or since 2007 - up to that point, I had experience with the resolution scheme with a facility. A period of months went by, but we went in one day, we sat down at a table; three people there asking questions; transcriber; facility manager; myself. Terrific. It was over in a matter of two hours. We all went home. We had been listened to. It was short,

sharp and effective, and I got more out of it than I expected to.

MS MACRI: Good.

MS BROWNE: Admittedly there were problems with that, otherwise it wouldn't have changed; there was no investigation. But we need the best of the resolution scheme, matched up to the investigative processes.

MR WOODS: Yes, agree with that.

MS MACRI: Yes.

MS BROWN: I can't impress that enough, and we need face-to-face - - -

MS MACRI: There has been a review, Merrilyn Walton's report.

MS BROWNE: Yes. She wasn't overly - - -

MS MACRI: Impressed.

MS BROWNE: Yes.

MS MACRI: And you'll find in our report that we've virtually adopted - - -

MR WOODS: Picked up her recommendations.

MS MACRI: - - - and picked up her recommendations.

MS BROWNE: I haven't been able to cross-check that - - -

MR WOODS: Okay. No. But when you do, you'll see that we've said, "Yes, that was an excellent report. It really gets to the point," and we've just largely picked up where she was heading.

MS BROWNE: That's wonderful. I heard a bit earlier on about it, but I haven't been able to follow it through. I think this is what we get frustrated about, too: that we are, in our private lives, trying to keep our lives, and as I said, it's financially, emotionally, physically. As past carers, we pick up the last 10 years of problems that have accrued healthwise - you know, dental problems; never before so much. Financial: never before such an issue. And so forth.

MR WOODS: Given that time has elapsed, and without staying up till 3 am, if at some time in the next few days you're able to go through and give us some feedback

on some of the recommendations you think are useful and would make progress and others where you may still have concerns - - -

MS MACRI: Great. Wonderful.

MR WOODS: Yes?

MS BROWNE: I'll get it to you.

MR WOODS: Excellent. So if you could just annotate those briefly in an email or a letter or whatever is most convenient to you and send them on to us, that would be exceedingly helpful.

MS BROWN: When you say "email" that's another one of the many. I don't have a computer at home.

MR WOODS: No.

MS BROWNE: Can't afford it. Many would have it - - -

MR WOODS: Write us a letter.

MS BROWNE: It's all those things that add up to make a mountain of difficulty, I think.

MR WOODS: Yes. We're happy to have a letter from you.

MS BROWNE: I'll practise my handwriting.

MS MACRI: Mike will print it up.

MR WOODS: You're very kind. Thank you very much.

MS MACRI: Thank you, and good luck.

MR WOODS: Can I ask VincentCare to come forward, please. Thank you very much. If each of you could, for the record, state your name, the organisation you're representing and any position you may hold in it.

MR BLEWONSKI (VCV): Thank you. My name is John Blewonski, and I'm the chief executive officer of VincentCare Victoria.

MS COLLINS (VCV): My name is Catherine Collins and I'm a board member of VincentCare Victoria, and I'm also the chair of the program policy and practice committee at VincentCare Victoria.

MR WOODS: Excellent. Can I say thank you for your contributions to date to this inquiry and the various case studies and information that you put together. That was very, very helpful and gave us some very good insight. So we're very pleased to have been able to engage with you already, and here's another opportunity for you to then give us your score out of 10 on our draft report.

MR BLEWONSKI (VCV): Thank you.

MR WOODS: Talk to us.

MS MACRI: Don't tell a teacher to give scores out of 10.

MR BLEWONSKI (VCV): Could I thank the commissioners actually for making the time available and for seeing us today. We've previously had the opportunity to meet directly with Robert Fitzgerald as well, so that's been very useful in helping us to frame our responses in our submission and subsequently our response to the draft report. Clearly it's an area of social policy that VincentCare has a tremendous interest in and we're very pleased that the commission has taken up the challenge of detailing some possibilities for reform within the system. We've obviously made an initial submission, a subsequent response to the draft report.

VincentCare is an organisation which primarily works with individuals experiencing severe disadvantage and so, rather than responding to the whole of the report, we want to focus particularly on how the issues impact upon our client cohort. There are four main areas that I wish to talk about today. Firstly, the market-driven approach as it relates to disadvantage, then issues surrounding funding, matters related to accessing the system and then finally the Gateway.

By way of background, VincentCare Victoria was established in 2003 by the Society of St Vincent de Paul to accept responsibilities for the society's disadvantage programs for homelessness and aged care. Obviously the St Vincent de Paul Society has a history of over 150 years working with the disadvantaged, so we have

somewhat of a strong legacy in understanding the needs of the client group. Specifically we operate seven aged care facilities throughout Victoria, five in metropolitan Melbourne and two in regional centres. In addition, an ageing in place day therapy facility is also part of our suite of services. VincentCare is committed to the practice of social justice in - - -

MR WOODS: Sorry, just on that, you've got the facilities but you also have - - -

MR BLEWONSKI (VCV): A day therapy centre.

MR WOODS: - - - a day therapy centre but no community care packages?

MR BLEWONSKI (VCV): Yes, we do. We have 25 community care packages which operate from our community centre in North Melbourne. The community centre is effectively a daytime drop-in luncheon service around which we have built a variety of services - podiatry, dental, GP and so forth - and we offer the CACP through that package, and it's something I'll come back to a little later, so thank you.

So the notion of focusing on disadvantage: in that context, while we're very pleased with the commission's approach in establishing a more effectively targeted definition of disadvantage, I suppose what we're concerned about is that it may in fact have the impact of freezing out elements of the community, particularly the disadvantaged. Our view is that market-driven services may in fact freeze those groups out where there may be providers, particularly in specific locations, who are not interested in providing those services - and the capacity of organisations such as VincentCare then to reach into those areas to deliver the services to the disadvantaged.

MR WOODS: In what sense does that change from the current situation? In both cases there would be quotas for supported residents, but there is nothing to require, beyond that quota situation, for providers now to reach into that group, and so you fill a space. Why will this, by freeing up, not only not change that but in fact give you much more opportunity so you won't have to worry about whether you've got 25 CACPs or all of those things if there are people who need the care and they choose you as their provider. Then you'll be able to reach out to them. So what causes it to be - - -

MR BLEWONSKI (VCV): Sure. A number of responses to that. Firstly, I suppose we do have a concern about the percentage by region of concessional packages that need to be offered by providers which, while we know that according to the act they're subject to sanctions, are not strictly enforced and we do know of a range of providers which don't follow that through. So that's an issue for us.

MR WOODS: Sure, but that's fixing that issue. Our structural change doesn't make that worse.

MR BLEWONSKI (VCV): No, but what it then means is for VincentCare to reach into one of those areas where there may not be a provider willing to provide care or packages for disadvantaged - our capacity to do so. As a not-for-profit agency our ability to establish centres and the like in those areas is very limited by the lack of capital funding. That would be our greatest concern: that there are areas of disadvantage that then aren't met by providers.

MR WOODS: I'm still struggling to work out why that's different under our reforms than what it is at the moment.

MR BLEWONSKI (VCV): It is the case at the moment, I accept that point, but the reality is we're not necessarily addressing that through the market-driven approach.

MR WOODS: All right, we'll have that discussion in a minute.

MR BLEWONSKI (VCV): What we would like to do is to have some consideration given to the notion of quotas and how that relates to the disadvantaged, ensuring that the disadvantaged will be able to get the care they need. That's a given. In relation to the CACP packages, we note the commission has put forward a proposal to gradually release the availability of CACP packages and residential care packages over five years. One of the thoughts that we've been exploring within our organisation is whether there would be some benefit in removing the ceiling on CACP packages immediately and perhaps maintaining that five-year reduction and restrictions on the residential care packages in order that that would free up some pressure on the residential care system and ultimately the acute system. We've been effectively able to use those CACP packages throughout our community centre to meet the needs of the disadvantaged.

MR WOODS: When you finish your initial presentation let's explore with you the consequences of quickly opening up, because there are workforce consequences, management consequences. So it's got to be orderly in some form, but whether it's five years, three years, whatever - let's have that conversation in a minute.

MR BLEWONSKI (VCV): Sure. The other issue, as I alluded to, was around funding and there clearly are some issues with the ACFI at the moment in meeting the needs of disadvantaged clients. The inadequacy of that funding to meet the specific needs of those with a disadvantage is causing significant problems. And I don't say that just as to what the ACFI is not providing. We actually were getting increased or larger amounts of funding previously under the RCS systems and within our submission there are a couple of case studies which demonstrate that and where

we have shortfalls in dealing with individuals with complex needs.

MR WOODS: And can I say that sort of good, solid, hard evidence is so valuable. It gives reality to what might otherwise be rhetoric.

MR BLEWONSKI (VCV): The key issue there is that the ACFI is not able to address the complex needs of our cohort, whether that's in behavioural issues or other needs that they have in terms of where they are, given their previous histories. What we're actually also looking at - and I touched on this earlier - was the notion of innovation in terms of response to the disadvantaged through aged care and the need for some provision for increased capital, and that's a struggle for our organisation. We are currently in the middle of a strategic planning process where we're looking at a variety of potential accommodation models that better meet the needs of the elderly disadvantaged. Capital is a significant issue for us in terms of how we might fund developments of that nature.

MR WOODS: Can I just pick that one up? Sorry about keeping interrupting you.

MR BLEWONSKI (VCV): That's okay.

MR WOODS: You're triggering so many interesting issues that we do need to explore. Put the quantum of capital bit aside for the moment but we will come back to it. When you talk about innovative models, that interests me. What are you thinking of? Where is your vision for the future?

MR BLEWONSKI (VCV): Certainly, without pre-empting the thoughts of board - and we're yet to complete our process - we have been exploring the - - -

MR WOODS: Nobody is listening except other - - -

MS MACRI: No, and we have to read - - -

MR WOODS: Because it's on record. But putting that aside - - -

MR BLEWONSKI (VCV): We have been exploring the notion of the development of community hubs where we can develop facilities which enable the pathways between our other services, our homelessness services, to actually relate through to aged care. What we've been looking at is a model that looks at two levels: what is it we create for the disadvantaged who are not yet in need of the aged care system; that is, enabling them to have some secure housing around which they can build employment, education opportunities and the like.

MS MACRI: I was going to ask there, have you got a component of social housing within your - - -

MR BLEWONSKI (VCV): Yes, we do.

MS MACRI: Yes.

MR BLEWONSKI (VCV): Yes. We run a number of crisis accommodation centres. We're a transitional housing provider in the north-western region of Melbourne, and we - - -

MR WOODS: ILUs as well?

MR BLEWONSKI (VCV): Yes, we do operate ILUs predominantly in regional centres - Bendigo, Ballarat.

MR WOODS: And that's where your two resicare facilities are as well, or - - -

MR BLEWONSKI (VCV): No. Our ILU facility sits independently in Bendigo and Ballarat, but we do have ILU facilities in Gippsland which are attached to a residential facility. The history of the VincentCare residential facilities is that they were born out of the St Vincent de Paul conferences, so we've got a hybrid version of developments across the state, which reflect the local community needs. So, in turn, getting back to our hub model, there would be something there within our community hubs that we're looking at for those clients which are pre aged care. Post aged care we look at it as a way of settling clients for long-term secure, sustainable housing.

MS MACRI: With support.

MR BLEWONSKI (VCV): Yes. I should say with adequate supports around that, and the notion of building that around some generic community facility. It can be something as broad as day care, as a cafe and the like, and there are a number of European models and American models which run along these lines, and I know there are a number of agencies interstate that are looking at similar models as well. So that issue of capital to develop something is an issue for us, and we would hope that the Productivity Commission - they have addressed that to some extent - would look at the specific needs of those specialist providers in the disadvantaged area, to perhaps make available some funding linked to the aged care system.

One idea around that has been actually the notion of block funding, and whether there could be for specialist providers - be they in mental health or substance abuse - who are working in the aged care area, to perhaps tender for block funding to

deliver a specific range of services for a particular client cohort, and that's one approach that we've been exploring within our program, policy and practice committee.

The other issue relates to access, and our experience has been that many older Australians are having difficulty accessing the system. As you'd appreciate, given the life experiences of our clients, many demonstrate premature ageing, and our experience has been that more regularly than not clients under 65 years of age are having difficulty accessing the aged care system, and there are a number of reasons for that, none the least being the nature of referrals, and confusion across various ACASs about the referral system, about the appropriate forms, and all those sorts of things go on day to day. The biggest concern is that, as you'd appreciate, once an application is rejected, there is no avenue at the moment for review, and a rejection can take place simply by having a form incorrectly filled out, which is very disturbing.

The other thing that VincentCare would look to within the ACAS system is the notion of having homelessness as a recognition factor, perhaps even documented on the form, and then some sort of mandate to suggest that if homelessness is indicated as a factor, that individual be identified as in need of some aged care, recognising as we do with the Indigenous community that that's an automatic entry.

Finally, in relation to the Gateway, there is no question that we see it as potentially a much more user-friendly service across the whole aged care spectrum, but - and as I talked about in the notion of pathways between homelessness and aged care - clearly our client group has some reluctance to deal with bureaucracies, has some difficulty navigating those systems, so we would like to think that the shape of the regional Gateway actually demonstrates some understanding of the needs of the disadvantaged, and the issues they will face in accessing that. We do note the recommendations surrounding case management and care coordination, and that could be one way through the agency. If we think of some of our clients coming from our community centre, they are connected to workers, and it would be good to see those workers or the work of those staff involved in accessing the Gateway actually funded on some basis.

At the moment, if I think of our facility in North Melbourne, where we have a number of individuals who have no family or community connections, in order to get to medical appointments, to get to day outings and the like. They are very much dependent on staff who are either paid to deliver those services, or a volunteer program but which in itself has inherently built-in costs in terms of managing those sorts of programs.

So before we get to your questions, the issue of particular support needs of the

disadvantaged and the costs associated with that is of concern to us; the issues around the market based system, and the capacity of the disadvantaged to operate within that; the ability of mainstream services ultimately being able to deliver to the needs of the disadvantaged, and also the disadvantaged being comfortable in those environments as well, so there is that issue; and, finally, the notion of the availability of funds for the development of innovative models. So that was sort of the summary of the response we've previously provided to the commission.

MR WOODS: That's very helpful. Picking up a couple of things: with your provision of care to the disadvantaged, some of which would be homelessness but not all of it, do you sort of try and do a cluster model for the homeless so that you can have specialist care and staff that deal with people who have come from that environment, or are they sort of generally dispersed through your facilities according to maintaining social engagement to the extent they do with - or at least with the familiarity from surroundings from where they come from? How do you operate in that context?

MR BLEWONSKI (VCV): Yes. I think the latter is an important point.

MR WOODS: Yes, that familiarity.

MR BLEWONSKI (VCV): The last thing we actually want to do is uproot people from their community.

MR WOODS: Dislocate them, yes.

MR BLEWONSKI (VCV): And if you (indistinct) our hubs, the appropriate client mix within those hubs and where those hubs would be located would have to reflect the demographic of that local area, so we wouldn't suddenly look at importing large numbers of inappropriate groups into different communities.

MR WOODS: In terms of the opportunities that the new model as laid out in our draft offers you, one that has been briefly discussed is your ability then to deliver care to more people particularly in a community or non-resicare environment, and if you've got ILUs and you've got social housing, and the broad range of alternative accommodation arrangements, do you see that what the proposals are would be a positive for you in being able to not need the so much intensive capital additional facilities, but being able to disseminate your care and support out through your other accommodation options; that, you know, you're not having to apply for packages and bits and pieces; if somebody has got an entitlement to care, and you're a provider whom they feel comfortable with, and you can deliver care to that environment - which would include all your ILUs and the rest of it?

MR BLEWONSKI (VCV): Yes, very much so, and that's why we're advocating for some opening up of the availability of those packages, so that we can offer that sort of support in the areas in which we operate at the moment. There's no question of that, and I do note your earlier comment, and I agree with you: the issue in opening up the CACPs system will create huge workforce issues too, as to where we'll get the staff to manage those programs. But it's more about trying to provide some level of service to a group, particularly the disadvantaged, that we're not accessing at the moment, and noting that, as we all do, no-one really wants to move into residential care. We'd all like to stay in some community, in some housing that's familiar to us, where we feel comfortable and so forth.

MR WOODS: In terms of the staffing issues then, if we were to more rapidly open up the community-delivered care side of it, what's your sort of current situation with being able to recruit well-skilled, properly-trained careworkers plus ENs, RNs to the extent that they are required, and others, access to the allied health professionals, et cetera? So what's the situation at the moment and, looking through to the next few years, what do you see as the sort of time frame where you could feasibly ramp up significantly more delivery of care?

MR BLEWONSKI (VCV): I'm sure you've heard from a number of providers the difficulties in recruiting good staff, or recruiting staff per se and then good staff beyond that. An added issue for us is, of course, staff who are able and wanting to work within the sector and comfortable with the challenges of working with clients who have come from some form of disadvantage. At the moment our staff grouping is fairly stable, but there's a relatively high turnover, I would think, particularly at the non-qualified end.

MR WOODS: So these are people with their cert IIIs?

MR BLEWONSKI (VCV): Yes, and we're investing fairly heavily in training with a view to get people staying with us longer, moving to RN-type qualifications and the like. So that's a workforce challenge issue for us. We have the same sorts of issues in our homeless sector as well. But we feel that it's a challenge worth pursuing, in terms of trying to get those services out to individuals.

MR WOODS: Do you differentiate between RTOs, in the sense of, when potential new recruits come to you, do you ask (a) do they have their cert III; and (b) where did they get it? Do you apply a two-tier filtering system, or do you just look at them and judge them on their own capacities and skills?

MR BLEWONSKI (VCV): Essentially, yes, and that's what it comes down to.

MR WOODS: Do you find the delivery of the cert III - or at least what skills

they've come to you with, having got the cert III - variable between different people?

MR BLEWONSKI (VCV): Different providers, yes, given where they have come from.

MR WOODS: Yes.

MR BLEWONSKI (VCV): But part of that is the challenge for the facility manager to actually work with them and bring them into our, I suppose, organisational culture.

MR WOODS: True. But is there something that we should be looking at sort of one step back - ie. what is the quality of training and skill development that is happening - or are you happy to say that as long as they've got a few basics you'll then train them within your framework?

MR BLEWONSKI (VCV): Yes, and that's essentially what's happening, yes, and I think we would continue that, given the shortages in the workforce.

MR WOODS: Okay, that's fair enough. Funding issues would be all-important because you need to actually be viable to be here, but on the capital side, the proposed reforms talk about providing more transparently a level of funding for supported residents that actually matches the accommodation standard that is required - and we can have a debate about what standard that is - - -

MR BLEWONSKI (VCV): Two beds? I gather the two beds are gone? Is that - - -

MR WOODS: I, for one, have waved the white flag, but - we're having that discussion, but, yes, I'm madly waving it. So there's a higher rate of pay for the accommodation for supported residents - and let's not get stuck in the finetuning of it - but there's also then the capacity for non-supported residents. What would be your ratio of supported or concessional and supported in all that bucket, compared to - - -

MR BLEWONSKI (VCV): Yes. That, in itself, has been a challenge for our board, to look at the notion of concessional versus real disadvantage - which is perhaps another topic - - -

MR WOODS: Yes.

MR BLEWONSKI (VCV): - - - but we try and maintain that 40 per cent level across all of our facilities for two reasons.

MR WOODS: In fact, would you be higher than that?

MR BLEWONSKI (VCV): Yes, and we have no issue with that.

MR WOODS: Yes, so what levels would you actually be operating at?

MR BLEWONSKI (VCV): At some of our facilities, closer to 50.

MR WOODS: Yes.

MR BLEWONSKI (VCV): Others would be 42, 43 per cent.

MR WOODS: Okay, yes. I would have expected in some, given the demographic that you focus on, that you are looking more at 50.

MR BLEWONSKI (VCV): Yes. What's becoming more of a challenge now is the fact that we are - it's the high care/low care mix for us.

MR WOODS: Yes.

MR BLEWONSKI (VCV): Where we're getting increasing numbers just one in high care - - -

MS MACRI: Yes.

MR BLEWONSKI (VCV): - - - the nature of our facilities - many of them are aged facilities - can't accommodate those individuals. So that's a challenge for us - - -

MS MACRI: Yes.

MR BLEWONSKI (VCV): - - - in terms of maintaining redevelopment - - -

MR WOODS: So you've got a redevelopment plan that you've got to also - - -

MR BLEWONSKI (VCV): Yes. We have very basic issues where we operate, for example, a 35-year-old nursing home, where we have a shared ward of four. In terms of maintaining those numbers, as you'd appreciate, if we have one resident moves out and it happens to be a man, we can't take the next person obviously because she's a woman. There's all those sorts of challenges. Where we have shared en suites, the same sort of thing applies. So it's that nature of the older facilities.

MR WOODS: But presumably that one has well and truly been paid off and it's

about time for redevelopment.

MR BLEWONSKI (VCV): That's more of the issue, is to redevelop the facility at current costs.

MR WOODS: It would just be generating cash for you at the moment.

MR BLEWONSKI (VCV): Yes.

MR WOODS: There wouldn't be too much by way of a capital charge left on it.

MR BLEWONSKI (VCV): True, yes.

MR WOODS: Yes. So there would be the higher payment for supported residents for their accommodation component - we're not talking about care, that's a totally separate thing - - -

MR BLEWONSKI (VCV): Yes.

MR WOODS: - - - but for the non-supported and that sort of 50 per cent plus of your population - as you say, they're increasingly high care rather than low care. Under our proposal all that distinction goes away. You charge a rate that reflects the quality of the accommodation; you have to offer a daily charge or weekly rental or periodic charge of some variety; as well as, if you wish, a bond. Do you see that as a significant issue financially, apart from the concept that you might actually have debt rather than bond offsets?

MR BLEWONSKI (VCV): Yes.

MR WOODS: But in terms of actual cash flows and ability to pay, have you done some modelling and played with numbers and - - -

MR BLEWONSKI (VCV): We're just in the early throes of that through our strategic planning. We actually had a discussion this morning at our finance committee about that. The lack of bonds - if we were to move into a total - - -

MR WOODS: Maybe a reduction in bonds, but - - -

MR BLEWONSKI (VCV): If we were to move to a total disadvantage focus in our provision, where we would only have supported residents for instance, we would have no bonds. So we need to work back from that provision. So it is an issue for - - -

MR WOODS: You could choose to do that now. The new structure doesn't change that.

MR BLEWONSKI (VCV): No. It doesn't change it, yes.

MR WOODS: That's a strategic issue for you, irrespective of which structure you're operating.

MR BLEWONSKI (VCV): Yes. Hence my thoughts around some extra provision for specialist providers who, because of the cohort they're working with, aren't necessarily going to attract bonds into a specialist facility.

MR WOODS: But that's the accommodation side, not the care side.

MR BLEWONSKI (VCV): The care side.

MR WOODS: So as long as the care cost is adequately reflecting the care provision, that's a separate issue to - - -

MR BLEWONSKI (VCV): That would be an improvement from what we've got now, yes.

MR WOODS: - - - the capital side.

MS MACRI: Yes. Just in terms of when you talk about ACFI on the funding - - -

MR WOODS: And RCS.

MS MACRI: - - - and RCS, we've had four people who are doing homeless-specific services and it's a particular cohort of people generally - younger onset of dementias and all sorts of things, through drugs, alcohol - and so we understand that the ACFI is not reflecting adequately those behaviours of that cohort of residents. When you talk about "disadvantaged", are you talking about homeless or are you talking about another cohort?

MR BLEWONSKI (VCV): No, sorry, the whole spectrum. So they may have been homeless; they may be, through substance abuse, suffering mental health issues and the like. So they're not necessarily all homeless.

MS MACRI: No.

MR BLEWONSKI (VCV): But they have a mixture of challenging behaviours or a lack of social supports which put them into our disadvantaged description.

MS MACRI: So is that lot also not being reflected - if I separate them out a little bit - because it's very hard for us to be saying - - -

MR BLEWONSKI (VCV): Sure.

MS MACRI: - - - ACFI needs to be rejigged or looked at in terms of a specific cohort of residents with very specific behavioural problems. It's fairly hard to then go across - because you can do that on a block funding - - -

MR BLEWONSKI (VCV): Yes.

MS MACRI: - - - in a hub or in a specific facility. But then, when it becomes a smattering of one or two here or one or two there, it becomes inherently a little bit more difficult to start tweaking the instrument for an individual. This is the thing we're wrestling with at the moment, as to what you do with a cohort of residents that are specifically in a facility, or whether you have a cluster, or then whether you have an integrated model.

MR BLEWONSKI (VCV): Yes.

MS MACRI: So just your thoughts - - -

MR BLEWONSKI (VCV): At this point in time we essentially work off an integrated model.

MS MACRI: An integrated model, yes.

MR BLEWONSKI (VCV): So that's where we're able to demonstrate pretty clearly the discrepancies in the funding we're getting for individuals with high needs, if you like. Let's call it that. In a cluster model it may be a little easier because you would have a whole group and you could provide, through block funding, specialist programs and the like. That was where our thinking was going with that notion around specialist funding for specialist providers.

MS MACRI: Because I might say, too, that people are telling us outside of that that ACFI is not reflecting adequately residents' behaviours anyway, just in the - - -

MR WOODS: As a general thing.

MS MACRI: In the general residential aged care facilities. There sort of seems to be two problems around that. One is around the people with dementia and behavioural problems and then the disadvantaged people that that will - - -

MR BLEWONSKI (VCV): That's a real challenge for us. If I think of one of our facilities in North Melbourne which is not far from the community centre, we have the highest number of supported or concessional residents but the others, while they may have some funds behind them, if you like, they still come to that facility because of the nature of their life experiences and their behaviour. We get huge variation in the funding for those individuals.

MR WOODS: I'm conscious of the time. Are there any final comments that you want to draw to our attention that we haven't covered or that haven't been dealt with in your submission?

MS COLLINS (VCV): As you can see, I've left John to do the talking but there are just two things: (1) I'd like to commend you on the inquiry. My sense in reading the summaries of it - I can't profess to have read all of it as I could see the size of it and that's why I didn't try to - is that in it you have attempted to deal with and attend to the dignity of older Australians. For me this is the essential aspect of what you've tried to do. If there is one or two, it's still how do we attend to the dignity of all older Australians? Sometimes they mightn't be able to be categorised and I think you have tried to do that to a large extent.

The matter of capital funding: we have our dreams and we hope our strategic plan comes up - the dream that has become, in our collective wisdom, the hub-type situation such as Habitats in Holland. We're never going to achieve that on our own but we would see it as normalising the lives of those, some of whose lives have never been normal, in their older age, whatever their incapacity - dementia, simply being older and as you get closer. You understand what that means?

MS MACRI: We do, too.

MS COLLINS (VCV): Financially; absolute loneliness; being alone.

MR WOODS: In isolation.

MS COLLINS (VCV): And all those things which I think you've alluded to as well. So I think to offer some capital funding to people who are prepared to be innovative, put their organisation on the line and attempt to achieve as much as they can to dignify those who are very disadvantaged in our community is wonderful; something to aspire to. So I would like to think you would consider that. We've already talked about the Gateway and in a way you would have read that case study of that 18 months it took for someone to try to gain the trust of someone just for that person's normal cleanliness and health and concerns, and went on to be a wonderful success.

That's the crux of who we're working with - and not to have bureaucracy here, and these people here, and somewhere there's a carer muddling in the middle - to as best you can provide for that service. It's really the dignity of those people that is critical. So I'm looking to say congratulations and I hope you're congratulating us on our report in attempting to enrich what you've already done.

MS MACRI: Yes.

MR WOODS: We are very grateful for your contributions. Thank you very much.

MR BLEWONSKI (VCV): Thank you.

MS COLLINS (VCV): Yes, thank you.

MR WOODS: Mary Archibald. Please, for the record, could you state your name and if you are representing any organisation to advise as well.

MS ARCHIBALD: I'm Mary Archibald and I'm representing myself as an individual.

MR WOODS: Thank you.

MS ARCHIBALD: Maybe older Australians, I hope. I want to read my submission today because I want to try and maintain the thread of the argument I'm trying to make here. So I'll just give you a little bit about my background. My comments are those of a registered nurse with over 40 years of work experience in the public and private sector, including working as a CEO and director of nursing in a public hospital and as a clinical educator in aged care from 2002 to 2008. I've held directorships in the public and private sector. I also write from experience as a guardian of a nursing home resident and latterly as a member of an incorporated association which is an approved provider under the Aged Care Act of 1997.

So my particular interest in speaking to you today is on the matter of boards of management in nursing homes. My submission concerns the management of aged care services at service provider level and, in particular, the regulation and operation of boards of management. The focus is private not-for-profit providers, which currently comprise the majority of providers in Australia. In my original submission in July of 2010 I discussed the regulation of corporate governance of nursing homes, noting that some were covered by federal law, the Corporations Act, and some by various state laws. So while approved providers are subject to the same regulation about standards of care, they are subject to very different forms of regulation in terms of their corporate governance. It all depends on the legal status of the approved provider and the state in which they are situated.

In my July submission I provided some examples of the different types of regulations applying to providers in the not-for-profit group. Where they are regulated under state law, regulation appears to be wafer thin. So the types of organisations: the Australian Institute of Health and Welfare classifies providers of aged care services. It distinguishes between private, not-for-profit, and government - state and local - providers. The largest group, representing 60 per cent of all providers, is the not-for-profit group. This classification is misleading, however, because the private category is also for profit and the not-for-profit category is also private. It would be clearer if the categories were private for-profit and private not-for-profit.

Incidentally, none of the privately-owned service providers, meaning almost all providers in Australia - like 98 per cent - is subject to freedom of information law.

This is relevant to the issue of transparency I will discuss below. An interesting but complex question is, who are the owners of the myriad of nursing home providers which are incorporated associations? Clearly this would be a matter for the specialist lawyers. Do the members of the association own these incorporated associations? Does the community? Obviously the lawyers will need to address this issue.

So I think what needs to be done is stronger recommendations need to be placed in the final report on a matter that I've just addressed, because I have observed first-hand poor management, both at board level and prior to 2009 at CEO level. I believe that in its final report the commission should make stronger recommendations concerning the management of nursing homes. Before outlining some proposed recommendations, I will refer to the coverage of management in the draft report, so Caring for Older Australians, the draft report, the issue of management. The draft report is silent on boards of management, as far as I could read the document.

The only reference to management at service provider level is in the context of recruiting and retaining an appropriate, skilled, permanent workforce and this can be found in the draft report on page 362. The draft report has only one relevant recommendation, and it relates to education for managers, but does not mention education for boards of management.

So the recommendations that I have come up with or tried to address are the following: the following are some of the suggested recommendations drawn from the issues raised in the discussion below. They are directed to boards governed by state laws, as distinct from those governed by the federal Corporations Act. It is assumed that the private for-profit providers will be governed by the Corporations Act. So my first recommendation is that there should be increased scrutiny of the recruitment, selection and terms of appointment of boards of management at private not-for-profit approved providers. At present the Aged Care Act at section 8 item 3A requires that:

> The suitability of members of a board of management who meet the definition of key personnel under the legislation be considered when an application is made to become an approved provider.

So that is at the beginning when an application is made to become an approved provider. There does not, however, appear to be any check on suitability of members over time to take account of changes in board membership, nor does there appear to be any check on the process of recruitment and selection of board members.

My second recommendation is that boards of management of private not-for-profit providers should be required to attend accredited directorship courses.

The purpose is to ensure that board members have the same skills and abilities as would be expected of directors in the corporate sector.

My third recommendation is that boards of management include at least one member with formal qualifications and experience in human resource management. In its discussion of workforce issues, the commission has recognised the importance of human resource management, and the eventual impact of such management on the quality of care able to be provided. It would be desirable for the skill profile of boards to include this important area of expertise - that is, human resource management.

My fourth recommendation is that a residents' representative be granted observer status at board of management meetings, with an obligation to report back to residents' and relatives' meetings. This recommendation relates to the general issue of transparency of governance in private organisations receiving large government subsidies, and is in the spirit of the charter of residents' rights and responsibilities.

So now I'll go to the regulation of public hospital boards of management. As I discussed in my July 2010 submission, the governance of public hospitals is regulated under state law. In Victoria, the regulation is detailed concerning the method and selection of their boards of management. There is transparency. Vacancies are advertised in newspapers, and criteria for selection are available to anyone interested. In my appendix to this document, I have enclosed this advertisement which was in the media, and if you go to the web site that it is noted on this, you then can print out this document and it reads:

> Appointment and remuneration guidelines for Victorian government boards, statutory bodies and advisory committees dated January 2010.

If you look at the index, you can see a rigorous process is in place to identify membership requirements, recruitment of board members, advertising guidelines, selection process, screening of board members, decision-making, annual report to cabinet, application of the Information Privacy Act 2000, appointment and reappointment procedures, termination of appointments, and so it goes on. I don't see any such rigour in the area that I have been talking about. The term of office and method of removal from office is also public knowledge in this document, and I believe this is not true for most nursing homes.

But public hospitals and private not-for-profit nursing homes have something significant in common. They all receive large subsidies from the public purse, and to me that is the significant issue. It's not about ownership. Like a publicly-owned public hospital being publicly funded, a privately-owned nursing home is publicly

funded.

So now I'll go to private not-for-profit providers covered by the Victorian law. This situation for nursing homes whose corporate governance is under the jurisdiction of Victorian law is now discussed. I firstly say the number of approved providers registered under the Victorian law is unknown. An inquiry to Consumer Affairs Victoria on 17 March 2011 established that there is no exhaustive list of registered associations, nor classification of associations by industry sector, hence the number of nursing home providers operating under this law is unknown. Anecdotal evidence suggests that there are hundreds perhaps thousands of associations of diverse kinds. If there are no lists of registered associations, this suggests that routine auditing of adherence to rules by the relevant government agency is unlikely. It is unknown whether, in terms of monitoring, distinctions are made between associations as diverse as suburban sports clubs, perhaps reliant on their own resources, and nursing homes receiving millions of dollars of public money.

Associations excluded from the Corporations Act: the relevant legislation in Victoria is the Associations Incorporation Act of 1981. Section 53 of this act provides that, "Unless an association is also registered as a company under the federal Corporations Act, the provision of the latter legislation does not apply." So what I'm saying is that the Victorian regulation is limited. The Associations Incorporation Act stipulates minimal requirements concerning boards of management, and under the act a board of management is referred to as "the committee", and the association rules must provide for:

(a) the election or appointment of members of the committee;
(b) the terms of office of members of the committee;
(c) the grounds on which or reasons for which the office of a member of the committee shall become vacant;
(d) the filling of casual vacancies occurring on the committee; and
the quorum and procedure of meetings of the committee.

This is taken out of the Associations Incorporation Act of 1981 schedule item 4. It is clear that this regulation leaves a great deal of discretion to boards; for example, there is no upper limit on the term of office. From my experience, some members on the not-for-profit private sector incorporated associations can be on boards up to 15 to 20 years. The limited provisions in the federal Aged Care Act that I have talked about earlier, and the Victorian Associations Incorporation Act suggest there's little scrutiny of the corporate governance of nursing homes registered under the state law in Victoria.

So I want to now go to my experience with boards of management, and

responsibilities of boards of management a case in point. Approved providers operating under state law will be governed by rules of association registered under that law. The following Victorian example is a case in point. Two typical responsibilities of boards are to develop policy and to appoint and select staff. This is evident in the rules of Association X which read:

> The board shall manage the business and affairs of the association, and shall have the power to perform all such acts as seen to appear to the board to be essential for the proper management of the business and affairs of the association, including responsibility for the policies of the association, and the appointment and termination of staff.

That's a direct quote out of this Association X rules. A board may delegate responsibilities to the CEO, and this occurs in the above example, where the CEO responsibilities are expressly stated in the rules. The board is ultimately responsible, but obviously a crucial decision a board makes is to appoint the CEO. The CEO then selects the staff. The skills and personal qualities of those selected are central to the quality of the service provided, so the board will drive the culture of the organisation, and we should not forget that the organisations involved here are responsible for the care of frail, dependent elders typically with multiple medical problems.

An illustration of board of management practice, from my experience: (a) unusual events during 2009. The approved provider in this example is based in Victoria and is among the 60 per cent of providers classified as not-for-profit by the AIHW. In earlier years, this annual statistical overview of residential aged care provided more detail on the types of organisation and in the earlier classification this provider would be classified under the category of community based organisation.

In this example, the approved provider is regulated by Victorian law, the Associations Incorporation Act of 1981, with respect to its governance. I believe the events relating to governance during 2009 suggest a lack of transparency in the processes for board appointments. It is pertinent to note that this association has been registered for over two decades. (1) Board processes: during 2009, the board launched a membership drive publicised through the association's newsletter. At the 2009 annual general meeting, members of the association were told that this was the first formal meeting of the association. They were advised that on previous occasions the AGM had been an informal meeting of all interested parties, without regard to financial membership of the association. This seems extraordinary, and it's hard to imagine an approved provider operating under the federal Corporations Act being able to do this.

The minutes also record that the existing board members had all nominated for positions on the board; a motion that the nominations be accepted was carried

unanimously; an agenda had been sent to members but, significantly, there was no formal call for nominations and there was no nomination form accompanying the agenda. There was no proxy vote form accompanying the agenda. In the abovementioned newsletter there had been an obscure reference to the right of a financial member to nominate for the board and the discussion of membership in the newsletter was sandwiched between commentary on second-hand clothing, winter menus and a new part-time nursing position.

My second point is they're operating with outdated rules. At this time, at this AGM, there was also discussion about the association's rules and the fact that they had not been authorised for many years and were no longer relevant. So the sequence of events was such that the board was elected unopposed, before the meeting was advised of a problem with the rules. I believe it is arguable that natural justice principles were not followed in relation to nomination for board positions, and it was unclear what rules were operating when the board was re-elected for a further three years.

Now, (b), my second point is the annual general meeting of 2010, following the 2009 episode that I've just described. I note behaviour by board members. At the annual general meeting of the association in 2010, questions were asked about risk management strategies and about due process in relation to board appointments. On raising risk management strategies, the questioner was subject to hostility and aggression from a board member. The risk management questions were prompted by the fact that a resident had recently experienced an acute psychotic episode, in which in excess of 20 panes of glass were smashed and some residents and staff were traumatised.

A letter was sent to the board chairperson in late December 2010, expressing concern about what had occurred at the AGM and, following no response, another letter was written in late January. A scrappy reply was received which did not deal with the substance of the letter but adopted a personalised approaching, citing the chairperson's health problems. I believe this is unprofessional. If a board person is unable to function, the responsibility should be temporarily passed to a deputy. The board in question would certainly benefit from some management education. It may well be that this lack of professionalism extends to other boards of incorporated associations.

My final point is this one: it's about the management culture. Over a period of three years, 2005 to 2008, the board of management and the CEO of this association did not deal with complaints on their merits. They were hostile to complainants, seeking to make the complainant the guilty party, and on occasion sending lawyers' letters designed to intimidate. The management culture did not accept the legitimacy of making a complaint. The association was subsequently found to be in breach of

the Aged Care Act on four separate occasions, including one instance where the then chairperson of the board was found to be in breach of his responsibilities. The four findings of breaches of the Aged Care Act are significant, because under the Aged Care Complaints Investigation Scheme the percentage of complaints that are upheld is in the range of 10 to 14 per cent.

In conclusion, I believe that the quality of management is critical to the nature of the services provided in nursing homes, and it deserves more attention than it has in the draft report. I urge the commission to give favourable consideration to the proposed recommendations I have made today.

MR WOODS: Thank you very much. That was certainly a very comprehensive and well-structured submission. You make some very valid points. Sue, have you got any particular questions?

MS MACRI: No, look, I don't really. Undoubtedly when we look at trying to get directors on boards today, in metropolitan regions it isn't so difficult, if we look at the industry as a whole across Australia. When you get out to small rural communities, sourcing directors from small local rural communities for community based services has been and continues to be a real issue. I think you raise some very good points there in terms of that, but I think again, in larger metropolitan regions, your talent and your capacity to access good board members is very different to getting out to smaller rural remote communities where it always tends to be, they tell me, the poor old doctor or the pharmacist and three or four organisations - - -

MR WOODS: Used to be the bank manager, but they don't have them any more.

MS MACRI: The bank manager normally. I think you raise some really legitimate and very important points, but sometimes it's not quite as easy to address in smaller rural remote communities as opposed to larger regional. But it's an issue; it is an issue. There have been some comments around the accreditation standards and the lack of standards around boards and general management in the accreditation standards, so I think you raise some very legitimate issues going forward for the industry in terms of that overall management.

MS ARCHIBALD: In your comment you seem to be referring to health services, hospitals, from my experience of what you're saying - - -

MS MACRI: No.

MS ARCHIBALD: - - - and you're not making reference to nursing homes, aged care services, are you?

MS MACRI: No. I'm making reference to smaller community based residential aged care facilities in rural remote areas.

MS ARCHIBALD: I'm talking in my submission about metropolitan Melbourne, probably 20 minutes from here.

MS MACRI: Yes, and I gathered that it was in a larger city. Yes.

MR WOODS: But we're looking at how it would apply nationwide, so we're looking at your principles and we're also looking at how they apply throughout Australia, so that's been quite helpful.

MS MACRI: Yes.

MS ARCHIBALD: I suppose what I'm trying to say is that the Aged Care Act doesn't seem to cover selection and appointment of board members, as I've pointed out. It's only at the initial selection of the provider and the selection of the board. There's no follow-through. And incorporated associations in Victoria, I've also pointed out the deficiencies. I'm on a disability services board myself as well, and I'm finding that it is an incorporated association and there are similar issues here; not about the choice of selection but about the monitoring and the scrutineering of what happens with boards of management. I've given you examples today, actual examples of my lived experience with a nursing home - - -

MR WOODS: We gathered that.

MS ARCHIBALD: - - - and I can tell you that it was a harrowing journey. I have significant experience and I'm not an ego motivated person, and I wish that nobody else would go through the experience that I had. Most of that board is still in situ, and I find it imponderable and difficult. I have not named them purposely, but I've put it through as a principle that I commend to you to think about, and I am thinking about all of Australia when I write this document today.

MR WOODS: Yes. Thank you very much.

MS MACRI: Thank you very much.

MR WOODS: We will adjourn until 3 o'clock. Thank you.

MR WOODS: Could you please, for the record, state your name and if you are representing an organisation, that organisation and the position you hold.

DR SILVESTER (AH): Sure. I'm Bill Silvester. I'm the director of the Respecting Patient Choices program based at Austin Health. It's a federal and state government funded program. I'm also an intensive care specialist.

MR WOODS: Excellent. Thank you for coming. I think I've actually read that somewhere, but I'll go back through it. But, please, talk to us.

DR SILVESTER (AH): Okay. What I wanted to say today is based on the assumption you've had an opportunity to look at our written submission. I've been accompanied today by Rachael Fullam and Rebekah Sjanta, who are two project officers from our group who have been working particularly in this area.

MR WOODS: Just on that, I notice that Rachael is due to appear next, but are you better doing a collective thing?

DR SILVESTER (AH): Both Rachael and Rebekah - - -

MR WOODS: Both. Come on up and let's just have a collective discussion. That will make life easier for everyone.

DR SILVESTER (AH): We've got two 20-minute timeslots.

MS MACRI: That's right.

MR WOODS: So, yes, we'll just put it all together and have a conversation. Could you each please, for the record, state your name and the organisation that you represent.

DR FULLAM (AH): Yes, I'm Rachael Fullam. I work for Respecting Patient Choices as a project officer.

MS SJANTA (AH): Likewise, I'm a project officer with Respecting Patient Choices, and I'm Rebekah Sjanta.

MR WOODS: Thank you. Please proceed.

DR SILVESTER (AH): As I said, I assume that you've had an opportunity to read our submissions. I just wanted to speak more from a personal perspective - but still representing the views of our organisation - of some of the sort of informal things that one can say that it's harder to put in a submission. So I'm just going to go

through a few notes that I made.

I think working as healthcare clinicians or healthcare professionals is both a privilege and a responsibility. In the context of what we're talking about today, it's a privilege to be there when a patient recognises that what you're telling them leads them to understand that they have a right to say what happens to their body, what happens to themselves, not only in the future when they lose the capacity to be able to make those decisions but, indeed, now. We often have patients who say, "So I can actually have a say what happens to me at this time?" It's also a responsibility, to always be acting in their best interests rather than in the interests of others, particularly the family or the doctor or other people.

As an intensive care specialist, I'm continually aware of my common law duty as a doctor to be acting as other reasonable doctors would do, and particularly to be sure that I'm working towards saving or prolonging life but also acting in a patient's best interests. No-one wants to be, from what I can tell - whenever I run instant show-of-hands surveys, I've never had anyone put their hand up and say they want to end up in a nursing home in a disabled condition; yet the elderly are amongst the most vulnerable in society.

I know that we've failed when we have an elderly patient who comes in from a nursing home with severe dementia, who lies in a bed in the orthopaedic ward for six weeks in a foetal position - because of their severe dementia - with a fractured hip while the surgeons and anaesthetists are trying to debate whether she's well enough to have an operation, until eventually her family are the ones that come to their senses and say, "Enough is enough," and then the patient is referred to palliative care. That's the sort of situation we see - not always that, obviously - but that sort of situation we see both in the hospital and in aged care facilities, where the vulnerable are not receiving the care that they would have wanted.

We know that we've missed the mark when we see so many people in nursing homes with severe dementia with PEG tubes, where in speaking to their families when it's eventually brought up, they indicate that's not how they would have wanted to end up.

MR WOODS: To clarify, on the previous example you have somebody, they've fallen, fractured their hip, it's a question of operate or not, capacity for recovery, the whole bit. But presumably during that time they are getting pain management in that sort of generic palliative care sense. So the difference then is whether that then becomes the primary treatment for the rest of that person's life rather than an intervention to try and correct a particular - - -

DR SILVESTER (AH): Sure. It's a good presumption, but it's not always the

reality. Frequently it's not the reality.

MR WOODS: Can you expand on that a little bit for me?

DR SILVESTER (AH): Yes. Often orthopaedic surgeons are operating on elderly people coming from nursing homes with fractured hips - - -

MR WOODS: Yes.

DR SILVESTER (AH): - - - simply to try and handle the pain, not because it's going to restore them to any good state of health. You're simply locking the two broken bones together - - -

MR WOODS: Yes, putting a plate - - -

DR SILVESTER (AH): - - - so that every time the nurses turn the patient over in bed or have to provide hygiene care they're not crying out in pain. So this woman, although she was severely demented, was in pain for six weeks, because it doesn't matter how much morphine you use in those sort of patients, they're still going to be suffering.

MR WOODS: I understand that.

DR SILVESTER (AH): That's frequently a problem.

MR WOODS: Okay.

DR SILVESTER (AH): Certainly from my personal experience, and the responses we get from the staff that we've trained in aged care facilities, it's a privilege to inform a family of a non-competent resident - and as you may or may not know, two-thirds of residents in aged care facilities across Australia are recognised as not being competent - that it's okay to discuss what to do if Mum or Dad should deteriorate or take a turn for the worse.

Many times I've seen, in those situations, a look of relief upon the family's faces when someone has given them permission to bring this up, because up until then what's been weighing on their minds has been exactly what to do, but they didn't know how to bring it up for fear that their concerns would be misjudged as being callous or uncaring or even calculated to finish things off or to get the family home or whatever. I'm amazed that I've even had well-informed, understanding general practitioners who have said the same thing, that they didn't even know how to bring it up when it was one of their parents.

So we know, from independent research, that the public - including the elderly - expect us as health professionals to bring up this whole issue about what to do if they deteriorate. Because they expect us to do it they don't bring it up, and if we don't bring it up because we're not trained or authorised, then patients frequently - hundreds of patient every year are falling through the cracks of receiving treatment they wouldn't have wanted because someone just never got around to or didn't know how to or didn't feel authorised to bring up the whole issue of advance care planning.

MR WOODS: So when they came into the facility, they didn't undertake an advance care planning process?

DR SILVESTER (AH): Absolutely. The surveys that we've done - and others - have shown that probably more than 80 per cent - in fact it would be higher than that - of facilities and staff in facilities don't do any advance care planning, apart from asking usually a couple of questions: "Who will be your funeral director?" and "Where do you want to die?" That really is not even beginning to do proper advance care planning.

MR WOODS: Absolutely. I totally agree. But I've also seen some very good advance care plans and been through the process of discussion and reflection that goes with it.

DR SILVESTER (AH): Yes.

MR WOODS: I've seen both ends of the spectrum.

DR SILVESTER (AH): Yes, both ends. For us, from our experience with the research we've been doing and the implementation we've done since about 2004, it's a win-win situation for all involved. It's appreciated by the patients. They feel listened to. They feel cared for. It's certainly appreciated by the family that their views are going to be taken into account and that they will have the opportunity to be informed by the resident about what they would want. It's also appreciated by the staff. Sometimes we've had, in the surveys they've done, nurses reporting back saying, "I feel good about being a nurse again. I feel like I've got some contribution to make."

It's also supported by general practitioners, once they understand what the process is and, in the work that we've done, although their involvement is voluntary, we find that they get very involved in witnessing medical enduring powers of attorney, with witnessing other forms that have been filled out, with talking to the patients and talking to the families. Their almost unanimous feedback has been that this is a very positive thing.

Of course we can't avoid the fact, and we've included it in our submission, that this is also good for readjusting where resources are spent. It's crazy that we have a system whereby we're doing things for patients which cost a lot of money and which use a lot of resources and which the patient never even wanted, if people had only bothered to find out.

MR WOODS: Which can reduce their dignity and their quality of - - -

DR SILVESTER (AH): Absolutely. So for us, making staff aware, teaching them the skills, giving them the authority and reassuring them that it's not instantly easy and that it will be emotional but it's still worthwhile, are all important parts of the training that we provide to staff who come from aged care facilities, get trained by us and then go back out into their working communities. I think it's because this is a win-win from all aspects and that this can be done in a practical way, that our submission to the National Health and Hospitals Reform Commission led to their two recommendations about the importance of delivering advance care planning to all of 3000 aged care facilities across Australia and beyond, out into the aged care community, and that there should be appropriate training for staff in all facilities. So those were the two recommendations which we referred to in our submission.

As I said, nurses feel good about being nurses again. This does take time but it's time that GPs don't have and so that's why it's appropriate to train non-medical staff to do this and to train nurse practitioners. So we bring them in, we train them, we facilitate the system changes that are required to support this, and then they go back out and, with support, they sustain that or we support them to sustain it. In our first implementation we found that doing advance care planning revealed that more than 90 per cent of the wishes expressed by the residents about what they did or didn't want were then respected subsequently when they were in the process of dying.

Often they would say they wanted to be kept comfortable, they wanted palliative care, although they didn't use that term. They wanted to stay in the facility and then they talked often about very important personal, often intimate, wishes like they wanted certain music to be played, irises in the vases, a penny in each hand for the ferryman, their rosary beads, call their priest, call family and so on. It was always really pleasing to see how much effort the nursing staff would go to to see those wishes being fulfilled. So it's not just about medical wishes, it's personal wishes.

MR WOODS: Totally agree.

DR SILVESTER (AH): And lastly I'd just like to point out, in terms of the work we've done in aged care facilities and that we're now starting to do out in the aged

care community, that we saw a significant reduction in the likelihood of residents being transferred to hospital to die. So we looked at the cohort of residents who didn't do advance care planning and nearly 50 per cent of those ended up being transferred to hospital to die and they died in the emergency department on a trolley, while waiting for a bed, or up in the ward or indeed in other places like the intensive care unit or in the operating theatre.

By comparison, of those who did do advance care planning only 18 per cent of those got transferred to hospital, and of those their length of stay was shorter than those who hadn't done advance care planning and often that was because the family had been informed about what they did or didn't want and they felt strong enough to then go to the doctors and say, "Look, this is not what Mum would have wanted. Please just keep her comfortable."

I'd like to just finish by reading you a letter that I just received yesterday. It's in relation to the article that I've given you a copy of and it's from a nurse who works in the aged care sector:

> Dear Dr Silvester, I'm unable to thank you enough for your caring, thoughtful and wonderful article in the Sunday Age. My 80-year-old father has just been diagnosed with cancer and has made the decision not to have active treatment and is not well enough for surgery. As an aged care nurse I struggled to get my father believe me, during our open and frank discussions about his dying and death, that he is the decision-maker up until the time he is no longer able to. Then, as medical power of attorney, I will follow his wishes.
>
> My father's greatest fear was that he would be kept alive against his wishes on a machine, with all dignity gone. I tried a number of times to explain about advance care plans, as we have had them in place at the facility I work in for quite a while. Dad had difficulty, due to past experience, accepting that these things are now part of the dying process. Upon reading your article he has now come to accept that when this process gets closer that people will listen to him and respect his wishes. I'm unable to express my thanks enough for the peace of mind your article has brought to my father. I have not seen him as relaxed and settled since hearing the sad news.
>
> Again, many thanks from a daughter who would move heaven and earth to make sure her father's wishes to die without pain and with dignity come true. Keep up the wonderful work. With gratitude.

I think what that epitomises is that advance care planning is all about the

discussion. It's the communication, it's a reflection, and so that's why we said in our submission that the draft report from the commission, which focused with regard to advance care planning mainly on the fact that there is no similar legislation in all states and territories, to us is immaterial because we've introduced this program to all states and territories. We run it under the support of common law. We're not fussed about what the legislative requirements are in each state and territory. Because it's all about the communication, the reflection, the discussion and it's not about the legalities and it's not about legislated forms, we've seen it's worked equally well in each place. So at that point I'd be happy to either take questions or - - -

MR WOODS: No, I think we're across it. But if I can just make the one point that at the heart of our draft report and our proposals, though, is the empowerment of the individual. That's the core of that and a natural expression of that is things like advance care plans. You referred to where we'd specifically used those words in the report, but the report itself is much more supportive of that general proposition that somebody has a right to determine who provides services and how they're provided and how they will choose to work through their end-of-life process. I think we're a lot more supportive, broadly, to that concept than just those bits where we happen to use those three words.

DR SILVESTER (AH): And I suppose in the eight years that we've been doing this we've found that empowerment is a great ideal and we see that this is a tool to deliver it.

MS MACRI: Yes.

MR WOODS: And we completely agree. Who's speaking next?

MS SJANTA (AH): I might go next, only because my background is 15 years in aged care and the last 10 years as an aged care facility manager; I guess from a personal professional point of view, just to add weight to the comments already made about the benefits to the individual - and that is the care recipient and the positive benefit to them of advance care planning - and to the family and the flow-on to the provider and the staff who work within the facility. Advance care planning is a process. I think we need to be clear that it can't be a one-stop shop where you sit down with someone, you talk about their advance care plan - - -

MR WOODS: Yes, fill in forms and they can't - - -

MS SJANTA (AH): - - - and potential end-of-life wishes. It is dynamic and it changes over time as the individual moves through their life story. We've looked at the proposal of the Seniors Gateway as a potential for early introduction of advance care planning, so that when an elderly person is captured, I guess, in the system,

there are things in place to check whether that person has previously had advance care planning and, if not, an opportunity to introduce the topic and then for that to carry through their care, wherever it is - whether it's in the community setting or whether it's in a residential setting.

I don't think we need to talk about the extent of chronic disease and the amount of management that that requires these days, and I think people aren't always well informed about their disease processes and potential outcomes. The education of the public and of staff who deal with these individuals - it is paramount that they fully understand disease trajectories and potential outcomes for people, and then there's that opportunity to have these open and frank discussions with the individual; to not make assumptions that the family are fully aware of what the individual may want when the time comes; that the discussion is had, and all parties are understanding the ground that they stand on.

From an aged care management perspective, where advance care planning in a facility is done and done well - because I think, you know, we also need to be aware that there's advance care planning that is done under the banner of advance care planning, but not necessarily a quality, effective communication process. Where it's done effectively, the flow-on effect in terms of the common understanding of what people's perceptions of needs and wants and care requirements, is just so much easier to navigate.

MS MACRI: Yes. The other thing that hangs off this that I think is important - and it just actually twigged me with this, with the Gateway - is the beginning of the journey as being really important. The other one: I'd be interested in your comments around the guardianship and power of attorney, and people not understanding the difference between enduring guardianship and enduring power of attorney. You know, you have this advance care planning, and my experience in another life is around the complexities with families and family members around this whole issue of the decision-making and the dysfunction that occurs between families from time to time. I'd be interested in your comments, because I think it goes very hand in glove with the advance care planning as well. I'd be interested in your comments.

MS SJANTA (AH): Definitely appointment of a medical enduring power of attorney is seen as part of the advance care planning process. Often the benefit of that is, it can be a very difficult subject to address with families, specifically where there are interpersonal relationship issues there, but I think if you can have that difficult conversation, or at least get people starting to think about appointing a particular spokesperson and getting an enduring medical power of attorney early on when a person has capacity, it's proactive rather than reactive, because you're putting things in place to hopefully prevent the crisis management that then inevitably happens down the track, where it becomes too difficult to deal with.

MS MACRI: Are GPs reluctant to become a medical power of attorney or guardian? Are any GPs a bit reluctant around that, or have you reasonably well educated them in terms of this as well?

DR SILVESTER (AH): We've really barely scratched the surface, I think, in terms of broad education of general practitioners about this. We've done some work with the Royal Australian College of GPs and with the Divisions of General Practice, but there's a long way to go with that. Generally we don't find that there are a lot of people wanting to appoint GPs as a medical enduring power of attorney. Usually it's either the family or a close long-time friend. I remember having one woman in her 80s who said she didn't want to appoint her daughter. She'd prefer to appoint the woman next door that had known her for 50 years. They'd had many, many discussions over the kitchen table, and she felt that she could actually trust this person more to honour her wishes, rather than her daughter.

But can I just add, in answer to your question about this whole thing, we know that medical enduring powers of attorney have more power than enduring guardians, and so that's why we encourage the appointment of medical enduring powers of attorney, but in the end it still comes down to the discussion, and the reason why the discussion is worthwhile is because firstly it happens in the cool light of day, rather than when decisions have to be made urgently.

Secondly, it gives people time to reflect upon it, and to have the arguments if they need to, and through the advance care planning discussion it gives us an opportunity to make sure that the focus comes back on the patient when, for example, I'm working in the hospital and I've got a sick patient who's been looked after for the last five years by her daughter, and her daughter knows what her mother does or doesn't want, and then the daughter's bossy brother from Brisbane bowls up and wants to take over.

The reason why he wants to take over is not only because he's a bossy brother, but also last time he had a talk to his mother they had an argument, or he forgot her birthday and he's feeling guilty. So all this is driving him demanding that we're going to do all these things, and we then bring the focus back and say, "Well, look, in fact we know your mother has said she does or doesn't want the following things, and by the way, your mother has also had what would appear to be the good sense to appoint her daughter as the enduring medical power of attorney, so in fact we have to follow the direction that your sister is going to be giving us."

But before even getting down to that point where it's playing one off against the other, which we don't want to do, by getting them to sit down and getting the brother to hear what's been going on, in the vast majority of cases you can resolve

those disputes, because you get the focus back on what the patient - - -

MR WOODS: Or at least resign yourself that that is what the solution is, that the older person, the parent, actually wants that.

DR SILVESTER (AH): Yes.

MR WOODS: "It's still not your choice; too bad."

DR SILVESTER (AH): At times we've had relatives who are saying, "Well, no, I don't really want to follow what Mum or Dad has said," and so we say to Mum and Dad, "Look, why don't you tell your spouse or your child why it is that you've told us that you don't want this or that or the other." When they hear it in their own words, expressed in their own way, they then come on board. So again it comes down to the discussion, and we try and steer away from the legalities, because if you use legalities, someone is going to feel dissatisfied, whereas if you use discussion and reflection, everyone is going to understand, and eventually when that person dies, those who are left behind are going to feel okay about it.

MR WOODS: But it is helpful to have the legalities sitting in the background.

MS MACRI: Yes.

DR SILVESTER (AH): It's helpful, but rarely do we actually need it.

MR WOODS: The discussion is where the resolution has to happen, but the little enforceability sitting behind it is quite a useful part of that process.

MS MACRI: And the Gateway is a nice place for the beginning, for both that medical and advance care planning.

DR SILVESTER (AH): For the guardianship as well.

MS MACRI: Yes, because it gives families also the opportunity to have that discussion as well, so that the discussion is not happening at the other end where everybody is emotional and stressed out of their brains. I've been there, so I know that one.

DR FULLAM (AH): So I really wanted to focus on some of the most marginalised aspects of the elderly population. Quite often, individuals who have moderate to severe dementia are left out of any discussion around treatment planning because they're presumed to be incompetent - incompetent to the point where they can't take part in that discussion. Now, the evidence in the research literature shows that that's

not actually true. People with moderate to severe dementia can take part to some extent in a discussion around their future preferences for treatment. That's a key component of the education model that we are rolling out in the RACF in our pilot project at the moment.

We also need to address elderly people who have severe and enduring mental illnesses as well. Again, when I've said to the RACF staff that we've been training, "How do you address advance care planning in people with mental illnesses?" "Oh, we don't. It's too difficult," because there's a dual presumption of (a) incompetency and (b) emotional instability in this population, and again, when you look at the research literature in this area, people with mental illnesses can in fact take part to some extent in treatment discussions, with only moderate distress. Obviously that's something that needs to be handled clinically by the highly skilled nursing staff at these facilities.

Again this is about really highlighting the complexity of the training that's needed, some of the educational points that we need to get across, to ensure that everybody within the population, particularly in the facilities, is able to be included as far as possible in the discussion. We even say that even if a resident is so cognitively impaired that they cannot take part in the discussion, the discussion should still take place round the individual's bed so that we focus on their best interests. That's a really important point.

We talked a little bit in the submission about the possible impacts on mental health that advance care planning may have. We know that between around 25 to 35 per cent of the general residential aged care facility population would meet the criteria for major depression - very high rates. There are a number of risk factors for depression, including neurological disorders, but also environmental factors, and pain particularly, and also feelings of disempowerment and loneliness.

We would suggest that having an effective advance care planning process that involves an in-depth discussion between the healthcare providers, the family and the resident, however they are able to join in, will help give a sense of control back to not only the resident but also the family. I'm not saying that this is a cure-all for depression, but it's about making small steps, with improved psychological interventions to residents, hopefully, in the future. It's about small steps to improving this problem.

We also make a point of teaching staff about the links between physical health and mental health. We know that there's a bi-directional relationship between the two. Advance care planning, coupled with good palliative care provision - actually reducing pain can reduce symptoms of depression, and treating depression effectively can reduce pain ratings and functional impairments related to pain.

I'm hopefully getting across that there are layers of complexity that we try and communicate in our education and it's again based around the discussion. With some of these very vulnerable groups, we say, "This is not a quick process. You need to have multiple discussions and sometimes you have to go very gently." That was really the area that I wanted to focus on.

MR WOODS: A couple of issues. Let's focus on the relationship between residential care and then possible acute interventions or other hospitalisation. An acute care plan that has been formulated within the geographic context of a residential care facility: what's the likelihood of that understanding actually then following the person should they require being put into ED or even then into subsequent treatment in hospital? What's the success rate of actually having gone through that process and then finding that it's being followed in another environment?

DR SILVESTER (AH): The success of that is impeded by whether the staff send that document with the patient, whether it arrives at the other end, whether the emergency department doctors or the doctors on the ward open the envelope, whether they pull it out and they have any understanding of it. In order for that to work, we need to intervene at multiple points, and it's part of the work we're doing in an ongoing way. We're really trying to take a multipronged approach.

We're working within the hospitals, we're working with general practitioners, we're working with the ambulance staff, we're working with the aged care staff, and we're working with the Health Department here in Victoria and with the Department of Health and Ageing to try and inject some understanding about the importance of advance care planning and how people need to change their systems in order to achieve that very thing. What's our success rate? We haven't measured it. Anecdotally, it's still not great, but we are still really, I think, early on in the overall intervention.

MR WOODS: You may have noticed in our draft report that we are proposing that, when somebody interfaces with the Gateway, you start to develop the basis of an electronic record, which is then added to each time, as they get entitlements, as they use services, as they have other interventions, and that these progressively build up a story. The perfect place of attachment for the advance care plan is in that record so that it's electronically accessible.

There are then still all the other vagaries of life: does somebody (a) know that they've got one when they arrive at the other end? Do they bother to open it up? Do they bother to comprehend or can they comprehend what that actually means in a functional sense? So it's not solving those vagaries, but at least it's getting over one

of the issues that currently exist.

DR SILVESTER (AH): Yes. I've been working with Mukesh Haikerwal, who is the clinical leader on the electronic health record.

MR WOODS: Yes, I know him very well.

DR SILVESTER (AH): He is very supportive of this. I've had a number of meetings with him and I'm on the advisory group that's meeting in Sydney again soon, working towards ensuring that advance care planning is a crucial part of the proposed personal electronic health record in the future to achieve that.

MR WOODS: We're following that debate with interest but, as with other parts of the health reform, the Medicare locals, et cetera, what we're trying to do is put in place a parallel system whereby, should all those medical reforms happen, or health reforms more broadly, then this can migrate into those, but we're not assuming that they will be particularly successful yet; but we're hopeful. So our proposal for our aged care record is such that it could easily migrate into that should it occur. But in the absence of that bit happening, we have still got this as a front end. We could see that that's a way of trying at least to get some progression of that understanding and resolution that's happened.

DR SILVESTER (AH): Some facilities are already trying to address that by having specific coloured envelopes with things written on the front saying, "This is really important. Open this and look inside," and that's where they put it, but still there's no guarantee that it will be opened and there's no guarantee that the doctors will remain patient-centric when they're considering what to do.

MR WOODS: Sad but true.

MS MACRI: This has become more complicated out in the community. The highest degree of aged care now is in the community and there is an increasing choice for people to be palliated at home and die at home.

MR WOODS: So how do you reach them?

MS MACRI: There's this added layer, yes.

DR SILVESTER (AH): Sure. Again, part of our multipronged approach: we've been working - again DOHA funded - to develop advance care planning that's specific for community palliative care services. At the moment we've got a Victorian government funded project where we're putting together a multimedia training kit for general practitioners, GPs in training and doctors in training, to show them how to do

advance care planning. We're working with the divisions to inculcate, through those, to the GPs and the nurse practitioners the importance of doing the advance care planning in a practical way.

MR WOODS: Given the progression of corporate primary care and that loss of relationship between the individual doctor and family - not all, but in many cases - does that make it harder, or are there opportunities there so that the corporate practice as such - that you can intervene there and get it spread through their corporate practice as a part of their ongoing activity?

DR SILVESTER (AH): I think, on balance, it makes it harder. The reason why I say that is because, instead of patients having their one GP that they've had all the time and the GPs having a relationship with X hundred - - -

MR WOODS: And the family.

DR SILVESTER (AH): Yes, and the family - it becomes much more of a conveyor belt - - -

MR WOODS: 10-minute slots.

DR SILVESTER (AH): Yes. Now, you say, "Well, maybe it's better because it's through a corporatised thing." I'm not a GP, but from my understanding, these corporatised general practices don't try and tell the GPs how to do their work clinically; they just make sure they extract their pound of flesh. So the teaching of the skills and the awareness is really still being done through the College of GPs and through the divisions rather than through that corporatised set-up which many of us have concerns about.

MR WOODS: I tend to agree with you. I was just curious as to whether it offered an opportunity, but I think I support your conclusions.

MS MACRI: I think it's a great initiative. Is it being rolled out in other states? Are there strong advocates like yourself continuing this work?

DR SILVESTER (AH): We've set up the advance care planning programs in each other state and territory, and some of them have then gone on to expand - this was the whole idea of the model - to expand what they're doing. In South Australia, for example, they've got a great Respecting Patient Choices program running there and they're now rolling it out into aged care facilities and other health services there and the same is happening in New South Wales; plus, there are others who have already had an interest in advance care planning that are promoting this as well. There's just such a lot to do. It's really very early in the process of seeing this being spread right

across the community.

MR WOODS: Are organisations such as COTA and National Seniors expressing interest in getting that information out to not only their membership but the older population?

DR SILVESTER (AH): They're certainly supportive. Because we have only had limited staff, our ability to infiltrate into all those target audiences has been minimal. We are now setting up a volunteer program to have volunteers that we have trained up - in fact, their workshop is tomorrow - so we're training volunteers to do this.

MR WOODS: So you're doing a train the trainer type thing.

DR SILVESTER (AH): On our steering committee that's managing this particular project of introducing this to aged care facilities, we have Rod Young represented; we have a COTA representative; we have other industry groups. We also have the Australian General Practice Network; we have people from La Trobe University to help guide us and to use them as vehicles out to their organisations. So there's certainly a lot of awareness. We are also aware that Alzheimer's Australia are very supportive of this as well. But so often, although we're chipping away, you feel like you're still just touching the tip of the iceberg.

MR WOODS: Is there any evidence that an advance care plan - however called - that has been almost unilaterally developed by an older person and talking to their children has a different set of outcomes from one that is developed in a more structured environment where you've got a third party who can, not ensure but try and make sure that there is a balance in the power in discussions and resolutions that occur?

DR SILVESTER (AH): What we do know is, when advance care planning involves not just the patient, or in an aged care facility as a resident, but also the family, not only does it achieve better completion of paperwork but it achieves more certainty that their wishes are going to be complied with, because if they end up being in a facility or a hospital where decisions have to be made, invariably the doctors are going to turn to the family and if the family have been involved in the process, they then advocate much more strongly for the patient as to what they would want.

MR WOODS: Yes. I understand the bit about the resident and their family, but I'm also curious as to whether having a third party objective person who is sitting in on that discussion leads to an outcome that more likely reflects the views of the older person as distinct from them sort of being pressured by family members to accept a certain outcome because it satisfies their sense or resolves their guilt or does

whatever it's doing for them as distinct from the older person who says, "Look, all right, if that's what you really want. I would have preferred to have been buried, but if you want me cremated so that you can spread my ashes somewhere, I'll do that." That's a very personal situation I've encountered. But if there had been a third person who could have said, "Well, let's keep discussing this. What is it about burial that you really want? What sort of spiritual satisfaction do you contemplate for that outcome, rather than your daughter's desire to have the cremation?"

DR FULLAM: Yes. The model that we're implementing in the facilities is facilitated advance care planning, so the staff member who's having the conversation, they are literally mediating the conversation between the resident and their family. Part of the education is dealing with difficult family dynamics and how to deal with unreasonable treatment requests from the family and pressure; family pressurising the resident. I think it's really important to have the healthcare provider, care provider there to facilitate that process.

MS SJANTA (AH): We have very much moved to work which involves what we call advance care planning clinicians. Again, there's conversation and there's quality conversation, and in our intense training program we teach people how to have that conversation well: how to ask the right questions; how to make sure that they have captured specifically the individual's wishes. Sometimes individuals may need referral to seek further advice about conditions that they have and so forth.

MR WOODS: And projectories of outcomes of - - -

MS SJANTA (AH): My experience - and, again, this is personal - to date is that if you've got that educated facilitator, that third party person who can mediate and who can ensure that it is the individual's wishes that are explored and defined, then I think you have a much better quality of advance care plan; that when the person does need possibly medical intervention, doctors are able to interpret what this person's wishes actually mean.

DR SILVESTER (AH): Yes. And you don't get the right answers unless you ask the right questions, so what we train people to do is to not only ensure that the resident or the patient has an understanding of their current illnesses and their treatment options but they also ask them, "How can we help you to live as well as possible?"

MR WOODS: Yes.

DR SILVESTER (AH): And, "What are your important goals at this time?" and just those two questions on their own trigger things that would not otherwise have come out. That's the moment when they say, "Well, look, I really want to be well

enough to get to my daughter's birthday," or, "I really want to be well enough to stick around until my grand-daughter gets married in three weeks' time," or, "Look, I don't want to suffer like this any more. Please, just keep me comfortable."

MR WOODS: That's been excellent. Thank you very much.

MS MACRI: Fantastic. Thanks.

MR WOODS: We do understand where you're coming from and we're very supportive, and we think it fits in with the broader thrust of our report.

DR SILVESTER (AH): Thank you for your time.

MR WOODS: I call the Brotherhood of St Laurence, please. Thank you very much.

MS MORKA (BSL): I'm Christine Morka, general manager for aged community care.

DR KIMBERLEY (BSL): I'm Helen Kimberley, principal researcher for the retirement and ageing transition in the Research and Policy Centre.

MR WOODS: Excellent.

MS MORKA (BSL): Within the Brotherhood, yes.

DR KIMBERLEY (BSL): Yes, in the Brotherhood.

MS MORKA (BSL): I'd just like to, as probably others have said - - -

MR WOODS: We have your response.

MS MORKA (BSL): You've got it. Okay.

MR WOODS: And we've read through that.

MS MORKA (BSL): All right.

MR WOODS: But please talk to it and then we'll ask some questions.

MS MORKA (BSL): Yes. That's what we wanted to do. We actually did put in a paper before your recommendations became available and this is a response to your recommendations basically. I think from the Brotherhood of St Laurence's point of view, we also try to look at the concerns for older Australians in respect to how they participate in our society. As you would be well aware in terms of the Brotherhood, part of our mission is to assist the most disadvantaged people in our community in different ways. So we felt it was very positive in terms of having put in the first submission and your responses - I know others have put in similar kinds of ideas - that they were taken up in some way.

Some of the things that the Brotherhood is involved in in terms of aged care: we have residential facilities; we have all the packaged aged care; we also have some recent consumer-directed care packages as well; we work in respite; and we also have disability services which are targeted at older people and carers, who are ageing, of older clients. So a full gamut of this sector. One of the things we possibly have a concern about is the treatment in terms of the recommendations for the

disadvantaged component of the sector, and part of that comes from the notion of a for-profit market base.

MR WOODS: We will have that discussion - because we have absolutely no bias or preference for for-profit, not-for-profit.

MS MACRI: Yes.

MR WOODS: We're talking about opening up the supply constraints, but we're not - so I don't know where that's come from, but let's have that discussion in a minute.

MS MORKA (BSL): All right. There are other issues in there - as you would have read from our response - that it's highlighting the independence and wellness and the contribution that older people make to society and how that can continue. So as you can see, we've gone through in different areas talking about some of those issues. So we're just kind of setting the scene of where our response came from.

In respect to the choice issue - so increasing choice, wellbeing and care quality - I'll just go through the response. The main issue there is about the recommendations for the Australian Seniors Gateway Agency. We talked about quality of care and through an assessment process and people having information, but although that is a valuable part of a system, we also think there is space for older people to be more involved in the system in terms of providing information for policy development, advocating for particular things, and giving feedback through the process in regard to the quality of services.

I think that probably is really important when we do say - from our perspective - that there will be market forces at play and people may make choices within that marketplace and perhaps not have those choices come to fruition in terms of what their expectations were from making that choice.

MR WOODS: Okay, the discussion will be: where is our proposal falling short, in the sense that what we're trying to do is, in fact, have more information out there and to empower consumers so that they can actually choose between providers? For-profit or not-for-profit is irrelevant, but - - -

MS MORKA (BSL): Yes, I don't think we're at issue in regard to having more information for consumers.

MR WOODS: Yes, okay.

MS MORKA (BSL): So just talking with you about that particular aspect - as

I said, we actually have some consumer-directed care packages and we're also involved in a research project - which is a three-year project - which is looking at consumer choice and making decisions. One of the things we would say in that area is that it's not all carers and families and recipients who want to go down that path.

MR WOODS: Sure.

MS MORKA (BSL): So that the choice should also be, "No, I don't want. I want to opt out" - that kind of system".

MR WOODS: We agree.

MS MORKA (BSL): We had an example, even with the new packages we had, that people put their hand up and said, "We really want to do this," and then withdrew, saying, "No, this is too difficult," and what we also are suggesting is that often carers - some carers will have lots of knowledge, information, and feel quite comfortable doing these things, but some carers are so caught up in their caring role and the stressors of that caring role, to take on another task is actually beyond them.

MR WOODS: Yes, and in our draft report we've made reference, too, that some people will just want to know what their entitlement is, find a provider they're happy with and let it all roll.

MS MORKA (BSL): Yes.

MR WOODS: Entirely appropriate.

MS MORKA (BSL): Yes, as long as there isn't a sense that people are forced into making that decision; that the system is saying to them, "No, you've actually got to take on some of this responsibility yourself."

MR WOODS: Yes.

MS MORKA (BSL): So we're in agreement in respect to that aspect?

MR WOODS: We are.

MS MORKA (BSL): The information we provided to you was in regard to making choices in the marketplace, and attached to that the payment of your accommodation and your day-to-day costs - and this is also in terms of bonds or what you might do with your home, because Brotherhood would put forward that if you can afford to do things then, yes, you should be paying for those things. So we're not against that at all, but the issue was more around: is there space for people, in terms of these major

decisions in their lives, such that if they are going to make a decision in the marketplace about where they would wish to be - whether it's in an aged care facility - and then they start to go through that process of selling home or gaining equity, and then having space to say, "Hang on, we feel we've made the wrong choice here"?

MR WOODS: Yes. That's exactly why we're requiring every aged care facility operator to offer daily or weekly rental.

MS MORKA (BSL): Yes.

MR WOODS: So that somebody who has some uncertainty or their trajectory is uncertain but may not be for a long period of time, why go through all the disruptions, just do a daily payment, and if they don't have the cash flow but do have significant wealth, it can just be an attachment to the equity. So it's for exactly those people to say, "Look, you don't have to make those big life decisions. You're already going through enough crisis at the moment" - going into a facility is a huge issue in itself, so let's take away all these financial ones and people can just pay on a weekly basis until such time as circumstances settle or they have some understanding of where they're at.

MS MORKA (BSL): I think it's like some of the issues you were discussing with the previous speaker, when you have family involvement as well.

MR WOODS: Yes.

MS MORKA (BSL): Because decisions can be made and some of those might be, "Yes, we gain equity in the home," or, "We sell the family home," et cetera, and it may be those people who are a little bit at risk as well, to say, "Family has pressured us into this situation," and at this point in time for the person, the care recipient, the decision is the wrong one.

MR WOODS: Yes, completely agree.

MS MORKA (BSL): So maybe that's part of the equation.

MR WOODS: And we're trying to give them some power over their decision-making and to give them the opportunities to make a wider range of decisions than what they currently have.

MS MORKA (BSL): The other question we had was about the Gateways: not against Gateways in any form as it has been expressed, but we were actually concerned how the Gateways were going to operate in respect to some of the other government policies and the decisions that the aged care one-stop shops or "no

wrong gate" and the Medicare locals which are proposed to commence this year in July and how it all fits - - -

MR WOODS: Yes, quite true.

MS MORKA (BSL): - - - because each one is saying they are doing exactly what the Gateway is actually saying they will do.

MR WOODS: We would have preferred that the Medicare locals were up and running and were demonstrably wonderful and that they were achieving all of their incomes, in which case we'd just say they should take this function as well. But given the multiple uncertainties, what we've said is, "This is the functionality that should occur. Let's at least make sure it's occurring for aged care. If it happens more broadly in the health sector and it's fabulous, then let's migrate this functionality into that one, but let's not lose what we need to do to simplify and consolidate a whole multiple range of complexities in understanding aged care. Let's at least make that bit of progress. If there's other progress out here which we have no control over, then that's terrific, but that's - - -"

MS MORKA (BSL): I think that kind of demonstrates to me that it is about the fine detail of some of these things.

MR WOODS: Yes.

MS MACRI: Yes.

MS MORKA (BSL): I don't think we would sit here and say, "This is wrong," or, "That is wrong." It was about how things will progress into the future, and one of the aspects, I suppose, from a provider's point of view, is that we have some control over the future and that we have input as things were to be implemented into the future.

DR KIMBERLEY (BSL): That's not just as a provider, I think, but also in the Brotherhood's capacity as an advocate for disadvantaged people.

MR WOODS: Yes, absolutely. So I think it would be worthwhile in our final report to reinforce the message that we're not trying to create a parallel system that would continue on ad infinitum, but that we are trying to design a system in a form that could integrate into a broader system, should that eventuate and prove to be successful.

MS MORKA (BSL): That sounds very good. The only other aspect we had in regard to the Gateway was for our disadvantaged groups and how they might access the information or the Gateway itself, so to even get into the door or on the phone

with the Gateway.

MR WOODS: You have various outreach and other workers in the community and you identify homeless or other at-risk people and you work with them. You would be that interface then that if the various range of services constitute that broad umbrella known as aged care - whether it's community care, whether it's social support, whether it's various forms of more medicalised support - then you would provide that interface. Now, in some cases you'll actually be sitting out with them in the park, helping fill in the forms and then get the professional assessments and all of that interface.

MS MORKA (BSL): I think the next section is in terms of homelessness. I might also add to that because we actually had a small group of eight providers come together just recently and we were talking about homelessness in the current system and one of the issues was around the ACATs in terms of those support workers that you've just talked about trying their best to get homeless people into the system. Because they are not aged 60 and because as support workers they haven't had the education and the training about what the aged care system requires of their referral, put in - - -

MR WOODS: There's no box that says - - -

MS MORKA (BSL): No, that's right. Exactly, and also - - -

MR WOODS: There's one that says "Indigenous" but not one that says "homeless".

MS MORKA (BSL): That's correct.

DR KIMBERLEY (BSL): Exactly.

MS MORKA (BSL): That would be one. I mean it's a simple thing to actually occur.

MR WOODS: That's right. I understand that.

MS MORKA (BSL): But it is also around other things, not just the box, and so those people do actually need some training too, and ACAT - well, the Gateway would need training to say this is a special needs group, and understand the complexity of that group and say, "These people are ageing early and they should actually have some access through to aged care services." And of course the big one which I'm sure lots of people have talked about was the ACFI tool, and for this group - - -

MR WOODS: Yes, behavioural and the whole bit.

MS MORKA (BSL): Yes, this group - and it actually doesn't identify all of the care needs for these people. It just identifies the level of behaviour for the person. It actually is a risk and this group that was together - there was a difference. The range of loss of income for this particular group, because they still continued to provide all the care that's required, was ranging from 150,000 through to 1.5 million, depending on the level of the services that were provided by those organisations. So in a sense we're saying, as we have in here, that there's a short-term viability issue and there's a longer-term issue in regard to: will providers of all types, whether they be for-profit or not-for-profit, actually then say, "This is something we can do in a viable manner"? So we might lose some of the services that are around at this point in time.

MR WOODS: And remembering in that conversation, though, to keep accommodation separate from care.

MS MORKA (BSL): Yes.

MR WOODS: They'll be supported residents, the accommodation payment will be transparently reflecting the cost of the accommodation, so that bit is separate and then it's the question of the care payment and whether that should be some block funding, whether it should be an RCS-driven sort of - - -

MS MORKA (BSL): We would actually recommend that that particular aspect needs probably another review to have a look at just that particular issue.

MR WOODS: Just on that one, though, it would be helpful if we could get as far as we can in this report as a foundation then for further development of the concept. There's yourselves and the VincentCares and the Benetases and Wintringhams and that.

MS MORKA (BSL): Exactly.

MR WOODS: Are you of a sufficient collective that you could work together in a submission, or do you have a whole range of views? I don't expect you to speak on their behalf but, given that you're sitting in front of me at the moment, would it be possible for that dialogue to happen within that broad family of providers?

MS MORKA (BSL): Yes, it would, and in fact we - - -

MR WOODS: And not ask for, you know, "Hey, what is our ideal? Let's go for that now," but more particularly, "Given where we're at, what are the particular

constraints and where could there be some options?"

MS MORKA (BSL): Most definitely we could do that sort of thing. Our executive director is a chair of the homelessness council, so it has impact at different levels as well and it will bring those kinds of issues at government level from that point of view. But it was quite easy to get those eight organisations together and they were your Wintringhams and St Vincents.

MS MACRI: It would be helpful if there was a collective voice, because sometimes individuals are being picked off.

MS MORKA (BSL): Right.

MR WOODS: So if you could collectively, but in a fairly short time frame - I would have to add - give some thought and then if you've drafted a position, if you want us to have a consultation with you on that, draft it out, come, and then come up with a final submission to us. We don't have a lot of time, but if you could contemplate that.

MS MORKA (BSL): Do you have a time frame you could give me?

MR WOODS: If you talk to Rosalie, who's at the back there - well, probably Mark by the time we've finished, but anyway either Rosalie or Mark, they can discuss the murky details of putting pressure on you for time frames.

MS MORKA (BSL): Okay.

MR WOODS: It's not for commissioners, is it?

MS MACRI: No, we're the nice guys.

MS MORKA (BSL): As you said before, it's not trying to do something against not-for-profits as it is for for-profits. I understand that but what we actually feel is there is a concentration on economics and business aspects.

MR WOODS: But you're a big business.

MS MORKA (BSL): We are.

MR WOODS: And we'd hope that you're managing your business as well as the for-profits.

MS MORKA (BSL): And we are, but I think we do want a special focus on what

not-for-profits actually might bring that is different from for-profits.

MR WOODS: I understand your view on that. We're going to be more neutral in that respect, but what we are interested in doing is ensuring that the not-for-profits, as equally as the for-profits, can have opportunities under the new scheme to expand into parts of the market where you specialise and you're particularly good at. You won't have to have packages any more and be limited in what's constrained. If there are people who have got entitlements out there and you can offer services to them and they accept you as their provider, it allows you to grow and flourish. If they find that, hang on, there's somebody else who's more tuned into their needs, well - - -

MS MORKA (BSL): I'd like to actually point out that an organisation like Brotherhood of St Laurence, our aim isn't to expand in the marketplace per se.

MR WOODS: No, I totally agree. I don't mean grow and take over. I mean be less constrained in meeting the needs of those on whom you are focused; what your mission is.

MS MORKA (BSL): I think what we're saying is, for that recognition to be there, it also needs financial recognition that you're doing something quite different and if you're doing research or you're doing something that's more innovative or you're actually focusing on a particular group, that that might need to be recognised financially.

MR WOODS: I'm sure you'd make that case.

DR KIMBERLEY (BSL): Yes. I was just going to put it in a slightly different way. I guess what we're concerned about is that the support - the level of monetary support - for those people who have no capacity to pay is adequate, not only to provide the care but also to allow some resources for innovation and what have you, where we can actually try new things that may well benefit the whole sector. When you're providing mainly - of course, as you know - for this particular part of society - - -

MR WOODS: Yes, to the disadvantaged.

DR KIMBERLEY (BSL): - - - you've got very little capacity to actually increase your income beyond the funding that's supplied for the purpose. So we can't be charging extra accommodation - - -

MS MACRI: No.

MR WOODS: In fact, you'll be set. I mean, for supported residents under our

proposals you'd be paid on the accommodation side a payment that reflects the cost of provision. For care for all people there would be a price set transparently. Now, it won't have a large R and D component tacked on, and especially one that says "and especially for the not-for-profits because they're going to do particularly well". So, I mean, that won't happen. But on the care side, if we can address these questions - particularly the behavioural and the additional social supports and that, that are needed for particular groups - then there's a way through at least to deal with them properly.

On the accommodation for the not-supported residents, you offer whatever you think will be in the marketplace, as long as one of the things that you offer is a published periodic charge, whether it's daily, weekly or whatever it is, but there's no constraints on you on what that charge is, other than the fact that if it doesn't reflect the quality of the accommodation, people aren't going to go into your facility, and you're going to have to adjust your price or adjust your quality of accommodation - one of the two.

DR KIMBERLEY (BSL): Our concern, too, though is with the pricing policy in relation to care. If that's a competitive system - - -

MR WOODS: Yes, but it's not competitive. Every provider gets the one price for that care.

DR KIMBERLEY (BSL): Okay.

MR WOODS: So the person gets assessed for their needs, and it would be a much more tailored set of services because we'll pick and choose out of different layers and things. You won't have packages and things, so they'll come out with an entitlement. That will have a price attached to it that is transparently set, and within that they will have their care co-contribution assessed, so the care co-contribution isn't on top of - you know, you don't get more if they're richer or less if they're poorer. You get the one price for the care, but the split between the government subsidy, or the taxpayer subsidy more correctly, and the individual's co-contribution will vary depending on their circumstances.

DR KIMBERLEY (BSL): Okay, thanks.

MR WOODS: So that neutralises that hopefully.

MS MORKA (BSL): One of the other things that we had there was the trading of supported resident quotas. You mentioned in the recommendations a regional quota for supported beds, and one of the concerns we have there - I think we've also voiced before in terms of it's most likely the not-for-profit area that might actually assist

these people - is that the trading might take place in geographical areas as well, because of the opportunity for - and I have to say - for-profits to trade those. It would be then, you know, are we isolating people? Where would the accommodation for the people who can't afford to pay for their accommodation be, and is that away from family and friends, et cetera?

MR WOODS: Yes. So we'd be very interested in your views (a) on the proposition as such; (b) on whether trade should be able to exist across the whole of the quota or only part of the quota; and (c) what should be the principles for developing regions?

MS MORKA (BSL): Yes.

MR WOODS: So if you can give some further thought - and we've read what you've got here in terms of the concerns, but in terms of then progressing that into actions or - - -

MS MORKA (BSL): Solutions.

MS MACRI: Yes.

MS MORKA (BSL): Yes, that's fine. I know from previous meetings that the single bedroom and bathroom you've already heard ad nauseam.

MR WOODS: Ad nauseam, yes.

MS MORKA (BSL): But we put it in there - - -

MR WOODS: Yes. And keep doing so.

MS MORKA (BSL): - - - as you've indicated it would be useful still to have that in the responses.

MR WOODS: Yes, absolutely. Keep it there.

MS MORKA (BSL): Yes.

MR WOODS: I've waved the white flag. I just want to make sure that that's the collective outcome.

MS MORKA (BSL): Carers and the workforce: that was an area of concern for us in regard to the notion of carers actually - so informal carers - being placed under "workforce".

MR WOODS: Yes. We'll give them a chapter heading all by themselves.

MS MORKA (BSL): All right.

MR WOODS: But I'm not sure that that actually makes any difference to the discussion and the recommendations, but if somehow that makes - - -

MS MORKA (BSL): I think it was the sense that there's an underlying assumption that they are part of a workforce.

MR WOODS: No. It was never intended but - - -

MS MORKA (BSL): Yes, all right. But that aspect in terms of the general workforce then, not the carers themselves - and you might have some more to say about the carers, Helen, I don't know - but to actually attract people into this area, because that is going to be a problem in the future, is perhaps to have a different approach to things, and look at this area as a profession as well. A lot of people, as you would know, in the workforce may be personal carers, and they get minimal wages, and the role is not seen to be a professional role that you have to have lots of skills and education for, and we feel if it were actually a career for somebody, and they could see how they could progress in this field, then you may attract different people into the field.

The other aspect of course for us is we also think older people - and when I say "older" I'll probably shock people, but I'm going to say from 45 onwards in respect to workplace and the difficulties that some people are having when they turn 45 and get retrenched et cetera, so there's other innovation. In fact, Brotherhood actually has what we call Good Food Matters which is a different model, where we are actually attracting people from the hospitality industry into aged care, and give them some training in aged care matters.

MR WOODS: Good.

MS MORKA (BSL): They are actually engaging with - so from the community side, in people's homes. For those people who are nutritionally at risk - - -

MR WOODS: Yes, hydration, nutrition; absolutely fundamental.

MS MORKA (BSL): Yes, and actually engaging with them and making them part of this, so this enablement stuff as well, in regard to being interested in food again, making choices, helping with the preparation of the meals, and because it's people with a different background with hospitality, they're not seeing it as a medical care

kind of mentality. So what we were thinking is, these are some of the things that people could be thinking about differently, and attracting to this particular area.

MR WOODS: Totally agree, yes.

DR KIMBERLEY (BSL): Just going back to carers for a moment.

MR WOODS: Yes, please.

DR KIMBERLEY (BSL): I think that probably our concern is that the way the report reads, it's predicated on the availability of carers to a large extent, or it doesn't actually discuss what the recommendations would be if the numbers of informal carers reduced rapidly, which I suspect that they are likely to do.

MR WOODS: We've done the analysis in the report, and we show the consequences on the workforce.

DR KIMBERLEY (BSL): But we're also concerned for the carers too.

MR WOODS: Absolutely.

DR KIMBERLEY (BSL): You know, what their role is going to be in comparison with what it is now, and we know that already many of them are really stressed by their caring role. We're concerned about what sorts of extra responsibilities they might have, and especially any extra responsibility they may be taking on in terms of risk, or the decisions that are risk-related. So I think that we probably want to see a system that is going to actually assist, or make the resources available to assist carers as much as the people that they care for.

MR WOODS: We do talk about the requirement of Gateway to assess not only the individual's needs - - -

DR KIMBERLEY (BSL): Yes, you do.

MR WOODS: - - - but the needs of the carers in association with assisting and caring for that person.

DR KIMBERLEY (BSL): I think that at the moment there's very little available for carers. I mean, I know there's this very small supplementary that they get but, beyond that, unless the provider is working with the care recipients, actually does some work to support the carers, there's no obligation for any of that to happen.

MR WOODS: No, but we see that they would be assessed to see what support

they get as funded support by way of education, training, other, and making sure that respite is sufficient and appropriate and that there's a broader range of people that they can call on to deliver the respite. All of those things are in the report. So I was a bit surprised when you said that as it stands the draft makes what might be unfounded assumptions about the role and availability. I thought we'd actually tracked a fair bit of that down in the report.

MS MACRI: Yes.

MR WOODS: But if there is a bit more that we haven't, please - - -

DR KIMBERLEY (BSL): Yes, but that didn't come through really clearly.

MR WOODS: Okay. I take that on board; because our intention is as we've discussed, so if the communication of it is not there or if we have not developed it fully, we're happy to do so.

MS MORKA (BSL): I think also just on a kind of day level, in terms of carers and how they see their responsibility, the fact that there may be respite services, et cetera, available doesn't necessarily mean that they take up that opportunity.

MR WOODS: No, and we're exploring why not and trying to overcome those barriers. So having a broader range of people who can provide respite and having a more adequate emergency respite capacity.

DR KIMBERLEY (BSL): Yes, different types of respite.

MR WOODS: So, yes, all of that we're conscious of and we're working through.

MS MORKA (BSL): Yes, okay.

MR WOODS: But tell us that as well, because it's always good to have it on the record.

MS MORKA (BSL): Okay. Age-friendly environments: obviously you do cover that in the report. I think in that area what we're saying is that, although you cover it, there isn't a strong statement about that and how that impacts on a person's life, the benefits for health and wellbeing in regard to somebody actually being in a community and engaging within that community. Some of the things are practical issues, about how they can get around.

MR WOODS: Yes, transport.

MS MORKA (BSL): Yes, transport and all those things, which are in there. But I think - and you did actually reference Brotherhood in this particular area - that we were saying there wasn't a national policy in this regard and that you recommended a body have a look at this. But what didn't come out as a strong recommendation from the report is that this is probably just as important to older people, in terms of their health and wellbeing, as care - if I can put the brackets around it - from the medical sense of care, and it impacts on their lives. In fact, if some of those things were put in place, people wouldn't end up in residential facilities. They'd be able to cope.

MR WOODS: Okay.

DR KIMBERLEY (BSL): There's been increasing research on the health benefits of social connectedness. The Brotherhood operates in some areas where it's difficult for people to have much connectedness because of either transport or terrain, or for a whole range of reasons and that's also part of why we'd like to see this emphasised in such a way that it means that other departments of government take note.

MR WOODS: I took on board your statement, and thought, "Well, we thought we'd done it". If we haven't, I'll look at the quality of language, but I don't think it's solved by then adding another 50 pages on this particular issue.

MS MORKA (BSL): No.

DR KIMBERLEY (BSL): No.

MR WOODS: Yes, it's the quality of the expression rather than the quantity of the expression that we'll go back and have a look at, otherwise we're going to have about four volumes.

DR KIMBERLEY (BSL): No, don't do that. That was enough.

MR WOODS: Yes, precisely. How many nights do you want to - - -

MS MORKA (BSL): We did actually have some information about the bonds and talking about the intergenerational costs, and in that area basically what we were trying to convey is there is a care cost anyway for informal carers being involved in assisting their loved one, and there may then be the impost of looking at what they might well believe is their inheritance - which is the old issue - and it's a subjective thing, it's an emotional thing, but maybe there needs to be more work in respect to that before we go straight into bonds and equity in a person's family home.

MR WOODS: I don't think we used that phrase in our report.

MS MACRI: No.

MS MORKA (BSL): Which phrase?

MS MACRI: "Family home".

MR WOODS: The "family home".

MS MORKA (BSL): All right.

MR WOODS: We talk about people's accommodation.

MS MORKA (BSL): The accommodation, yes.

MR WOODS: That they live in at different times of their lives in different forms.

MS MORKA (BSL): Yes.

DR KIMBERLEY (BSL): That's how easily it's translated.

MS MORKA (BSL): We were really positive - and I hope that did come through as well as some of the questions we raised - because it is a real opportunity for policy into the future to be changed.

MR WOODS: Excellent.

MS MORKA (BSL): That's our real concern.

DR KIMBERLEY (BSL): Just the very short response we gave tells you that we actually - - -

MR WOODS: Yes. No, we did read that through. I was just a bit puzzled by a couple of the expressions, but we've dealt with those in this discussion. That's been very helpful. I'm glad you've actually come so that we can have this discussion.

MS MORKA (BSL): Good.

MR WOODS: We've given you a couple of other little bits of homework. If you could deal with those, we'd be very grateful.

MS MORKA (BSL): Yes, we'll get back to you. Good. Thank you for the opportunity.

DR KIMBERLEY (BSL): Thank you.

MR WOODS: Michael Taylor, please. Sorry to have kept you waiting.

DR TAYLOR (AIPCA): That's fine.

MR WOODS: For the record, your name, and if you are representing an organisation, that organisation and any position you hold in it.

DR TAYLOR (AIPCA): My name is Dr Michael Taylor. I am a research fellow at the Australian Institute for Primary Care and Ageing at La Trobe University. My academic expertise is in the regulatory and administrative aspects of the health system - or rather its design and reform. My specific research focus is the Commonwealth Medicare program and the influence of policy and regulatory requirements on clinical services delivery. AIPCA has made a submission on the commission's draft report, which went in on Monday.

MR WOODS: Yes.

DR TAYLOR (AIPCA): I don't know if you - - -

MR WOODS: We've been on the road. We're conscious that it had come, but regrettably haven't had the chance to - - -

DR TAYLOR (AIPCA): I do have hard copies today. I will actually be speaking to some graphs. Can I provide you with the hard copies now?

MS MACRI: Yes.

MR WOODS: Yes, very wise.

MS MACRI: Thank you.

DR TAYLOR (AIPCA): The submission makes some general comments on the aged care workforce broadly. That is the work of my academic betters, Profs Rhonda Nay, Jeni Warburton, and Yvonne Wells. Our submission also discusses specific issues around the residential aged care and primary healthcare interface which is the subject of my presentation today, and I'm speaking to section 11.4 of the commission's draft report. I just want to provide the commission with an overview of the analysis that we've performed on the problems with the interface and to answer any subsequent questions you may have.

Just as background, the National Health and Hospitals Reform Commission identified the interface between the primary healthcare system and residential aged care as highly problematic, and a number of the initial submissions to this inquiry

described the practical issues that GPs experience in providing such services. Of particular note on this point are the submissions made by the Australian General Practice Network and the Australian Medical Association in the initial phase, submissions 295 and 330 respectively. The major issue discussed in those submissions was the financial disincentive to providing these services, and other problems that they identified were rushed consultations by GPs and the general shortage of GPs willing to provide care for residents. Both of those issues are what I'd like to discuss today with our analysis.

The commission's draft report discusses the Aged Care Access Initiative, the ACAI, which is the Commonwealth's response to concerns about resident access and the financial disincentive for GPs to provide care. Briefly, the initiative uses service volume thresholds to pay incentives for GPs. So I, as a GP, provide a certain number of services and I get an incentive payment for doing so.

The commission's draft report makes extensive reference to an analysis provided by the Department of Health and Ageing, as endorsed by the Australian National Audit Office. That concludes that the ACAI has increased service delivery to residents. Our submission takes issue with what is meant by the phrase "service delivery to residents". The major point that I wish to make to the commission today is that, while all residential aged care GP services may count equally towards the ACAI thresholds, not all of those services are indeed equal in an operational sense. The level of detail contained in DOHA's analysis is, I would submit, not sufficient and AIPCA wishes to provide the commission with a more detailed view of what's happening.

MR WOODS: Have you been speaking to David Cullen as well in DOHA, or not?

DR TAYLOR (AIPCA): No, I haven't. I am relying on principally the ANAO's publication on the practice incentive program generally, to which the AICI belongs. Last year, AIPCA published an analysis of GP consultations under Medicare in the Medical Journal of Australia. It demonstrated long-term shifts in the GP consultation pattern throughout the community. In general, longer and more complex GP activity in the community has declined considerably in the past few years and this has been accompanied by an increase in shorter - what are known as - level A consultations. Just for the benefit of the commission, the major types of GP consultations are described by their levels. Level A is short and of limited clinical activity, through to level D, which is longer and more complex activity.

MR WOODS: We understand.

DR TAYLOR (AIPCA): Beyond that we have special items and in the residential

aged care setting that's such things as the residential medication management review. Just for instance, level B consultations are the most frequently provided GP service through Medicare. The hierarchy of consultations also applies to residential aged care; however, the DOHA analysis considers total service volume only and doesn't break - the analysis doesn't work by consultation type. As I said, there's considerable operational differences between those Medicare services, and I draw your attention to 2.3 in our submission, which provides a summary of two distinct examples of what's happening: a level A consultation with relatively limited requirements versus the fairly hefty regulatory requirements around a residential medication management review.

The point that I wish to make there is that there's quite a difference between the two but both count for one run, so to speak, on the board when it comes to the ACAI. For our submission we have repeated our analysis of the Medicare system, focusing on the residential aged care facility consultations only. Those services were not included in our original study because we were focused on consultations in a GP surgery, rather than outside.

I refer the commission to figure 1 on page 6 of the submission and further to the discussion on page 5. Just with the figure, the black line there represents total service volume and, as you will see, there is a slight trend upwards over time, which is of course in accord with DOHA's view that there has been an increase in the number of services being provided per resident. However, the coloured lines is what occurs when you break that down into its constituent parts and the pattern, I have to say, is far more interesting.

What's happening there is you'll see that the level B services, the line closely matches the overall services because that is the majority of activity. However, you will also note that level A services indicated in the blue line have increased quite considerably post the introduction of the ACAI.

MR WOODS: Is that characterised by walking past each patient?

DR TAYLOR (AIPCA): In-corridor activity, yes. That actually is an interesting point. This is actually mirrored system-wide. There has been a shift towards these consultations. In the broader community it's not quite in the corridor but there is a shift towards them. So in part this actually does reflect what's happening broadly throughout Medicare, although it is the fastest-growing service within residential aged care.

Perhaps of further note is, of course, the longer consultations and things such as the residential medication management reviews, represented there by the green line. As you'll see, over the past two years that has flatlined.

MR WOODS: That's interesting because you seem to have decomposed the green line into level C-D and special items which grew and flatlined, and level C-D only, which sort of grew at a lesser rate. So is the special items what's generating - am I reading that graph correctly?

DR TAYLOR (AIPCA): The special items were progressively introduced from 2003 onwards, which is why the line bifurcates like that. Because this graph is expressed relative to the service level in the base year - - -

MR WOODS: Okay, so it's a low base.

DR TAYLOR (AIPCA): Yes, increasing like that. However, it hasn't gone anywhere in the past two years.

MR WOODS: Have you got the raw numbers that live behind that graph somewhere?

DR TAYLOR (AIPCA): I do, yes.

MR WOODS: The relative changes are in large part a consequence of the size of the base, as much as the actual pattern of behaviour, so even if - we don't need to read them out at the moment, but if you could mail them to us or do something.

DR TAYLOR (AIPCA): I could provide a summary in a bit more detail.

MR WOODS: That would give us a sort of magnitude issue as well as relative.

MS MACRI: Yes.

DR TAYLOR (AIPCA): Absolutely. As I said level B is far and above, by magnitude, the largest consultation.

MR WOODS: It would be what, 80 per cent?

DR TAYLOR (AIPCA): Around that, yes. The special items in level C and D occupy quite a reasonable space but larger of course when you consider them by cost.

MR WOODS: Yes.

DR TAYLOR (AIPCA): But this is service only.

MR WOODS: In fact, yes, both issues, the cost and the number that live behind the relative change, are of very great policy interest.

DR TAYLOR (AIPCA): Absolutely. I'd be happy to provide further information for you. That's the problem, I suppose, with expressing things as relative rates. It summarises things but also doesn't provide much detail. As I said, we take some issue with what's meant by the phrase "service delivery to residents". I think that the commission may need to consider what the service mix is that's increasing. As we've seen here, there are actually some fairly dramatic changes that have occurred recently. There are a number of reasons why level A consultations might be increasing in this manner. One of them might be, as some of the submissions have pointed out, rushed consultations by GPs, so it may just reflect the general pressure on GPs.

Alternatively, it may be, as we've just spoken about, the in-corridor conversations, that there is a minor problem that a GP has attended to simply by being there. That in itself is a good thing but also might reflect some other issue; for example, it may be that those minor problems that the GP is now dealing with might previously have been handled by nursing staff within the facility. So if nurses are unavailable to do so, then that may be spilling over the interface into requiring a GP service, in which case there's a certain amount of system drag there. There would be then questions about whether - - -

MR WOODS: I like that phrase "system drag".

MS MACRI: Yes.

DR TAYLOR (AIPCA): Study it intently. It does raise some questions about whether this is the most appropriate use of GP time.

MR WOODS: Absolutely.

MS MACRI: Absolutely.

MR WOODS: And of public money.

MS MACRI: Yes.

MR WOODS: I'm sorry, do you also then split out between the increase in the number of practice nurses - and I'm not talking nurse practitioners, but practice nurses - who go through and do the first cull, and then the GP who comes along behind and verifies and gets the additional fee?

DR TAYLOR (AIPCA): I haven't actually got that level of detail available to me.

MR WOODS: That would be an interesting piece of analysis - - -

DR TAYLOR (AIPCA): Absolutely.

MR WOODS: - - - as to whether it has got more system drag in it, to use a phrase.

DR TAYLOR (AIPCA): Yes. I don't have those numbers to analyse that.

MR WOODS: Tuck it in the back of your mind and see one day if you can - - -

DR TAYLOR (AIPCA): If it comes up, yes.

MS MACRI: Yes. Do many practice nurses in the GP's rooms actually go out to nursing homes?

DR TAYLOR (AIPCA): I would imagine - - -

MS MACRI: I don't think they do.

MR WOODS: There is some of it starting to happen.

MS MACRI: Some of it, but I think it's - - -

MR WOODS: I'm just curious as to whether it's - - -

DR TAYLOR (AIPCA): I can't say that they're being funded.

MS MACRI: Yes.

MR WOODS: Anyway, okay.

DR TAYLOR (AIPCA): I'd also just like to make some general points about GP workforce issues. We've provided some analysis of that as well, and previous submissions by Catholic Health Australia, the AMA and AGPN have also spoken about the problems of taking on new residents.

MR WOODS: Yes.

DR TAYLOR (AIPCA): Residents who are arriving at facilities, and they're in a position where their previous GP can no longer continue to care for them, and they

often - - -

MR WOODS: And does no longer continue to care for them.

DR TAYLOR (AIPCA): And does no longer continue, and they are being taken up by GPs already providing services to other residents.

MR WOODS: And in fact management of some very good homes have arrangements with local either GPs or nurse practitioners or combinations of the two, and offer that as a service for the new resident to say, "Well, if you wish, this is the arrangement that we have with the local medical practice," however defined.

DR TAYLOR (AIPCA): Which is also a practice with pharmacies.

MR WOODS: Yes, exactly.

DR TAYLOR (AIPCA): Provider pharmacy. I mention that simply because I'm a former pharmacist and I used to do that. With regard to workforce, DOHA have indicated that GPs receiving the ACAI incentive payments have increased their patient loads, I think it was about 5 per cent was the quoted figure. Whether this is a result of resident seeking, so to speak, by GPs enthusiastically embracing the ACAI, or GP seeking, so the reverse problem, by residents who need to find a new GP, I can't comment. It may be that the GPs receiving ACAI payments are simply just the ones who are there.

I refer the commission to figure 2 of our submission on page 8. This is a graph of the estimated proportion of the GP workforce that is providing any level of service in residential aged care facilities, and by that I mean be it one consultation per quarter or 50. So this is just how many had any involvement. As you will note, over the last five years, this proportion has declined from approximately 38 per cent of the GP workforce to 35 per cent over a five-year period.

MR WOODS: If the vertical scale was one to a hundred, that would almost flatline.

DR TAYLOR (AIPCA): It would almost be flatline, yes. 38 to 35 per cent is not a great deal.

MR WOODS: It looks very dramatic when it - - -

DR TAYLOR (AIPCA): It does on that scale, I agree.

MR WOODS: It's amazing what you can do with presentation.

DR TAYLOR (AIPCA): But if the 38 per cent proportion had been maintained over time, that would translate to an extra 700 GPs across Australia providing services in the last financial year.

MR WOODS: I do understand what's - - -

DR TAYLOR (AIPCA): I was prepared for that. This data, I've stressed, is system-wide, and from the publicly available data that's available to me, I can't actually tell you which GPs are in or out of the ACAI, so to speak. That, of course, does limit the interpretation and application of my analysis, but I would submit that the ACAI does not appear to encourage new GPs into the system, because they seem to be leaking out.

MR WOODS: Yes, quite true.

DR TAYLOR (AIPCA): Following on from this, if patient loads per GP are increasing as suggested by DOHA, and the ACAI incentive becomes increasingly diluted as this load increases, which is the point made by the AGPN submission, there may come a point where the ACAI just - its utility is exceeded basically as a method of combating I suppose - to use a sort of aggressive metaphor - the financial disincentive in providing services. Just as a theoretical point, as a health services researcher, I'd also argue that there may be an issue when it comes to the optimum resident load for a GP, and by that I mean when we reach a point where a GP is having to take on so many residents that they're not able to adequately care for them, and, yes, so there's a sort of diseconomy of scale.

MR WOODS: Yes.

MS MACRI: And I guess it depends on the GP practice, too.

MR WOODS: What support they've got.

MS MACRI: I mean, I know there's a GP in South Australia who's fantastic, who virtually just operates out of the boot of a car, and her whole practice is around residential aged care facilities.

DR TAYLOR (AIPCA): Yes. Just in summary, we submit that some closer consideration of the interface is required. While service delivery to residents is at an overall level undoubtedly increasing, I think we need to consider the underlying mix of services being delivered, and what that actually means.

MR WOODS: Quality of service delivery is somewhat important, not just the

volume.

MS MACRI: Yes.

DR TAYLOR (AIPCA): Absolutely. Complex and comprehensive care has apparently stalled, and GP involvement in the sector overall is declining albeit slowly. It could be argued with that graph that when I say it's stalled, it could be counter-argued that it has actually reached equilibrium with demand. I accept that that's possible; however, I don't agree in that if you look across the system, using the residential medication management reviews as an example, I calculated it at almost one in four residents that's receiving one of those reviews per year. So there's somewhere between 20 and 25 per cent.

As a former pharmacist who was deeply involved in dispensing to large residential aged care facilities, I think that that's probably not the right level, but there is far more demand within the system with that. My figures presented to the commission are working on an overall Australia-wide level. If you break that down into small areas, you would find divisions of general practice where residential medication management reviews are almost non-existent.

MR WOODS: That's interesting, isn't it? And then you've got that data that shows it by regions.

DR TAYLOR (AIPCA): I'm actually involved at the moment - we're undertaking a research project on the system patterns which predict more comprehensive GP care in residential aged care facilities, which is exactly that: the residential medication management reviews, the comprehensive medical assessments and multidisciplinary care planning.

MR WOODS: Because it would be fascinating even just to sort of point to the extremes and then show that most are in fact closer to one end rather than the other, but to say, "How come in some regions this is the pattern? In other regions this is the pattern," and yet is that saying something about the underlying needs of the patients, or is it saying something about the culture and behaviour of the health service in those regions?

DR TAYLOR (AIPCA): Yes, the dynamics of local practice, yes.

MR WOODS: Absolutely.

DR TAYLOR (AIPCA): There are a number of factors, I can assure you.

MR WOODS: That would be fabulous.

DR TAYLOR (AIPCA): One of the more interesting ones is the degree of sessionality which - - -

MR WOODS: Yes.

DR TAYLOR (AIPCA): It's a word that we've effectively made up, I suppose.

MR WOODS: It's called aggregation of visits.

DR TAYLOR (AIPCA): Yes, the number of consultations provided by a GP per visit - - -

MR WOODS: Yes.

DR TAYLOR (AIPCA): - - - which could range from one through to five or six, and I recall when I was a pharmacist that sometimes it was quite normal for the local GPs to finish work in the surgery, on their way home, drop in at the nursing home, do whatever needed to be done and go home.

MR WOODS: Yes.

DR TAYLOR (AIPCA): Versus the doctor in South Australia that you just described who's, well, obviously conducting quite a long session. Our preliminary findings suggest that a higher degree of this sessional practice seems to predict more comprehensive care provision, so something about the GPs being more involved, I suppose, or engaged with residential aged care practice is associated with providing more comprehensive care.

MR WOODS: Although if there was also a correlation between level A visits and sessionality, that would also give an indication of alternate behaviours on behalf of GPs.

DR TAYLOR (AIPCA): Absolutely. My indicator of sessionality has been calculated on level B alone, so I actually wouldn't see that. It's rather difficult to reconstruct the data in such a way that I could tell that. But, yes, it would be an issue and an interesting analytical challenge.

I would suggest just as a final point, the point about quality versus quantity, which I've actually heard discussed in the previous submission - the ACAI is operating in a way that considers services very crudely. Perhaps it needs to include some form of service weighting or, when it comes to a quantity target, that we look to some things such as sessional practice as the way to get the run on the boards, so

to speak, and quality could be built in through the more comprehensive care services such as the medication review.

MR WOODS: It would be a pity to go from a blunt instrument to an only-slightly-less blunt instrument.

DR TAYLOR (AIPCA): Indeed. It would require very careful design.

MR WOODS: Yes. I was sort of looking for the magic solution at the back, and I've got some sense of possible directions, but I haven't quite read yet the - - -

DR TAYLOR (AIPCA): Off the top of my head, the blunt-instrument approach to the ACAI might be to weight it according to the most readily available method of weighting GP consultations, which is their cost.

MR WOODS: Yes.

DR TAYLOR (AIPCA): Rather than 60 or 140 services - I'm sorry, I can't remember the current threshold - that it is a certain volume of billing, which of course, given the relative disparity between a level A consultation payment, and I think it's 99.95 for a medication review - obviously those thresholds are far easier to reach with lots of medication management reviews than they would be with level A; that would involve quite a lot of effort on the part of the GP. So that is one way to realign the system - perhaps not the most subtle, but certainly something that could be done within the current framework.

MR WOODS: Wouldn't it be nice to actually align quality measurements with outcomes rather than with supplier-driver inputs?

DR TAYLOR (AIPCA): Absolutely. I am limited by the data available to me. We have wonderful data when it comes to services provided. The outcomes of said services I'm afraid I couldn't tell you. There is evidence to suggest that there are positive outcomes coming from the GP and pharmacist collaboration in a residential medication management review. I sort of take it as being inferred from a higher delivery of those that quality outcomes then flow. But, yes, I absolutely agree with your point.

MR WOODS: Terrific. Anything else?

MS MACRI: No.

MR WOODS: I think we have interrogated you sufficiently on the way through, but that has really been very helpful. If you could add the next paragraph at the

bottom that says "and this is the best solution to measure quality outcomes", that would be really good.

DR TAYLOR (AIPCA): And the magnitude.

MR WOODS: Yes. If you can talk to Mark and we can get some links back to some of that other data, that would be great.

DR TAYLOR (AIPCA): Okay, yes.

MR WOODS: Thank you. That was very helpful.

MS MACRI: Yes, very. You might give my regards to Rhonda.

MR WOODS: That concludes the scheduled participants. Is there anyone else who wants to make an unscheduled contribution? That being the case, today this does conclude the Melbourne hearings for this inquiry and we will resume in Hobart. Thank you.

AT 4.54 PM THE INQUIRY WAS ADJOURNED UNTIL
THURSDAY, 24 MARCH 2011